THE CHALLENGES OF REPLICATING

DRUG CONSUMPTION ROOM POLICY IN

AUSTRALIA AND CANADA

A Comparative Exploration of Policy Transfer

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Table of contents

List of Tables

List of Figures

Acknowledgements

Abstract

The development of government policy to respond to the use and impact of illicit drugs is marked by controversy and the contestation of ideas. The aim of this thesis is to understand why some policy ideas succeed and others fail by exploring the challenges of replicating drug consumption room policy. Drug consumption rooms are government-sanctioned facilities that allow drug users to legally consume illicit substances under supervision to reduce the harms associated with drug use. Formal evaluations attested to their success as public health interventions, yet the body of evidence supporting their effectiveness has not resulted in the interventions becoming mainstream policy. The focus of this thesis is the challenges and barriers to the replication of policy both nationally and sub-nationally in Australia and Canada. The research applies a multiple case study methodology which combines documentary analysis and thematic analysis of semi-structured interviews with key informants, focused on four cities in the two countries.

Through the theoretical lens of policy transfer, this thesis identifies the different sources of policy change which have constrained or facilitated the replication of policy. Comparative analysis undertaken of successful and failed policy diffusion in the case study sites demonstrates the interactions between the structures of the state, ideas and agents. The thesis finds there is a tendency towards conservatism within institutional structures which constrains policy learning. The dominant ideology of drug prohibition and other ideational factors such as stigma serve to inhibit change. Crisis and civil disobedience are the two factors found to be significant where change has occurred. The actions of civil society challenge institutional power from the bottom up; a factor inadequately captured by the policy transfer framework with its focus on top down change. Following an appraisal of the framework, a modification is suggested to include civil society as a fifth source of policy change.

List of acronyms

ACF	Advocacy Coalition Framework
ALP	Australian Labor Party
BC	British Columbia
CBD	Central business district
CDSA	*Controlled Drugs and Substances Act 1996*
COPE	Committee of Progressive Electors
DCR	Drug consumption room
DPEC	Drug Policy Expert Committee
DTES	Downtown Eastside
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EPB	Evidence-based policy
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
HRAS	Harm Reduction Action Society
IDU	Injecting drug user
INCB	International Narcotics Control Board
MSIC	Medically Supervised Injecting Facility
MSIR	Medically Supervised Injecting Room
NADS	National Anti-Drugs Strategy
NDS	National Drug Strategy
NPA	Non-Partisan Association
NRCH	North Richmond Community Health
NSP	Needle syringe programme
NSW	New South Wales
OPS	Overdose prevention site
PHS	Portland Hotel Society
RCMP	Royal Canadian Mounted Police
RTC	Randomised controlled trial
SCC	Supreme Court of Canada
SCS	Supervised consumption site
SIF	Supervised injecting facility

TOSCA	Toronto and Ottawa Substance Consumption Assessment Study
UKDCP	UK Drug Policy Commission
UNGASS	United Nations General Assembly special session on drugs
VANDU	Vancouver Area Network of Drug Users

Chapter one
Introduction

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1.1 Introduction

> "At first people refuse to believe that a strange new thing can be done, then they begin to hope it can be done, then they see it can be done – then it is done and all the world wonders why it was not done centuries ago." (Hodgson Burnett, 2012 p.281)

For some 'strange new things', acceptance comes via the linear pathway described above as an idea, at first rejected, gains support and then is normalised through demonstration of its effectiveness. This thesis is concerned with ideas, evidence and normalisation in the sphere of public policy, and specifically, policy governing illicit drugs. It is concerned primarily with understanding how to account for ideas that travel on non-linear pathways: ideas that can be demonstrated as being ostensibly successful but fail to gain acceptance, where policy stalls rather than flourishes. Frances Hodgson Burnett's epigraph speaks to a world of rationality that proponents of evidence-based policy would recognise. But what happens when evidence is not persuasive? What contexts, what structures, what agents can account for whether an idea triumphs or fails? To explore these concerns, this research focuses on the contested policy of drug consumption rooms: a public health intervention where, in a specific physical space, the state sanctions the otherwise illegal activity of illicit drug consumption in the interests of reducing harms. Specifically, the research seeks to understand why replicating drug consumption room policy has proved so challenging in Australia and Canada.

In 2001 the first supervised injecting facility outside of Europe opened in Australia on a trial basis. The Medically Supervised Injecting Centre (MSIC) in Kings Cross, Sydney, is a government sanctioned and funded service that provides a safe, clean environment where injecting drug users can consume illicit drugs under medical supervision. By 2016, one million visits had been made to the service and over 6000 overdoses had been managed. Despite the risk posed by drug overdose, no one has ever died at the facility (Uniting Church, 2018; personal communication, A. Salmon, Research Manager, MSIC, 29 January 2018). A statutory

review in the same year recommended ongoing support for the service on the grounds that there was continuing need and the facility was exceeding its targets (NSW Government, 2016).

In 2003, the city of Vancouver in Canada followed suit with the establishment of Insite, a stand-alone supervised injecting facility in the Downtown Eastside offering 12 injecting booths and onsite medically trained staff. Insite was sponsored by the Vancouver City Council and received the approval of both the federal government which ensured its legal status, and the provincial government which provided C$3.2 million for its initial capital and operational costs (Read, 2003). As a three-year pilot project, Insite was externally evaluated, and over thirty studies were published in its first five years of operation (Harati, 2015).

Today, MSIC and Insite continue to operate in their initial sites, demonstrating the technical and legal feasibility of such services in their current settings. They have both been subject to extensive evaluation and research which, as will be discussed below, has found the services to be effective. This is consistent with the international literature on drug consumption rooms. For example, an international review conducted by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) concluded:

> "Taken in sum, the available evidence does not support the main concerns raised about this kind of intervention and points to generally positive impacts in terms of increasing drug users' access to health and social care, and reducing public drug use and associated nuisance." (Hedrich et al., 2010 p.305)

The combination of the evidence of effectiveness and the significant public investment might lead to an expectation that these two facilities would serve as exemplars in their respective countries, resulting in a scaling up of such interventions where commensurate need was established. This did not occur in Australia; in Canada, where scaling up has very recently occurred, it was only after a significant hiatus where the policy remained stalled. The initial concern of this thesis was to understand the challenges and barriers to the replication of drug consumption room policy. Developments in Canada during the course of the research have

broadened the scope of the thesis, providing an opportunity to identify not just the challenges and barriers, but those factors that have facilitated policy diffusion.

Drug policy and the contested role of evidence

Drug policy is an intersectoral government undertaking engaging a number of portfolios concerned with justice, law enforcement, health and education. This thesis focuses on drug policy that relates to the health outcomes associated with illicit drug use. It recognises however that these policies are not developed in isolation and are strongly influenced by the broader policy environment; in particular, the dominant prohibitionist architecture that divides the world of psychoactive substances into the licit and the illicit. Enforcement of these laws takes the lion's share of public spending on drug policy, estimated at 64 per cent of government drug policy expenditure in Australia and 70 per cent of federal government spending in Canada (Ritter et al., 2013; Office of the Auditor General of Canada, 2001). The remaining funding is directed towards prevention, treatment and harm reduction. This is a contested policy domain where debate is subject to visceral reactions. The UK Drug Policy Commission (UKDPC), an independent body, spent six years examining the evidence associated with the development of drug policy in the UK, only to conclude "there is little political space for informed debate about policy options" (UKDPC, 2012 p.134). This concern with the lack of objectivity in policy making has led to strong arguments for the development of a better evidence base to inform drug policy.

The evidence-based policy (EBP) paradigm emerged in the 1990s, initially in the UK before being more widely adopted. With its origins in evidence-based medicine, EPB represents an attempt to make more effective use of research in social policy. In the UK, Solesbury (2001) argues, the turn to EPB was deliberately anti-ideological, calling for new ideas and new ways of doing things, rather than a reliance on past practice that was embedded in political preference not pragmatism. Science was presented as the antidote to the politicisation of

policies developed to respond to complex social problems. Research and evidence, it was intended, would work not only to guide new approaches, but also to provide the means by which interventions would be evaluated to establish their validity and effectiveness, and consequently, their replicability.

The harm reduction movement, approaching drug use and its consequences from a public health perspective, has embraced evidence as a fundamental element of drug policy (Rhodes and Hedrich, 2010). The close links between the public health and drug policy communities were forged as the emerging threat of HIV drew attention to the critical role that injecting drug users could play in combating the epidemic. As a result, the practices of public health, with its focus on predominantly quantitative research and 'gold standard' evidence, have been readily adopted by the alcohol and other drugs field (Olsen et al., 2015). The call for evidence has also become a part of the political rhetoric of the harm reduction movement. This was demonstrated by the Vienna Declaration of 2010, a statement urging drug law reform on the grounds of the gap between evidence and public policy, released to coincide with the 18th International AIDS conference (Wood et al., 2010).

As will be discussed in Chapter Two, multiple problems have beset EBP, including the inability to form a consensus as to what constitutes evidence. Moreover, the methodologies that have driven evidence-based medicine do not lend themselves to the more complex array of social issues that require public policy responses. As Smith (2013) demonstrates, even in areas such as public health where there is a degree of consensus as to its aims and approaches, studies are not finding that policies *are* evidence-based. Drug policies, when subjected to the same scrutiny, also fall short, with empirical evidence demonstrating the gap between policy and a scientific evidence base (Nutt et al., 2007; Stevens, 2007; Bennett and Holloway, 2010). Of equal concern is the challenging assumption, underpinning EBP, that policy making can or should be 'free' of politics, values and beliefs (Nutley et al., 2007).

In response to the problems that have beset evidence-based policy approaches, a critical stream of drug policy scholarship has emerged that focuses on the policy making process itself in order to understand change. These post-evidence-based approaches are concerned with exploring the roles of multiple stakeholders, politics, ideas and narratives based on ideational and social constructionist approaches to researching policy making (Gstrein, 2018). If we accept that evidence is a contested and problematic concept (Lancaster, 2014), it becomes critical to further our understanding of how ideas and knowledge have impacts on drug policy making. Why might 'good' ideas fail to be diffused or effective interventions fail to be scaled up? This thesis contends that by focusing on the issue through a policy transfer lens, new light can be shed on policy replication and policy learning. The argument presented to support this choice of theoretical framework is its capacity to appreciate not only the ideational elements of policy making, but the structures or contexts in which that deliberative process occurs. Policy transfer, in short, offers a heuristic that encompasses multiple sources of policy change, including multiple levels of governance and multiple agents operating and interacting within this environment. Through case studies and the insights provided from interviews with key stakeholders engaged in the policy making process in both Australia and Canada, this thesis contributes to our understanding of the challenges, barriers and facilitating factors that impact the diffusion of policy in a contested domain.

1.2 Research aims and objectives

The aim of this thesis is to understand why the replication or diffusion of drug consumption room policy has been problematic in Australia and Canada. The research seeks to identify factors that have either constrained or facilitated policy transfer at both the national and sub-national levels, in order to increase our understanding of the challenges of achieving policy change in relation to how we respond to illicit drugs and their social consequences.

The adoption of a policy transfer lens will enrich our understanding of the policy making process through its accommodation of the interaction of both structural and agency factors. Policy transfer theory also encompasses the exploration of ideational factors in order to understand the impact of ideas and knowledge in the process of policy development. This is an important area to address, given the challenges inherent in understanding the role of evidence in public debate and deliberation, as reflected in the divergent approaches to this issue in the literature. Through the construction of case studies and comparative analysis of empirical findings from field work in the case study sites, this thesis will make both empirical and theoretical contributions to drug policy literature. The opioid overdose crisis currently underway in Canada demonstrates the need for informed and innovative solutions in a dynamic environment. The findings of this thesis, and its reflections on the policy change process over a two-decade period, aim to contribute to our capacity to debate, develop and realise better policy in response to illicit drug use. Table 1.1 presents the specific objectives that the research will fulfil in order to achieve these aims.

Table 1.1 Research objectives and key research questions

Objectives	Key research questions
1. To critically review i) the literature on the use of evidence in drug policy, and ii) the literature on ideational and social constructionist approaches to drug policy	How has evidence been contested in drug policy scholarship? How have ideational and social constructionist approaches been applied to drug policy problems? How have they been used to understand policy change and the use of evidence in policy making? What gaps exist in the literature?
2. To develop a conceptual framework to analyse the challenges of replicating drug consumption room policy	How can the policy transfer framework contribute to our understanding of the challenges of policy replication?
3. To identify factors which constrain and facilitate the replication of policy in the case of drug consumption rooms, with a focus on four case studies in Australia and Canada	What factors can be identified which constrain or facilitate the transfer of policy? Which sources of policy change are significant in the policy making process?
4. To further interrogate those factors through the thematic analysis of stakeholder interview data	Why is the policy contested? How are debates on DCRs framed? How is evidence used in the policy making process?

5.	To test out the policy transfer framework	Is the policy transfer framework an appropriate heuristic for improving our understanding of drug policy making? Are there factors that sit outside the framework that are significant? Can any modifications to the framework be suggested?
6.	To draw conclusions about the factors affecting the diffusion of policy and the scaling up of drug consumption rooms	What structural and agency factors have affected policy development in this domain? What conclusions can we draw about the impact of ideas on the policy making process?

1.3 Drug consumption rooms: background and literature

This section has two aims. The first is to contextualise the thesis by introducing drug consumption rooms and the harm reduction philosophy under which they operate. The second is to provide an overview of the approaches that have been taken to understanding DCRs. This review of the literature demonstrates the limited extent to which the issue of replication of DCR policy has been explored, justifying the thesis' focus on the policy making process to address this knowledge gap about the stalled diffusion of policy in Australia and Canada.

1.3.1 Drug consumption rooms in context

Drug use is pervasive in human societies. For complex historical and political reasons, drugs have broadly been divided into two categories: those which are legal to use but regulated, and those which are prohibited and therefore illegal to use (Berridge, 2013). The global scale of illicit drug use is vast. The United Nations Office of Drugs and Crime estimates 275 million people, or 5.6 per cent of the population aged between 15 and 64 years, used an illicit drug in 2016. Not all drug use is problematic, but according to the same report, some 31 million people would be considered problem drug users, who were drug dependent or suffering from drug use disorders. It is estimated 11 million people injected drugs in 2016, and over 12 per cent of those people are thought to be living with HIV. The annual number of deaths that

can be directly attributed to drugs is increasing, up 60 per cent to 168,000 in 2015 compared to 105,000 deaths in 2000 (United Nations Office of Drugs and Crime, 2018). The opioid overdose crisis in North America will see global figures climb higher, with the United States alone recording 70,237 drug overdose deaths in 2017 (Centers for Disease Control and Prevention, 2019).

As these figures demonstrate, the prohibition of drugs has not resulted in their decline or eradication despite a massive effort, led by the United States, to achieve this goal under the so-called 'war on drugs'. A European Commission study into global illicit drug markets concluded that during the decade from 1998 to 2007, there was no evidence that the global drug problem had been reduced despite the dominance of prohibitionist policies. It found instead substantial unintended harms that could be attributed to the enforcement of drug prohibition (Reuter and Trautmann, 2009). This finding is shared by the United Nations Office on Drugs and Crime's evaluation of a century of international drug control efforts (1909-2009), which acknowledges the violent consequences of the illicit drug industry (United Nations Office of Drugs and Crime, 2009).

The emergence of the HIV virus provided the impetus for the development of more diversified approaches to drug issues over recent decades. Injecting drug use is a major mode of transmission for HIV and other blood-borne viruses, and explosive epidemics among injecting drug users have occurred in diverse countries including the United States, Scotland, China and Kazakhstan (Ball, 2007). Harm reduction was first explicitly adopted in a national drug strategy in Australia in the mid-1980s. Other countries in both the developed and the developing world followed in the next two decades, often in the context of national HIV strategies or health sector plans (Ball, 2007). According to the International Harm Reduction Association, 97 countries and territories have adopted harm reduction approaches (Stoicescu, 2012 p.13). Rhodes and Hedrich (2010) define harm reduction as "…interventions,

programmes and policies that seek to reduce the health, social and economic harms of drug use to individuals, communities and societies" (p.19). Such policies include the adoption of measures such as needle syringe programmes (NSPs), opioid substitution therapy and 'low threshold' services, being those that provide support to drug users without requiring abstinence from drug use in order to receive services.

Drug consumption rooms are an example of a harm reduction intervention, seeking to tackle both the private harms that affect people who use drugs, such as the risks of overdose and the transmission of blood borne virus, and the public harms that accrue through public injecting and street-based drug scenes, such as public nuisance and the littering of drug paraphernalia (Hunt and Lloyd, 2008). Drug consumption rooms are also known as supervised injecting facilities or supervised consumption sites (SCSs). The term drug consumption room is generally used in this thesis as it encompasses different forms of consumption, including injecting, smoking, inhaling and snorting. Supervised injecting facility is used where it is important to delineate those centres which are only sanctioned to supervised injecting drug use and not other forms. The first official drug consumption room opened in Berne, Switzerland in 1986 (Hedrich, 2004). The number of countries now offering official drug consumption services stands at ten. Table 1.2 shows the distribution and number of DCRs operating in 2018. Planning is underway to open DCRs in three further countries: Ireland, Portugal and Belgium (EMCDDA, 2018).

Table 1.2 Countries with official drug consumption rooms, 2018

Country	Number of DCRs
Australia	2
Canada (includes approved sites where opening is pending)	28
Denmark	5
France	2
Germany	24
Luxembourg	1
The Netherlands	31
Norway	2
Spain	13
Switzerland	12
TOTAL	**120**

Sources: EMCDDA, 2018; Health Canada, 2019.

Drug consumption rooms are targeted interventions with two primary aims: to reduce public and high-risk drug use, and to improve public amenity where it has been affected by street-based drug markets (Hedrich et al., 2010). According to the EMCDDA, the target population of DCRs are:

> "those who inject in the streets, who are characterised by extreme vulnerability as a result of social exclusion, poor health and homelessness, and who often lack, in addition to health care, food, hygienic facilities for drug consumption and access to drug services." (Hedrich, 2004 p.9).

Four models of DCRs can be identified: i) stand-alone or specialised; ii) integrated, where the capacity to supervise drug consumption is incorporated into existing health facilities; iii) mobile; and, iv) overdose prevention sites (OPSs) where drug consumption takes place under observation but not necessarily medical supervision and may or may not have legal sanction (Hedrich, 2004; Wallace et al., 2019). Regulations differ, but it would be common for users to register with the centre and exclusions often apply, preventing access for anyone under 18 years of age, pregnant women and first-time injectors (Belackova et al., 2017). Facilities are supervised by staff trained in resuscitation, who can administer oxygen in the case of overdose, and, in some jurisdictions, naloxone, a drug which blocks or reverses the effects of opioids. Clean injecting equipment is provided, and whilst staff do not help with the injecting itself, they will provide education regarding safer drug consumption techniques (Kelly and

Conigrave, 2002). A range of additional services is generally available, including primary health care assistance, counselling, referral to drug treatment and in some cases, housing.

Opponents of drug consumption rooms have composed values-based arguments, as well as critiques of the aims and effectiveness of DCRs. Such services are seen to 'send the wrong message' and condone drug use. Concerns have also been raised they will attract drug users to the area where they are established and therefore increase drug dealing and drug-related crime in the locality. DCRs, it has been argued, maintain addiction and therefore divert people from drug treatment (Elliot et al., 2002; Kimber et al., 2003; Hall and Kimber, 2005; Hedrich et al., 2010). Through the formal evaluations of both MSIC in Sydney and Insite in Vancouver, and through other studies, these questions have been subject to rigorous scrutiny as discussed below.

1.3.2 An overview of drug consumption room literature

Evidence of effectiveness

Drug consumption rooms have been in operation for over thirty years and have been subject to considerable quantitative and qualitative research. While earlier European facilities did not consistently apply rigorous evaluation methods, the establishment of the pilot interventions in Sydney and Vancouver in the early 2000s added substantially to the evidence base concerning the effectiveness of DCRs. Belackova and Salmon's (2017) overview of the international DCR literature identifies 75 studies addressing aspects of effectiveness. Studies have focused on three broad areas: the feasibility of DCRs, including their ability to reach target populations; the impact on health, including risk behaviours, overdose and transmission of blood borne viruses; and the impact on communities, including public order and crime outcomes (Hedrich et al., 2010; Hunt and Lloyd, 2008). A number of reviews of the evidence have been undertaken to appraise international findings (Kimber et al., 2003; Hedrich, 2004; Kerr et al., 2007; Hedrich et al., 2010; Potier et al., 2014). In addition to this

scientific literature, there are reports which assess the evidence base with a view to making recommendations as to the appropriateness of services for specific jurisdictions (Parliament of New South Wales, 1998; Drug Expert Policy Committee, 2000; Independent Working Group, 2006; The Coroners Court of Victoria, 2017; Parliament of Victoria, 2017).

Potier et al.'s (2014) systematic review of findings considers evidence related to both the benefits and harms of DCRs. Seventy-five studies met the inclusion criteria for this review, 85 per cent of which concerned Vancouver and Sydney. The exclusion of non-English studies suggests a bias towards these sites. An earlier review by Hedrich (2004) was inclusive of non-English studies. Potier et al. are unequivocal in their conclusions on the question of DCR effectiveness:

> "All studies converged to find that SISs [supervised injecting services] were efficacious in attracting the most marginalised PWID [people who inject drugs], promoting safer injecting conditions, enhancing access to primary health care, and reducing overdose frequency. SISs were not found to increase drug injecting, drug trafficking or crime in the surrounding environments. SISs were found to be associated with reduced levels of public drug injections and dropped syringes." (Potier et al., 2014 p.48)

This conclusion is also supported by Belackova and Salmon's (2017) more recent review of the international literature. In addition, their report notes that DCRs can be associated with increasing access to treatment, preventing blood borne viruses and yielding cost savings in relation to averted HIV and Hepatitis C infections.

While the literature points to a convergence around findings of effectiveness, there are some important limitations that need to be acknowledged. It is not possible, due to ethical issues and the question of equipoise, to conduct a randomised controlled trial (RTC) to measure the efficacy of DCRs – RTCs being considered the 'gold standard' in the hierarchy of evidence (Maher and Salmon, 2007). Observational study designs have, however, been adopted (Kerr et al., 2005). As Maher and Salmon (2007) argue, given the limitations in relation to research design, it is necessary to have realistic expectations about what evidence is able to be produced and what can be concluded from it. A major limitation, for example, is that people

who use drugs may only use the facilities irregularly, making it difficult to distinguish the impact of the DCR from other interventions or factors (Fischer et al., 2002; Kelly and Conigrave, 2002). This is a particularly difficult factor in attempting to assess the impact of SIFs on the transmission of blood borne viruses and is compounded by the lack of coverage of SIFs (for example in Sydney, where there is only one), raising questions as to the expectation that DCRs can have a population-level impact (Hall and Kimber, 2005). These methodological issues, in casting doubt about the certainty with which claims of effectiveness can be made, illustrate the contested nature of evidence in this complex area.

Feasibility of DCRs

In addition to research focused on effectiveness and impact, studies have explored different aspects of the feasibility of drug consumption rooms. Legal and regulatory issues have been at the forefront of concerns, due to the challenge posed by the criminalisation of drugs and drug use. Given the specificity of local legal requirements, studies in this area have generally been country-based, although international law is relevant because of the drug control treaties administered by the International Narcotics Control Board (Williams, 2016; Burris et al., 2009; Fortson, 2006; Malkin et al., 2003; Elliot et al., 2002; Malkin, 2001). In general, this literature is concerned with legal issues that relate to establishing drug consumption rooms. As this thesis is primarily concerned with replication rather than establishment, its concerns fall outside the scope of this literature, the exception being the legal challenges that were mounted against the service in Vancouver, which are addressed in detail in Chapter Six.

Other studies of feasibility have considered the potential of DCRs in specific sites. This has included assessments of need and viability in particular locations; for example, Melbourne (Dwyer et al., 2016); Toronto (Jozaghi and Reid, 2015); Semaan et al's (2011) assessment of the potential of SIFs to reduce BBV transmission and overdose mortality in the United States; and Lloyd and Hunt's (2007) commentary on the potential to pilot drug consumption rooms

in the United Kingdom. Another important aspect of feasibility has been assessments of the attitudes of injecting drug users to the introduction of services (O'Shea, 2007; Kerr et al., 2003; Fry, 2002; Fry et al., 1999) and to other stakeholders such as police (Watson et al., 2012), local community (Strike et al., 2015; Strike et al., 2016), and policy makers (O'Shea, 2007).

Policy development

The process by which drug consumption rooms have come to be established or, in some cases, have failed to be established, has garnered the interest of researchers. Such research seeks to understand the factors beyond evidence that have influenced the policy process, such as the roles of public opinion, public discourse and stakeholders (Jauffret-Roustide and Cailbault, 2018; Hallam, 2006; Small et al., 2006; Gunaratnam, 2005; Mendes, 2002). Policy change itself, through the lens of multiple streams analysis, is the subject of Houborg and Frank's (2014) study of the factors that led to the establishment of Denmark's drug consumption facilities. A relatively small body of comparative work is also emerging that compares the experience of developing, or attempting to develop, DCR policy. This includes Skretting's (2006) consideration of the different approaches taken in the Nordic countries; Zampini's comparative study of governance and government in England and Australia; Hayle's (2015) study of Canada, England and Wales; and most recently, Lloyd et al.'s (2017) research comparing responses to drug consumption rooms in the UK and Germany. The latter study identifies four key points of difference between the experience of the two countries: the impact of the level of focus on the issue (national versus local); the nature of the problem; the role of 'direct action'; and, the presence of stigma in media reporting. In addition to comparative studies at the national level, just three studies have been identified that undertake comparative analysis at the sub-national level: Gunaratnam's (2005) comparison of the policy debate on supervised injecting in three jurisdictions in Australia; Fitzgerald's

(2013) study focusing on the role of policy narratives in two Australian cities; and Hayle's

(2017) comparison of the policy making process in Vancouver and Toronto, utilising Lenton's

policy change framework.

The issue of greatest pertinence to this study, the question of replication of policy, has seen

little engagement by scholars. There have been commentaries calling for the scaling up of

initiatives, but these have been argued largely from within the evidence-based paradigm, for

example, Kerr et al.'s commentary in *The Lancet*, calling for the global scaling up of supervised

injecting facilities, in which they argue:

> "Ongoing harms among injection drug users, such as HIV infection warrant innovative
> and swift action that is based on the best available scientific evidence. More than 25
> years of experience with supervised injection facilities has shown that the time for the
> global scale-up of these programmes has come. Such scale-up, however, can only
> occur if political leaders are willing to take the courageous step of putting scientific
> evidence and public-health interests ahead of ideology." (Kerr et al., 2008 p.355)

Questions around scaling up services have been largely focused on Canada. Commentaries

and articles have focused on questions of cost effectiveness, as well as general effectiveness

(Kerr et al., 2017; Enns et al., 2016; Jozaghi et al., 2013; Andresen and Jozaghi, 2012). Further,

Jozaghi and Andresen's (2013) qualitative study into the impact of Insite on injecting drug

users' lives calls for scaling up based on the transformative role their study demonstrated.

Hyshka et al.'s (2013) policy case study contributes useful insights into the prospects of

scaling up of DCRs in Canada in light of the Supreme Court of Canada's 2010 ruling on the

constitutionality of supervised injecting. While identifying barriers and facilitating factors

that might contribute to scaling it, it does not, however, analyse these through a theoretical

lens. No studies addressing the issue of scaling up in Australia were identified and no

comparative studies on the issue have been uncovered. On the different, but related issue of

policy replication and policy transfer, a striking lacuna exists in the drug consumption room

literature. McCann and Temenos' (2015) study, reviewed in detail in Chapter Three, stands

out for its direct application of concepts from the policy mobility literature as it traces the

mobilisation of the DCR model from Europe to Australia and Canada, and the policy learning that occurred in that process.

This overview of the scholarly literature demonstrates the dominance of the focus on building the evidence base to address questions of the feasibility and effectiveness of this innovative public health intervention. The controversy that has accompanied policy debates, and the stalling of the scaling up of services, warrant further attention. The limitations of the existing literature addressing the issue as one of policy change have been presented above, providing an opportunity for this thesis to make an original contribution on the subject. This contribution will be situated within the broader drug policy literature which is the subject of the review presented in Chapter Two.

1.4 Outline of the thesis

This chapter has introduced what has been problematic about the stalled diffusion of policy in relation to drug consumption rooms in Australia and Canada, and outlined the objectives and rationale for this research. It has examined the existing literature exploring drug consumption rooms, and highlighted the strong focus on the generation of evidence of effectiveness. The focus of this research is to address gaps in relation to the policy making process and, in doing so, to provide a conceptual and theoretical basis for identifying barriers, challenges and facilitating factors that impact on the policy transfer process.

Chapter Two situates the research by undertaking a broad review of drug policy literature. It establishes the relationship between drug policy scholarship and evidence-based policy, analysing the literature that has focused on improving the use of evidence, including understanding the barriers to the uptake and utilisation of evidence in drug policy making. The main body of the chapter, however, is focused on the alternative accounts that have arisen as a challenge to the dominance of the evidence-based policy paradigm. This literature rejects the privileging of evidence as the main driver of policy, and recognises multiple

influences including ideas and knowledge; political and non-political agents; networks; narratives; and problem construction. The chapter presents the findings of a scoping review of ideational and social constructionist approaches to understanding policy change and development in the field of drug policy. This review identifies several gaps in an otherwise rich field of literature, including an absence of theorising on replication and the scaling up of interventions; the limited application of comparative methodologies; and insufficient consideration of the impact of national policy on local jurisdictions and sub-national policy transfer.

Chapter Three sets out the theoretical orientation of this thesis. Building on the findings of the literature review, a case is made for the adoption of concepts from the policy transfer literature to explore the issues affecting the stalling and diffusion of policy in the chosen case studies. Following an exploration of the debates within the policy transfer and policy mobilities literature, and their application to drug policy, arguments are presented as to the merits of adopting a policy transfer framework to address the research question concerning the replication of policy. These arguments include the capacity to appreciate the influence of multiple levels of government; to accommodate comparative analysis; and to consider the roles of policy transfer networks and policy-oriented learning. It is contended that the policy transfer framework provides a robust lens through which to analyse sources of policy change and stall at multiple levels, consistent with a critical realist ontology that acknowledges the dialectic relationship between structure and agency. Critically, this theoretical orientation accommodates both ideational and constructionist concepts.

The purpose of **Chapter Four** is to lay out the ontological foundations of the research and to describe the methodological approach and the research design. The chosen theoretical framework for the thesis is underpinned by a critical realist ontology. Critical realism accommodates a dialectical understanding of the interaction between structure and agency,

supporting a central tenet of the policy transfer framework with its focus on multi-level and multiple agent analysis. These issues are explored alongside a discussion of the relationship between material and ideational structures. In this worldview, ideas are attributed with causal power that exists independently of material interests: a concept that is at the heart of understanding the role ideas play in achieving policy change in a contested policy domain. The research design of this thesis combines a multiple case study methodology with thematic analysis to address the research question. Case studies are developed from extensive documentary analysis and interview material. Thirty semi-structured interviews conducted at the four case study sites in Australia and Canada provided the data for undertaking thematic analysis to identify patterns of meaning that shed light on the research concern of policy replication.

Having established the theoretical and methodological foundations of the research, three empirical chapters then follow. **Chapters Five** and **Six** present four case studies that explore the policy making process in the Australian cities of Sydney and Melbourne, and the Canadian cities of Vancouver and Toronto. Spanning a period of two decades from the late 1990s, the case studies provide an account of how the idea of drug consumption rooms came to be on the policy agenda, and the success or failure of that idea in the policy process over time. These case studies explore the political and policy contexts in which supervised injecting was debated and deliberated, seeking to understand the impact of different sources of policy change. In addition to focusing on formal policy settings and processes, consideration is given to the impact of civil disobedience in each case. Comparative analysis is undertaken to distinguish general and specific features of the cases. Instances of both policy stall and policy diffusion are in evidence, providing the foundations for analysis of the key factors which constrain and facilitate policy replication in a contested policy domain.

Chapter Seven presents findings from thematic analysis undertaken of interview data gathered from key stakeholders who have been engaged in the policy making process in the four case study sites. Relevant views on a range of challenges and opportunities for policy reform were collected through semi-structured interviews with informants, including former politicians, policy makers, researchers, law enforcement officers, advocates and practitioners. The analytical strategy involved a round of open coding, followed by two rounds to review and consolidate the themes. Six themes are presented in this chapter, addressing issues including: problem definition and the role of crisis; the effect of interactions between different levels of government; policy conflict; politics and political leadership; controversy, stigma and discrimination; and the role of evidence. This analysis provides significant insights into the policy making process, complementing the earlier case study findings.

Chapter Eight returns to the theoretical concern of the thesis in order to understand what factors have been significant in constraining or facilitating policy transfer and, therefore, replication. Evans' (2004) policy transfer framework identifies four sources of policy change. The chapter begins by mapping the empirical findings to this framework and assessing the significance of each component. The results of this analysis demonstrate the relative weakness of international sources of policy change when compared to the strong impact of state-centred sources and policy-oriented learning. The role played by civil disobedience in catalysing change is considered through this theoretical lens. It is demonstrated that the actions of communities challenged institutional power from the bottom up. It is then argued the policy transfer framework's top-down orientation limits its ability to capture this significant source of policy change. A modification to the policy transfer framework is therefore proposed whereby a fifth source of policy change – civil society – is added to improve the heuristic.

Chapter Nine concludes the thesis by summarising its main findings and discussing its empirical and theoretical contributions. Two scenarios are compared, one of policy stall and one of policy diffusion, in order to demonstrate how structural, ideational and agency factors have combined to affect policy development and policy learning. Reflections on the contributions of the thesis are presented, including a discussion of how this research relates to the current body of drug policy literature exploring policy change through both ideational and social constructionist approaches. Limitations of the research are considered before future research directions are proposed. These focus on ideational, governance and participatory issues, and include a recommendation for further research that tests the utility of the proposed modification to the policy transfer framework beyond the drug policy field.

Chapter two
A review of the literature
● ●

2.1 Introduction

> "Once again, Australia is experiencing rapidly increasing drug overdose deaths. Why when the need for MSICs is so great and the evidence is so compelling has it had to be such an uphill battle to establish a network of such centres in drug hotspots across the country?" (Wodak, 2018)

Alex Wodak, a long-time champion of drug law reform in Australia, is not alone in expressing frustration at the barriers to the adoption of drug consumption rooms in the face of the evidence of their effectiveness. It is a frustration felt across a range of drug policy issues, in a myriad of countries, and has led to calls, at the highest levels of national governments and international organisations, to look to evidence to formulate better and more effective policy in relation to illicit drugs (Wood et al., 2010; Editorial, 2016). The rise of evidence-based policy in the 1990s dovetailed with the growth of the harm reduction movement, which advocated for public health approaches to drug use issues, spurred on in part by the intersection of concerns about rising HIV risk among injecting drug users. The arguments for harm reduction are often formulated in the language of public health and reflect public health's affinity with evidence-based policy approaches (Steward and Smith, 2015; Lancaster, 2014). Despite an oft-cited commitment to the use of evidence in policy making, examination of policies and how they were derived shows evidence-based policy has been difficult to actualise. In Ray Pawson's words, "Evidence-based policy is much like all trysts, in which hope springs eternal and often outweighs expectancy, and for which the future is uncertain as we wait to know whether the partnership will flower or pass as an infatuation" (Pawson, 2006 p.1).

In this chapter, I explore the literature in relation to evidence, drug policy and policy change with the objective of establishing the basis for the theoretical orientation of the thesis. Broadly, there are two main strands of drug policy scholarship which have attended to the question of evidence-based policy and the use of evidence in the development of drug policy. Section 2.2 introduces the literature which is concerned with achieving evidence-based

policy or improving the use of evidence in drug policy. It explores scholarship that seeks to establish an evidence-base for drug policy as well as research that exposes the ineffectiveness of many current policy approaches in order to argue for reform. Other relevant literature in this area has focused on addressing barriers to the uptake and utilisation of evidence to inform policy.

The shortcomings of EBP have given rise to alternative accounts of drug policy development based on ideational and social constructionist approaches that challenge the orthodoxy of drug policy as an evidence-based policy endeavour. Section 2.3 presents the findings of a scoping review, capturing and summarising the breadth of scholarship in this field. This review, developed as part of this doctoral project, has appeared in the *International Journal of Drug Policy* and is largely reproduced here (Gstrein, 2018). The discussion in Section 2.4 focuses on the unresolved issues that arise from the review and identifies specific gaps in the literature. Consideration is then given to the linkages between the findings of the review and the research concerns of the thesis, in order to provide a rationale for the adoption of the theoretical stance introduced in Chapter Three.

2.2 Evidence-based policy and drug policy scholarship

This section provides a foregrounding to the scoping review presented in Section 2.3. The first part examines the normative agenda promoted through research focused on establishing both evidence of effectiveness and evidence of ineffectiveness as a means of arguing for reform to prohibitionist and other drug policies. It also looks at arguments that are mounted in support of evidence as a path to rational policy development in a contested area. The second part of this section introduces the literature that has recognised the shortcomings of achieving evidence-based policy, and has pursued an agenda of understanding the barriers to EBP and improving the use of evidence in the drug policy field.

2.2.1 Evidence-based drug policy: a normative agenda

Harm reduction-oriented drug policies gained ascendency in many jurisdictions as a direct result of the need to address the challenges posed by the HIV pandemic and the increased risk of HIV transmission for people who inject drugs. Many of the policies promoted to reduce the spread of HIV support interventions were devised as mainstream public health approaches and therefore fit comfortably in an evidence-based policy paradigm (valentine, 2009). Concurrently, there has been a strong research base that has scrutinised the effectiveness of interventions and policies in the area of illicit drugs, disseminating the findings of the research as a normative agenda promoting 'better practice' and arguing for policy reform in relation to drug use (Ball et al., 2005; Ball, 2007; Rhodes and Hedrich, 2010; Strang et al., 2012). In this field, there has been a marked focus on quantitative research, compounding an association of 'evidence' with quantitative data. A 2015 review commissioned by the *Drug and Alcohol Review* found that qualitative research makes up a minority of outputs across drug and alcohol journals. Of the journal's own papers published in 2014, only five out of 138 were qualitative research papers, representing four per cent of outputs – an issue the journal has been keen to address (Olsen et al., 2015 p.474).

Much of the research has been technical in nature, with outputs collated and disseminated by organisations such as the World Health Organisation and UNAIDS through instruments like the 'Evidence in Action' series (2008) and the Centre for Harm Reduction's *Manual for reducing drug related harm in Asia* (Costigan et al., 2003). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has also been heavily engaged in research, collating a database of evidence and producing policy and practice briefings. Rhodes and Hedrich's (2010) important volume on the evidence, impacts and challenges of harm reduction was published by the EMCDDA and is an example of the literature in this field promoting the evidence base for new approaches to drug policy. Researchers have continued to be at the forefront of vocal and, ironically perhaps, highly political calls to apply evidence-based

approaches to challenge existing drug policy regimes internationally through actions such as the Vienna Declaration, the establishment of the Johns Hopkins-*Lancet* Commission on Drug Policy and Health, and engagement in the UN General Assembly Special Session on Drugs (UNGASS) in 2016 when global approaches to drug policy were debated (Wood et al., 2010; Editorial, 2016; Werb et al., 2016).

The other side of the 'evidence of effectiveness' coin is the 'evidence of ineffectiveness', arguments which are used to challenge prohibitionist drug policies. For example, an assessment of the state of illicit drug policy in Canada notes the discordance between evidence and policy in this area, with the majority of resources going to drug use prevention and drug law enforcement activities that have been proven to be ineffective, while strategies that have been assessed as being effective, such as needle syringe programmes, supervised injecting facilities and opioid substitution therapy, remain underfunded (Wood et al., 2012 p.e35). On the international stage, the Johns Hopkins-*Lancet* Commission on Drug Policy and Health has extensively examined the evidence in relation to the health impacts of drug policy based on prohibition (Csete et al., 2016). The conclusions of the Commission are that prohibitionist policies present a paradox, undermining the health status of the populations they are meant to be protecting. They argue that the evidence suggests prohibition has "contributed directly and indirectly to lethal violence, communicable-disease transmission, discrimination, forced displacement, unnecessary physical pain, and the undermining of people's right to health" (Csete et al., 2016 p.1429).

The third area for discussion in this section is the push for evidence-based policy as a remedy to the contested nature of drug policy. The use of evidence-based policy has been advocated as a means of 'de-politicising' drug policy by offering a 'rational' means by which to make decisions. Such work is exemplified by the attempt by Nutt et al. (2007) to develop a 'rational scale' to assess the harms associated with drugs. Nutt et al. argue that the classification

system used in the UK to divide drugs into categories of harm based on the purported danger they pose is not founded on scientific evidence, resulting in "ill-defined, opaque, and seemingly arbitrary" processes driving policy making in this area (Nutt et al., 2007 p. 1047). The authors instead propose a transparent methodology based on nine categories of harm which could be used to rank both currently legal and illicit drugs. The application of the assessment tool challenged the current classification system, producing, amongst other results, the outcome that alcohol, based on harms caused, could well sit with other class A drugs such as heroin and cocaine. As a 'licit' substance, it currently falls outside the UK *Misuse of Drugs Act 1971*, leading the authors to question why assessments of the dangers of drugs should be subject to prejudice and arbitrary decisions as to which drugs are deemed illicit and subject to control (Nutt et al., 2007).

Aligned with these concerns to provide a rational or scientific basis for policy decisions, are the arguments in support of evidence-based policy as a countermeasure to the prejudices and stereotypes that appear to underlie drug policy (MacGregor, 2011). The use of stigmatising language and the misconceptions regarding drugs and addiction that have accompanied public debate and media reporting have been well researched (Elliot and Chapman, 2000; Bright et al., 2013; MacGregor, 2013; Chalmers et al., 2016). That scientific evidence could, however, divorce policy development from the political processes which mediates such public discourse is highly problematic and predicated on evidence and politics being framed as opposing forces (Smith, 2013). Such ideas are discussed at more length in Section 2.3 below.

2.2.2 Closing the gap: better use of evidence

The section above introduces EBP's links to health-based drug policy. Looking beyond the normative stance – the desirability of evidence-based drug and public health policies – assessments generally conclude that there is little indication that policies are actually

evidence-based (Smith, 2013; Oliver et al., 2014). For example, Bennett and Holloway's (2010) study of UK drug policies focused specifically on the question of the extent to which they were evidence-based. They found that while policies made reference to what they determined was good quality evidence, issues remained with the interpretation and reporting of research used, and the authors specifically noted biases in the selection of research used to support policy decisions. Bennett and Holloway acknowledge that policy is the result of multiple influences, but express concern that claims are made in policy documents that they are evidence-based:

> "Managing the conflict inherent in promoting on the one hand an ordered ideal and describing on the other a more chaotic reality has resulted in a somewhat distorted picture of the role of research in drug policy." (Bennett and Holloway, 2010 p.416)

This recognition of the limitations of the achievement of evidence-based drug policy is consistent with the findings of more general policy scholarship. There has been a longstanding interest in the better utilisation of research and the identification of barriers to the use of research and evidence (Weiss, 1979; Caplan, 1979; Nutley et al., 2007; Boaz et al., 2008). There has also been a strong focus within drug policy literature on improving the accessibility of research and developing better collaborative relationships between policy makers and researchers. This is exemplified by the work of the Drug Policy Modelling Program, based at the University of New South Wales. This program has actively supported a research agenda that aims to provide more and better evidence to inform drug policy (in recognition of shortcomings in the evidence base), while also seeking to understand and thereby reduce the barriers that might prevent the uptake of evidence in the policy making process (Ritter et al., 2007; Ritter, 2009). While making a convincing case for the benefits of improving the availability and use of evidence, proponents of this work have also readily acknowledged that it would be 'naïve' to assume that evidence of effectiveness is the only criterion on which to base policy. They have instead recognised the complexity of the policy making process and its many inputs (Ritter et al., 2007; Ritter and Bammer, 2010). Duke's

work has also made an important contribution in this regard, through her empirical investigation of the interplay of research, evidence and policy making in relation to drugs and prison policy. She concludes that researchers could have greater impact by being more proactive in the earlier stages of policy development to better shape the policy agenda and framing of the problems to be addressed (Duke, 2001).

2.2.3 Beyond evidence-based policy?

The literature on drugs, their uses and addiction has been dominated by scientific disciplines such as epidemiology, psychiatry and biomedicine (MacGregor, 2011). These disciplines have favoured the production of the gold standard evidence seen as the pinnacle of EBP. However, it is unsurprising that this wealth of scientific data has not produced rational, 'value-free' drug policy. Evidence-based policy has been subject to sustained critique as questions are raised about the barriers to its adoption, the legitimacy of privileging evidence in policy making, and the tendency to ignore the complexity of the policy making process itself by relying on a contested model of linear, rational policy making (Smith, 2013; Boaz et al., 2008; Clarence, 2002). These concerns from the broader policy literature apply equally to drug policy and have given rise to alternative explanations for the state of drug policy making, drawing in particular on social science disciplines such as political science, policy studies and sociology. Two significant strands of this literature, ideational and social constructionist approaches, are explored in depth below.

2.3 Ideation, social construction and drug policy: a scoping review

The logic of evidence-based policy posits a model of policy making that is both linear and rational. For many in the drug policy field, the achievement of a better evidence base should have resulted in reforms to drug policy that would reflect 'what works' to tackle complex drug problems. However, as Ritter and Bammer capture, researchers have been vexed by the

way research has been both utilised and underutilised in policy making. From this frustration, a rich field of research has emerged that explores the complexity and unpredictability of the policy making process by introducing and testing new concepts and models, particularly from political science (Ritter and Bammer, 2010). While some excellent studies exist that address specific drug issues or interventions, there is, as yet, surprisingly little work that reflects on this field of scholarship and its future directions. It was therefore timely to undertake a scoping review to capture and summarise the breadth of scholarship in this field. The findings of this review, presented below, appeared in the January 2018 edition of the *International Journal of Drug Policy* (Gstrein, 2018). As will be discussed in Section 2.4, the gaps identified in the field of research have helped develop the theoretical orientation of this thesis.

The research question posed by this review is: how have ideation and social constructionism been used to analyse drug policy? These two broad theoretical approaches were chosen as two of three dominant narratives that are used to explore and challenge drug policy (Stevens and Ritter, 2013). The third, characterised as 'authoritative choice' by Stevens and Ritter, is a narrative in which policy constitutes a technical process of solving problems; this is captured by the discussion of evidence-based policy and research utilisation in Section 2.2 above.

Ideational theories have arisen as a challenge to interest-based approaches in politics, and seek to explain the role of ideas and beliefs in policy making. Ideation theorists contend ideas are a primary source of political behaviour, as they shape not only how we understand political problems, but how we subsequently develop and embrace (or reject) approaches to those problems. In ideation theory, the focus is on the processes of meaning, not choices. Interests matter, but they too are subject to the interpretative frameworks that are developed and guided by our ideas (Béland and Cox, 2011; Braun, 1999). Ideational approaches provide a way of accounting for a myriad of influences in politics, by including

actors whose roles had previously been marginalised in political analysis, such as non-political organisations and networks. Despite acknowledging the dynamic nature of ideas, coherence can emerge through shared beliefs and values. Hall's notion of paradigms, for example, or Haas' epistemic communities, describe how collective action can occur, not motivated by direct interests, but by shared ideas (Hall, 1993; Haas, 1992). Other key policy change theories that have made an impact on drug policy scholarship are the multiple stream heuristic (Kingdon, 2010) and the advocacy coalition framework (Sabatier, 1988). These two approaches provide a means of interrogating how certain policy problems and solutions come to prominence. The ACF for example, is concerned with coalitions that coalesce around shared beliefs and compete with other coalitions to secure policy outcomes through the domination of their ideas. The multiple streams theory is concerned with how particular ideas and policy solutions come to be adopted, positing that the idea must simultaneously be high on the agenda of three streams of policy action characterised as politics, problems and policies.

Ideas are also at the heart of social constructionist approaches to exploring policy making. Social constructionism places a particular focus on problem construction; the impact of the construction of target populations; and frames and narratives. Rather than see policy making as a rational, linear process where solutions are produced in response to recognised and understood problems, social constructionists see the problems themselves as being constructed through the policy making process. Bacchi (2009) has been particularly influential in this regard, inspiring extensive use of her framework, which asks 'what the problem is represented to be', in order to challenge underlying assumptions about the policy problem that is being addressed.

This literature review applies the Arksey and O'Malley (2005) methodological framework for scoping reviews. This method is outlined in Section 2.3.1. The stages of the review are

described in Section 2.3.2, followed by the presentation of results in Section 2.3.3. The results are analysed quantitatively, before a narrative synthesis is presented that summarises the key theoretical approaches and introduces significant contributions. The discussion in 2.3.4 considers the implications of the review, and its findings and limitations.

2.3.1 Method

The Arksey and O'Malley (2005) framework for scoping reviews provides a means of summarising and capturing the breadth of literature in a particular field. It has similarities with the systematic review method, but where systematic reviews generally focus on narrow areas of inquiry with an emphasis on the quality of studies, scoping reviews are more concerned with the 'extent, range and nature of research activity in a particular field' (Brien et al., 2010). The framework provides an effective means of collating and categorising strands of scholarship. The findings are presented through a narrative synthesis that allows conclusions to be drawn from the existing literature regarding the overall state of research activity (Arksey and O'Malley, 2005).

The Arksey and O'Malley (2005) framework has five distinct stages:

1. Identifying the research question

2. Identifying the relevant studies

3. Study selection

4. Charting the data

5. Collating, summarising and reporting the results

The first stage, identification of the research question, sets the parameters of the study and shapes the development of the search strategy. The second stage is focused on a comprehensive search of primary studies from a variety of sources, including electronic databases, key journals, networks, organisations and conferences. The third stage employs inclusion and exclusion criteria appropriate to the research question to determine the

relevance of studies, which are reviewed and, if necessary, eliminated: first by title, then abstract, and finally review of the full article. The fourth stage of 'charting the data' involves the extraction of key information through the application of a common analytical framework to all the studies. The fifth and final stage is two-fold: basic quantitative analysis is undertaken of the charted data to describe the scope of the body of literature, and, a narrative account is given of the existing literature based on a framework or thematic construction, reflective of the purpose of the research question that first guided the review (Arksey and O'Malley, 2005).

2.3.2 Application of the framework

Stage 1 – The research question

A broad research question was established: how have ideational approaches and social constructionism been used to analyse drug policy? Drug policy was narrowly defined, focusing on government policy that addresses the issues arising from the use of illicit drugs, with a particular but not exclusive focus on health outcomes. Excluded from the area of inquiry (unless there is an explicit link to drug policy) is literature primarily concerned with drug addiction, drug treatment, drug supply and markets, and drug-related criminal justice and law and order concerns. As with any area of social policy, boundaries in academic literature are not neat, so where there was cross-over and connection between issues, an inclusive approach was used.

Stage 2 – Identification of relevant studies

My initial search, conducted in April 2016, accessed three databases, employing a combination of relevant search terms. No time or language restrictions were placed on the searches. Table 2.1 shows the search terms employed, resulting in 1114 records identified.

Table 2.1 Search terms and records identified

Database	Search terms	Records
Scopus	drug* AND policy AND ideation	72
	drug* AND policy AND frames	254
	drug* AND policy AND narrative*	242
	drug* AND policy AND construction*	188
	drug* AND "advocacy coalition framework"	4
ProQuest	drug* AND policy AND ideation NOT suicid*	7
	drug* AND policy AND "advocacy coalition framework"	10
	drug* AND policy AND "social construction*"	226
	drug* AND policy AND narrative AND illicit	37
	drug* AND policy AND frames AND illicit	27
Medline	drug* AND policy AND ideation NOT suicid*	3
	drug* AND policy AND "social construction*"	24
	drug* AND policy AND narrative AND illicit	18
	drug* AND policy AND "advocacy coalition framework"	2
		1114

The initial search in Scopus using the term 'ideation' revealed a strong link to articles on suicide, so subsequent searches were modified by including the term 'NOT suicid*' to eliminate literature related to suicide and drug use from the search. The use of the term 'illicit' was also included after the initial Scopus searches to eliminate articles related to pharmaceutical drugs. This is a problematic distinction as harm from drugs does not a priori relate to whether drugs are licit or illicit, but government policies relating to problematic drug use do tend to be inclusive of illicit drug use, making this a useful term to narrow the inquiry. The search terms were derived from background reading of both drug policy and policy theory literature. Table 2.1 captures the initial searches that were undertaken in April 2016. The search process was iterative, allowing for modification to the search terms. The subsequent hand searching process based on a review of the initial included literature allowed further searches to be undertaken based on specific theories, theorist and fields of literature that were uncovered.

Stage 3 – Study selection

The 1114 records were screened by title, and only 68 were thereby selected for inclusion. Despite modifications to the search terms to try to refine the results, many studies were focused on pharmaceutical drugs and policy, vaccinations, paediatrics and psychiatry, and were therefore excluded. Of the 68 studies selected, 15 were duplicates, reducing the number of articles to be screened by abstract to 53. At this stage, a further 20 were removed. Works were excluded if they were journalistic, historical narratives, or opinion pieces. Studies were also excluded if they did not primarily address the development of drug policies, as were studies related only to alcohol and tobacco. 33 articles from the initial list of 1114 then remained to be screened by full text.

Ongoing hand searching was undertaken during the review period, as the included studies revealed relevant literature through citations and bibliographies. A methodical search was also undertaken of the following journals: *International Journal for Drug Policy*; *Drugs Education, Prevention and Policy*; *Harm Reduction Journal; Addiction; Substance Use and Misuse; Addiction Research and Theory;* and *Drug and Alcohol Review.* This process yielded an additional 19 works, four of which were subsequently excluded as their approach did not meet the criterion of a focus on ideation or social construction. With 15 hand searched studies and the original 33, the total number of studies included in the review came to 48 (see Figure 2.1). Consistent with Arksey and O'Malley's emphasis on accessing a variety of literature sources, 69 per cent of studies were retrieved through the initial database search with the remaining 31 per cent being added through hand searching.

Figure 2.1: Flow chart of study selection

Database search results

n=1114

Screened by title

n=68

(1046 removed)

Duplicates removed

n=53

(15 removed)

Screened by full text

n=33

(20 removed)

Hand searching   Total reviewed

n=15   n=48
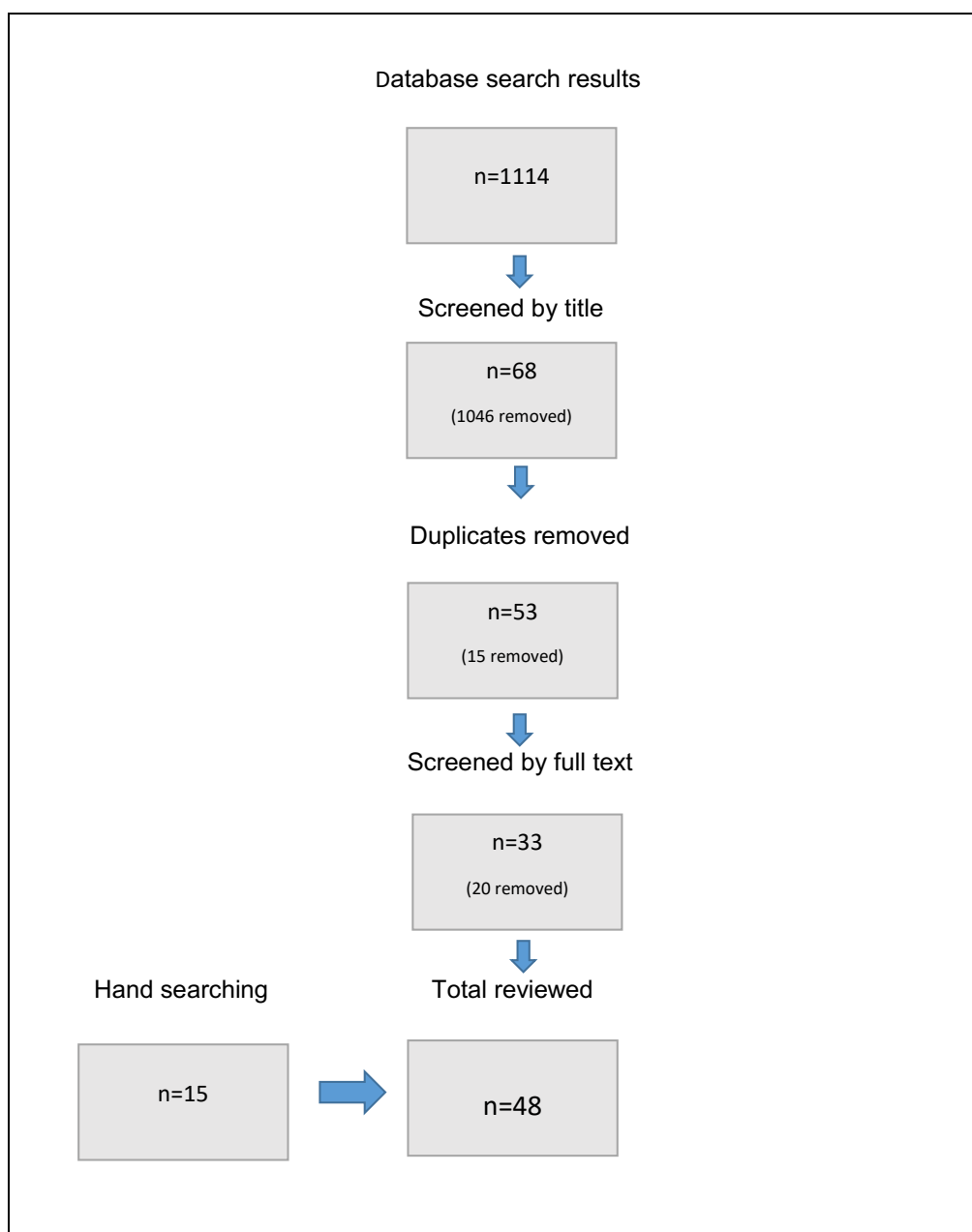
Stage 4 – Charting the data

Information on each study – including geographic coverage; theoretical approach; drug policy or issue; method; and data source – was extracted and recorded on an Excel spreadsheet, which forms the basis of Appendix 1. In categorising the literature, there was a risk that the studies' approaches would be oversimplified in order to have them conform to set headings or

categories. Despite this risk or limitation, the process provided structure for the findings and allowed the literature to be critically analysed according to a thematic framework that built upon the type of theoretical approach applied in each study. This analysis is summarised in a narrative review, as reported under Stage 5, below.

2.3.3 Results

Stage 5 – Collating, summarising and reporting the results

In keeping with Arksey and O'Malley's (2005) framework, this final stage of the review presents the results in two parts. The first section reports the outcomes of applying quantitative analysis to the charted data to present a picture of the scope and distribution of the literature. The second part presents a narrative synthesis of the literature, which is organised thematically according to the dominant theoretical approaches that were first analysed through the initial charting of the data.

5.1 Scope and distribution of the literature

The charting of the data revealed the limited geographic coverage of the literature, with studies relating to only 14 countries, nine of which are in Europe. The most represented country is Australia, with 40 per cent of the studies (*n*=19) focused on its drug policies and issues, followed by the UK (*n*=8) and the US (*n*=7). The majority of the studies (*n*=40) focus on one country only, with just one study coming from Asia (Afghanistan) and no studies from Central and South America, Africa or the Middle East. Of the remaining eight studies, four are comparative, examining the approaches of two or more countries. A further two take an international perspective, while the remaining two relate more generally to the issues of social construction and drug policy, without being country-specific.

Time restrictions were not placed on the search, but articles that met the criteria were published from 1996 to 2016. Up until 2011, there was a fairly steady flow of studies appearing,

after which there was a significant increase. Of the 48 studies, 22 appeared in the first 16 years (from 1996 to 2011), whilst the remaining 26 (54 per cent) appeared between 2013 and 2016.

43 of the 48, or 90 per cent of the studies, were found in peer-reviewed journals. Of these articles, a third appeared in the *International Journal of Drug Policy* (n=14). The remaining studies comprised a PhD thesis (*n*=1), books (*n*=2), a book chapter (*n*=1) and a report (*n*=1).

At the end of the charting process, five broad theoretical approaches or underpinnings of the studies could be identified: ideational policy theory (predominantly influenced by Kingdon (2010) and Sabatier (1998)) (*n*=14); problem construction (predominantly based on the work of Bacchi (2009)) (*n*=15); narratives and frames (*n*=15); construction of target populations (drawing on Schneider and Ingram's (1993) work) (*n*=4); and, policy transfer and mobilities (influenced by the work of Dolowitz and Marsh (2000), Evans (2009) and Stone (1999, 2000)) (*n*=5). Five of the studies are identified as fitting into two categories; therefore, the count of studies exceeds the total of 48. As outlined above, the process of categorising work requires judgements to be made that may restrict how work is described. In general, however, these categories usefully capture the spread of studies across the broad theoretical approaches. The work is described in more detail below (see 5.2 Narrative synthesis).

Reflecting the concern with ideation and social construction, all studies are qualitative and utilise an array of data sources, including policy documents, parliamentary records, media, interviews, surveys, ethnographic material, participant observations, grey literature and research texts. Table 2.2 captures the range of topics that emerge in the literature. Again, the count exceeds the number of studies as more than one topic is evident in many works. That the works addressed drug policy was a criterion for inclusion in the review; the use of a 'drug policy' category reflects that some studies specifically sought to address the subject in a more direct way than others.

Table 2.2 Topics covered by studies

Topic	Count
Drug policy	19
Evidence/research	13
Specific drug programs	9
Specific drugs	8
Media	9
Discourse	5
Drug users	3
Moral panic	3
Law	2
Networks	1
	72

5.2 Narrative synthesis

This section is organised according to the key theoretical approaches that were initially identified during Stage 4. It seeks to directly address the question of how ideational and social constructionism are used to analyse drug policy. Studies are organised according to the main theoretical underpinnings or concerns that influenced their work. This section is followed by a discussion of the gaps in the literature and potential future directions for research.

2.3.4 Ideational approaches to policy analysis

Ideational approaches to drug policy have been used to critique evidence-based policy; test 'multiple streams' approaches to policy making; and explore the transfer, translation and sharing of ideas.

Evidence and drug policy

Ideational theories have been used to provide a framework for critiquing evidence and its relationship with the political process of developing policy in a contested area. Critiques of EBP are concerned with what constitutes evidence and how effectively it is utilised, as well as

challenging the "naïve" assumption that policy making can be de-politicised by the judicious application of science to societal problems (Stevens and Ritter, 2013).

One of the most influential scholars in this area is Stevens (2007), who explores bias in the use of evidence, claiming there is an underlying misunderstanding about the link between evidence and policy. He proposes a new theoretical approach to understanding that relationship, based on an evolutionary analogy. While he illustrates that evidence is used selectively to entrench the legitimacy of powerful groups, he does not suggest that evidence is irrelevant or that the idea of using evidence in policy should be abandoned. Rather, Stevens argues that evidence is only one of a number of determinants of policy, and that it is the narratives used to frame social problems that provide the key to whether evidence enters policy (Stevens, 2007).

Monaghan (2011) challenges Stevens' conceptualisation by focusing his inquiry on the nature of evidence itself. Monaghan questions the presented dichotomy of policy as either 'evidence-based' or 'evidence-free', the latter being read as ideologically driven. Through his work on the UK drug classification system and the reclassification of cannabis, Monaghan identifies three perspectives, representing different views of evidence, and concludes that a plurality of evidence exists, casting into doubt the notion that a consensus on evidence-based policy is achievable. Monaghan's stance is reflected in Roumeliotis' (2014) study of Swedish drug policy (discussed below), which is premised on the argument that knowledge itself cannot be free from ideology.

MacGregor (2013) asks the question: are politicians the problem in relation to the barriers that impact the use of evidence? While her work is discussed below in relation to frames and narratives, it is important to note that this vexed question of the relative influence and the nature of evidence itself continues to be a very active line of inquiry in drug policy scholarship (see also Ritter, 2009; Tieberghien, 2014; Lancaster, 2014; Lancaster and Ritter, 2014; Van

Toorn and Dowse, 2016; Fraser and Moore, 2011; Dwyer and Moore, 2013; Bright et al., 2013; and Everett, 1998).

Policy change theories

Policy making theories, drawn from political science, provide useful frameworks for exploring contested policies; in turn, drug policy scholarship provides valuable case studies to contribute to theory testing and development. For example, Lancaster et al.'s (2014) examination of the development of methamphetamine policy in Australia tests the extent to which Kingdon's multiple stream heuristic is a useful tool for the analysis of drug policy issues. This comprehensive study draws on a range of source documents that are classified against each of the three streams (problem, policy and political). While finding strengths in Kingdon's approach, the authors also provide an insightful critique, questioning the extent to which the streams operate independently, and whether policy windows are necessary for action. In addition, they identify in Kingdon's approach a potential underestimation of the role the media plays in agenda setting.

Kingdon's framework is also employed in two papers exploring the introduction of drug consumption rooms in Australia and Denmark, respectively (Gunaratnam, 2005; Houborg and Frank, 2014). These papers are concerned with the debates conducted on introducing facilities, and the roles played by stakeholders and politicians. Despite the very different circumstances and locations, both studies draw similar conclusions, noting the critical role played by political actors in exercising their powers over legislation and resources allocation. Houborg and Frank's work on policy change in Denmark can be understood in terms of a shift from 'government' to 'governance'; they conclude there is limited space for governance in drug policy, on account of the legal and prohibitive foundations of the policies (Houborg and Frank, 2014). This is an important reminder of the constraints placed on the engagement of civil society and other actors in the development of new approaches to drug policy, particularly when attempting to

understand the factors that may ultimately lead to policy change. Gunaratnam's (2005) conditional endorsement of Kingdon's approach, to explain why a trial proceeded in New South Wales but not in the other two jurisdictions also pursuing safe injecting facilities, is more problematic. While I would agree that Kingdon's multiple streams can be used to *describe* the outcomes, Gunaratnam does not provide sufficient explanation for why politicians ultimately supported different outcomes in three jurisdictions.

The Advocacy Coalition Framework (ACF) (Sabatier, 1988; Sabatier and Jenkins-Smith, 1999) promises to shed light on drug policy issues with its argument that policy outcomes are the result of competition between coalitions which hold different beliefs about policy problems. Studies that have utilised the framework focus on understanding how one set of ideas becomes ascendant over another within a policy sub-system (Hallam, 2006; Kübler, 2001; Monaghan, 2011; Sobeck, 2003). Scholars such as Kübler (2001) and Hallam (2006) demonstrate the utility of the ACF when applied to drug policy issues, albeit with modifications to the framework in each case. Monaghan (2011) treats the ACF more as a springboard, replacing the notion of 'coalitions' with 'appreciative perspectives' in his study of the UK drug classification system. The strengths of the ACF lie in its recognition of the role coalitions play in carrying ideas to policy outcomes, while acknowledging the crucial role played by the decision-making power that resides in government structures. An ongoing challenge for the application of the ACF lies in testing out whether the influence of coalitions is overstated: coalitions can be identified, but can it be demonstrated that the policy goals that were achieved were the outcome of collective action (Schlager, 1995)?

In providing case studies for policy theories, drug policy scholarship has further challenged the underlying presumption of coherence in policy making. For example, Hughes et al.'s (2014) study of the drug trafficking legal threshold highlights the complexity of introducing policy in areas that affect multiple policy stakeholders. Drawing from both Kingdon and Sabatier's

approaches, this study focuses on four key aspects of the policy process: the roles of formal policy actors; public opinion; the 'problem'; and the available research that could inform the policy solutions. This framework is deftly applied and the authors draw the conclusion that the policy development process has been "arbitrary and messy", raising concern about the extent to which policy development should proceed in the absence of evidence.

Where the study on legal thresholds takes a relatively narrow aspect of policy, Hudebine's (2005) paper looks at broader changes to drug policy over a longer period of time, focusing on the advent of harm reduction policies in the United Kingdom. He, too, concludes that consensus and coherence are the exception rather than the rule in drug policy. Like Houborg and Frank (2014), Hudebine identifies that the prohibitive elements of policy have a powerful effect; in this case, achieving the deviantisation of the drug using population. Attempts to ensure the social inclusion of this marginalised population (through harm reduction approaches) result in a duality, creating tension and ambiguity. The picture he paints is one of dynamic but not deep change, where drug policies are better understood as an exercise in 'containment': a political balancing act severely challenged by the emergence of HIV (Hudebine, 2005).

Policy transfer and mobility

The final area of literature with a focus on an ideational approach is that of policy transfer and mobility. A limited number of studies were identified that directly address the process by which policy makers from one jurisdiction borrow ideas or use knowledge about institutions or practices from another jurisdiction (McCann, 2008; McCann and Temenos, 2015; Temenos, 2016; Bewley-Taylor, 2014; Butler, 2013). These works are illuminating as they seek to trace the circulation of ideas and consider the factors that affect the successful transplanting of policies from one place to another. Consideration of policy transfer sits comfortably with the study of the impact of evidence on drug policy; scholars explore a notion of 'best practice' and demonstrate the limitations of policy as 'technical solutions' when applied in new settings.

Both Butler (2013) and Bewley-Taylor (2014) present case studies that explore the explicit borrowing of policies by national bodies, Butler examining the Dublin pilot drug court in Ireland which sought to transplant the US model, and Bewley-Taylor reconstructing the events that led to the development of the Afghan National Drug Control Strategy. While Butler's study employs a limited number of interviews with key informants, he is able to highlight some of the potential pitfalls of policy transfer, illustrating the scepticism with which this 'outside' idea was met, and the failure of the policy sponsors to embrace the underlying philosophy of therapeutic jurisprudence, which he argues is central to the American drug court practice. Butler succeeds in presenting a convincing picture of the complexity of policy transfer, stressing the tensions in this particular field between political aspirations, separation of powers functions and inter-governmental cooperation (Butler, 2013). Bewley-Taylor's study of Afghanistan considers the impact of local setting on this instance of policy transfer. He argues the inclusion of (progressive) harm reduction approaches in the strategies demonstrates evidence of the impact and influence of international policy networks in Afghanistan (Bewley-Taylor, 2014). Both Bewley-Taylor and Butler stress the power of the symbolism embodied in the adoption of the particular policies in their respective case studies – an outcome far removed from concerns of effectiveness or best practice that might more readily be associated with the motivation for adopting others' policies.

Finally, mobility is a central theme in the work of McCann (2008), McCann and Temenos (2015) and Temenos (2016). Mobility is explored not just in relation to policy, but in relation to people who carry ideas and have interactions in 'real' places. These articles promote broadening the focus of policy transfer from state actors to others engaged in sharing knowledge and experience, through case studies of the development of Vancouver's Four Pillars drug policy (McCann, 2008); the global model of drug consumption rooms (McCann and Temenos, 2015); and the role of harm reduction conferences as sites where policy mobilisation occurs (Temenos,

2016). An extensive discussion of both the policy transfer and the policy mobilities literature, and their contributions to our understanding of drug policy, will follow in Chapter Three.

2.3.5 Social construction

The utilisation of social constructionist approaches to analyse drug policy has focused on four areas: problem construction; narratives and frames; drug users as a target population; and the construction of drugs themselves.

Problem construction

The literature in this field has been significantly influenced by Bacchi's (2009) approach to problem construction and her 'what's the problem represented to be' framework. A central tenet of Bacchi's work is that problems are not solved by policies, but rather made by them. This is not to argue that the issues are not real, but that they are defined and 'made' by the policy that seeks to address them. Problem construction has proved to be a useful underpinning for work on drug policy in two ways. First, it provides a means of unpacking the underlying assumptions of drug policy, helping to shed light on limitations of current approaches and opening up the possibility of reform. Secondly, it provides a robust critique of the evidence-based policy paradigm by challenging the validity and authority of evidence in the policy making process.

Lancaster and Ritter's (2014) examination of Australian national drug strategy documents, and Lancaster et al.'s (2015) comparative study of the 'recovery' agenda in Australia and the UK, apply Bacchi's concept of 'problematisation' to demonstrate how ideas of problems shape what is possible in terms of policy 'solutions'. While Lancaster and Ritter (2014) find a connection between the construction of the problem of drugs in the Australian context and what is then proffered as an appropriate set of responses, the latter paper is able to show, through its comparative approach, that meanings (in this case in relation to the 'recovery' agenda) are not fixed and are subject to negotiation (Lancaster et al., 2015).

Fraser and Moore (2011), in a similar vein, apply Bacchi's approach to explore meaning and the role of causation and evidence in the development of policy responses to amphetamine-type stimulants in Australia. By focusing on representations of the substances themselves in policy documents, Fraser and Moore seek to understand the extent to which drugs can be seen to be deterministic (i.e. to what degree they can be said to cause a particular effect). They conclude that despite an acknowledged paucity of evidence, causation (for harm) is still attributed, thus justifying the policy responses in the documents. In another paper, Moore and Fraser (2013) use problem construction to examine addiction treatment and practices, arguing that by conceiving of addiction as a bounded problem that can be treated in isolation, the system works to produce 'addicts' who are defined by the treatment regime (i.e. the policy solution). Moore and Fraser demonstrate the unintended consequences that flow from this approach, including the outcome that "As addiction comes to be produced by the very system designed to treat it, the scale of the problem appears to be growing rather than shrinking" (Moore and Fraser, 2013 p. 916).

The second stream of work to emerge under the banner of problem construction is a consideration of the role evidence plays in the formation of policy, and the way in which it is increasingly relied upon as a means of 'knowing the problem' in the context of national drug strategies (Roumeliotis, 2014; Lancaster and Ritter, 2014). Roumeliotis examines knowledge utilisation in the development of national drug policy in Sweden and concludes there has been a shift from seeing drugs as an issue of social exclusion to a problem of individual behaviour, the solution to which lies in the domain of experts, not politics. Van Toorn and Dowse (2016), using Bacchi's framework to compare the use of evidence in two policy areas (drug policy and child protection), conclude the role of evidence is to construct a common frame through which meaning is applied and resolutions to problems sought, as opposed to being used to 'solve' policy problems.

Lancaster (2014) argues against evidence being treated as inherently valid and therefore privileged in the policy making process. Her commentary offers the possibility of pushing for reform by developing policy through a more inclusive process that breaks the monopoly of 'valid' knowledge. If we understand policy as constructed, the possibility must exist to 'reconstruct' it in a new form with new influences. However, questions remain as to how key interest groups participate and are heard in policy processes. Dingelstad et al.'s (1996) study concludes that debates about drugs are socially constructed and linked to the key interest groups that participate in those debates. The authors, however, offer no insights into what allowed those particular interest groups to dominate the debates, or into other questions about the operation of power or influence. Of all the works, Fraser and Moore's is the most reflective, arguing that neither a material view or an entirely socially constructionist view is sufficient to understand the interactions that produce the 'problem' of drugs. They contribute the following useful insight: "We need, instead, to understand the problem as both factual and political, and policy as a site in which the politics and materiality of drugs are made" (Fraser and Moore, 2011 p. 500).

Narratives and frames

Stone's (1989) work on causal stories resonates with drug policy scholars, providing a framework for accounting for the often repeated but relatively unfounded narratives that dominant representations of drugs. These narratives, in which drugs are framed in terms of criminality or as an issue of individual morality, curb the policy solutions that are offered. MacGregor delves into the question of the over-arching but rarely challenged narrative that 'drugs are dangerous', which she sees as dominating public debate (MacGregor, 2013). Her comprehensive study of drug policy in Britain since 1979 comprises document and media analysis as well as participant observation and interviews. To MacGregor, the frames signal a set of interests and values that relate to politicians 'playing the game' of electoral survival,

constrained by a collective decision-making model. MacGregor's work demonstrates how particular narratives prevail and remain remarkably unchanged despite the emergence of new evidence and knowledge. Moreover, MacGregor succeeds in situating her work squarely in the sphere of politics and political actions, while still demonstrating the value of a social constructionist perspective on the influence of ideas.

Where MacGregor identifies continuity in the underlying narrative shaping British drug policy, it is change that is identified in a comparative study of the framing of drug consumption and gambling in Germany and the Netherlands (Euchner et al., 2013). Encompassing a sixty-year period, this study draws on parliamentary and government documents to identify dominant frames, concluding that morality framing, while present in the mid-twentieth century, lost its importance over time, and that close connections can be identified between 'frame shifts' and policy outputs. A further interesting application of the analysis of policy narratives comes from Fitzgerald's work on two divergent attempts to introduce supervised injecting facilities in Australia. To better understand the cause for the failure of the Victorian initiative, Fitzgerald identifies a distinctly different narrative dominating the policy debates in relation to law enforcement in the two locations, concluding the lack of confidence in the police in New South Wales opened the way for more acceptance of alternative framing and solutions to the street-based drug scene (Fitzgerald, 2013).

Media

A series of studies has sought to understand the role the media plays in framing debates on drug issues and drug policy, raising, amongst other issues, the question of how influential the media is in policy debates and political outcomes. Useful starting points to this literature are Lancaster et al. (2011) and Bright et al. (2008). The former article identifies four key functions played by the media: agenda setting; framing; shaping attitudes towards risk; and feeding into political debates and decision making. The latter employs a social constructionist approach,

identifying the dominant discourses that recur in Australian media and exploring how those discourses impact on how we conceive substance use, providing a rationalisation for the policy outcomes that are offered. Interestingly, the study identifies six dominant discourses, challenging more binary conceptualisations of debates hinging on proponents and opponents of particular policy positions (Bright et al., 2008, and for contrast, see Hallam, 2006).

The media plays a readily identified role as a vehicle for creating 'moral panic', seen in the work of Everett (1998), Bright et al. (2013) and Alexandrescu (2014). Each study deals with the media reaction to the appearance and impact of a single drug (crack cocaine, Kronic and mephedrone respectively), and all make the case that the media played a significant role in drawing the public's attention to these drugs and, in doing so, agenda setting through demanding a response from government. Each study raises the concern the narratives that recur through media reports are divorced from a scientific evidence base, and can carry the unintended consequence of increasing risk to the public as a result of media focus.

Two studies stand out for presenting more nuanced and ambiguous findings about the role of the media (Tieberghien, 2014; Hughes et al., 2011). Tieberghien explores the representation of scientific knowledge in the Belgian media, in relation to drugs. She concludes that while the media was found to support an 'enlightenment' role, incorporating scientific information in reporting on drugs, the presentation was often inaccurate or distorted, demonstrating a selective use of research (Tieberghien, 2014). Hughes et al.'s (2011) study of Australian print media, which aimed to understand how generalisable findings of media bias and sensationalism are, offers important insights into the debate on the role of media and moral panic. Their research found that, overall, there was a bias of reporting towards frames that depicted crime or deviance; however, most articles were reported in a neutral manner and crisis framing was absent, leading the authors to conclude that media reporting (in Australia)

"may be less overtly sensationalised, biased and narrowly framed than previously suggested" (Hughes et al., 2011 p. 285).

While the above studies demonstrate that framing of drug issues occurs, linking that framing to political or policy outcomes is more problematic. Two studies that seek to achieve this are Elliott and Chapman (2000) and Lawrence et al. (2000), both of which examine media coverage during the attempt to introduce a heroin trial in the Australia Capital Territory during the 1990s. Where Elliott and Chapman focus on the representation of drug users, Lawrence et al. are concerned with the orientation of reporting on any aspect of heroin. Both studies conclude that the extensive negative coverage contributed to the failure of the trial. While the arguments are compelling, these two works (like other media analyses) are limited by only being able to suggest or imply a link between the outcomes and the reporting, as neither study demonstrates a direct impact that the reporting had on the political and policy decision making process, being limited methodologically to analysis of media.

This limitation suggests that there is a need for further work exploring the impact of the agenda setting function played by the media. An approach to this is demonstrated in Everett's (1998) study of the US federal sentencing guidelines for crack cocaine. Utilising a public arena framework, Everett depicts the media as challenging political elites' ability to frame and define social problems. Complementing his media analysis, Everett explores the interactions between the Congress and the US Sentencing Commission when the laws were subject to review following exposure of the racial bias that accompanied the enactment of the sentencing guidelines. Given how divorced the sentencing laws were from evidence about the relative harms of crack cocaine versus powder cocaine, Everett makes a compelling case for the ability of the media to set an agenda that enabled legislators to pursue ideological positions in the face of contrary evidence (Everett, 1998).

Target populations

The social construction of drug users as a target population arises in a number of studies from the US, UK and Australia (Amundson et al., 2015; Lybecker et al., 2015; Neill, 2014; MacGregor, 2013; Stevens, 2011; Hudebine, 2005; Elliott and Chapman, 2000). Influenced by the works of Schneider and Ingram (1993) and notions of 'deservedness', these studies focus on the impact on policy of the negative construction of drug users as a deviant population. MacGregor (2013) and Stevens (2011) see British policy as having been strongly influenced by underlying assumptions and characterisations of drug users that have served to inextricably link drug users and criminality, oversimplifying the complexity of circumstances surrounding drug use. Evidence is also of concern here, as studies such as Amundson et al. (2015) conclude. In examining the public discourse of state legislators in the US during debates on welfare drug testing, this study finds proponents did "little to distinguish welfare recipients from drug abusers…Although empirical evidence does not support a connection between welfare receipt and drug use" (Amundson et al., 2015 p.458).

Neill (2014) specifically applies Schneider and Ingram's (1993) notion of social construction to two drug policy models (law and order, and public health). Neill finds the dominant model depends on how the drug population is perceived and concludes by advocating for a public health approach based on a 'drug addiction as disease' model. In doing so, Neill fails to take the social constructionist analysis through to its logical conclusion that the disease model is also a social construct, and itself subject to criticism for its underlying assumptions. Neill, in privileging 'medical treatment' above 'politically based solutions', fails to explore the complexity of the issue, placing herself at odds with other scholars, such as Roumeliotis (2014), who argues that in treating drug use as an issue of the individual, rather than society, opportunities are lost to see the wider social circumstances that make drug use problematic.

Construction or enactment of drugs

The final area of literature to emerge from social constructionist approaches concerns the impact on policy of the construction of drugs themselves, or the way in which they are produced and reproduced in public discourse (Moore and Fraser, 2013; Dwyer and Moore, 2013; Kolind et al., 2016). Moore and Fraser's (2013) article using Bacchi's approach is discussed above, but two additional relevant works were found that derive from a Science and Technology Studies approach. Dwyer and Moore (2013) critically examine the way methamphetamine is 'produced and reproduced' in public discourse. This study looks beyond public policy documents, searching webpages, health promotion, education and campaign materials, media accounts, grey literature and research texts. More innovatively, the authors compare their findings from this public discourse with consumers' experiences of methamphetamine use, taken from an ethnographic study. They find that public discourse "enacts methamphetamine as an anterior, stable, singular and definite object routinely linked to the severe psychological 'harm' of psychosis" (Dwyer and Moore, 2013 p. 203). This is at odds with the findings of the ethnographic accounts (which indicate a range of experiences) and, for the authors, gives insufficient consideration to the social and cultural contexts in which the drug can be taken – a factor which is "well established as essential to any understanding of drug experiences and effects" (Dwyer and Moore, 2013 p. 206).

Kolind et al.'s (2015) work complements Dwyer and Moore's study in its examination of the way both legal and illegal drugs are enacted in Danish prisons. Following identification of three enactments of drugs in Danish prison settings, the authors conclude that drugs do not have a static meaning, but that meaning will depend on the particular situation. This work demonstrates social construction at play beyond the construction of the problem of drug use, to the very substances themselves, the meaning of which cannot be taken for granted in policy development.

2.3.6 Limitations of the scoping review

This scoping review has a number of limitations which should be noted. The narrative synthesis of the results groups the findings by themes based on theoretical approach. There is a risk that the studies presented are 'pigeon-holed' to fit the thematic schema, and the breadth of their approach and findings may not be fully conveyed. However, the thematic groupings were easily found through the process of extracting data during Stage 4, suggesting that the included literature is representative of the work being undertaken in this field.

A further limitation lies with the issue of the completeness of the review. While a reasonable attempt has been made to rigorously apply Arksey and O'Malley's framework, there are still questions as to how many databases should be searched initially and how much hand searching should be undertaken. The use of Scopus, in particular, should give excellent coverage but defining and refining search terms is crucial to the process. The number of articles that were subsequently picked up through hand searching key journals was surprising but may reflect the key words used by authors. Despite no language restrictions being placed on the searches, no non-English language studies were returned. This is unexpected given relevant work being undertaken, particularly by European scholars. While English search terms were utilised, databases such as Scopus contain translations of materials (at least at the abstract level). This, and the issue of search term returns, warrant further investigation.

Further, the process of establishing and applying inclusion and exclusion criteria will greatly affect the range and volume of literature subsequently reviewed and selected for inclusion. The decision as to which studies are selected can only be resolved by constant reference to the central research question. Studies focused on governance comprise one area of literature that was largely excluded as falling outside the immediate area of inquiry, but these studies contribute fruitfully to drug policy research and would be of interest to drug policy scholars. Finally, Arksey and O'Malley (2005) recommend an optional step of undertaking stakeholder

consultation to augment a review's findings. This step was not undertaken due to time and resource constraints but could well have served to improve the completeness of the review.

2.4 Discussion

As the scoping review demonstrates, drug policy scholarship's adoption of ideation and social constructionist approaches goes back only two decades. As a relatively young field, there is considerable scope for continuing to pursue these theoretical positions in more depth. This discussion presents selected gaps revealed by the review and draws together some key unresolved issues in the literature. These issues are:

i) the continued problematisation of evidence;

ii) opportunities to broaden the range of policy change theories being applied to drug policies;

iii) the narrow geographic focus on the current literature;

iv) the relationship between different levels of policy, particularly between national and local jurisdictions; and

v) the absence of theorising on replication and the scaling up of interventions.

The problem of evidence

The starting point for this chapter's review of the literature was the relationship between evidence-based policy and health-oriented drug policy. Concern with the problematic nature of EBP and the privileging of evidence in the policy process gave rise to alternative accounts of the influences on the policy process. The findings of the scoping review demonstrate the issue of evidence remains unresolved in the ideational and social constructionist drug policy literature, although there is consistency in the position that a 'pure' form of evidence-based policy is unachievable. What emerges is a spectrum of positions on how much evidence does and should matter. It is perhaps this question of how much evidence should matter that ensures the issue continues to be problematised, leaving room for ongoing exploration of what

constitutes evidence and 'whose' evidence we are referring to and consulting in the policy process. There appears to be a new normative agenda emerging, with a focus on broadening the scope of what we consider evidence to be as a means of legitimating participation in policy making. Scholars in this area are also exploring questions of broadening participation in policy making and the relationship between evidence, values and democracy (Lancaster, 2014; valentine, 2009; Lancaster et al., 2017; Ritter et al., 2018). There is a social constructionist cast to the current literature in this area, opening up potential to explore these same questions from a policy change and political science perspective.

The application of policy change theories

Emerging from the critique of evidence-based policy is the recognition that if evidence is demonstrably not the prevailing influence on policy outcomes, then other influences on policy must be accounted for. As the scoping review illustrates, drug policy has provided rich grounds for exploring the process of policy change and testing out policy change theories and frameworks which recognise the multiple influences on policy development, including ideas and knowledge, political and non-political actors, networks and coalitions, the media and crises. A theme identified in the review was the issue of the 'coherence' of drug policy, with studies describing policy as "arbitrary and messy" (Hughes et al., 2014) and characterised by "ambiguity and ambivalence" (Hudebine, 2005). These characteristics of drug policy potentially challenge more conventional applications of policy theory models, providing opportunities to test out the boundaries and applicability of familiar frameworks and approaches, such as the Advocacy Coalition Framework and Kingdon's multiple stream approach. What is apparent from the scoping review is that some influential theoretical approaches remain less explored, such as Haas' (1992) epistemic communities or Baumgartner and Jones' (1993) punctuated equilibrium theory (for exceptions, see Ritter and Lancaster, 2013 and Rychert and Wilkins, 2018). While there are studies that embark upon theory building (see Stevens, 2007 and Monaghan, 2010 as examples), of the 48 studies in the scoping review, only three articles were

primarily concerned with the state of theory in the body of drug policy research, presenting an opportunity for further consideration and debate of the field itself amongst drug policy scholars (Lancaster, 2014; Ritter and Bammer, 2010; and Stevens and Ritter, 2013).

Geographic focus

The review has revealed a narrow geographic focus in the body of literature. Work being undertaken in Australia dominates, ahead of the UK and the US, with the majority of the remaining studies focused on European countries. Given the significance of drug issues in South America, Asia and Africa, there is a remarkable gap in the literature in this regard. Bewley-Taylor's (2014) study of Afghanistan's national policy stands out; while it could be a model for exploring policy transfer approaches in other countries, there is a more fundamental need to explore policy making in different political systems from domestic perspectives. Also revealing is the lack of comparative literature in this field, with only four studies captured by the scoping review examining the approaches taken in two or more countries. There is a significant opportunity to contribute to our understanding of policy development by undertaking comparative research.

The relationship of national policy to local policy

An insufficiently explored area in the literature is the relationship between different levels of policy and, in particular, the impact of national policy on local jurisdictions. The importance of this issue will vary from country to country and be dependent on the local context, but its exploration brings with it opportunities to interrogate the gap between policy and implementation, and issues of local interpretation and policy transfer issues sub-nationally. Of the works reviewed, Hudebine (2005) provides the best example of an attempt to understand the consequences of ambiguity in national policy, leading to alternative interpretations of policy implementation at the local level. Further work in this area is warranted and would frame

the exploration of questions such as the impact of national level discussion and narratives on the reality of implementing drug policy and services at the community level.

Policy replication and scaling up of initiatives

An area very under-researched, as revealed by the scoping review, is the scaling up of interventions and the replication of policy initiatives (whether at the national or sub-national level). These issues are of direct concern for this thesis and its exploration of drug consumption rooms. Arguably, the concern in many studies with the impact of evidence reflects a preoccupation with the evaluation of policy and questions of effectiveness, but there is still an identifiable gap in the literature in relation to replication, policy learning and scaling up, moving beyond the rhetoric of evidence-based policy. The policy transfer and mobilities literatures is the exception in this area, although as discussed in Section 2.3.4 above and more extensively in Chapter Three below, there has been very limited application of these approaches to drug policy issues.

2.5 Conclusions

This chapter has had three key purposes. It has demonstrated the strong relationship between health-based drug policy and the evidence-based policy paradigm. It has scoped the field of alternative accounts that challenge the centrality of evidence in the policy making process in relation to illicit drugs, introducing the breadth of literature that employs ideational and social constructionist lenses. Finally, it has identified some gaps and unresolved issues in the literature, enabling this thesis to genuinely pursue some original lines of inquiry in relation to its research concern with drug consumption rooms and policy replication.

While drug consumption rooms provide the topic under exploration, this study's primary concern is that of change in a contested policy area. As the literature review demonstrates, scholars have been drawing on theoretical frameworks from political science and policy

studies to better understand the barriers to and influences on policy development. The 'problem' of drug consumption rooms offers a multitude of issues that can help us address critical areas in relation to drug policy more generally. The following chapter will make the case that, of the policy change theories explored above, it is the policy transfer framework that appears to be the most appropriate approach to provide insights into the process of policy change across the chosen case studies. The policy transfer framework also has the benefit of accommodating comparative research, which is an identified gap in this field, and of providing a framework in which the relationship between local and national policy development can be explored. Finally, the review of the literature demonstrated the valuable contribution that is being made to drug policy scholarship from a social constructionist perspective. Policy transfer, as will be argued in the following chapter and the discussion on ontology in Chapter Four, sits comfortably with a 'thin' constructivist approach that accepts the co-existence of both structural forces and social constructions (see Section 4.3.2 below). This is important, as it allows this thesis to be reflective of contributions from both an ideational and social constructionist perspective.

Chapter three
Theoretical framework
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3.1 Introduction

This thesis seeks to understand the barriers and challenges to replicating drug consumption rooms with reference to the policy processes in the case study countries. The literature review in Chapter Two demonstrates how two distinct approaches, ideational and social constructionist, have been applied to studying drug policy. These approaches recognise the complexity of the policy process and the role of multiple agents in influencing and developing policy outcomes. They also interrogate the role played by evidence and knowledge in the policy making process. The review demonstrated there are gaps in the literature in relation to comparative studies that address drug policy making, not only between states, but within countries at the sub-national level. In addition, the review identified that limited empirical and conceptual work had been undertaken in relation to utilising the concepts of policy transfer and policy mobility to interrogate questions of drug policy development.

Policy transfer, depending on its interpretation and application, has straddled both ideational and constructionist spheres. The chapter outlines the debates within the literature that have shaped our current understanding of the movements of policy across national and sub-national boundaries under the banner of policy transfer. It explores the alternative interpretations of policy transfer that have been developed, primarily by geographers exploring urban policy mobility, before demonstrating the limited ways in which these approaches have been applied to questions of drug policy. A case is then made for why a policy transfer lens is an appropriate theoretical framework for addressing the issue of stalled policy development in the case of the replication of drug consumption rooms, with particular reference to the need to investigate multiple levels of governance and undertake comparative analysis. The chapter presents a framework, based on the work of Evans and Davies (1999) and Evans (2004) which interrogates various levels of inquiry and the impact of policy-oriented learning and policy transfer networks. It reflects an appreciation of policy as a complex undertaking engaging multiple state and non-state actors and will form the

basis for interpreting the findings from the case studies in Chapters Five and Six, and the outcomes of the thematic analysis presented in Chapter Seven.

3.2 Conceptual review

3.2.1 From policy transfer to policy mobilities

Policy transfer literature developed within political science and international studies as a response to the growing phenomenon of policy ideas and approaches from one political setting being drawn on or influencing the development of policy and institutions in another political setting. Building on earlier literature on policy learning, lesson drawing, diffusion and convergence, Dolowitz and Marsh developed a conceptual framework with a focus on the voluntary and coerced elements of policy transfer. They went on to further refine this framework, encouraging researchers to look beyond checklists concerning the process in order to provide greater explanatory value as to the motivations behind policy transfer and the relationship between policy transfer and policy success or failure (Dolowitz and Marsh, 1996; Dolowitz and Marsh, 2000).

A multitude of empirical studies across a range of disciplines has enquired into the extent to which, and the means by which, policy may have travelled between jurisdictions and what the consequences of that may be (Benson and Jordan, 2011). As this scholarship reveals, and as Dolowitz and Marsh (2000) have argued, there is an indisputable growth in evidence of transfer or borrowing as a result of new technologies and the rise of globalisation. This gives rise to the question: if this is no longer a novel phenomenon is there value in focusing on policy transfer rather than policy development or policy change in general? Even before the advent of much of this work, Evans and Davies (1999) were posing the question that if policy transfer were such an 'every-day' part of policy development, does policy transfer analysis continue to be a meaningful exercise?

The utility of a theory or theories of policy transfer has been much debated, as have the theoretical credentials of such approaches, with Dolowitz and Marsh (2012) maintaining that their framework is a heuristic rather than a theory. Critique of policy transfer has focused on the political science 'shortcomings', particularly of the earlier work, which was criticised for its focus on a rational and linear model of policy development. The limitations, according to Peck and Theodore (2010), include a presumption that policy makers will optimise outcomes by choosing the best policies from a market place where ideas are freely exchanged, allowing "good policies to drive out bad, in a process for optimizing diffusion" (Peck and Theodore, 2010 p.169). Below it is argued that these valid criticisms have been addressed by newer approaches to policy transfer that are rooted in alternative political science approaches, but first I will introduce the response to orthodox policy transfer approaches from the interdisciplinary body of critical policy studies.

Benson and Jordan (2011), in their review of the policy transfer literature, pose the question as to whether academics more or less know what should be known about policy transfer. They suggest a stasis may have been reached in its conceptual value and that there is minimal additional knowledge to be gained by further enquiry. In rebuttal, McCann and Ward (2012) argue that there is much to be learned about the global circulation of policies, which continues to be an active area of enquiry for many scholars working outside of traditional political science. Stepping away from the limitations implied by 'policy transfer', McCann and Ward detail an emerging field that they argue departs significantly from earlier conceptualisation with its focus on policy mobilities, mutations and assemblages. Working from a constructivist perspective, scholars critical of policy transfer have contested the narrow linear notion of a 'neatly parcelled' policy travelling from jurisdiction A to further jurisdictions. They argue instead that in the process of the journey they "are not simply traveling across the landscape – they are remaking this landscape, and they are contributing to the interpenetration of distant policy making sites" (Peck and Theodore, 2010 p.170).

Furthermore, in the process of travel, policies mutate as they engage with social, spatial and political factors and will have different effects in new locations (McCann and Ward, 2012).

One of the key concepts utilised is 'assemblages', derived from the work of Deleuze (McCann, 2011). Assemblages is used in the sense of 'parts from elsewhere' being brought together but not necessarily in a fixed way.

> "Assemblages are always coming apart as much as coming together, so their existence in particular configurations is something that must be continually *worked* at…Assemblages are always works in progress. They involve invention, labour, politics and struggle on the part of those involved." (McCann, 2011 p.145, italics in original)

Prince emphasises that the policy transfer process is both technical and political; it is in the making of an assemblage that a policy transfer is effected. The resultant policy then exists as an assemblage of "texts, actors, agencies, institutions, and networks" (Prince, 2010 p.173). The study of such assemblages therefore relies on detailed empiricism to capture multiple layers of actors and complexity, existing in a state of fluidity.

While the work of critical scholars places a welcome emphasis on the multiplicity of influences on the policy process and makes a strong case for why the results of any policy transfer process will necessarily be shaped by local factors, critical questions remain. The concern for scholars of policy mobility appears to have shifted once more to the *process* of policy transfer (however that is conceived). The conceptual lens of 'assemblage' will render every case unique, and uncovering those cases will require detailed empirical study, raising questions about the generalisability of the findings. The claims of 'constant flux' leave few fixed points, with the exception of the spatial domain under investigation, although even territories, in the eyes of Deleuze, are "not fixed for all time, but are always being made or unmade" (Wise, 2005, quoted in McCann, 2011 p.144).

The varying positions held on policy transfer are, as Dolowitz and Marsh (2012) contest, a reflection of the ontological and epistemological positions held by the scholar. I contend that, despite the valuable contribution being made to the literature on policy mobility by critical

policy scholars, there are still strong arguments to be made for adopting an approach to policy transfer that acknowledges the role of both agency and structure in the processes. The remaining parts of this chapter first discuss the limited application of policy transfer analysis to drug policy before addressing the question of the suitability of applying a policy transfer framework to the research question at hand, particularly in light of the critiques presented above. Finally, a proposed policy transfer framework is presented, incorporating a multi-level approach to policy transfer analysis (Evans, 2004).

3.2.2 The limited application of policy transfer and mobility lenses to drug policy

Despite the relatively rich body of work in drug policy scholarship that is concerned with policy change and the impact of evidence and ideas, the use of concepts from policy transfer and mobility literature has been limited, as illustrated by the introduction to the literature presented in Chapter Two. The purpose of this section is to explore that literature, illustrating how it has been utilised to capture aspects of drug policy development. Mirroring the more general literature, the application of policy transfer concepts to drug policy issues falls neatly between more classic studies based on the work of Dolowitz and Marsh and Evans (applied by Butler, 2013 and Bewley-Taylor, 2014), and the mobilities literature by McCann (2008), McCann and Temenos (2015), Temenos (2016; 2017) and Longhurst and McCann (2016).

Butler (2013) and Bewley-Taylor's (2014) studies are concerned with the transfer of policy from one national jurisdiction to another. Both refer to the works of Dolowitz and Marsh (2000), while Bewley-Taylor also draws on Evans (2009) and Stone (1989) to provide insights into this process. Butler (2013) examines the introduction of an American model of drug courts into Ireland; having established a ten-year history of poor outcomes, Butler seeks to understand why the 'trial' was allowed to continue and political support was maintained for the programme. While he does not use Dolowitz and Marsh's (2000) terminology, he is clearly arguing this is a case of 'inappropriate transfer'. His findings attribute the outcomes

to the transfer being treated as a 'discrete technical process' which ignored the incompatibility of the intervention with the underlying judicial philosophy in operation in the Irish court system. Butler's conclusion is that, while there is strong evidence of a failure of implementation, the symbolism of the transfer has served a political purpose. In contributing to our understanding of drug policy and policy transfer, Butler's study serves as confirmation that policy transfer without adaptation for local circumstances and context is unlikely to succeed. It contributes to the body of empirical studies that seek to explore unsuccessful transfer in line with Dolowitz and Marsh's (2000) call to examine cases of both success and failure.

Bewley-Taylor's (2014) study of the development of the Afghan National Drug Control Strategy adopts a multi-level perspective that incorporates elements of both Dolowitz and Marsh (2000) and Evans' (2009) frameworks. He is concerned with interrogating various levels of enquiry; capturing the roles played by multiple agents (within and outside government); and exploring the policy transfer network that operates across international, state and inter-organisational levels. Bewley-Taylor supplements this policy transfer framework with narrative policy analysis, which he uses to differentiate the motivations of the various agents at work within the policy network. He uses a process of historical reconstruction or process tracing to uncover the roles played by different policy actors. Unlike Butler, Bewley-Taylor is not concerned with an assessment of the success or failure of the transfer process, but rather what can be learned about the influence of the actors and their agendas, many of whom represented international organisations or foreign governments. Like Butler, Bewley-Taylor identifies "inappropriate content" which "left the Strategy in many ways divorced from the realities of some aspects of the drug market within the country" (Bewley-Taylor, 2014 p.1016). What he describes, however, is not a case of coercive policy transfer (Dolowitz and Marsh, 2000) but an instance of a 'recipient' government deliberately embracing a "predominantly exogenous document" as an entrée

back into the international community by embracing the "normative expectations of the international drug control regime" (Bewley-Taylor, 2014 p.1016). Bewley-Taylor's analysis furthers our understanding of the importance of *motivation* in policy transfer scenarios. Using policy transfer as an 'analogical model' rather than a theory, the study demonstrates its usefulness in interrogating multiple levels of actors and influence.

The work of McCann (2008), McCann and Temenos (2015), Temenos (2016; 2017) and Longhurst and McCann (2016) all shares an approach to policy mobility that has developed from urban geography and introduces spatiality into the analysis of policy movement. The main concerns of these scholars are the circulation of knowledge and the networks of policy actors and the spaces in which they interact. By tracing the movement of policy ideas through global circuits of knowledge, policy mobility scholars study the 'assemblage' of policy at local sites and the mutation or adaptation of those policies as the local context and local actors interact with ideas from 'elsewhere' and in turn contribute to the global 'models'. This process of assembly is "a thoroughly political process" (Longhurst and McCann, 2016 p.111) and, as all these studies reflect, the use of a policy mobility lens is intended to shed light on the power and politics at the heart of policy making processes. McCann and Temenos (2015) describe the mobilisation of policy as "a complex, power-laden social process" and argue that "policy mobilities are always about power and politics" (pp.217-218). They state that knowledge exchange is inherently a political process, going so far as to argue knowledge exchange and politics are "two sides of the same coin" (p.221).

The focus on a multitude of actors reflects an ontological belief that power lies with agents, not within institutions or structures, although Longhurst and McCann (2016) do acknowledge the effects of a constrained political-institutional environment in their study of the constrained mobility of harm reduction drug policy in Surrey, British Columbia. Temenos (2017) effectively dismisses formal political structures as being able to contribute to change,

due to their capture by neoliberal forces in what she argues is a 'post-political condition'. The political action that she sees as important, as discussed below, focuses on actions outside state structures. This idea is challenged by the findings of this thesis, as will be discussed in later chapters.

McCann has been at the forefront of the development of the policy mobilities approach, and some of his earliest work has focused on drug policy. His study of the development of Vancouver's four pillar drug strategy is a thorough analysis which develops his earlier (McCann, 2008) concept of urban policy mobilities. It is concerned with the movement of ideas and policy from city to city through 'global circuits of policy knowledge'. McCann is interested in the complex relations and interconnections of urban policy actors, of which he identifies a broad range, thus contributing to a focus on practices and actors that sit outside the formal state apparatus. McCann's work, importantly, is concerned with the spatialities "where experts work, connections are made, and where truths are deployed, legitimized, questioned, and operationalized" (McCann, 2008 p. 16). For drug policy scholarship more generally, McCann's work contributes an acknowledgement of the role of an epistemic community (although this is not a term used by McCann); one democratically conceived, where expertise may be from community activists and people who use drugs, not just academics and policy experts.

Temenos' (2016; 2017) two papers are concerned with drug policy activism and its influence on policy development. The first paper explores the role of conferences as 'convergence spaces' where policy mobilisation occurs. Temenos (2016) argues that her focus on micro-spaces, as she terms them, sheds light on the role played by policy activism in the process by which policy is assembled. She highlights the role of transnational advocacy networks in knowledge exchange, as well as being interested in the political impact of a city's role in hosting conferences in the context of local and national government relationships.

The second study describes the contestation over harm-reduction-driven public health activities in three diverse cities in Canada, Dominican Republic and Luxembourg. Temenos argues that harm reduction is a technical response, embedded in expert medical knowledge and aimed at risk reduction, yet it is also a radical social movement with roots in participatory democratic practice. She wishes to explore the political geographies of public health and drug policies and argues that a focus on policy mobilities can illuminate the relationship between policy and politics. Temenos sets this analysis in a context of the 'post-political condition', arguing that "exclusion of people from the state blocks debate over *what* should be governed in favour of discussion of techno-managerial questions regarding *how* best to order and police social lives" (p. 585, italics in original). She is therefore interested in the disruptive role played by activism, privileging, as she calls it, 'everyday proper politics' over more traditional politics, which she argues have been reduced to the management of technical issues and no longer provides a forum for debate over fundamental ideological differences. Her position therefore would seem to disregard the role of formal political institutions as a site for reform or change, given their 'capture'; a claim challenged by this thesis by its continued focus on state-centred institutions. Temenos' work demonstrates policy mobility scholarship's concern with fluidity, flux and dispersed networks that act both globally and locally.

Finally, reflecting their concern with spatiality, Longhurst and McCann (2016) contribute a concept of the 'policy frontier' where "mobile policies encounter resistance, barriers, and challenges as they are mobilised" (p. 111). In this conceptualisation, they argue that in 'frontier politics' outcomes remain politically open but are sites of contestation and struggle over policy ideas and ideology. They use the case study of the attempts to introduce harm reduction policies in Surrey, British Columbia, a neighbouring city of Vancouver, identifying this as a case of constrained mobility where agents for change have met resistance and barriers. Once again, the focus of this work is on mutation, with Longhurst and McCann arguing that policy models will always be subject to adaptation; the policy frontiers are

viewed as "spaces in which alliances can be built, debate can occur, and experimentation can take place" (Longhurst and McCann, 2016 p. 120).

3.2.3 The case for applying a policy transfer lens

The application of a policy mobilities lens to questions of drug policy development has brought a focus on the role of multiple agents, and contributed to our understanding of how policies are shaped and interact at local, regional, national and global levels. I would contend, however, that despite this valuable contribution, there is existing scope within policy transfer literature to continue to offer utility without having to go down a constructivist path that privileges agency at the expense of structure. I argue instead that the adoption of a policy transfer framework offers a suitable lens for interrogating the question of the replication of drug consumption rooms by looking at different levels of governance and considering the relationship between agency and structure to be dialectic.

The debate over the utility of the concept of policy transfer has, according to Newburn et al., largely focused on "the overly rationalistic, occasionally positivistic tendencies of much orthodox policy transfer scholarship" (Newburn et al., 2018 p.567). These shortcomings have, however, been addressed by Dolowitz and Marsh (2012) in response to the criticisms of McCann and Ward (2012), and by Evans and Davies (1999) in their discussion on the complexity of modern governance. Work within the field of policy change more generally, as discussed in Chapter Two, has also developed to respond to the increasing complexity affecting policy development, offering insight into the roles of multiple agents, ideas, narratives and discourse. I therefore maintain that policy transfer remains a useful concept, particularly when it is utilised from an appreciation of the complexity of policy change, such as through the framework developed by Evans and Davies (1999) and Evans (2004).

As the review of the drug policy literature demonstrates, there have been very few attempts to apply policy transfer concepts in this field, although the policy mobilities literature is better

developed. The restricted volume of the literature is perhaps surprising, given that a fundamental concern of drug policy literature has been to interrogate the role played by evidence and evidence-based policy. Policy transfer is about ideas and the sharing and transfer of knowledge, and therefore highly relevant to how drug policy is developed. It also shares a concern with how 'global' ideas, such as those developed through a social movement like harm reduction and through epistemic communities, are accepted or adapted at the local level. Within drug policy scholarship, there has been a call that "Much more attention needs to be paid to issues of problem construction, politics, ideology, power and the messy complexity of the policy process" (Stevens and Ritter, 2013 p.169). The potential for policy transfer to contribute to our understanding of these issues has been underutilised to date, and it is the intention of this study to address this lacuna.

While the policy mobility literature shares the concerns of knowledge exchange and circulation, I would argue its ontological underpinnings that privilege agency over structure blind it to the highly relevant role played by structure in the cases being explored; therefore, an approach that allows for the interaction between agency and structure will more fully shed light on the policy processes under examination. This decision has been made in recognition that while the debate and deliberation over drug consumption rooms has engaged many agents, the implications of the criminalisation of drugs are that there is a critical legislative and institutional element that comes into play in the policy process. This is not to restrict the research to the realm of formal politics, but the study recognises that institutional structures have served to constrain or shape policy development and the approach to the study needs to incorporate their role. A more detailed discussion of the ontological underpinnings for the study and the justification for adopting a critical realist perspective is undertaken in the following chapter.

Policy transfer or policy change?

Before introducing the proposed policy transfer framework, it is necessary to address the issue raised by James and Lodge (2003) when they queried the explanatory value of policy transfer approaches, as distinct from other literature focused on policy change. Using Dolowitz and Marsh's case study of the 'failed' transfer of the British Child Support Agency model, they argue that analysing the case from a policy transfer perspective does not result in an explanation for failure in terms of the *process* of transfer itself, but rather, other factors that were at play. This may well be a valid criticism of that particular case but I argue employing a framework developed around the concept of policy transfer provides some 'additionality' to other policy change theories. I will develop three arguments to support using a policy transfer lens for this particular study.

This study seeks to address the question of why drug consumption rooms were not replicated or were slow to be replicated in the case study countries, looking at the experience of four different cities where a case could be made for drug consumption rooms to address a specific identified need in relation to street-based drug use. My first argument is that it is indisputable that drug consumption rooms are an idea that has travelled from Europe to both Australia and Canada, as has been documented by McCann and Temenos (2015) and Dolan et al. (2000). For this thesis, the question then arises as to why there was such a significant lag time between the initial official sites in Sydney and Vancouver, and any subsequent adoption or replication of the policy, whether locally, regionally or nationally, particularly given the technical feasibility had been established by those pilots. By examining the question of the challenges or barriers to diffusion of the policy across sub-national jurisdictions, this study seeks to make a contribution to policy transfer literature, which has largely been concerned with the transfer of policy across rather than within national boundaries (Dolowitz and Marsh, 2012).

A second but related point is that the comparative nature of the study lends itself to a policy transfer framework. Each of the four case studies is concerned with the same policy initiative. Both Dolowitz and Marsh (2012) and McCann and Ward (2012) make the case for examining unsuccessful instances of policy transfer, so the literature in this field provides a relevant guide to interrogating the research question's interest in replication and policy stall. A policy transfer framework should be sufficiently broad and multi-layered to interrogate a range of factors to see which are the most influential in each case and to analyse the findings for commonality and differences between the cases.

There is a final aspect that makes the concept of policy transfer very relevant to the concern of this research, which relates to the question of 'success' or 'failure'. It could be argued that earlier policy transfer studies were often concerned with technical aspects related to the process of policy transfer, in order to determine if the transfer had been fully achieved or partial or inappropriate (Dolowitz and Marsh, 2000). It is not the intention of this study to forensically examine the policy transfer process in order to make determinations about the process of transfer. As Marsh and McConnell (2010) argue, claims for the 'success' of a particular policy are commonplace but are rarely justified against systematic criteria. This prompted them to propose that policy success can be conceived in three dimensions: process, programmatic and political. This is a useful heuristic to apply to questions of policy transfer 'success' and seems highly relevant to the cases at hand, where, as will be discussed below, a wealth of 'evidence' points to programmatic success of the pilots yet subsequent policy development stalls. A policy transfer framework, focused on multiple sources of policy change, offers an opportunity to examine the conditions that impact on policy outcomes and replication. The concerns of this study therefore sit comfortably with two of Dolowitz and Marsh's (2000) key questions, considered in the development of their policy transfer framework: what restricts or facilitates the policy transfer process? How is policy transfer

related to policy 'success' or policy 'failure'? This final question leaves open the possibility for the study to conclude that policy transfer was not the primary driver in some or all cases.

3.3 Theoretical framework

3.3.1 A multi-level approach to policy transfer

The research question is concerned with the policy process in each case study city site; however, the cases, which focus on the interface of public health and law enforcement policy, are not constrained by local governance boundaries but are enmeshed in regional, national and international contexts and settings. It is therefore necessary to apply a theoretical framework which incorporates a multi-level approach to analysis. The work of Evans and Davies (1999) and Evans (2004) provides such a focus. The following section outlines the key features of their policy transfer framework and explains how this framework will guide the analysis of the empirical findings of the four case studies.

Evans and Davies (1999) approach to policy transfer analysis was developed out of a concern that political scientists from different subject areas were grappling with similar problems related to uncertainty and complexity, but were not benefiting from each other's insights. Looking across the discipline, Evans and Davies sought to deliberately integrate five approaches that they felt could enlighten the study of policy transfer. Those approaches are "international structure and agency and the epistemic community approach, domestic structure and agency, policy network analysis and formal policy transfer analysis" (Evans and Davies, 1999 p.363). The result is a heuristic model of a multi-level approach to policy transfer based on three dimensions: global, transnational and international levels; the macro-state level; and the interorganisational level. The model is developed on a foundation of structuration theory that sees structure and agency in a dialectic relationship. At each level of analysis, the authors are concerned about the impact of structural processes on the

process of policy transfer, and also whether the actions of agents have had an impact on external structures.

> "We must assess whether structural processes external to the process of transfer we are looking at have an impact (directly or indirectly) upon the context, strategies, intentions and actions of the agents directly involved. Conversely we must also run the counterfactual and assess whether the strategies, intentions and actions of agents can constrain and/or enable structures." (Evans and Davies, 1999 p.370)

Table 3.1 Multi-level policy transfer analysis

1
Global, International and Transnational Structures Economic, technological, ideological and institutional structures constrain but do not determine the behaviour of state actors at levels 2 and 3
2 *The State Project (e.g. the UK Competition State)* The state has some autonomy from structural forces (economic, technological, ideological and institutional) at the level of strategic selectivity
3 *Meso-Level: the Policy Transfer Network* A network of indigenous and exogenous agents in resource-dependent relationships with some level of autonomy from structural forces at the level of options analysis and implementation in processes of policy transfer. Events at level 3 can often be explained by reference to the interactions of 1 & 2.

(Source: Evans, 2004 p. 23.)

Table 3.1 depicts the three levels of analysis based on Evans and Davies' (1999) conceptualisation. At the macro level, analysis should focus on those structures identified at the global, international and transnational level that either enable or constrain action in relation to the attempted policy transfer. State-centred forces constitute a second macro-

level of analysis. Evans describes state-centred explanations of policy change as "changes that emanate from systems change (electoral, institutional, ideological), historical legacies and the sharing of similar problems" (Evans, 2004 p.33). As Evans and Davies (1999) argue, for example, a policy idea that does not align with the strategic concerns of the state is unlikely to be adopted. At the meso-level of analysis, the focus is on policy transfer networks. Integrating ideas from policy networks and epistemic communities literature, Evans and Davies developed the concept of the policy transfer network, conceived as an ad hoc, action-oriented policy making structure comprised of state and non-state actors. Their primary interest here was in developing a tool for analysing the acquisition and utilisation of knowledge by decision makers. Evans (2004) adds a fourth level of analysis, being the micro-level processes of policy-oriented learning. He identifies four forms of policy-oriented learning: copying, emulation, hybridisation, and inspiration. Analysis at this level would seek to identify factors that constrain policy-oriented learning, which Evans groups into cognitive, environmental, and international and public opinion.

3.3.2 Modifying and applying the framework

I propose to use this framework (see Figure 3.1) to analyse sources of policy change or stall in order to better understand the issues affecting the replication of drug consumption rooms in the case study cities. The analysis will be based on the findings of the case studies (Chapters 5 and 6) and the empirical findings from the thematic analysis of the qualitative interviews (Chapter 7). This analysis will be presented in the discussion section (Chapter 8). The use of this policy transfer framework will shed light on the policy process in each case study site while allowing for comparisons to be made across project sites. There will be an opportunity to test out the adequacy of the policy transfer framework to contribute to our understanding of drug policy development in these sites. Given the gap identified in the literature, this will serve as an important contribution to drug policy scholarship. In the process of mapping the findings to the framework, I will be attempting to identify factors that lie outside the

framework, which, if significant, may result in modifications being proposed and therefore a contribution also being made to the body of policy transfer literature.

Figure 3.1 Sources of policy change and stall

Global/international structures Eg. Role of UN agencies and international drug treaties	State-centred forces Eg. National/provincial/local levels of government and their interactions
Sources of policy change/stall (adapted from Evans, 2004)	
Eg. Micro-level factors that constrain learning Policy-oriented learning	Eg. Agents that facilitated policy transfer Policy transfer networks

As a contested concept, policy transfer has been subject to debate and interpretation as discussed above. Dolowitz and Marsh (2000), in drawing together the various strands of scholarship, illustrate the breadth of concerns that are studied under the guise of being policy transfer problems. They also illustrate that these problems can be approached from a number of angles, depending upon whether the concern is embedded in process issues or a search for more explanatory factors that have influenced policy outcomes. In developing their initial framework, Evans and Davies (1999) purposively sought to integrate ideas that were circulating among political scientists, and argued that their approach to policy transfer was as a model of policy change. Their framework as it stands is an ideal analogical model to identify sources of policy change and stall that can help shed light on our understanding of the issues affecting the replication of drug consumption rooms.

3.4 Conclusions

Drug policy scholarship has been increasingly engaging with literature from political science and policy studies in order to better understand the complexity of policy change in the contested area of illicit drug policy. There have been few attempts by drug policy scholars to engage with the concepts offered by policy transfer, despite a shared interest in the use of evidence and knowledge, policy learning and policy success and failure. As a comparative study seeking to understand barriers to policy replication and diffusion, the utilisation of a policy transfer lens offers an opportunity to analyse sources of policy change and stall at multiple levels while acknowledging the roles of both structure and agency in the process. The robustness of this framework will be considered through the analysis of the empirical findings from the four case studies and the thematic analysis of the study's qualitative interviews and if necessary, modifications will be proposed in the discussion in Chapter 8.

Chapter four
Methodology

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4.1 Introduction

The previous chapter, in outlining the debate between scholars concerned with theorising policy movement and change, demonstrated the significance of the ontological and epistemological issues that underlie theory development. In large part, the differences between the schools of thought on policy transfer and policy mobility lie with a difference in worldview as to the nature of the reality being investigated and how we can gain knowledge of that reality. The purpose of this chapter is two-fold. First, to state the ontological position held by the researcher to justify and support the choice of theoretical approach. And second, to introduce the methodological approach best suited to explore and analyse the research question in light of that ontological position and the chosen policy transfer framework introduced in Chapter Three.

The chapter is divided into six sections. The first, section 4.2, outlines the tenets of critical realism and examines the implications of critical realism for developing an understanding of the dialectic relationship between structure and agency, an issue problematised in the previous chapter. The role of the ideational is also explored, making the argument that ideas are critical due to their causal role which exists independently of material interests. That stance opens the way for critical realism to accept elements of interpretivism and sit within a spectrum of constructivism. Section 4.3 provides a bridge between the discussion on ontology and methodology by linking the ontological position with the theoretical approach and the broad research design. The chapter then addresses methodological issues in sections 4.4 and 4.5, introducing the case study methodology, data sources and methods of collection. Section 4.6 discusses the methods of data analysis, including the construction of the case studies and the use of thematic analysis. Ethical issues are the focus of the final section (4.7).

4.2 A critical realist ontology

Furlong and Marsh (2010) urge us to consider our ontological position as a 'skin' rather than a 'sweater', meaning it is something we always carry with us rather than something we 'put on' only when we address the philosophical issues underlying our research. This section will introduce the critical realist ontology that underpins this thesis and outline the links between this ontological position, its epistemological consequences and the theoretical stance introduced in the previous chapter.

One of the fundamental tenets of realism is its assertion that the world exists independently of our knowledge of it (Furlong and Marsh, 2010). For realists, 'events' which are considered "observable and experienceable phenomena" are generated by underlying structures which are not directly observable (Willig, 1999). These structures include social structures, which through their ability to generate events are considered to have causal powers. As they are not directly observable, they must be 'discovered' by searching for their effects. This is not, however, a case of relying upon empirical evidence or what can be observed, for the structures can exist but produce no events, and events may occur whether observed or not (Marsden, 2005). As Furlong and Marsh argue, there are significant methodological implications of this: "It means that realists do not accept that what appears to be so, or, perhaps more significantly, what actors say is so, is necessarily so" (Furlong and Marsh, 2010 p.204). The aim therefore of realist science is to explain observable phenomena by referencing the underlying structures and mechanisms (Blaike, 1993). The device through which this is done is theory (Hay, 2002).

Modern critical realism, based on the work of Bhaskar (1975) and Archer (1998), maintains that there are three levels of reality, the domains of the 'real', the 'actual' and the 'empirical'. The 'real' are generative mechanisms or structures or processes that generate events. The 'actual' are the events, whether observed or not. The 'empirical' are the experiences of events. These levels of reality are, according to Marsden (2005), 'interrelated, but distinct

and irreducible'. As stated above, structures are considered to have causal powers; however, for critical realists, causation "is an object's capacity to act and is intrinsic to its internal structures and mechanisms" (Marsden, 2005 p.134). Empirical observation, therefore, does not provide an explanation for events. As Sayer explains:

> "What causes something to happen has nothing to do with the number of times we have observed it happening. Explanation depends instead on identifying causal mechanisms and how they work, and discovering if they have been activated and under what conditions" (Sayer, 2000 p.14).

Importantly, this rejection of a positivist model of causation as successionist (from cause to effect), opens the possibility of viewing the social world as an 'open system' where the same causal power can produce different effects (Sayer, 2000). The acknowledgment that there are alternative possible futures ('potentialities') creates the opportunity to theorise about change and transformation (Willig, 1999).

While arguments ensue as to whether structure and agency are considered ontologically separate under critical realism, it is agreed that there is interplay between the two, whether that is conceived as Archer's 'morphogenic' approach or Jessop's 'strategic relational' approach (Hay, 2002). I have adopted a dialectic interpretation of structure and agency that allows us to conceptualise structures as constraining, but also offering opportunity, and individuals as having the capacity to exercise agency in relation to these structures. As Archer articulates, "…there are properties and powers particular to people which include a reflexivity towards and creativity about any social context which they confront" (Archer, 1998 p. 190). In this way, neither structure or agency is privileged. It is through an acceptance and examination of the interplay between the two that we might seek meaning.

The acknowledgement of the role of structure sets critical realism apart from interpretivist or constructivist positions that reject the notion that the world exists independent of our knowledge of it. Rather, social constructivists conceive of the world as being purely discursively or socially constructed, where meaning does not exist independent of our

interpretation. These interpretations can only be understood through the discourses or traditions attached to the social phenomenon under investigation (Furlong and Marsh, 2010). Whilst there is a fundamental difference in the ontological positions of critical realism and idealism, critical realism accommodates some of the tenets of interpretivism. Critical realists in their acceptance of an 'unobservable' reality, also accept there is a socially constructed element to that 'reality'; agents act based on perception and a discursive construct. The implications of this are significant as agents' actions, *whether undertaken on the basis of reality or a perception of reality,* have causal power. As Furlong and Marsh explain, "We need to identify and understand both the external 'reality' and the social construction of that 'reality' if we are to explain the relationship between social phenomenon" (Furlong and Marsh, 2010 p.205).

Critical realism, therefore, accommodates the ideational, which is of fundamental importance to the theoretical underpinnings of this thesis. The critical realist position on the relationship between the ideational and the material, like that between structure and agency, is dialectical. Hay groups critical realists within a spectrum of constructivism, where ideas are attributed with an independent causal role that is not reducible to underlying material interests. His argument for this is that actors do not have perfect information with which they can negotiate the contexts (structures) in which they are required to operate; therefore, their interactions with that context must involve an element of interpretation. As he puts it, '*Ideas provide the point of mediation between actors and their environment*' (Hay, 2002 pp.209-210, italics in original). Elaborating on the dialectical nature of the relationship between agency and structure, Hay states:

> "Political outcomes are, in short, neither a simple reflection of actors' intentions and understandings nor of the contexts which give rise to such intentions and understandings. Rather, they are a product of the impact of the strategies actors devise as a means to realise their intentions upon a context which favours certain strategies over others and does so irrespective of the intentions of the actors themselves." (Hay, 2002 p. 208)

Within this spectrum of constructivism, Hay characterises the 'thick' constructivists as those who privilege the role of ideas but recognise material factors, whilst the 'thin' constructivists (including critical realists) emphasise the role of the material world in constraining discursive constructs.

To summarise, the following points from the above discussion provide the basis on which we can devise an appropriate methodology to explore our concern with policy change in the context of the theoretical framework of policy transfer introduced in Chapter Three.

1. Critical realism maintains there are three levels of reality: the 'real', the 'actual' and the empirical'. Explanation depends on identifying the underlying causal mechanism, not exclusively on empirical observation.

2. Structure (context) and agency (conduct) are in a dialectic relationship, where structures can act as constraints, but individuals can exercise agency in relation to these structures.

3. Critical realism accepts there is a socially constructed and interpreted element to 'reality'. We cannot observe the 'real'; therefore, agents rely on interpretation of their contexts. Ideas therefore have an independent causal relationship which affect political outcomes. Both the material and the ideational matter and are in a dialectical relationship. Critical realism therefore accommodates a form of (thin) constructivism.

4.3 Ontology, the theoretical framework and research design

The critical realist ontology described above underpins this thesis' exploration of policy change. Having established a position on what constitutes the nature of the reality being investigated, it is appropriate to introduce the proposed approach as to how we will gain knowledge of this reality and what research strategy will be employed. The purpose of this section is to provide a bridge between the discussion of ontology and the methodology of

the thesis by addressing the compatibility of the critical realist approach and the chosen theoretical approach of policy transfer, followed by a broad outline of the research design.

4.3.1 Critical realism and the policy transfer framework

Having established an ontological position, an epistemological question arises. How can knowledge of this reality be acquired? The assertion of critical realism – that reality exists at three levels (the real, the actual, the empirical) – creates a dilemma, as it rejects empiricism on the grounds that the 'real' consists of unobservable underlying structures and the events of the 'actual' may or may not be observed. It therefore falls to theory to map these real relationships (Marsden, 2005). In Hay's words, theory is deployed "as a sensitising device to reveal structured reality beneath the surface" (Hay, 2002 p. 122).

As described in Chapter Three, the policy transfer framework developed by Evans and Davies (1999) and Evans (2004) is based on multi-level policy analysis. In seeking to identify sources of policy change the framework's authors have devised a model that is consistent with a critical realist ontology, acknowledging the roles of both structure and agency and attributing causal power to both. It is a dialectic model that sees elements of structure and agency working to enable or constrain attempts at policy transfer. Operating on multiple levels, the framework encourages the identification of sources of policy change from both international and state-centred structures. Further, the framework incorporates a concern with agency through its focus on the role of agents in Evans and Davies' (1999) conception of 'policy transfer networks'. The agents in these networks are understood to have causal power and operate with some level of autonomy from the structures with which they interact. A concern with ideas and the transfer and passage of knowledge sit at the heart of policy transfer. Here, the ideational can be expressed both through embodiment in structure, where ideas are embedded in institution structures (Béland and Cox, 1999), and through the impact of ideas on agents. The latter is captured through the concept of a policy transfer network where the

focus is on the passage of ideas and the acquisition and sharing of knowledge (Evans and Davies, 1999).

4.3.2 Research design

The ontology of critical realism does not provide a prescribed approach or research method (Marsden, 2005). The discussion above describes the compatibility of critical realism with a 'thin' constructivist approach that espouses the co-existence of both structural forces and social constructions. In order to identify both structures and constructions that may act as enablers or constraints in relation to the research questions under investigation, it is proposed to combine a case study methodology largely based on documentary analysis and thematic analysis of interview data. The relationship between these elements is captured in Figure 4.1 below.

Figure 4.1 Relationship between ontology, epistemology and research strategy
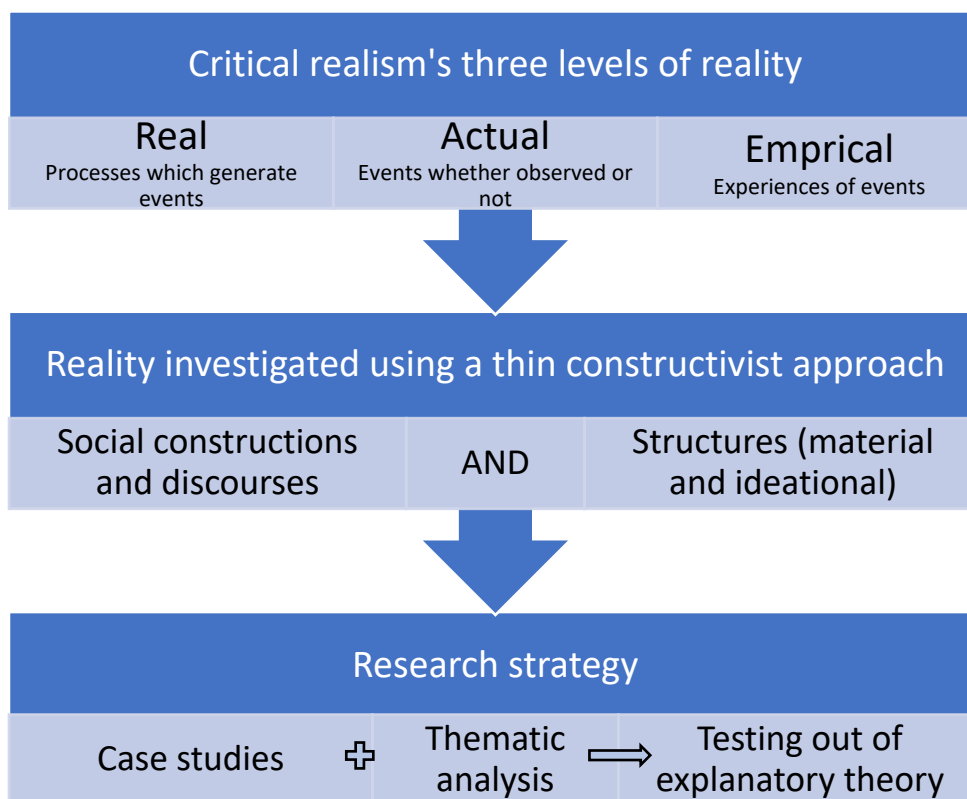
4.4 Case study methodology: selection and analysis

A multiple case study methodology (Yin, 2014) has been chosen as the appropriate method to capture the specific cases of the drug consumption room policy development in two chosen countries, Australia and Canada. In both countries, there have been both successful and failed attempts to change drug policy to allow for the establishment of DCRs. Four cities have been selected as cases to explore in depth these attempts at policy change. The choice of cases is consistent with a theoretical sampling approach, where these cases have been selected on the basis of their relevance to my research questions and my theoretical position. As Mason explains:

> "Theoretical sampling is concerned with constructing a sample…which is meaningful theoretically, because it builds in certain characteristics or criteria which help to develop and test your theory or explanation." (Mason, 1996 pp. 93-94)

Case studies are well suited to qualitative research in the social sciences, where the purpose of theory is not to be predictive. Flyvbjerg, elaborating on this point, argues that what the social sciences can offer is "concrete, context dependent knowledge", for which the case study is particularly suited (Flyvbjerg, 2006 p. 223). The generalisability of cases follows a theoretical logic, rather than generalisability to populations (Bryman, 1988 cited in Silverman, 2014). An equally important part of the multiple case study methodology is the use of comparison, as it allows for both in-case and cross-case analysis. By choosing two case study sites in each of the two countries, there is also opportunity to consider (consistent with the multi-levelled theoretical approach) the impact of national factors as well as those at the local level.

Australia and Canada have been chosen for the study as, at present, they have the only official drug consumption rooms in the English-speaking world, as detailed in Chapter One. The remaining 90 drug consumption rooms worldwide are on the European mainland, spread across eight countries as detailed in Chapter One (see Table 1.2). Both the initial Australian facility (MSIC, established in 2001) and the Canadian facility (Insite, established in 2003) were

set up under legislation and run on a trial basis. In both of these cases, the evaluations of the pilot projects generated credible evidence that established the effectiveness of the centres against their objectives (KPMG, 2010; Wood et al., 2006). This thesis' research question is concerned with the challenges of replicating these successful services, with a focus on the policy process. Four cities, two in each country, have been chosen as case study sites: Sydney, Melbourne, Vancouver and Toronto. The period of the study is approximately 20 years, from the late 1990s to the present day. The rational for this period is that it covers the time from when DCRs were first considered as a policy option, to recent, significant events in this policy domain. As the case studies will demonstrate, by considering the issue in each site over a two-decade period it is possible to analyse the process of policy development in depth without the potential risk of drawing conclusions from isolated events were the timeframe shorter.

At the commencement of the research project in 2015, there were only the aforementioned two sanctioned centres in Sydney and Vancouver. As the case studies in Chapters Five and Six will demonstrate, this situation changed during the course of the research: new centres were opened across Canada (including in the selected case study cities) and a medically supervised injecting room was opened in Melbourne, Australia. These developments necessitated some flexibility as to the methodology of the thesis, as the initial premise of the selection of the cases was consistent with a replication logic based on a 'change/no change' criterion (Yin, 2014). Fortunately, the unanticipated developments did not invalidate the case selection but served to enhance the study by adding a richness to the processes being explored.

As part of the research design process, consideration was given to including a country from Europe, where drug consumption rooms have been more prolific. This would have opened up interesting research questions with regards to policy transfer and replication. Given the

diversity of countries in Europe, the inclusion of a case study from that region would not have been grounds for generalising about a 'European' approach to drug policy. However, exploring the challenges to policy change under different political configurations and regimes would be a fruitful branch of future comparative research. The final choice to use case studies from Australia and Canada was made on three grounds. First, the shared political characteristics of Australia and Canada in terms of their federalism and Westminster-style parliamentary systems allows for cross-case analysis based on some similarities, strengthening the replication logic noted above (Yin, 2014). Secondly, despite a noted divergence in policy development paths during the course of the study from 2016 onwards, for much of the twenty-year period under examination, both countries followed a remarkably similar path in regard to non-replication of DCRs. Finally, on a practical level, given the importance of documentary analysis to the methodology of the project, working with material that was in a common language was deemed to more likely produce rigorous and comparable analysis. The same issue was also pertinent to the choice to conduct interviews only in English, without the aid of translators. Ultimately, given the resource constraints and the nature of collecting data as a single researcher and not as part of a multi-researcher team, it made sense not to attempt to incorporate foreign language material.

The multiple case study methodology encompasses both in-case and cross-case analysis. The in-case analysis allows for consideration of the factors specific to each site, including, but not limited to, patterns of drug use and their public health implications; the local drug policy context; local political considerations; the level of active campaigning; and funding issues. The second stage of analysis, cross-case analysis, considers those factors that the sites have in common and those factors that are specific to the local context. See Table 4.1 below for an illustration of the different levels of analysis.

Table 4.1 Multiple case study methodology analysis

In-case analysis		Cross-case analysis			
Australia	C1 Sydney	National comparison	Australia (C1 & C2)	International comparison	Australia and Canada
	C2 Melbourne				
Canada	C3 Vancouver		Canada (C3 & C4)		
	C4 Toronto				

4.5 Data sources and methods of collection

The case study methodology was supported by the collection of qualitative data from documentary sources and semi-structured in-depth interviews.

4.5.1 Documentary sources

A systematic approach was taken to the collection of both primary and secondary documentary material. The process of collecting material was documented through research memos to ensure an audit trail was maintained. The initial search began with secondary material in the academic literature. Earlier background and literature review searches were augmented with keyword searches of relevant journals, such as the *International Journal of Drug Policy* and *Drugs: Education, Prevention and Policy*. References from journal articles were followed up, including the material contained in the systematic reviews of drug consumption rooms. A review was then conducted to source primary material for each case study site, including reports, policies, transcripts of parliamentary debates, legislation, court findings and evaluations (see Table 4.2 below). These documentary materials provided insight not only into processes, but also the nature of the debate and framing of the issues, capturing the complexity and contested nature of the subject. The documentary materials were a resource for identifying potential interview participants, but also provided reference

points for the interviews. Participants provided valuable insights from 'behind the scenes' into documentary materials; for example, through reflections on the presentation of issues or events in the media, and how and why official reports had portrayed issues or outcomes.

Media materials were also an important data source for the case studies. The database Nexis was used to search for and access media reports from Australia and Canada using keyword searches. The data collection process was iterative, enabling the ongoing collection of material as it came to light through further reading and the interview process. A network of relevant contributors to debate and discussion on drug policy was established through Twitter, which was monitored regularly as a means of staying abreast of any new articles, events or developments that would have bearing on this thesis.

Table 4.2 Key documentary source categories

Key documentary source	Examples
Parliamentary reports	Parliamentary Committee Reports and background research reports
Parliamentary transcripts (Hansard)	Debates to introduce legislation to allow for provision of drug consumption rooms
Legislation	Acts pertaining to supervised injecting
Government reports	Statutory review reports required under legislation
Government policy papers	Official drug strategy documents
Public health documents	Drug surveillance bulletins issued by Public Health departments
Committee/Council Minutes	Board of Health meeting minutes
Submissions to Committees	Responses to calls for submissions to public inquiries from organisations and individuals
Evaluation documents	Independent evaluations conducted on services
Research documents	Journal articles, academic literature
Coroners' reports	Reports addressing overdose risk and supervised injecting
Media	Reporting on overdose, drug use and supervised injecting, including current and archived material
Press releases	Statements outlining positions of organisations or individuals in relation to supervised injecting
Project proposals	Feasibility studies for drug consumption rooms
Websites	Government and non-government agencies' websites
Social media sources	Twitter feed

4.5.2 Interviews

Interviews are considered one of the most important sources of evidence for case studies (Yin, 2014) and they were an integral part of the research design. Combined with documentary analysis, interview material can be used for methodological triangulation (Duke, 2002). Extensive preliminary background analysis was undertaken prior to entering the field, allowing for the focused selection of participants in order to use the interviews to corroborate key aspects of the case studies (Yin, 2014). In addition, the interviews were an opportunity to gather views and perceptions of participants, and to that end the selection of interviewees was purposely undertaken to achieve a broad representation of roles and occupation in relation to the policy process.

Following the granting of ethical approval from Ulster University, a semi-structured interview guide was developed for each case study site, consisting of 14 questions (see Appendix 2). The four guides followed the same logical ordering but were tailored to reflect the circumstances of each site. The intention was to conduct a 'topical' interview, where my role was to guide participants in a focused way through areas of concern, rather than allowing for free-ranging discussion (Arthur and Nazroo, 2003). However, flexibility was employed in order to accommodate the different perspectives and roles played by participants, as well as to allow their specific concerns and areas of focus to be captured. In this sense, the interviews were undertaken in quite a conversational way, rather than rigidly following the guide.

Sampling and recruitment

Participants for the study were recruited based on their involvement and experience with the policy making process specifically in relation to drug consumption rooms and drug policy more broadly. The range of roles undertaken by participants included policy makers, politicians, researchers and academics, public health practitioners, law enforcement officers, lawyers, advocates and non-government organisation representatives. These categories are

condensed to four major roles: Policy Maker, Practitioner, Researcher and Advocate. Potential interviewees were identified through the initial documentary analysis, including through media reports in which they may have featured or been quoted. Report authors, members of committee and spokespeople for organisations were also approached. In addition, some suggestions were made to me through informal discussions with former colleagues. In all, 48 requests for interview were made by email: 32 of these were accepted. Two individuals indicated they were not available during the dates of my field visits and 14 individuals did not respond to the initial email or a follow-up request for them to consider the invitation. 31 interviews were conducted in total; one potential participant was not interviewed due to her unavailability in the interview window (see Table 4.3). Table 4.4 provides a breakdown of the participants by role. Further reflections on the response rate are discussed at the end of this section.

Table 4.3 Recruitment of interview participants

Site	Requests	Acceptance	Unavailable	No response	Total interviews completed
Sydney (C1)	11	8	0	3	**8**
Melbourne (C2)	12	8	2	2	**8**
Vancouver (C3)	13	7	0	6	**7**
Toronto (C4)	12	9	0	3	**8**
Total	**48**	**32**	**2**	**14**	**31**

Table 4.4 Interview participants by category (role) and site

Site	Policy Maker	Practitioner	Advocate	Researcher	Total
Sydney (C1)	2	4	1	1	**8**
Melbourne (C2)	2	1	2	3	**8**
Vancouver (C3)	0	2	2	3	**7**
Toronto (C4)	3	1	2	2	**8**
Total	**7**	**8**	**7**	**9**	**31**

Interviews were undertaken at the case study sites during two two-week field visits to Canada and Australia undertaken between April and June 2017, with the exception of one interview which was conducted by Skype. Participants were provided with an information sheet and all signed consent forms which acknowledged that their participation was voluntary and that they had the right to withdraw from the study at any time. Interviews took approximately one hour; with the permission of participants, all were recorded and then transcribed using an online software called Trint. Participants were asked if they would like to receive a copy of their transcript. Only two participants requested to see their transcript and one submitted changes to the information recorded, including the deletion of statements she had made. No names were recorded on the transcripts in the interests of maintaining the anonymity of the participants; codes were instead ascribed to the data.

The response to the requests for interview was very positive, particularly given the logistics of conducting fieldwork in four locations in two countries in a tight timeframe with a limited budget. Two issues regarding recruitment should be noted. First, no policy makers were interviewed in Vancouver despite attempts to recruit there. I attribute this in part to the public health crisis that was underway in the city but also to a sense of fatigue. Vancouver has been heavily researched and responses to requests to participate in this research

reflected that. To counteract this potential gap, attention was paid to the policy making process through the use of primary documentation, such as committee meeting minutes and policy documents. While it would have been ideal to interview some policy makers, I do not believe it has compromised the outcomes of the research and the interviews that were undertaken reflected a strong knowledge of the policy making process, even if the participant's primary designation was not 'policy maker'.

In addition, there was an issue with recruiting participants who had voiced strong opposition to drug consumption rooms. I approached four people who were on the public record opposing drug consumption rooms but did not receive any response to the original requests for interview, using the standard interview request email, or to a follow up email. While the sample I was able to recruit expressed a plurality of views, it was disappointing that I could not explore in more depth the strong opposition arguments that were uncovered in the documentary review process. For future research, more time would need to be spent developing a network that could assist in gaining access to 'opponents'. In this instance, the task was made more difficult by undertaking the study at a distance from both project locations, minimising opportunities to probe and develop appropriate connections. This issue is discussed further under 'Limitations' in the concluding chapter of the thesis.

A brief reflexive account of the interview process

Conducting interviews in a contested policy domain can be fraught with challenges, including the negotiation of the relationship between the interviewer and the interviewee (Lancaster, 2017). The process of undertaking interviews for this research proved a rich experience which was made all the more interesting by the continuous development of events during the research period. The following provides some brief reflections on my position as a researcher and the impact of real time policy developments.

I came to this research with familiarity of the fields of drug policy and harm reduction through my professional background in public health, and overseas aid and development. While this gave me insights into the area and access to networks, I needed to exercise caution regarding any preconceptions that I may have. My professional involvement also went back a period of time and I was conscious that I was not a current 'expert'; a fact that perhaps allowed me to engage more openly and with curiosity with interviewees. Having a background in the area did, however, allow me to gain trust of many of the participants, leading to rich interviews. I was known to a number of participants by virtue of my previous roles. Through the interview guide I was able to cover a broad range of areas and keep questions open. Where I felt in the interviews that presumptions were being made about my own knowledge in the area I would attempt to prompt people for their own critical perspectives and reflections on the topic under discussion. I found that participants were largely very confident regarding their knowledge and keen to discuss their perspectives. I encountered very little reticence from participants, with the only observation that those who held bureaucratic positions were the most likely to exercise caution as to their responses.

Having lived and worked in Australia I was more familiar with the networks, context and politics. However, there is richer literature on the experience of drug consumption rooms in Canada, so I entered the field having read extensively from both primary and secondary sources. I conducted the Canadian interviews first and my time in the field coincided with the unfolding public health emergency presented by the opioid overdose epidemic. The crisis was very tangible, from the presence in the streets of emergency services, notices on health clinics cautioning about dangerous batches of drugs and very regular local media reporting. Some participants became quite emotional during the interviews as a result of the impact of the crisis. For example, a number of participants made a reference to the shock caused in policy circles by the death of a prominent activist on the eve of a national gathering to discuss responses to the epidemic. It was important to give participants an opportunity to reflect on

current events and their impact, but I also endeavoured to probe events in the past to reflect my interest in the passage of this policy issue over a number of decades.

While there was not a comparable sense of crisis in Australia, participants were still highly engaged in the interviews and passionate about the issues. They often spoke of the circumstances in Australia in comparison to Canada and displayed a high level of knowledge and interest in developments in Canada. These insights were particularly interesting from a policy transfer perspective, demonstrating the impact of the flow of information and knowledge across national boundaries and a keenness to reflect upon and learn from the experiences of others. The prominent case of the epidemic in Canada also gave participants (mostly unprompted) a chance to place the experiences of Australia in an international perspective which was most interesting.

4.6 Methods of data analysis

This section outlines the analytical strategies used to develop the case studies and to undertake thematic analysis of the interview data. The results of the analysis are presented in Chapters Five to Seven.

4.6.1 Construction of the case studies

The development of the four case studies, presented in the following chapters, concentrated on providing the rich contextual information that would allow for meaningful analysis of the interview material, presented in Chapter Seven, and the subsequent discussion and theoretical reflection in Chapter Eight. The starting point for the construction of the cases was the development of a timeline which highlighted events and milestones in the policy development process. The decision on what constituted pertinent events was made on the basis of their relevance to the research question. The cases were then constructed in more detail, relying on both the documentary sources and information provided by interviewees. By utilising both documentary sources and interview data in a combined fashion, information

and ideas could be pursued and probed in depth, rather than relying on only one account or version of events. This was particularly useful as events that proved critical to the study were unfolding while the research was being conducted.

The cases are presented as narratives, based on a common structure that reflected the key issues that were relevant to developing policy in this area. It is important to note that these narratives do not claim to be complete historical reconstructions or comprehensively detail all factors that might be critical to the policy making process. Rather, they are structured to best reflect the concerns of the specific research question. For example, a different framing of the research question may have required extensive presentation and analysis of epidemiological data. While public health concerns are obviously critical to the policy process, the purpose of the research is not to make a judgement of the 'need' from a public health perspective, but rather to identify issues that appeared to have influenced outcomes *regardless of their scientific validity.* The 'descriptive-analytical' approach adopted allows for similarities and differences between the cases to be identified, supporting comparative analysis (Hughes, 2006). This facilitates analysis at the national level, which is important to the chosen theoretical framework of policy transfer with its focus on multi-level analysis.

4.6.2 Thematic analysis

The method chosen to guide the analysis of the interviews is thematic analysis. It provides a means for "identifying, analysing, and interpreting patterns of meaning ('themes') within qualitative data…" with the aim being to "…identify, and interpret, key, but not necessarily all, features of the data, guided by the research question" (Braun and Clarke, 2016 p.1). The steps in the analytical strategy are captured in Table 4.5 below. NVivo 11 qualitative data analysis software was used to undertake coding and aid the analysis. Thematic mapping was undertaken in Excel.

Table 4.5 Phases and processes of thematic analysis

Phases	Process	Purpose
1. Familiarisation with the data	Transcribing data; reading and re-reading data; importing data into NVivo. Noting initial ideas.	Data management
2. Generating initial codes	Coding interesting features of the data systematically across the entire data set; collating data relevant to each code	
3. Searching for themes	Collating codes into potential themes; collating all data relevant to each potential theme.	Identifying emerging themes
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2); generating a thematic map	Refining, mapping and naming themes
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme and the overall story the analysis tells, generating clear definitions and names for each theme	
6. Producing the report	The final opportunity for analysis. Selection of extracts; final analysis of extracts; link to analysis of research questions and literature. Write up.	Explanatory account

Source: Adapted from Braun and Clarke, 2006 p. 87

Working case by case, an initial open round of coding was undertaken with 30 of the interviews. (One of the interviews was found to contain inconsistencies in the information provided and was therefore excluded in its entirety from the coding process on the grounds of its potential unreliability. The interviewee claimed credit for published work that when later checked was attributable to someone else.) The initial round of coding produced 67 codes, which ranged in frequency from 94 references to 'evidence and evidence-based policy' to single references for 'demonisation of drugs', 'personal or family experience of drugs' and 'gender'. These 67 codes and their references were then reviewed in order to be collated into themes. The initial themes were then reviewed, resulting in eight dominant

themes which are captured below in Table 4.6. The empirical findings presented in Chapter Seven do not mirror these themes exactly but are based on a further process of review and analysis to extract the themes which offered the best insights into the challenges facing the replication of drug consumption rooms. This is consistent with the key research concern of the thesis: to explore the issue of replication and policy change in the context of pursing a theoretically-driven explanation.

Table 4.6 Final themes from thematic analysis

Theme	Sample codes contained within theme
The 'problem'	Amenity Visibility Need Crisis Proximity Controversy Drug markets and drug scenes
Discourse and narrative	Arguments in support Arguments in opposition Moral arguments Stigma and discrimination Effects of media
Evidence	Evidence-based policy Effectiveness Transferability Persuasiveness Problematic use of evidence
Legality and law making	Legal arguments Legislation Parliamentary processes Prohibition Crime and criminality
Law enforcement	Police as stakeholders
Policy Making	Policy making Policy change Policy transfer, mobility and learning Policy conflict (public health versus law enforcement) Activism and civil disobedience Advocacy and campaigning Community consultation and participation
Politics	Political leadership Electoral politics Interactions of different levels of government
Models of DCRs	Alternative models (linked to meeting need)

4.7 Ethical issues

Ethical approval was granted by Ulster University to undertake this research prior to the commencement of the fieldwork. The project conformed to the University's research governance standards for research on human subjects. Steps were undertaken to ensure all participants consented to their involvement, were fully informed as to the aims of the research and apprised of the processes for securing and maintaining the confidentiality of the data. Participants' names were delinked from their interview transcripts and replaced by codes. They were not identified in the presentation of the findings, other than by their code and occupational group, maintaining their anonymity. Great care was taken throughout the transcribing process to ensure that interviews were accurately captured.

The criterion for inclusion as a participant in the project was having played a role in some capacity in relation to policy development regarding drug consumption rooms. These roles included but were not limited to policy development, advocacy, practitioner or research, and could relate to attempts to establish drug consumption rooms or change policy, regardless of whether the outcome was successful or not. The purpose of the research was not to establish the acceptability or efficacy of services for potential or existing clients; therefore, no specific consideration was required with regards to the potential vulnerability of study participants. All potential participants who were identified were considered to have acted in a professional or occupational capacity, with most appearing at some point on the public record in relation to their views or actions. Interviews were however conducted with due regard to potential sensitivities given the range of views that drug use elicits across society.

4.8 Conclusion

Working to address the ontological issues posed by the chosen theoretical framework of policy transfer introduced in Chapter Three, this chapter provides a detailed explanation for the adoption of a critical realism. The discussion demonstrates how critical realism

accommodates a dialectical understanding of structure and agency which is key to exploring the multi-level analysis required for the policy transfer framework. Similarly, critical realism was shown to encompass both material and ideational structures in a dialectic relationship. Ideas are accepted as having independent causal power, which is a critical issue for exploring policy transfer, with its focus on the movement and sharing of ideas and knowledge in the policy sphere.

Having established the compatibility between the critical realist approach and the theoretical stance of the thesis, the chapter then introduces the methodology and methods of the research. The multiple case study methodology and its 'descriptive-analytical' approach is demonstrated to provide the rich contextual information required to support comparative analysis both between cases and at the national and international level. In addition, the case studies provide critical insights into the nature of the debates and discourse concerning this contested policy area. An argument is then made for the use of thematic analysis to seek patterns of meaning in the interviews. The findings of the case studies are presented in Chapters Five (Australia) and Six (Canada) before the empirical findings from the thematic analysis are presented in Chapter Seven.

Chapter five
Australian case studies:
Sydney and Melbourne
• • • • •

5.1 Introduction

The following two chapters present the four case studies that provide the "concrete, context dependent knowledge" (Flyvbjerg, 2006 p.223) upon which the policy transfer framework can be tested, in order to interrogate the question of what constrains and facilitates the replication of policy in the case of drug consumption rooms. As described in the previous chapter, this thesis' research strategy combines both case studies and thematic analysis. The case studies presented here have been constructed using both primary and secondary documentary sources (see Table 4.2) and evidence collected through the interviews undertaken at the field sites. They are designed to provide an account of why and how drug consumption rooms came to be considered as a possible public health intervention in the case study sites and to probe pertinent questions in relation to opportunities for, or constraints on, the scaling up and transfer of policy. Comparative analysis is applied between the cases, facilitating the multiple levels of analysis – local, regional, national and international – that are relevant to the thesis' concern with policy transfer.

This chapter is focused on Australia and is divided into four main sections. Section 5.2 introduces the case study of Sydney in the state of New South Wales. It traces the origins of supervised injecting from a Royal Commission into police corruption and an unprecedented five-day high-profile Drug Summit, to the establishment of the South Hemisphere's first medically supervised injecting centre in 2001. Consideration is given to potential opportunities for the expansion of services beyond the original site. Section 5.3 focuses on events in Melbourne, Victoria. Although the state of Victoria appeared to be on track to approve five supervised injecting facilities in the late 1990s (responding to its multiple open street-based drug markets), its first and only centre did not open its doors until 2018. This section is concerned with the ebbs and flows of political and community debate and the impact of the changing landscape of Melbourne's drug markets in that period. Section 5.4 seeks to contextualise the Australian case studies by considering the political and policy

settings in which these events occurred. It focuses particularly on the different levels of government engaged in policy debate and the role of state level party and parliamentary politics. The impact of civil disobedience as a disruptive force on the more formal policy process is then considered. Finally, Section 5.5 draws together findings from the two case studies, noting the many similarities between the two sites in relation to issues that affect replication of the policy.

5.2 Case study 1: Sydney, Australia

In May 2018, in the course of a coronial inquest into the deaths of six opiate users in New South Wales, Deputy State Coroner Harriet Grahame stated: "We have one medically supervised injecting centre in the whole of NSW…by now I would've thought we would have more" (Thompson, 2018). Sydney's Medically Supervised Injecting Centre (MSIC) opened in the inner-city area of Kings Cross in 2001. It was the first facility of its kind to be established outside of Europe and, until July 2018, it remained the only facility to offer medically supervised drug consumption in Australia. This case study examines the establishment of MSIC, tracing the key events and actions that brought the idea of supervised injecting into the public domain and political debate. Through the use of documentary evidence and the contributions of study interviewees, the opportunities for, and constraints on, the expansion of services in Sydney are also explored.

5.2.1 The emerging issues

By the late 1990s, both drug use and drug overdose deaths were high on the public agenda in Australia. The number of heroin-related overdose deaths had increased three-fold, up from 302 in 1989 for the 15-44 year age group, to 960 in 1999 (Warner-Smith et al., 2001a p.1113). Fifty per cent of those deaths occurred in NSW, host to two prominent street-based drug markets: Kings Cross, a renowned inner-city red light district, and suburban Cabramatta, in south-western Sydney. Twenty per cent of heroin-related overdose deaths occurred within

two kilometres of Kings Cross, while Cabramatta recorded 15 per cent of the cases (Warner-Smith et al., 2011b viii, p.19; Parliament of NSW, 1998).

The idea of supervised injecting sites as a response to issues associated with overdose and injecting in public began circulating in the early 1990s. During this time, illegal 'shooting galleries', linked to the sex industry, had begun operating in Kings Cross. Hotels offered rooms for a short period of time, specifically to inject drugs, and also sold injecting equipment. Ingrid van Beek, MSIC's first Medical Director, recalls discussions as early as 1990 with the local police commander about legal supervised injecting as a response to managing the multiple risks posed by shooting galleries (van Beek, 2004). Between 1995 and 1997, Justice Wood presided over a Royal Commission into the New South Wales Police Service, called to address concerns about systematic and entrenched corruption in the force. The Commission found that some of the shooting galleries were tolerated by the Kings Cross Police, and corrupt payments had been received from the proprietors (Wood, 1997 p.98). In his Final Report, Commissioner Justice Wood recommended that the NSW Government trial supervised injecting rooms, arguing:

> "At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding they will be used to administer prohibited drugs. In these circumstances, to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short-sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour." (Wood, 1997 p.222)

The Commission then recommended:
> "Consideration be given to the establishment of safe, sanitary injecting rooms under the licence or supervision of the Department of Health, and to amendment of the *Drug Misuse and Trafficking Act 1985* accordingly." (Wood, 1997 p.229)

5.2.2 Phases of the response

Policy debate and legislative development (1997-1999)

The Royal Commission's findings led to a new phase of activity in the consideration of supervised injecting facilities. The NSW State Government, led by Australian Labor Party (ALP) Premier Bob Carr, referred the recommendation to a Joint Select Committee of Parliament which reported in early 1998. The Committee's report ran for over 300 pages and extensively detailed arguments both for and against supervised injecting facilities, considering health, social, legal and economic perspectives. Substantial public interest was shown in the inquiry; the Committee took evidence from 89 witnesses and received 103 submissions. Contributions came from individuals, residents' groups, interest groups, religious organisations, user groups, and non-government organisations. In addition, many professionals engaged in the process, including from the Ambulance Service, prisons, the police force, and public health and medical research bodies. Members of the Committee toured DCRs in the Netherlands, Switzerland and Germany, and met key stakeholders including politicians, bureaucrats and non-government and church-based service providers. The report reflected this concern with overseas experience by documenting what had been learned. In addition, visits were conducted of potential local sites, including Kings Cross and Cabramatta. The Chair of the Committee provided a dissenting report but a majority of the Committee recommended against proceeding with a trial of supervised injecting rooms. They cited safety concerns, the impact on the local community, the potential for an increase in crime, that it sent the 'wrong message' about drug use and that resources could be better deployed to treatment (Parliament of New South Wales, 1998). As a result, no legislation was brought to the House at that time.

In 1999, supervised injecting returned to the political agenda. In January, the *Sun Herald* newspaper published a photograph on its front page, purportedly of a teenage boy injecting

heroin, prompting Premier Carr to promise to hold a summit on drugs should he be re-elected (Fitzgerald, 2013). The following month, a welfare agency, Open Family, announced plans to establish supervised injecting rooms in the suburbs of Cabramatta in Sydney and Footscray in Melbourne (AAP Newsfeed, 1999). The Premier responded to the national press coverage by labelling the proposal "irresponsible, dangerous and illegal" (Swain, 1999 p.3). Carr was returned to government the next month and the Drug Summit was announced for May 1999. Fearful that supervised injecting was to be excluded from the Summit agenda, a group of 'concerned citizens' opened an unsanctioned injecting room at the Wayside Chapel in Kings Cross in May 1999. The service opened on five occasions before closing after a clergyman and three clients of the service were arrested following police raids. The charges were later dropped (Wodak et al., 2003). See Section 5.4.2 below for further discussion of these actions.

The Drug Summit was held over five days and participants included 135 NSW Parliamentarians, two Federal Members of Parliament, 80 invited delegates and 45 associate delegates (Swain, 1999). Non-parliamentary delegates represented a cross-section of interest groups, government departments, non-government organisations, local government representatives and academics. There was considerable debate over a proposal to trial injecting rooms, but a recommendation was passed with a very clear majority of support. Resolution 3.15 of the 172 Summit resolutions read:

> "The Government should not veto proposals from non-government organisations for a tightly controlled trial of medically supervised injecting rooms in defined areas where there is a high prevalence of street dealing in illicit drugs, where those proposals incorporate options for primary health care, counselling and referral for treatment, providing there is support for this at the community and local government level. Any such proposal should be contained in a local Community Drug Action Plan developed by local agencies, non-government organisations, volunteers and community organisations. These should be submitted to full public and community consultation processes (such as those used in urban planning law) and preferably a local poll. They must be part of a comprehensive strategy for local law enforcement, health, community and preventative education initiatives." (Swain, 1999, Appendix 3, Resolution 3.15)

As a result of the Summit, the *Drug Misuse and Trafficking Act 1985* was amended in 1999 to allow for the possession and self-administration of illicit drugs in specifically licenced premises. The Opposition opposed the Bill, although a number of its members crossed the floor to vote with the Government (Gunaratnam, 2005). The legislation allowed for the granting of "one licence in respect of only one premises" (*Drug Misuse and Trafficking Act 1985*). This restricted NSW to having only a single supervised injecting facility in the whole state unless the legislation was amended by the Parliament. This issue is further discussed in Section 5.2.3 below.

Establishment and evaluation (2000-2016)

Although not without challenges, Australia's first Medically Supervised Injecting Centre opened in Kings Cross in May 2001 on an 18-month trial basis. Initially the Government approached the Catholic organisation Sisters of Charity Health Service to develop the service, but the direct intervention of the Vatican forced their withdrawal. The Uniting Church then stepped in to take up the licence (van Beek, 2004). The centre was further delayed by a legal challenge from the local Kings Cross Chamber of Commerce, which objected to the proposed location of the facility. They argued in the Supreme Court that there had been inadequate consultation with local businesses and residents. The Court did not uphold this claim, allowing the Uniting Church to proceed (Gunaratnam, 2005). Surveys conducted prior to the establishment of MSIC and in subsequent years demonstrate a majority of both local residents and business operators supported the establishment of MSIC.

Table 5.1 Support for the operation of MSIC in Kings Cross

	Survey years		
	2000	2002	2005
	%	%	%
Residents (Agree)	68	78	73
Business operators (Agree)	58	63	68

Source: Salmon, 2008 p.82

MSIC's initial 18-month trial was extended through legislative amendment on three occasions, in 2002, 2003 and 2007. The first extension bridged a gap between the finalisation of the independent evaluation committee's report and the first trial period. That report, published in July 2003, assessed the feasibility and impact of the service, producing overall positive results, including a finding that "the majority of the community accepted the MSIC initiative" (MSIC Evaluation Committee, 2003 p.207). A second set of evaluation reports was published with further positive results in 2006-2007, resulting in a four-year extension to the 'trial' being granted in 2007 (Ralston, 2007).

The continuous cycle of evaluation created uncertainty and raised questions about the purpose of maintaining a trial status. Each extension required legislative amendments to be debated in the Parliament. Evidence featured heavily in the parliamentary speeches. For example, the Government, introducing the amendment in 2003, said the decision to continue was based on the outcomes of the evaluation report and advice from the NSW expert advisory group on drugs, and framed the approach as being "in line with this Government's evidence-based approach to drug policy" (Parliament of NSW Hansard, 2003). Liberal MP Catherine Cusack, however, challenged the Government to justify the ongoing trial status:

"A real trial has a beginning, a middle and an end. If it's successful, it is replicated into general policy; if it is unsuccessful, it is concluded. In all seriousness, I ask the Government to tell us what is the trial seeking to accomplish and when and how will we know when it has been accomplished." (Hanna, 2003)

The independent evaluators for the first two rounds of evaluation declined to be involved in

the final round, saying:

"It seemed to us that to continue looking at it as a trial was not ideal from a public health point of view, to keep looking for an answer to the question of 'Is this working?'. The case seems to have been made in general terms." (Nicholls, 2010 p. 3)

In 2010, legislation was passed that removed MSIC's trial status, granting it permanency. This

followed the publication of a further evaluation report by KPMG which was commissioned

by the NSW Health Department to assess the performance and effectiveness of MSIC. The

report confirmed, once again, that MSIC was delivering on its objectives (KPMG, 2010).

5.2.3 Opportunities for expansion or replication

The introduction to this case study noted the NSW Deputy State Coroner's remarks that she

would have expected NSW to have more medically supervised injecting centres in 2018

(Thompson, 2018). The purpose of this section is to review the evidence, obtained from the

case study, that demonstrates concerns with supervised injecting beyond the Kings Cross

centre.

As described above, the initial legislation was deliberately restrictive, supporting the

establishment of the specific facility in Kings Cross rather than endorsing the general principle

of supervised injecting. During the parliamentary debate, Liberal Party Member Kevin Rozzoli

attempted but failed to move an amendment to lift the restriction of one licence. Rozzoli

argued that it made no sense to only provide the service in one location:

"I propose the establishment of four injecting centres on two bases. First, it provides flexibility to have four centres in the city – possibly two in the Kings Cross area and two in the Darlinghurst area, or we may widen the experiment by having, say, two centres in the Kings Cross area and two centres in Cabramatta." (Parliament of NSW, Legislative Assembly Hansard, 1999)

Three factors can be identified that influenced the restricted nature of the legislation:
political risk; a perception of community fear; and value-led political decision making. On the
issue of the risk inherent in pursuing the controversial intervention, one interview participant
recalled the response of the then-Premier of NSW Bob Carr in 1998, when she had suggested
that there would be a need for four or five centres in NSW, including Cabramatta, and
Redfern in the inner city of Sydney.

> "And he looked at me like I'd grown another head…[and] he said, "if it ever happens it
> will be one and it will be a trial, okay". He said to think about three or four or five would
> be complete political suicide." (Practitioner 7, Sydney)

A Policy Maker who was interviewed argued the legislation provided reassurance for
Parliamentarians in the face of questions and fear from their communities, noting in
particular South Western Sydney where Cabramatta was located.

> "And I think that in many ways it was to assuage the concerns of… Labor MPs with the
> South Western Sydney seats who were concerned that they were the next cab off the
> rank. And I think it … allowed the Government to argue very clearly it was a trial. It was
> contained. You know, it said in the legislation is was only going to be in Kings Cross. It
> meant that people couldn't run the scare campaign [that] a medically supervised
> injection centre is coming to your suburb soon. I think it was a very deliberate political
> containment strategy, and an important one." (Policy Maker 6, Sydney)

Finally, Premier Carr, whose leadership was instrumental in this process, brought the power
of his personal convictions to bear on the issue of drugs and drug taking, demonstrating the
importance of the exercise of agency in the policy process. The Premier's brother had died
of a heroin overdose and he readily admitted that the evidence and testimony presented at
the Drug Summit had persuaded him to revise some of his own views (Humphries and Totaro,
1999). He is attributed with exercising great influence over the outcomes of the Summit,
including the resolution in support of the supervised injecting trial. As one Policy Maker
participating in the study observed: "…if Bob Carr wanted to stop it, he could have.
Absolutely. Absolutely" (Policy Maker 6, Sydney). Instead, Carr urged others to support the
proposal, arguing for new approaches while also maintaining his personal abhorrence of drug
use (Morris, 1999a). He continued to frame the Government's position in a way that made

clear that support for supervised injecting did not equate with condoning drug use, stating, "I will not accept the normalisation of heroin in our society…I say to people who live in hope that the stigma related to heroin use will be removed that we cannot do that" (Morris, 1999b).

The case study uncovered evidence that consideration was given to sites other than Kings Cross, with both Cabramatta and Redfern featuring in debate. Cabramatta had been closely investigated in the course of the Joint Select Committee in 1997 due to its high-profile street-based drug market and the incidence of public injecting and overdose. Unlike Kings Cross, where a majority of local people had expressed support for a service (Salmon, 2008), there was strong opposition to the idea in Cabramatta and politicians were firm in their opposition on behalf of their communities. Labor MP Reba Meagher, who sat on the Joint Select Committee, argued:

> "The local area would be turned into a drug ghetto, there would be an increased crime risk and drug dealers would congregate nearby…There's also the safety issue, how can you maintain a safe injecting room where people are using an uncontrolled and illegal substance." (Sands, 1998)

Cabramatta had very different characteristics to inner city Kings Cross. In evidence to the Joint Select Committee in 1998, researcher Dr Lisa Maher expressed reservations about proceeding with a trial in Cabramatta.

> "My personal opinion is that Cabramatta is perhaps not the best place to trial the safe injecting facility, given that there are very complex issues to do with the ethnic communities there. There is already, I think, a high degree of perhaps hostility and opposition that we have seen in relation to the needle and syringe issues in that community." (Parliament of NSW, 1998, p.105)

The Mayor of Fairfield, the council area in which Cabramatta sat, was adamant in his opposition, saying, "We won't be approving any in Fairfield" (Clennell, 1999). According to Wodak et al. (2003), a proposal for a trial in the southwest was put to the NSW Cabinet in 1999, but was dropped because of Meagher's "relentless opposition".

Redfern, an inner city area in Sydney, was raised in the parliamentary debate in 1999. Legislative Assembly MP Clover Moore, on noting the support of her constituents for supervised injecting in the vicinity of Kings Cross, said:

> "At the other end of my electorate, in Redfern-Darlington, there is also strong support for a supervised injecting facility and frustration that so far only one trial has been approved. While the legislation could be amended in future to allow other trials to take place, I seek a strong commitment from government on behalf of my constituents to allow further trials." (Parliament of NSW, Legislative Assembly Hansard, 1999)

The issue was raised again at the Standing Committee on Social Issues inquiry into Redfern and Waterloo in 2004, when Moore (then Lord Mayor of Sydney) again urged consideration be given to establishing a SIF in Redfern to "take injecting off the streets, getting people into treatment and saving lives from overdosing" (Parliament of NSW Legislative Council, 2004 p.131). Other witnesses to the inquiry spoke against such a proposal. For example, Clive Smith said that the service "would send the message that the Government accepts that Redfern will continue to have flagrant and open drug markets, supported mostly by 'visitors' to the area" (Parliament of NSW Legislative Council, 2004 p.131). Premier Carr did not rule out the possibility but said it would only be considered if there was support from local Aboriginal leaders, the police and other stakeholders (Parliament of NSW Legislative Council, 2004 p.132). The Committee did not support the proposal.

In 2016, a Statutory Review of MSIC was conducted by the Departments of Health and Justice (NSW Government, 2016). Overall, the review found MSIC continued to meet its objectives under the Act and was economically viable despite a reduction in visit numbers. This review specifically addressed the issue of removing the Act's restriction on NSW only having one supervised injecting centre. Twelve submissions were received (out of 25 in total) that recommended lifting the current restriction. Two findings were made on this question. First, that "the evidence suggests that there is significant need at the current location, compared to other areas" (p.9), leading to the recommendation that no change be made to the current location. Secondly, the review stated:

> "According to the data currently available regarding unplanned emergency department admissions relating to opioids, incidents of use/possession of narcotics and the number of ambulance callouts to heroin overdoses already prevented, there does not appear to be a clear need for another supervised injecting facility elsewhere in NSW at this time." (NSW Government, 2016 p.11)

The general view of interviewees in the case study was that Sydney's open drug scenes of the 1990s no longer exist on account of gentrification, civic developments and changing patterns and visibility of drug dealing (Practitioner 7; Policy Maker 5; Policy Maker 6, Researcher 6, Advocate 4 all Sydney). The argument was made that the conditions that gave rise to the establishment of MSIC were no longer present:

> "Well I mean it arose as a specific kind of policy problem in a particular context that doesn't exist anymore, you know, substantial street base injecting, huge volumes of public needle discards, and a sense of crisis." (Advocate 4, Sydney)

As one Policy Maker said in relation to the Statutory Review's finding not to support further centres: "Look there's probably a fair point about injecting rooms. I'm not sure where you would set one up to be honest." (Policy Maker 5, Sydney) In addition, the trend was noted that there had been a shift away from heroin-related overdoses to overdoses related to pharmaceutical opioid misuse, reducing the focus on injecting (Advocate 4, Sydney).

These changes to Sydney's drug markets over time have impacted on the process of policy transfer, particularly the appropriateness of the model of SIF that was adopted in 2001. The potential for a new centre in South Western Sydney was noted by a Researcher, but her comments were couched in terms of the need to look carefully at the model of service, speaking of "mobile" services or "micro-sites" (Researcher 6, Sydney). This was an issue also taken up by another interviewee, who spoke of the need for a "much more mature debate about what the model of service delivery can be" (Practitioner 4, Sydney). One group to advocate for an alternative model of supervised service is the Noffs' Foundation, which began a campaign in 2015 for the introduction of drug consumption rooms in Sydney that would offer supervised inhalation for crystal methamphetamine ('ice') users (Noffs, 2016). Liverpool in South Western Sydney was proposed as a possible location. There is little

evidence that this campaign has gained any traction in NSW, and the proposal was rejected by the then-Assistant Minister for Health Pru Goward and the local Liverpool Chamber of Commerce (Park, 2016). The reception from local businesses and residents at the first community meeting on the proposal was reported in the national media to be "cool" (Metherell, 2016).

5.2.4 Current status

New South Wales' only Medically Supervised Injecting Centre continues to operate from its original site in Kings Cross, Sydney. In 2016, MSIC marked its millionth visit to the service (Uniting Church, 2018). Numbers of average daily visits have declined since the early 2000s, reflecting the changing nature of the drug scene in Kings Cross and surrounding areas. At the highest point, the facility supervised an average of 220 injections per day in 2003, but it now supports an average of 130 injections per day (Salmon and Jauncey, 2015; Researcher 6, Sydney). The Statutory Review undertaken in 2016 found that MSIC exceeded quarterly targets for referral to treatment, counselling and clinical services (NSW Government, 2016). It has managed over 6000 overdoses without any fatalities since 2001 (personal communication, A. Salmon, Research Manager, MSIC, 29 January 2018).

5.3 Case study 2: Melbourne, Australia

Proposals for supervised injecting facilities in response to open street-based drug markets circulated in the state of Victoria in the 1990s, at the same time as the issue was being considered in New South Wales. There have been both similarities and differences in the paths that these two states have travelled as policy ideas circulated and political and community debate took place. This case study explores two distinct phases of engagement: the first in the late 1990s and early 2000s, and a second phase from around 2010 onwards. During these two decades, considerable changes took place to Melbourne's drug markets; these have influenced the patterns of need and the visibility of the issue of street-based drug

use. This case study is characterised by deep engagement of the institution of parliament; a significant investment in research and evidence gathering through formal inquiries; and extensive community consultation and debate. The prospects for the scaling up of drug consumption services in Melbourne are considered in the context of Victoria's first medically supervised injecting room opening only in July 2018.

5.3.1 The emerging issues

The development of proposals exploring the introduction of supervised injecting facilities in Melbourne, Victoria, came at a time of increasing concern with public drug use. In the 1990s, there were a number of distinct and dispersed street-based drug scenes across the city of Melbourne. The problems were multi-faceted, affecting the community through the harms such as overdose and the spread of blood-borne viruses, and also in terms of amenity and safety in local neighbourhoods. In 1996, the Premier's Drug Advisory Council raised a concern with the increased availability of high-purity heroin in Victoria and the risk this posed for young users (Premiers Drug Advisory Council, 1996). Between 1996 and 1999, the state government allocated A$100 million to its Turning the Tide strategy, aimed at supporting a multi-sectoral response to illicit drugs and their impact on the Victorian community (Department of Premier and Cabinet, 2000 p.1). Despite this investment, drug-related overdose deaths from heroin continued to rise, and by 1999 there were 359 recorded, up from 49 in 1991 (Drug Policy Expert Committee, 2000 p.vi). This 'toll' was in the public domain through a daily report published in the local paper, the *Herald Sun*, alongside the annual toll of road-related deaths (Hughes, 2013 p.7).

The open street-based drug scenes brought with them a decrease in amenity, evidence of drug litter and increasing public nuisance (Micallef, 1998). Across the city, five 'hot spots' were identified in local municipal areas, and local councils developed their own action plans to address drug related harms. Those municipalities were Greater Dandenong, Maribyrnong,

Melbourne, Port Phillip and Yarra (Drug Policy Expert Committee, 2000). A local politician from one of the hot spot areas in Greater Dandenong wrote of the community's "wide and strongly felt" concern and a "growing sense of anxiety" (Micallef, 1998 p.2). One study participant recalled the community's frustration with what was perceived as a lack of government action to deal with the levels of "mayhem" that had come with the emerging street-based drug scenes.

> "What the community wanted was an end to injecting in their face, they wanted an end to their kids standing on used needles, or the fear of their kids standing on used needles…And they wanted less violence…" (Practitioner 8, Melbourne)

5.3.2 Phases of the response
Policy learning, community debate and legislative development (1997-2000)

As in New South Wales, the process of policy development in Victoria was led by the institution of the state parliament, although local governments engaged actively with the issues. There is also strong evidence in Victoria of policy learning occurring through the utilisation of research from the NSW experience and from overseas, as discussed below. The first reference to the possibility of supervised injecting came in a Council report on 'safety clinics' prepared for the City of Greater Dandenong in September 1997 (Micallef, 1998). The issue was also considered by the Drugs and Crime Prevention Committee of the Victorian Parliament in the course of its inquiry into the Turning the Tide strategy the same year. The Committee expressed the view:

> "that there is some merit in the idea of suitably regulated and controlled safe houses. **The committee urges that there be greater public debate concerning the possibility of safe houses, and that that debate be guided by appropriate evidence.**" (Parliament of Victoria, Drugs and Crime Prevention Committee, 1997 p.155, emphasis in original)

Continuing to promote the idea, Committee member Eddie Micallef (1998) wrote a discussion paper for colleagues on the question of whether Victoria should have a supervised injecting trial. This was followed by a formal Occasional Paper, produced under the auspices of the Committee considering the justification and viability of SIFs in the Victorian setting.

This paper drew heavily on the work conducted by the NSW Joint Select Committee and its inquiry report released in 1998, as well as utilising both local and overseas academic research. The findings of this paper encouraged further exploration of the issue and stated, "There are few interventions other than Safe Injecting Facilities that are specifically suited to <u>comprehensively</u> deal with the range of harms arising from public street injecting" (Parliament of Victoria, Drugs and Crime Prevention Committee, 1998 p.i, emphasis in original).

By 1999, supervised injecting facilities had become an electoral issue (see more detail in Section 5.4.2 below). The incumbent Liberal Government of Jeff Kennett officially opposed any proposals, while the Australian Labor Party, under the leadership of Steve Bracks, campaigned on a platform supporting five supervised injecting centres. Following the ALP's unexpected electoral victory, Professor David Penington was appointed to head a Drug Policy Expert Committee (DPEC), charged with investigating and recommending to the Government a course of action on supervised injecting (Dolan et al., 2000). Penington's inquiry was extensive and involved an assessment of the current local context of drug issues, but also sought guidance internationally and included visits to Sweden, the Netherlands and Germany, demonstrating a clear interest in learning from the policy approaches elsewhere.

Stage One of the Committee's terms of reference focused on the development of a local drug strategy for municipalities with high levels of drug use, and addressing the issue of the implementation of a trial of supervised injecting. The Committee received 130 public submissions, held local community meetings and consulted with key stakeholders. It also conducted a community survey specifically on the issue of supervised injecting which found "nearly two-thirds of respondents in the five municipalities nominated for injecting facilities support the trial, providing a suitable location can be identified" (Drug Policy Expert Committee, 2000 viii). The Committee recommended to the Government that a trial should

be implemented where there was local municipal support. The Report's recommendation for the trial was embedded in the development of local drug strategies and the engagement of key stakeholders. With the Government pledging that centres would not be established in communities without local Council approval, legislation was introduced in the Victorian Parliament in May 2000, only to be defeated in the Upper House that November (Mendes, 2002). Despite the electoral mandate and the extensive consultative work of the DPEC, the Government did not seek to re-introduce the legislation following its defeat.

Ongoing advocacy, political consideration and establishment (2010 – 2018)

While the issue died down in terms of high-profile public debate, the idea of supervised injecting facilities continued to circulate in policy and research networks (Fitzgerald, 2013). This occurred in the context of shifting patterns of drug use in Melbourne and a decrease in overdose rates (Fry, 2011). While some drug markets retracted, North Richmond and adjacent Abbotsford continued to host an active street-based drug scene. A local community group, the Yarra Drug and Health Forum, advocated for a SIF to address community concerns over drug use (Papanastasiou et al., 2009). In 2011, the City of Yarra Council voted 6:1 in support of a proposal to establish a SIF, but failed to gain the necessary support of the state government, then under the leadership of Liberal Ted Ballieu (Gregoire, 2016).

By 2016, annual heroin-related deaths in Melbourne had risen once more to 190 (Wahlquist, 2017) and a broader coalition of support for a supervised injecting facility in Richmond had coalesced and won the support of Sex Party politician Fiona Patten who introduced a private member's bill to the State Parliament in February 2017 (Preiss, 2017). In the same month, Coroner Hawkins of the Coroners Court of Victoria released her findings of the inquest into a heroin-related death in Richmond. In exercising the role of the Court in relation to preventing future deaths, the Coroner called on expert witnesses (including the Medical Director of MSIC in Sydney) and received written submissions. She also called on two Australian experts to

review and report the evidence of the efficacy of SIFs. Coroner Hawkins' first recommendation, directed to Martin Foley, the Minister for Mental Health, was to establish a supervised injecting centre trial in North Richmond (The Coroners Court of Victoria, 2017). The Coroner's report noted the Department of Health and Human Services' submission did not address the issue of SIFs, concluding that they were bound by current government policy. This provides an interesting contrast to the proactive role played by the public health agencies in Canada, which is explored in the following chapter.

The Government, through Minister Foley, did not commit to the trial but referred the matter to the Parliamentary Committee's Inquiry into Drug Law Reform that was due to report in March 2018. The stated position at this time was that the Government had an established policy against trialling a supervised injecting room (Carey, 2017). In parallel to the Drug Law Reform inquiry, the Legislative Council (Upper House) referred the bill to its Legal and Social Issues Committee. The Committee, in addition to calling for public submissions and being addressed by stakeholders, considered evidence concerning both MSIC in Sydney and the EMCDDA's review of DCRs (EMCDDA, 2018). The Committee also made a site visit to the MSIC facility. The report concluded that medically supervised injecting facilities "improve the health of injecting drug users and reduce signs of drug use in surrounding streets" (Parliament of Victoria, 2017 p.xv). In addition, the Committee found that "drug use in North Richmond has reached crisis level" (p.xv). However, no recommendation was made to proceed. This was despite 46 of 49 submissions to the Committee supporting a trial (p.xv). The critical issue on which the decision seemed to pivot was that of community support, as explained in the Chair's Foreword:

> "The Committee believes that the views of the community, all stakeholders and local government must be considered when deciding matters relating to a supervised injecting centre. The Committee was not set the task of confirming the level of local support and had practical restrictions on its capacity to do so definitively. One of the most contentious issues for the Committee was reaching a shared understanding of the level of support for a supervised injecting centre in North Richmond; the list of

submissions confirms that while most were in favour of a trial, these were from organisations from outside North Richmond." (Parliament of Victoria, 2017 p.xii)

In October 2017, the Victorian Government, in a surprising reversal of policy, approved a two-year trial of a supervised injecting facility in North Richmond, with Premier Andrews announcing: "This is a change in policy, there's no doubt about that, but it's a change that's needed. We have the highest heroin death toll since 2000" (Wahlquist, 2017). This decision to reverse stated Government policy came as the Labor Government was faced with a by-election in the inner-city electorate of Northcote in November 2017. A rally of around 600 people had come out in support of the proposed SIF in the lead-up to the election, demonstrating the salience of the issue and the degree of public support (Houston and Preiss, 2017). The ALP faced a strong challenge from the Greens Party, which supported the proposal. It has been suggested that the Government was attempting to appeal to potential Greens voters through a series of policy announcements around health and housing. The Government lost the by-election in a 11 per cent swing to the Greens but proceeded to put the supervised injecting legislation to the Parliament (Raue, 2017). The legislation successfully passed through both houses and the amended Drugs, Poisons and Controlled Substances Act was assented to in December 2017 (*Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017*).

5.3.3 Current status and opportunities for expansion

The Victorian legislation endorses a two-year trial of a medically supervised injecting room (MSIR). Like the New South Wales Act, Victoria's legislation specifies provision of a single licence for a single site. However, it goes further, naming the location as the North Richmond Community Heath (NRCH) centre, which is registered as both a company limited by guarantee and a charity (North Richmond Community Health, 2015). NRCH has been a methadone service provider and needle and syringe outlet since the 1990s. The trial is designed to offer an integrated service, rather than a stand-alone service, as in Sydney

(Wahlquist, 2017). The service is restricted to those 18 years and over (*Drugs, Poisons and Controlled Substances Amendment (Medically Supervised Injecting Centre) Act 2017*). An Expert Advisory Panel has been appointed to assist in establishing the service and, additionally, a review panel will be convened to evaluate the MSIR's effectiveness (Department of Health and Human Services, 2018). The trial commenced in July 2018 and the centre received 8000 visits in its first two months of operation (Preiss, 2018).

Post-dating the passing of the legislation, the Government's Inquiry into Drug Law Reform reported in March 2018. The report acknowledged the Government's decision to proceed with the trial; the parallel Legislative Council inquiry concerned itself with the key finding from the evidence it had collected. That evidence was informed in part by an overseas study tour that had included visits to supervised injecting sites in Spain, Switzerland, Germany and Canada. The Committee noted the issue of the potential benefit of multiple sites and mobile supervised injecting services. It also acknowledged the strong arguments that had been made in relation to the need for a supervised injecting centre in North Richmond, noting that with the exception of the Australian Christian Lobby and Drug Free Australia, all other inquiry stakeholders had supported the intervention (Parliament of Victoria, 2018 pp.482-483). The report made no general recommendation, on account of the recently passed legislation, but made two specific recommendations in view of the evidence it had collected, including that from the overseas study tour. It recommended allowing various illicit substances to be consumed in the North Richmond site, including amphetamine-type substances. It further recommended that the centre operate on a low threshold model to encourage accessibility; for example, not insisting that identification be produced as a condition of entry (p.484). Finally, it considered the potential future threat that might arise from the arrival of fentanyl or an equivalent synthetic opioid into the local drug market (such as has been experienced in Canada). The Committee recommended that consideration be given to possible temporary medically supervised injecting facilities in areas of high concentration of injecting drug users

and overdose. This recommendation was specifically influenced by the Committee's visits to Vancouver's 'pop-up' overdose prevention sites, which arose in response to the opioid overdose crisis (p.488 and see Section 6.2.3 below).

In terms of replication or expansion of facilities in Victoria, it appears unlikely that services will be expanded beyond North Richmond at this time. In addition to the legislation in Victoria mirroring the 'single licence, single premises' model of NSW, there is recognition that the street-based drug markets which have prompted calls for supervised injecting services have retracted in Victoria. This was acknowledged in the Parliamentary Committee Inquiry into Drug Law Reform which heard evidence that North Richmond was identified as "the last open street-based drug market in Victoria" (Victorian Parliament, 2018 p.482). The Committee did, however, in reflecting on the unfolding situation in Canada in relation to the arrival in the market of the synthetic opioid fentanyl, give consideration to the fact that significant changes to the drug market could give rise to new need (p.488).

In a postscript, Victoria went to the polls in November 2018 with the Liberal opposition campaigning to close the MSIR should they be re-elected. The Liberals suffered a 6 per cent swing against them, assuring an ALP victory and the continuation of the service in North Richmond (ABC News, 2018).

5.4 Contextualising the Australian case studies

The case studies have provided a detailed, chronological account of key events and influences on the policy making process in relation to supervised injecting in the two Australian locations. The purpose of the following section is to contextualise those case studies by examining the political and policy settings in which these events occurred. The case studies are notionally city-based due to the nature of the street-based drug scenes that supervised injecting facilities have the potential to address. However, as has been demonstrated, the policy setting is much broader, encompassing international institutions, and federal, state

and local levels of government. Guided by the sources of policy change and stall identified by

Evans (2004) in his policy transfer framework, this section explores both structural and

agency factors that have impacted policy development. In addition to contextualising the

formal political setting in which the policy debates occurred, a comparative consideration is

given to the role of civil disobedience in the two sites, providing critical analysis that will

inform the application of the theoretical framework of policy transfer in Chapter Eight.

5.4.1 Political setting

International sources of policy change

Evans (2004) notes that policy transfer can be constrained by international institutional

structures that affect the behaviour of state actors. Australia's position as a signatory to

international drug control treaties created the potential for the Federal Government to

exercise power in relation to states' decision making on drug issues. The treaties are

administered by the International Narcotics Control Board (INCB), an independent expert

body consisting of 13 members elected by the UN Economic and Social Council (International

Narcotics Control Board, 2018). The INCB reacted swiftly to the debate in Australia, stating in

its annual report in 1999:

> "The Board urges the Government of Australia not to permit the establishment and
> operation of drug injection rooms, or so-called "shooting galleries". In the view of the
> Board, such establishments would provide an outlet for illicit drug abuse and facilitate
> or encourage illicit drug trafficking, which, under the international drug control
> treaties, Governments are obliged to combat in all its forms." (International Narcotics
> Control Board, 2000 p.62)

Prime Minister Howard, in turn, wrote to all Premiers and Chief Ministers (the Heads of

Government of the two Australian Territories) calling on them to abandon any plans for SIFs

(Coorey, 1999). The claim that Australia would contravene the treaties was contested on the

grounds that any initiative would have trial status and therefore was permissible within the

terms of the treaties. The NSW Parliamentary Inquiry in 1998 had considered this issue and

concluded that any proposed centre would not cause a treaty breach (Parliament of NSW,

1998). Ultimately the Federal Government, despite its threats, did not move to enact its external affairs powers. Howard was under political pressure at this time for paying little heed to international treaty obligations on the human rights front (Mendes, 2001), and by mid-2000 it was apparent that the Federal Government would not intervene (Chappell, 2000). The INCB itself was not able to provide definitive evidence that its treaties were breached, despite its rhetoric, which did not help the Federal Government prosecute a case (Totaro, 2000).

There have been no further signs of possible federal intervention in the issue. Any impetus for the Federal Government to intervene on the grounds of treaty breaches has been removed by the INCB taking a new stance on drug consumption rooms after many years of public condemnation of countries which operate DCRs. The INCB's 2016 annual report noted:

> "the ultimate objective of these measures is to reduce the adverse consequences of drug abuse through treatment, rehabilitation and reintegration measures, without condoning or increasing drug abuse or encouraging drug trafficking. "Drug consumption rooms" must be operated within a framework that offers treatment and rehabilitation services as well as social reintegration measures". (International Narcotics Control Board, 2017 p.91)

In Australia, the current Liberal-National Party coalition Federal Government did not engage in the issue as Victoria developed its plans for a supervised injecting facility. Prime Minister Malcolm Turnbull, who held the office at the time the Victorian legislation passed, represented the NSW electorate in which MSIC is based. When asked, early in 2017, about his position on the facility, he expressed support, saying on balance it "had been more successful than not" (AAP Newsfeed, 2017).

National drug policy in Australia

Australia's national drug policy and the institutional arrangements that support it have the potential to facilitate policy transfer with their focus on evidence-based policy and cooperative institutional structures. A national drug strategy framework has been in place since the mid-1980s. The current National Drug Strategy 2017-2026 aims to minimise the

harms of alcohol, tobacco and other drugs through the three pillars of demand reduction, supply reduction and harm reduction. Drug consumption rooms are recognised in this current strategy as an example of evidence-based and practice-informed approaches to harm minimisation (Commonwealth of Australia, 2017 p.51). Given the controversy that has surrounded them, this is perhaps surprising, but it is indicative of the overall acceptance of the ideology and practice of harm reduction in Australian drug policy. As such it is an ideational factor with potential to facilitate policy transfer.

The national strategies are built on the principles of partnership and coordination, recognising the impact of Australia's constitutional arrangements and division of powers between governments. They also explicitly recognise the need to work in partnership with community, industry and professional groups, including researchers (Fitzgerald and Seward, 2002). This approach is supported by institutional structures that bring together relevant State, Territory and Federal Ministers from health, justice and law enforcement portfolios in a Ministerial Drug and Alcohol Forum. Its work is supported by the National Drug Strategy Committee, made up of senior bureaucrats (Commonwealth of Australia, 2017). Until 2014, the Prime Minister had convened an advisory body, the National Council on Drugs, which contained a cross-section of representatives with expertise and experience of drugs and alcohol; the Council facilitated policy sharing and learning across jurisdictions (Australian National Council on Drugs, 2014).

State-centred sources of change: federal, state and local government politics

The capacity for engagement in the development of drug policy by three levels of governments, across multiple policy portfolios, has complicated policy transfer in relation to drug consumption rooms in Australia. Consistent with Evans' (2004) conjecture, the case studies demonstrate that structural forces have been significant, as we see through the strong focus on the role of political institutions such as parliament in the policy process. Also

consistent with Evans' conceptualisation is the autonomy that is exercised by forces such as political parties through strategic selection of their support or opposition to the idea of supervised injecting at various junctures. That strategic selection has been influenced strongly by political leadership being exercised at critical points of the policy process, a factor which demonstrates the dialectical interaction of structure and agency. These issues are explored below, beginning with the role played by the Federal Government.

Under Australia's federal system of government, the states retain powers over criminal law and the provision of health care, but the federal government's capacity to raise taxes sees it influencing national agendas and resourcing of initiatives in areas such as health and drug policy. The federal government has been a major funder of drug policy initiatives, allowing it to set policy directions and exert structural power (Ritter et al., 2011). John Howard, a conservative Liberal Prime Minister, launched the multimillion-dollar federal initiative 'Tough on Drugs' in 1997. As debates on drug consumption rooms got underway in three jurisdictions in the late 1990s (NSW, Victoria and the Australian Capital Territory), the Federal Government announced a $220m plan to tackle illicit drugs, focusing on treatment and diversion programs (Rollins and Hannan, 1999). Howard was staunchly opposed to supervised injecting facilities, arguing there was insufficient evidence from overseas of their effectiveness, and that SIFs sent the wrong signal to the community about illegal drugs (Mendes, 2001). In this way, he used his position as a powerful agent to influence the debate, asserting his own ideas, embedded in his conservatism, to challenge evidence and lay moral claim to the arguments that opposed SIFs. Moreover, the significant funding controlled by the federal government influenced the type of programmes which could be implemented by the states.

At the state level of government, institutional factors proved significant in the development of drug consumption room policy in Australia. States not only have the residual powers under

the federal system to develop new drug policy, legislatively, but are also accountable to local communities and electors to deliver policy solutions to the problems presented by drug markets and public injecting. In both case studies, parliaments were central to the development and consideration of policy through multiple inquiries and committee reports. Bureaucratic bodies have been less prominent. Other significant fora included the NSW Drug Summit (which all NSW parliamentarians attended) and, in Victoria, the convening by the Bracks Government of the Drug Policy Expert Committee under Professor Penington. Throughout the policy making process, evidence gathering has been central through study tours, contributions from expert witnesses, public submissions and commissioned reports. These institutions also actively sought input from the community and facilitated debate through public meetings.

Despite robust and consultative processes, politically the decision on whether to proceed or not with supervised injecting facilities continued to be a difficult one for governments to make. This conflict for governments represents a process of strategic selection which can be explored by examining the various positions that political parties took in both government and opposition. It illustrates the conflicting agendas that governments faced, which challenged the salience of the idea of supervised injecting at varying points of electoral cycles. Significantly, a closer examination of the standing of political parties demonstrates the significance of the role of political leadership – a key act of agency in the policy change process.

In Victoria, Labor Governments introduced both the initial bill in 2000 (which failed) and the successful bill in 2017. Yet for many years in between, the ALP did not actively pursue or support a supervised injecting room. For example, the Bracks ALP Government won a landslide election only two years after their failure to secure Upper House support for their legislation, but never returned the proposal for supervised injecting facilities to its party

platform. Daniel Andrews' Government, too, spent many months resisting calls to address North Richmond's escalating drug crisis with the introduction of supervised injection. Andrews' reversal of party policy on the issue only came with mounting pressure from Fiona Patten's private members bill, the Coroner's report and a strong community campaign. More significantly, electoral pressure from the Greens Party and the threat of losing the by-election contributed to the Government's changed stance.

The Liberal Party's record of support for supervised injection in Victoria has been mixed. Whilst in power, leader Jeff Kennett demonstrated that he was open to the idea, making public statements to that effect when Open Family announced their plans to establish rooms in both Victoria and NSW in early 1999 (AAP Newsfeed, 1999). Whilst Mendes (2002) is correct in pointing out that Kennett ruled out support for a SIF during the 1999 election, three key informants I interviewed were of the view that Kennett intended to proceed with a facility following the election that he was expected to easily win (Practitioner 8, Policy Maker 7, Researcher 8, all Melbourne). Section 5.4.2 below provides more details. However, following the Liberal's electoral defeat, newly installed Liberal leader Denis Napthine opposed the legislation when it was introduced by the Bracks Government in 2000. The Opposition Leader argued that the proposal sent the "wrong message" and was not reflective of community wishes (AAP Newsfeed, 2000). With sufficient numbers in the Upper House and the failure to permit a conscience vote, the Victorian Liberals' position ensured the defeat of the legislation.

The Labor Party also successfully passed the bill supporting MSIC in NSW. Initial proposals were blocked by the parliamentary scrutiny of the Joint Select Committee. Support only came after the five-day NSW Drug Summit, where the issue was subject to intense scrutiny. Without the leadership of Bob Carr, who was convinced by the evidence presented to the Summit, it is difficult to see how enough support would have been rallied among Labor ranks.

There was strong opposition from ALP members, such as Reba Meagher, who argued a proposal for supervised injecting facilities was at odds with the needs of the community she served in Cabramatta (Sands, 1998). In any case, the Labor Party in NSW has remained committed to the argument that this is an exceptional measure for exceptional circumstances, and have sought to reassure their voter base that they do not condone drug use. John Della Bosca, Special Minister for State, in his second reading speech on the introduction of the legislation in 1999, emphasised this point:

> "In all instances the Government remains committed to the view that self-injection of addictive substances cannot be normalised, and must be rejected as a behaviour on social, health and moral grounds…This is a centre for rehabilitation, a centre for treatment, a centre for counselling and referral – it offers a gateway to treatment." (Parliament of NSW, Legislative Assembly Hansard, 21 October 1999)

The Liberal Party of NSW has, in general, opposed the Government of the day on supervised injecting, but members have crossed the floor to vote with the Government (Gunaratnam, 2005). The Liberal Party of NSW opposed the 1999 bill, with leader Kerry Chikarovski arguing that the bill "conveys the wrong message" and that "this process merely entrenches and expands a culture that says illegal drugs, such as heroin, are acceptable within our community" (Parliament of NSW, Legislative Assembly Hansard, 11 November 1999). By 2010, with the introduction of the bill to end the trial status of the MSIC, Liberal MPs were granted a conscience vote by Opposition Leader Barry O'Farrell and once again members crossed the floor. The parliamentary debate reveals the conflict for parliamentarians in supporting the *idea* of supervised injecting, lest being seen to condone drug use. This conflict is captured by the speech given by Deputy Leader of the Opposition, Jillian Skinner:

> "As I said during the 2007 debate, I have struggled with the concept of the injecting centre and I could go either way in voting on the bill. The message the centre sends that people can take drugs safely is not right. We should never allow people to think we condone drug taking and that people can inject drugs safely… However, it all comes down to those who use the centre. Their average age is 34, most are male, many are on some form of government income benefit and many have been in prison. They are chronic users and have underlying health problems, such as HIV and hepatitis C, and other medical problems. … So despite my personal discomfort, as an aspiring Minister for Health with an abiding determination to put patients first as a guiding principle and

being firmly of the view that the medically supervised injecting centre helps people stay alive and improves their health and wellbeing, I will be supporting this legislation." (Parliament of NSW, Legislative Assembly Hansard, 20 October 2010, p.26395).

Local government responses

An examination of the role of local government reveals the critical role played by both ideational and structural forces in the policy transfer process. Local governments grapple directly with the contesting of the idea of supervised injecting by their communities as they come to terms with the reality of the concept. In addition, tensions are generated by a local problem that requires a state-level solution. In terms of successful policy transfer, this latter tension is a potential constraint. DCRs are generally a response to a geographically-bound problem through their association with specific street-based drug scenes. Whilst the capacity to deliver the required legislative frameworks sit at a higher governmental level, local Councils have a responsibility to their communities for safety and amenity. A significant tension arises between the desire of local Councils to determine a local response and the necessity for the debate to be taken to a much broader audience, which is not necessarily in touch with the day-to-day experiences of the affected communities.

Councils have taken strong stances both for and against proposed injecting sites. In New South Wales, the strongest push for SIFs came through the deliberative process of the Drug Summit, but its recommendation to trial supervised injecting was not met with support from local Councils such as Fairfield, the administrative area in which Cabramatta sits. There was a strong fear that local Councils would have injecting rooms 'forced' on them by the State Government. To counter the State Government, 46 Councils agreed to form an Australian wing of a grouping called the European Cities Against Drugs in order to work together to resist any such imposition from the State Government (Penberty, 1999). Other Council areas such as South Sydney, which included the inner-city area of Kings Cross, came out in support of the proposal (Clennell, 1999). That Council recognised, however, that it could not go it

alone without the State Government, citing legal and resourcing issues (Sands, 1998). Ultimately, the narrow scope of the bill, specifying the trial of only one injecting facility, eliminated the concern that centres would be 'forced' on unwilling local councils. The corollary of this position was that it also removed the possibility for other local Councils to pursue a centre in the absence of a legislative amendment.

In Victoria, Councils were split in their support as the Bracks Government pursued its agenda of five injecting sites in the 'hot spots'. At the time of consideration of the legislation in 2000, three municipalities were supportive, but two, the Cities of Greater Dandenong and Melbourne, had cast local votes within their Councils to reject any proposals (Mendes, 2002). The appointed Drug Policy Expert Committee under Professor Penington had developed a number of community and consultation processes but the debate stirred up considerable anxiety and concern (Dolan et al., 2000). Community groups mobilised both for and against the proposals and actively made their voices heard (Gunaratnam, 2005). According to one interview participant, at times public meetings on the issue descended into "shouting matches" (Researcher 8, Melbourne). The Government appeared to respond to this pressure by having a 'bet both ways'. While arguing that sites would only proceed if they had the support of the local municipalities, in an effort to garner support on the floor of Parliament, the Government committed to adding a condition to the bill that Parliament would have the authority to approve (or disapprove) the service agreements (Gunaratnam, 2005). Should the bill have passed, this could have opened the way for State Parliament to overrule local decision making on the issue.

Moving forward to 2010 in Melbourne, the marked changes to local drug markets meant that there was arguably only one street drug scene that would appear to meet the criteria for benefiting from a supervised injecting facility (Dwyer, Power and Dietze, 2013). North Richmond and Abbotsford experienced a thriving street-based drug market, and the public

nuisance and amenity issue that accompanied that. The local Council, the City of Yarra, had supported a number of proposals over the years for a trial of a supervised injecting facility, including passing a vote 6:1 in favour in 2011 (Gregoire, 2016). This vote did not generate the required support from the State Government, so the proposal did not progress. In their submission to the 2017 Legislative Council Committee inquiry into Patten's bill, the Council outlined the limitations of its position:

> "Whilst Council is committed to improving the amenity of Victoria Street, it has limited powers and responsibilities in other aspects including the measures recommended by Coroner Hawkins…Yarra City Council urges the Victorian Government to act on the extensive evidence available that supports the establishment of as SIF as a means of reducing drug-related harm in our community, and calls on the Victorian Government to implement the recent recommendation made by the Coroner Hawkins and to amend legislation to allow this to occur". (Yarra City Council, 2017)

That inquiry, as discussed above, did not make a recommendation to support the trial. In her foreword to the report, the Chair emphasised the importance of taking into account the views of the community and local government. She went on to say that the Committee, however, was not "set the task of confirming the level of local support" (Parliament of Victoria, 2017 p.xii). The implication of this statement is that without some definitive measure, the inquiry was not justified in recommending for the trial to proceed, even with 46 of the 49 submissions in favour, including an unequivocal recommendation from the local Council. This demonstrates the problematic issue of interpreting 'community' views in the policy making process, but also the potential for 'buck passing' to occur between the different levels of government: an issue of relevance in the Canadian case studies.

5.4.2 Civil disobedience

Both case studies in Australia captured acts of civil disobedience via the provision of an 'illegal' supervised injecting service prior to legislation sanctioning services. This section explores the contexts and impact of such actions in each case. A different pattern of activity is discernible between the two cases, with Sydney's very visible Tolerance Room serving a

highly successful agenda setting function, while Melbourne experienced a more 'behind the scenes' approach as Wesley Central Mission tried to move forward with developing a functional service in tandem with political developments.

The opening of the unsanctioned injecting room at the Wayside Chapel in May 1999 in the lead up to the NSW Drug Summit was, at the admission of its instigators, intended to be symbolic and deliberatively timed to put pressure on the Carr Government (Wodak et al., 2003). The organisers actively engaged with the media and the drama of the arrest of clergyman Reverend Ray Richmond following police raids was well-covered in the national press (Harris and Jackson, 1999; Trimingham, 1999; Carlton, 1999). While there appears to be a consensus that this act of civil disobedience can be credited with supervised injecting being placed on the Drug Summit agenda (van Beek, 2003), it is of note that one member of the group was a former member of the NSW Parliament and continued to effectively use her influence amongst her parliamentary network through "discreet contact", in contrast to the highly visible act of civil disobedience (Wodak et al., 2003 p.615).

In Melbourne, civil disobedience has not been a prominent feature of campaigns to establish drug consumption rooms. In May 1999, the Community Coalition for Heroin Reform and the Militant Socialist Organisation set up a temporary safe site in Collingwood (Mendes, 2002). With the debate having entered the political domain and become an electoral issue, there is some question as to what a civil disobedience campaign would have achieved, particularly once the ALP had pledged A$4.5m of funding for the five sites (Dolan et al., 2000).

A factor that may have undercut a push for civil disobedience was the effort of local Melbourne Church group Wesley Central Mission to develop a supervised injecting room in the central business district (CBD) in 1999, prior to the political or legislative resolution of the issue. These efforts were subject to a fierce community debate involving Wesley and a local group, Residents 3000. The Health Minister John Thwaites entered the debate and said

assurances had been received from Wesley that they were not in breach of the law and that any evidence of facilities would be referred to the police (Martin, 2000). No action was taken, but Melbourne City Council voted against support for the facility in June 2000 (Finlay, 2000). Interview participants in this study indicated that Premier Jeff Kennett was well aware of Wesley's plans in 1999 and was secretly supportive of them. According to one source, Kennett had provided "tacit agreement" to an injecting facility being established in the CBD (Policy Maker 7, Melbourne). Another participant said:

> "Anyway, they [the Government] knew about it. But they tried to keep it secret. I believe what Wesley were being told was, 'We can't come out and support this…but wait until after the election.' So they kept developing it." (Researcher 8, Melbourne)

Further, a Practitioner recalled, "But I mean I think they built the room; they were ready to go. And really, if Jeff Kennett had have got elected, re-elected, maybe it would actually have happened" (Practitioner 8, Melbourne).

While civil disobedience was a factor in Sydney, it does not appear to have been a tipping point in the debate, given the number of other influences, including growing public concern with drug issues and prominent media coverage. In Melbourne, pressure was brought to bear in a more formal way with Wesley Central Mission openly developing a service in advance of government approval, but without threatening to provide service in the absence of appropriate frameworks. It is noteworthy that in both cases, change was being pushed strongly from Church-based organisations, being the Wayside Chapel, a parish of the Uniting Church in Sydney and Wesley Central Mission in Melbourne. Ultimately, in both Sydney and Melbourne, change was still required to be delivered through formal government processes to ensure the delivery of credible services.

5.5 Findings and conclusions

The case studies above are detailed by their nature as an exercise in reconstructing key events and influences as supervised injecting policy has been debated by both the

community and in formal political institutions. Spanning two decades, the case studies of Sydney and Melbourne may appear on the surface to have been quite different. However, it is striking, in comparing the two cases, how many similarities there are in terms of the main findings that can be drawn in relation to the replication of policy. This section presents those key findings, focusing first on the similarities of the cases and then any differences that are of note, before drawing some general conclusions. The findings presented here will be drawn on in Chapter Eight to apply the policy transfer framework to understand what influenced the success or failure of policy transfer in the Australian and Canadian case studies.

While all three levels of government in Australia have been involved in the process of developing policy on the issue of supervised injecting, it is clear from both cases that the state level of government has dominated. Parliaments in both New South Wales and Victoria controlled the policy process through the decision to pursue a legislative response (as opposed to an administrative or discretionary response). With the exception of the failed legislation in Victoria in 2000, the other two, successful pieces of legislation have been deliberately crafted to limit the provision of service to single sites. This has sent the strong message that supervised injecting is an extreme measure supported in very specific circumstances. It should not be viewed as a service that Governments embrace, other than when there is a 'crisis' of a magnitude that can justify such a measure. In both cases, the Governments have been able to make the argument that they support supervised injecting in these specific instances, while attempting to persuade the community that they have nothing to fear as the measure is strictly contained (both geographically and temporally). The narrowness of the legislation in both sites is not an encouragement for policy learning, despite the framing of the interventions as trials and the focus on evaluation and the development of an evidence-base.

Another means by which state governments have sought to assuage communities is through extensive consultation, yet the case studies demonstrate a tension between community 'opinion' and political support for supervised injecting. In both Sydney and Melbourne, there was evidence that more people in the community supported trials of supervised injecting than did not, but it remained a difficult issue politically for elected representatives (Drug Policy Expert Committee, 2000; Salmon, 2008). Politicians appear to be conflicted in their role as representatives as to whether they take a moral stand, reflect community opinion or calculate for potential electoral backlash. This is issue is taken up in Chapter Seven. In both states, decisive political leadership was a prerequisite for the passage of legislation but not necessarily a sufficient condition, as the Bracks Government's failure in 2000 indicates.

In terms of the other levels of government, a degree of coordination has been required which adds to the complexity of policy change in this area. The Federal Government, while having the potential to act through its external powers in relation to international treaties, ultimately chose not to challenge the states' positions on the issue. Local governments, through the Council structure, have been actively engaged through their concern with amenity, health and safety issues in their local areas, but have been unable to act alone to provide services. They have, in some cases, attempted to assert the right not to accept services (for example, Fairfield Council in NSW and City of Melbourne in Victoria), although there has never been any test of whether a state government would choose to override a local authority and insist on service provision.

The Australian case studies provide evidence that the introduction of supervised injection was influenced by experience from overseas; policy development in both jurisdictions therefore contained elements of policy transfer. Both Victoria and New South Wales policy makers embarked on study tours, and evidence from overseas was tabled in Parliamentary reports and inquiries (Parliament of New South Wales, 1998; Drug Policy Expert Committee,

2000; Victorian Parliament, 2018). Australia's national policy has been broadly supportive through its recognition of harm reduction as a pillar of drug policy. However, despite this potential for policy learning to occur through the partnership approach that underlies Australia's national drug policy and its institutional structures, policy has not been scaled up nationally. It can be concluded that despite exposure, for example, of Victorian politicians to the experience of MSIC in Sydney, including a site visit (Victorian Parliament, 2018), sub-national policy transfer has had a limited impact. Victoria's comparatively late establishment of their MSIR, seventeen years after Sydney's MSIC, did not occur without a thorough reconsideration of the evidence and questioning as to the appropriateness of the service for 'local' conditions, as demonstrated by the extensive work of two Parliamentary inquiries in 2017-2018 (Parliament of Victoria, 2017; Parliament of Victoria, 2018). The 2017 inquiry, for example, despite finding that medically supervised injecting facilities were effective, did not recommend one for North Richmond (Parliament of Victoria, 2017). It can be concluded that there is not, in the Australian cases, evidence of a straightforward adoption of policy from one jurisdiction to another: an issue given further consideration in Chapters Seven and Eight.

A final similarity of note between the two cases is the shared experience of changes to each cities' street-based drug markets. The evidence points to a contraction of open drug markets, which appears to have been influenced by a number of factors, including gentrification; changes to drug dealing that have been brought about by the widespread uptake of mobile phones; and shifts in methods of consumption and types of drugs being consumed. These changes have influenced perceptions of the policy problem and the magnitude of the 'crisis' that needs to be addressed in Australian cities in relation to street-based drug use. It also has implications for the model of drug consumption that may be appropriate in a more dynamic market, suggesting that consideration must be given to temporal factors in the process of policy transfer.

In terms of differences in the findings of the cases, only two of significance are noted. The first relates to the role played by civil disobedience. Whilst the case studies revealed acts of civil disobedience in both sites, Sydney's Tolerance Room appears to have had the greatest impact in terms of agenda setting. However, in neither site has there been any act of civil disobedience which pushed for further services after 1999, limiting the impact that civil disobedience has had on policy development in both sites. This point is relevant in terms of later discussion of the cases in Canada.

The other significant difference relates to the original strategy that was pursued in Melbourne to support five potential supervised injecting sites compared to a more limited focus in Sydney. Bracks' strategy did not succeed as the legislation was rejected by the Upper House. One participant was earlier quoted as saying that NSW Premier Carr had called her suggestion that they would require four or five centres in Sydney "political suicide" (Practitioner 7, Sydney). It was certainly the case that there was vocal opposition expressed in Melbourne within communities, as well as two of the Council's formally passing motions to express their opposition to supervised injecting facilities being established in their jurisdictions. However, given that the State Government proceeded to take their legislation to the Parliament, it is not possible to say whether the strategy of pursuing five rather than one centre at that time had any bearing on the legislation's defeat in the Upper House.

In conclusion, the case studies of Sydney and Melbourne's experiences in relation to developing policy on drug consumption rooms show that while supervised injecting was supported in both locations following extensive community and political debate and scrutiny of evidence, including from overseas, the scope of the interventions was deliberately constrained. The legislation put in place limited the political risks associated with the controversial measure by specifying, in both cases, that only one licence for one premises would be granted. While further amendments to this legislation are possible, the likelihood

for the scaling up of services seems very remote at this time – despite the acknowledged success of MSIC in meeting its objectives. This is due to a number of factors, including the contraction of street-based drug markets and the changing perception of the problems associated with public drug taking. The limited prospects for the policy of supervised injecting becoming more mainstream as a public health intervention reflect an underlying conservatism within the Australian political landscape in relation to illicit drugs. Following the case studies from Canada which are presented in Chapter Six, further consideration will be given, in Chapters Seven and Eight, to the factors that have constrained and facilitated policy change in this area.

Chapter six
Canadian case studies:
Vancouver and Toronto
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6.1 Introduction

This chapter builds on the foundations laid in Chapter Five by presenting the two further case studies of the Canadian cities of Vancouver and Toronto. The Australian case studies demonstrated how policy replication and sub-national transfer were affected by the control exercised over policy by state governments, and the changing nature of street-based drug use in the cities of Sydney and Melbourne. The Canadian cases present a complex picture that spans three levels of government. The distribution of powers under federalism and the multi-sectoral nature of drug policy engages a number of institutions and a significant level of coordination to achieve policy change. The idea of supervised injecting in the Canadian context has been politically and ideologically contested. From its origins in activism and civil disobedience, innovative policy emerged in Vancouver, borrowing directly from European ideas and experiences. Policy replication stalled, however, despite a strong evidence base of the effectiveness of Canada's first official supervised injecting facility, Insite. Supervised injecting became an issue of national concern that was contested through the institutions of parliament and the judicial system. However, the current escalating epidemic of opioid overdose deaths has challenged governments in Canada to respond, resulting in the scaling up of drug consumption services after a period of policy stall. These two case studies are constructed utilising the same methodology as the Australian cases (Yin, 2014), using extensive primary and secondary documentary sources and drawing on data collected from interviews undertaken at the field sites.

Following the format of the previous chapter, the Canadian case studies are presented in four main parts. Section 6.2 is concerned with the city of Vancouver in British Columbia. Vancouver has led SIF policy development in Canada, engaging a range of stakeholders across multiple agencies and levels of government to address the public health crises facing the city in the last twenty years. Factors constraining the scaling up of policy in the city and the province are analysed. Section 6.3 introduces the case study of Toronto in Ontario where

supervised injecting policy has developed in the context of a very different drug use environment than Vancouver. This case study is characterised by the leading role played by the bureaucracy, as proposals to address street-based drug use were subject to extensive community consultation and a lengthy needs and feasibility assessment. Section 6.4 places events in Vancouver and Toronto in the political and policy context of the Canadian federal system, as both structural and agency sources of policy change are identified. Comparative analysis is undertaken of the impact of these factors at each site. The role and impact of civil disobedience on the scaling up of supervised injecting services is considered. Finally, Section 6.5 summarises the key findings of the case studies.

6.2 Case study 3: Vancouver, Canada

Vancouver's supervised injecting facility Insite is commonly introduced as the first facility of its kind in North America, having been established in 2003. Less frequently mentioned are the number of unsanctioned sites that pre-dated Insite, including the Dr Peter Centre, which operated with the knowledge of local authorities for fourteen years before gaining legal status. This case study of drug consumption services in Vancouver traces the development of these multiple sites, considering the role played by local government, policy makers and community activists. Evidence of the effectiveness of Insite in meeting its objectives did not prevent ongoing contestation of the idea of supervised injecting as an appropriate policy response to problematic drug use. Engagement of the federal level of government and the Supreme Court elevated events in Vancouver into the national political sphere, resulting in implications for the transfer of policy sub-regionally within Canada. The impact of successive public health crises and pressure on the state through acts of civil disobedience are explored in order to better understand the complex factors that contributed to the stop-start expansion of supervised drug consumption in Vancouver.

6.2.1 The emerging issues

As a port city, Vancouver was particularly vulnerable to the increasingly fluid international drug market and experienced an influx of illicit drugs in the 1980s and 1990s (MacPherson, 2000). Drug use was spread across Vancouver, but was concentrated in an area called the Downtown Eastside (DTES), the "epicentre of Vancouver's illicit drug and sex trade economies" (Kerr et al., 2008a p.110). Some 5000 injecting drug users were estimated to live in a ten-block area and the Downtown Eastside accounted for 80 per cent of the city's drug arrests (Kerr et al., 2003a p.579; Roe, 2009 p.86).

In the early 1990s, the Chief Coroner and former Royal Canadian Mounted Police (RCMP) superintendent, John Cain, launched an investigation into heroin-related deaths in British Columbia. Annual drug overdose deaths in the province had increased from 39 in 1988 to 357 in 1993 (Armstrong, 1998). Cain urged the Government to consider the impact of the so-called 'war on drugs', which he termed an expensive failure, and to instead approach addiction and drug use as health and social issues. He argued for more innovative harm reduction approaches that would facilitate the safer use of illicit drugs. More radically, he urged consideration of a degree of legalisation and decriminalisation of illicit drugs (Cain, 1994). According to Campbell et al. (2009), there were no tangible results to come from Cain's report; they quote one source as attributing this to a lack of courage in all levels of government (Campbell, 2009 p.59). Overdose deaths continued to rise. By 2001, over 2000 overdose deaths had been recorded in Vancouver over the previous decade, and drug overdose deaths had become the leading cause of death among people aged 30-49 (Elliot et al., 2002).

Concomitant with rising overdose deaths, Vancouver experienced an increase in HIV infection rates. Prevalence of HIV among Vancouver's injecting drug users (IDUs) rose from 4 per cent in 1992-93 to 23 per cent in 1996-97 (Canadian HIV/AIDS Legal Network, 1999 p.9), in what has been described as "one of the fastest spreading HIV epidemics ever documented

in the developed world" (Urban Health Research Initiative, 2009 p. 7). The increasing availability of inexpensive cocaine and the practise of injecting cocaine at high rates of frequency (up to twenty times a day compared to two to three times for heroin) was linked to an escalation in risk behaviour (Kerr, 2000 p.14). In addition to the disease burden of HIV, 88 per cent of IDUs in Vancouver had contracted Hepatitis C by 1998 (Kerr, 2000 p.14). Concern with these issues at a national level led to the 1997 declaration by the National Task Force on HIV/AIDS and Injecting Drug Use that Canada was in the midst of a public health crisis (National Task Force on HIV/AIDS, 1997).

6.2.2 Phases of the response

The potential of supervised injection as a means of ameliorating the risks faced by injecting drug users in Vancouver surfaced in the mid-1990s, and is a story of unlawful and lawful activity. Three distinct phases are discernible: a period of establishment of unsanctioned sites and then an officially sanctioned service, Insite (1995-2003); a period of contestation, and political and legal battle over supervised injecting (2006-2015); and currently, a period of expansion as Vancouver, and Canada more generally, grapples with an unprecedented opioid overdose epidemic (2016-2018). Throughout these phases, both structural and agency factors interact as ideas are contested and the replication of policy is challenged through the engagement of multiple levels of government and the courts.

Establishment (1995 – 2003)

The journey from the promotion of the initial concept to the establishment of Canada's first government-approved drug consumption room was the culmination of the work of a range of agents: activists, bureaucrats, and politicians. Three strands of activity interwove and intersected: activism, which included advocacy, protest and civil disobedience through the direct provision of unsanctioned supervised injecting; policy study and debate, including drawing from international experience; and, finally, political contestation and resolution.

Activism

Growing official concern with this burgeoning public health crisis had been preceded by a wave of community activism and advocacy, at the heart of which was the user-run organisation known as the Vancouver Area Network of Drug Users (VANDU). VANDU, along with community organisations such as the Portland Hotel Society (PHS) and advocacy group the Harm Reduction Action Society (HRAS), became instrumental in advocating for, and demonstrating, the benefits of harm reduction and people-centred approaches to tackle drug problems (Osborn and Small, 2006; Small, Palepu and Tyndall, 2006; Harati, 2015). They also worked in alliance with a family support group, From Grief to Action (FGTA), which was effective politically in re-framing drug use as an issue that could affect anybody (McCann, 2008). Activists were key agents for change through acts of civil disobedience that demonstrated service delivery; equally importantly, they contributed to the development and circulation of policy ideas.

The first unsanctioned supervised injecting site opened in the DTES in 1995. A group of drug users and activists known as IV Feed, developed the 'Back Alley Drop-In' which operated for nearly a year, seeing around 100 users a night, before being closed by the police (Folz et al., 1999; Kerr et al., 2003b). According to Lawrence (2017), while no further organised sites operated for a number of years, members of VANDU offered their own rooms in the DTES as a safe place to inject. The idea of supervised injection, and the experience from overseas, was brought to the Downtown Eastside in 1998 when a group brought speakers from Europe and the United States to address over 700 people at a one-day conference called 'Out of Harm's Way'. This led to the establishment of the Harm Reduction Action Society, whose mission was the promotion of a SIF in Vancouver (Kerr et al., 2008a). HRAS developed a proposal for an 18-month pilot of two supervised injecting facilities (Kerr, 2000). It also ran two 'mock' SIFs at a local DTES church to dispel myths about supervised injection, attracting public interest and media attention (Kerr et al., 2008a).

Between 2000 and the opening of Insite in 2003, three more unsanctioned SIFs operated in Vancouver. Two were run by activist Ann Livingston, a key instigator of the Back Alley, in 2000 and 2003. The latter operated for five months until the official opening of Insite, despite the threat of closure from police (Small et al., 2006). The third site was the Dr Peter Centre, a private HIV/AIDS care clinic which began an unsanctioned site in 2002 at their premises in Vancouver's Downtown area. The case of the Dr Peter Centre is discussed below.

Policy development and political resolve

Following the declaration of the public health crisis in 1997, supervised injecting gained support in policy circles at different levels of government across Canada. With support from Health Canada, a series of important reports emerged that sought to address the issues of HIV and Hepatitis C among injecting drug users. Amongst their findings (echoing Cain) was the conclusion that the legal status of drugs in Canada was contributing to difficulties in tackling HIV/AIDS among injecting drug users (Canadian HIV/AIDS Legal Network, 1999). The potential for supervised injecting to address the risks posed by HIV and Hepatitis C was raised in a Consultant's report put to the Vancouver/Richmond Regional Health Board in 1997. This proposal was immediately rejected by Provincial Health Minister Joy MacPhail prior to the Board's own deliberations on the matter (Matas, 1997). The Board, however, convened a panel to consider supervised injecting, under the chairmanship of Bud Osborne, a key VANDU activist and health board member. In 1998, the panel recommended the establishment of four supervised injecting sites in the DTES (McMartin and Bains, 1998). The response to this report from key stakeholders was largely negative, but the idea continued to circulate with the production in 1999 of a policy options paper for pursuing supervised injecting rooms (Folz et al., 1999).

A critical development came with the launch of the City of Vancouver's Four Pillars drug strategy in November of 2000, which focused on the four pillars of prevention, treatment,

enforcement and harm reduction (MacPherson, 2000). This policy explicitly drew on the experience and evidence of effective models of care from outside Canada and has been described as "an assemblage of expertise and resource from close-by and far afield" (McCann and Temenos, 2015 p.219). The policy called for a feasibility study of supervised injecting facilities in British Columbia. Bureaucrats have been key members of the policy transfer network that continued to promote the option of supervised injecting. This role is acknowledged by Small et al, who wrote:

> "These bureaucrats were in numerous departments of the municipal, provincial and federal governments including the Vancouver Coastal Health Authority and Health Canada. They deserve recognition for their advocacy as without them a state endorsed and funded SIF would simply not have been implemented." (Small et al., 2006 p.75)

The strands of activism and policy development required political leadership to advance the policy idea. That resolve came in the form of a conversion from opponent to proponent by Vancouver Mayor Philip Owen, followed by an electoral victory fought on the issue of drugs by his successor and ally Larry Campbell. Owen was Mayor of Vancouver from 1993 to 2002, representing local municipal party, the Non-Partisan Association (NPA). Owen's position on supervised injecting sites in the late 1990s was unequivocal: "I'm totally and violently opposed to this at this point. It's absolutely wrong" (Armstrong, 1998). It was a position he reversed by 2001 to steer the Four Pillars policy through a hostile Council, including the recommendation for piloting supervised injecting. Owen's championing of a new and alternative approach has been attributed to a genuine effort to understand the problems at the level of the street, coalition building and a capacity to draw in expertise and experience from other cities, particularly in Europe (Campbell et al., 2009). However, Owen's outspoken support of drug policy reform cost him the endorsement of his party; the NPA nominated an alternative candidate for the mayoral election in 2002 (Vancouver Sun, 2002).

The city's drug policy and the Downtown Eastside were contested issue in the election. The Committee of Progressive Electors (COPE) fielded Larry Campbell, a former coroner and

police drug squad officer, who campaigned on a platform of opening a supervised injecting centre (McCann, 2008). Family advocacy group From Grief to Action held a mayoral debate in the lead-up to the election where, as Campbell et al. describe, no one spoke out against supervised injecting sites and "candidates were grilled on how they would ensure that at least one such site would open in Vancouver" (Campbell et al., 2009 p.170). Campbell won by a landslide and pledged to open a facility (Boyd, 2013).

While the issue was being resolved politically in Vancouver, the Federal Government was providing the necessary legal cover for SIFs to begin operation in Canada. The *Controlled Drugs and Substances Act 1996* (CDSA) made the possession of certain drugs illegal in Canada, but also contained the provision under Section 56 of the Act for the Minister of Health to exempt individuals and or/illegal substances from the application of the Act, provided that "…in the opinion of the Minister, the exemption is necessary for a medical, or scientific purpose or is otherwise in the public interest" (*Controlled Drugs and Substances Act 1996*). In December 2002, Health Canada issued draft guidelines stipulating that proposals for SIFs could be made to the Minister seeking such an exemption, but such sites would be required to be operated as scientific research projects (Bula, 2002). Following an application from local health authority, Vancouver Coastal Health, an exemption was granted by the Liberal Federal Government of Jean Chretien, enabling a sanctioned supervised injecting centre to be established.

<u>The establishment of Insite and evidence of effectiveness</u>

Insite opened its doors in Vancouver's Downtown Eastside in September 2003 as a three-year pilot project under a partnership between the Portland Hotel Community Services Society and Vancouver Coastal Health. The Provincial Health Ministry contributed C$2 million for operational costs and a further C$1.2 million towards renovation costs (Read, 2003). The site offered twelve injecting booths, a nursing station and a 'chill out' space. Insite has since

expanded to offer on-site detoxification and a recovery program (Harati, 2015). The service would typically have between 700-800 visits a day, but numbers can reach 1100 (Street Roots, 2010).

Insite was licenced for scientific purposes only (consistent with a Section 56 exemption) and Health Canada developed new Federal Guidelines to govern the monitoring of the site (Christie et al., 2004). Evaluation of the pilot was undertaken by the B.C. Centre for Excellence in HIV/AIDS and over 30 studies were published in the first five years of operation (Harati, 2015). According to the most recent systematic review of the benefits and harms of safe injecting site published in 2014 by Potier et al., 68 per cent of the literature came from studies of the Vancouver site (*n*=51). Studies addressed the acceptance of the SIF to the local drug using community; public order issues; safe injecting education and practices; HIV risk behaviour; referral for addiction treatment; overdoses; and community impact. Consistent with other international literature (Potier et al., 2014; Hedrich et al., 2010) the peer-reviewed evaluations of Insite have been overwhelming positive in their findings, documenting "a large number of health and community benefits, and…no indications of community or health-related harms" (Wood et al., 2006 p.1403). (See Chapter 1 for further discussion.)

Dr Peter Centre

While Insite has dominated the story of supervised drug consumption in Canada, one organisation provided supervised injection services without government sanction for fourteen years before finally being granted an exemption in 2016. The Dr Peter Centre is a private HIV/AIDS care facility located near the St Paul's Hospital in Vancouver's Downtown area. In 2002, following two episodes of overdose, the Dr Peter Centre began offering a dedicated space and supervision by nurses for its clients who were injecting drug users (Davis, 2007). The Executive Director of the Centre, Maxine Davis, went public about the

practice at a press conference in April 2002 (Bohn, 2002a). The Vancouver Police, when asked

to comment on the potential illegality of their actions, responded by saying:

> "Nurses are not injecting these individuals with the drug...They're teaching them about proper usage of intravenous needles. There's no criminal connection, so we wouldn't be seeking any action." (Bohn, 2002b)

As detailed above, an exemption from the *Controlled Drugs and Substances Act 1996* (CDSA)

gave both users and providers of a supervised injection service legal protection from

prosecution on possession, trafficking or aiding and abetting charges. The Dr Peter Centre,

however, effectively turned the question of lawfulness on its head by arguing that for nurses

in their employ to *not* provide such a service might place them in breach of their own

professional standards as per the province's *Nurses (Registered) Act RSBC 1996* (Davis, 2007).

The Association of Registered Nurses of British Columbia, when consulted by the Dr Peter

Centre, agreed that "providing clients with evidence-based information to more safely give

themselves intravenous injections is within the scope of registered nursing practice" (Wood

R. et al., 2003). Health Canada, when approached about the issue, referred it back to the

province, arguing medical practices lie within provincial jurisdiction (Bohn, 2003b). The Dr

Peter Centre provided its service without interference from health or law enforcement

authorities, even as the political environment at the federal level became increasingly hostile

towards supervised injection.

Contestation (2006-2015)

In 2006, the deadline of the expiration of the three-year trial period of Insite coincided with

a change of federal government. Steven Harper's Conservative Party formed a minority

government, after 13 years of Liberal Party rule. Harper made his opposition to supervised

injecting sites known during the election campaign, stating, "We as a government will not

use taxpayers' money to fund drug use" (Boyd, 2013 p.236). The Federal Health Minister,

Tony Clement, however, issued a 15-month extension to Insite's exemption in September

2006. He argued further time was needed to determine the outcomes of the pilot. No funding

was provided for continued evaluation, but the Government convened an advisory panel.

Clement's position was that the existing research was not conclusive and therefore the

Government could not support new applications. His press release stated:

> "Initial research has raised new questions that must be answered before Canada's new government can make an informed decision about the future of Vancouver's drug injection site or consider request for any new injection site…"…Right now the only thing the research to date has proven conclusively is drug addicts need more help to get off drugs," Minister Clement says. "Given the need for more facts, I am unable to approve the current request to extend the Vancouver site for another three and a half years."…Health Canada will not entertain any applications for the establishment of additional injections sites in other parts of Canada until the new NDS [National Drug Strategy] is in place, and the Vancouver review is completed." (Personal communication, Health Canada, 17 March 2017)

The advisory panel commissioned a study which endorsed the B.C. Centre for Excellence on

HIV/AIDS' findings that Insite had not had a negative effect on public order and that it was

viewed by local residents and business owners as having a positive impact on the

neighbourhood (Boyd, 2013). Clement continued to contest the evidence which led to an

investigation by the Pivot Legal Society. Through a series of Freedom of Information requests,

they exposed the 'research' to which Clement referred was produced for the Royal Canadian

Mounted Police. The RCMP commissioned four pieces of work. The first two commissioned

reports were found to be largely favourable of Insite. Two further articles questioning the

methodology and integrity of the evaluation process were published in a non-peer reviewed

online *Journal of Global Drug Policy and Practice*, including one by the Director of Research

at the Drug Prevention Network, Colin Mangham. These articles were used as justification by

the Minister to question the effectiveness of supervised injecting and prevent the expansion

of services beyond the Vancouver site (Paulsen, 2008; Boyd, 2013).

The court challenges

Facing uncertainty, the Portland Hotel Society and two injecting drug users challenged the

federal government in court in August 2007. The case was argued around two key

constitutional points: the first was that the federal government was overstepping its rights

in relation to the province by enforcing provisions in the CDSA; the second, that the federal government's prohibition of a controlled substance (which thus prevented access to Insite) violated the right to life and security that was within the Charter of the Constitution of Canada (Voell, 2012).

The case was heard first in the BC Supreme Court by Justice Pitfield, who found in favour of the plaintiffs in May 2008. Justice Pitfield dismissed the first argument, but accepted the arguments that addiction was an illness and that, given that the risks associated with the injection of drugs could be ameliorated by doing so in the presence of a health care professional, to deny access to such health care was a violation of the right under Section 7 of the Charter to life, liberty and security of the person (Voell, 2012). Evidence of the outcomes of the Insite pilot played a crucial role during the case, with the judge's decision resting on determinations about the *effect* of the intervention, as well as consideration of where risk most lay for drug users. The judge concluded that the risk was not inherent in the drugs themselves, but rather in the contexts in which drugs were consumed (Small, 2012). Justice Pitfield ruled that, despite the capacity for an exemption to be granted under Section 56 of the CDSA, the process was too arbitrary resting in the hands of the Minister of Health, and therefore granted Insite a constitutional exemption from the CDSA, allowing it to continue to operate outside the 'intrusion' of criminal law (Boyd, 2013).

The federal government appealed the decision in the Court of Appeal in January 2010, but the appeal was upheld in a 2:1 finding. The government's subsequent appeal to the Supreme Court of Canada (SCC) was also lost, in September 2011. While the SCC dismissed the argument of interjurisdictional immunity (which was the basis of the majority finding of the Court of Appeal), it did find that the Minister of Health's decision not to grant an exemption under Section 56 of the CDSA was unconstitutional and ordered such an exemption be granted. The Supreme Court upheld Justice Pitfield's finding that the denial of access to

health services violated Charter rights, recognising that the risks associated with addiction and injecting could be ameliorated by being supervised by health professionals (Voell, 2012). As Boyd describes, the Supreme Court's decision did not provide a blanket endorsement of supervised injecting services, but rested specifically on the evidence that Insite was effective and its operations did not run contrary to other criminal law objectives of the federal government (Boyd, 2013).

Respect for Communities Act 2015

The Federal Government responded by using its capacity to legislate to set new requirements for exemptions under Section 56 of the CDSA. The *Respect for Communities Act*, enacted May 2015, established 26 criteria that an application would be required to address in order to make the case for a supervised injecting facility. The Government argued that the bill ensured a better balance could be achieved between public health and public safety concerns (The Canadian Press, 2015). In many ways, the requirements mirrored the considerations outlined in the Supreme Court ruling of 2011 instructing the Minister as to what to consider when granting an exemption (Canada (Attorney General) v. PHS Community Services Society, 2011 paragraphs 152-153). The argument was made, however, that the bills were ideologically driven and privileged the voices of opponents of harm reduction (The Canadian Press, 2015; Zlotorzynska et al., 2013). Concerns were raised that the legislation both had implications for Insite's ability to renew its exemption, and set unreasonable hurdles for the establishment of any further supervised injection sites in Canada (Hayle, 2015).

The capacity of the Act to stall or block supervised injecting was never fully tested before the Harper Government was defeated by Liberal leader Justin Trudeau's landslide victory in October 2015 (Murphy and Woolf, 2015). The Trudeau Government signalled its willingness to approve further drug consumption rooms and subsequently, the Dr Peter Centre

successfully applied for a licence which was granted in January 2016, allowing it to shift its

long running unsanctioned service onto a more stable legal footing (Hayle, 2017).

6.2.3 Current status and expansion of services (2016-2018)

Away from politics, a major public health crisis was unfolding in British Columbia with the

introduction into the illicit drug market of a powerful synthetic opiate called fentanyl. This

prescription painkiller can be up to a hundred times more potent than morphine. It was first

detected as a cause of overdose by the Coroner's Office in 2012 (Hunter, 2016). Illicit drug

overdose and overdose death rates have reached unprecedented levels, according to public

surveillance reports, and a public health emergency was declared by the British Columbia

Medical Officer in April 2016. The B.C. Coroners Service recorded 993 illicit drug overdose

deaths in 2016. This rose by 50 per cent in 2017 to 1486 (B.C. Coroners Service, 2018a p.5).

It is estimated that fentanyl will be detected in 85 per cent of illicit drug overdose deaths in

2018, up from 4 per cent in 2012 (B.C. Coroners Service, 2018b p.2)

Despite the change of federal government, the *Respect for Communities Act* still stood in

2016, presenting a major obstacle for any organisation or local government wishing to open

a new supervised injecting facility. In defiance of the law, a group in Vancouver established

the Overdose Prevention Society. From a tent in the Downtown Eastside, they offered a place

for people to both inject and inhale, and access to the drug naloxone which successfully

reverses opiate overdoses (Lupick, 2016a). With pressure mounting, and an average of four

people dying from overdose every day across the province, the British Columbia Health

Minister, Terry Lake, issued a Ministerial Order in December 2016, allowing overdose

prevention sites to open. The province thus provided a means for services to be offered

without the burden of the federal requirements by arguing these services only monitored

drug consumption, but did not medically supervise injecting or offer the ancillary services

that a facility such as Insite did. By March 2017, 20 overdose prevention sites had opened

across British Columbia and had monitored 67,000 visits (Shore, 2017). (For further discussion see Section 6.4.2 below.)

In parallel to the opening of the overdose prevention sites, proposals for two further supervised injecting facilities in Vancouver were submitted to Health Canada. Vancouver's third site, known as Powell Street Getaway, opened its doors in July 2017 (Vancouver Coastal Health, 2017). The proposal for a facility at the Heatley Integrated Care Centre had not been approved as of December 2018 (Health Canada, 2018).

Significantly, federal legislation was passed in May 2017, replacing the *Respect for Communities Act*. The new Act removes barriers to application for new supervised consumption sites by reducing the number of criteria from 26 to five broader conditions that reflect the concerns of the Supreme Court decision (*Controlled Drugs and Substances Act 2017*). Applicants must show: "proof of need; community consultations; evidence about the site's effect on crime; that there is an administrative structure in place; and that there are adequate resources to maintain the site" (Woo, 2017). Table 6.1 shows the number of approvals for exemptions by province that have been issued by the Minister through Health Canada as of December 2018, and the number of centres which are operational (the remainder are undergoing renovation). This table does not include data on the overdose prevention sites.

Table 6.1 Approved drug consumption rooms by province, December 2018

Province	Exemptions	Number of operational centres
Alberta	6	6
British Columbia	9	9
Ontario	11	9
Quebec	4	4
Total	**30**	**28**

Source: Health Canada (2019)

6.3 Case study 4: Toronto, Canada

Although more than double the population size of Vancouver, Toronto has not faced the same scale of problematic drug use, overdose death rates or HIV and Hepatitis C prevalence. However, since the mid-2000s, the City of Toronto has recognised the need to develop effective responses to both licit and illicit drug use through coordinated intersectoral policy and programme action. A proposal for consideration of supervised injecting services was raised in 2004-2005; over twelve years lapsed before that idea translated to the first service opening its door in August 2017. This case study of Toronto begins with a brief exploration of the specific nature of the drug issues facing the city, followed by a description of the different phases of activity, some of which can only be characterised as 'stalled action'. The importance of the burgeoning opioid crisis to hit Canada from 2016 onwards becomes apparent as the very slow journey of policy change moves more rapidly to policy implementation. This case study of Toronto demonstrates the persistence of the policy idea of supervised injecting in the face of an unreceptive political and community response. The key role of the local public health bureaucracy in continuing to develop policy options shows the critical role played by institutions and policy networks in this case. Once again, political leadership has also been decisive, as has the role of crisis framing, on the prospects for the replication and translation of policy.

6.3.1 The emerging issues

Visible public drug use in Toronto manifested later than in Vancouver but was prevalent in the city by the early 2000s, with the primary drugs of concern being alcohol and crack cocaine (Toronto Drug Strategy Advisory Committee, 2005). Toronto's drug scene has been characterised as dispersed rather than concentrated, a factor acknowledged in the City's first drug strategy through comparison to other cities across the world:

> "Toronto does not have large, concentrated, open drug scenes like the Downtown Eastside of Vancouver or the infamous "needle parks" of Zurich or Frankfurt. In

Toronto, substance use is spread throughout the city, often hidden from view. Hidden use can be risky as it is harder to reach people who may need help." (Toronto Drug Strategy Advisory Committee, 2005 p. 2)

Toronto did not experience the same patterns of disease outbreak among its drug-using population as British Columbia, with HIV rates estimated to be around 5 per cent in 2004 and Hepatitis C around 54 per cent (Toronto Drug Strategy Advisory Committee, 2005 p.3). The factors that contributed to this include both the prevalent types of drugs and the modes of consumption. The risk of transmission of infection is particularly heightened by injecting rather than other forms of consumption. Fischer et al. (2005) noted, in their comparative study of illicit opioid use in five cities in Canada, that participants from Toronto primarily employed non-injection routes of administration, and while crack cocaine can be injected it is more commonly smoked (Santibanez et al., 2005). Toronto was also the first city in Canada to offer a needle syringe program, with an unofficial program commencing in 1987, followed by an official one in 1989 (Canadian Centre on Substance Abuse, 2004).

6.3.2 Phases of the response

Toronto's path to the establishment of supervised injecting facilities has been largely bureaucratically- and task force-driven, in contrast to the strong role played by activism and acts of civil disobedience in Vancouver. There have been distinct phases of activity, from the initial period of strategy development (2004-2005) to the lengthy period of the needs and feasibility study (2006-2012) that produced the TOSCA Report and its recommendation of the viability of three supervised injecting sites for Toronto. The final phase (2013-2018) has witnessed both initial political inaction and then change as the public health crisis and rising overdose deaths increased the pressure on local, provincial and national authorities.

Strategy development (2004-2005)

In 2004, the City of Toronto produced a comprehensive drug strategy aimed at coordinating and integrating the city's responses to both licit and illicit drug use (Toronto Drug Strategy Advisory Committee, 2005). Fourteen public consultations (focus groups and town halls)

were conducted to gauge responses to the strategy. Following debate in the Council, the policy was passed with a vote of 24:15 in December 2005 (Spears, 2005b). Its four pillars approach, focused on prevention, treatment, enforcement and harm reduction, was modelled on successful international examples and Vancouver's pioneering drug strategy. Included in its recommendations was a proposed needs and feasibility study for supervised consumption (injection and/or inhalation) services in Toronto.

The recommendation attracted considerable controversy in the media and during Council debate over the strategy (Spears, 2005b). A key issue was whether supervised consumption was appropriate for Toronto. The recommendation for the feasibility study had the support of the city's Medical Officer for Health, Dr David McKeown; however, members of Council were sceptical about the fit between supervised consumption and Toronto's specific drug use patterns and issues. Councillor Kyle Rae, who headed up the Drug Strategy committee, while arguing for the benefits of supervised consumption sites in general, expressed concern that supervised injection might not be the right solution for Toronto, where crack cocaine was more predominant than heroin (Porter, 2005). He did, however, stress that the option should be explored: "Everything should be on the table…You get to say no if you don't think it's the right thing to do, but at least you've considered it" (Spears, 2005a). Despite concerns, the Drug Strategy and all its recommendations were passed by the Council. Recommendation 65 for the needs and feasibility assessment of supervised consumption sites was passed with amendment to ensure the study considered, amongst other things, the effects of drug use on neighbourhoods, businesses, crime patterns and property values, and that residential groups be consulted (Toronto Drug Strategy Advisory Committee, 2005 p.86).

Needs and feasibility study (2006-2012)

While the mandate from Council was apparently clear, progress on the issue hit a major stumbling block as no specific funds were earmarked to support the study. This lack of

funding changed both the nature and the timeframe in which this critical piece of work could be delivered. With no direct resources to call on from the public purse, independent researchers from the university sector were approached to undertake the study *and to secure the funding*. Having to operate within the competitive research funding environment impacted the objectives, structure and duration of the project, as was confirmed by a participant interviewed for this thesis (Researcher 4, Toronto). The resultant study was undertaken as a collaboration between the University of Toronto and St Michael's Hospital, and encompassed both Toronto and Ottawa, thus becoming the Toronto and Ottawa Substance Consumption Assessment Study, or TOSCA Report (Bayoumi et al., 2012).

The TOSCA report was released in 2012, nearly seven years after the recommendation for the study was adopted. It is a remarkably comprehensive study, assessing the need for consumption services; modelling the potential economic impact, in particular on Hepatitis C prevalence; and addressing issues of community support and acceptance. The key recommendations to emerge from the TOSCA Report were that Toronto would benefit from three, fixed site supervised injection facilities, that should not be standalone, but integrated into existing services. The report also found that there was "insufficient evidence to support a supervised smoking facility" (Bayoumi et al., 2012 p.15). An important issue highlighted in the report was that the location of the proposed centres was a major concern for Torontonians:

> "Even residents and business owners supportive of supervised consumption facility implementation did not necessarily want to see a facility in their own residential neighbourhoods or near their businesses" (Bayoumi et al., 2012 p.10).

Resistance, crisis and action (2013-2017)

It was the local bureaucracy, through Toronto Public Health, that pressed forward with the recommendations, under the leadership of the Medical Officer of Health, David McKeown,

who reported to the Board of Health (BoH)[1]. This contrasts to the other three case studies where political institutions have tended to play a leading role. In June 2013, Dr McKeown recommended the BoH seek the support of the provincial government to fund integrated supervised injection services on a pilot basis (Toronto Public Health, 2013). Following public submissions and presentations to the Board, this recommendation was adopted (Board of Health, 2013). It failed, however, to gain the required political support to progress at either the local or provincial level. Toronto Mayor Rob Ford declared it the "worst thing that could happen to the city" (Editorial, 2013). Nor was support forthcoming from the provincial government under the premiership of Liberal Kathleen Wynne. A spokeswoman for the Health Minister cited a lack of support from the federal government:

> "Given that the federal government's approval would be a prerequisite, at this point we have no plans to move forward with supervised injection sites." (Dale, 2013)

Public Health Toronto continued to keep the idea in circulation in policy circles and in the community during 2013-2015. It undertook public consultations and produced a 'Supervised injection services toolkit' which provided information for those considering establishing supervised injection sites, including guidance on meeting the criteria set out by the 2011 Supreme Court ruling (Toronto Drug Strategy, 2013). In 2014, a local not-for-profit group, St. Christopher House, formed a Residents' Reference Panel on Supervised Injection Services, randomly choosing 36 members from letters sent to 7,500 households. The purpose of the panel was to seek input on how local residents should be consulted and their concerns addressed, through the development of guiding principles for community consultation. As a result of this consultation, a report was produced containing recommendations and a roadmap on how such a service might best proceed (St. Christopher House, 2014).

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[1] The Board of Health is a City of Toronto board which oversees the work of Toronto Public Health and comprises 13 members, including six Council member, six citizen members and one educational representative.

While the issue of supervised injection did not appear to be gaining much political traction in Toronto at this time, the impact of drug use was getting worse, creating an opportunity for change to come about in the context of a new public health crisis. Overdose deaths increased by 41 per cent between 2004 and 2013 from 146 to 206 (Toronto Public Health, 2015 p.1). Deaths attributed to opioids increased from in 44 to 126 over the same period: an increase of 186 per cent (Toronto Public Health, 2015 p.7). Between 2006 and 2013 in Ontario, there were nearly 20,000 visits to emergency departments to treat forms of opioid toxicity and these resulted in over 10,000 hospital admissions (Miller, 2017). As in Vancouver, fentanyl was beginning to pose an overdose threat to drug users, as were prescription opioids such as oxycodone. In Ontario, deaths attributed to fentanyl (from licit and illicit sources) increased from 63 in 2009 to 111 in 2013 (Toronto Public Health, 2015 p.3).

In 2016, the issue of supervised injection sites was brought twice before the Board of Health by the Medical Officer of Health. In March, Dr McKeown announced to the Board that three local health services were planning to introduce supervised injecting as part of existing services: Toronto Public Health (The Works), Queen West-Central Toronto Community Health Centre, and South Riverdale Community Health Centre. He sought and received unanimous approval to participate in community consultations in those areas in order to meet federal government requirements for the exemption process (Toronto Public Health, 2016; Board of Health, 2016a). In July 2016, the Board of Health approved support for the three proposed services, and to the initiation of an exemption application to Health Canada and a request to the provincial government to support the full costs of implementation (Board of Health, 2016b). Previously absent political support materialised and the decision was endorsed by the City of Toronto Council in a 36:3 vote in favour, with support from the Mayor John Tory and Toronto Police Chief, Mark Saunders (CBC News, 2016). An application for federal exemption was submitted symbolically on World AIDS Day, 1 December 2016, but it was another month until the provincial government pledged its support. Its delay was

criticised by Ontario New Democratic Party Leader, Andrea Howarth, who in an open letter to the Premier, Kathleen Wynne, argued:

> "It should not take six months, in the face of a national overdose crisis, for the provincial government to approve funding and issue letters of support for the City of Toronto's supervised-injection sites." (Miller, 2017)

Despite the new Trudeau Government's support for supervised injecting, the timing of the exemption applications (late 2016) meant that the 26 criteria in the *Respect for Communities Act 2015* were still to be addressed. These applications were approved by Health Canada, and Ministerial exemptions to the *Controlled Drugs and Substances Act 1996* were issued for the three sites in Toronto in June 2017 – some twelve years after the initial recommendation for consideration was made in the Toronto Drug Strategy.

Activism and civil disobedience

Toronto has not had the extent of activism that is apparent in the case study of Vancouver. Since 2017, however, activists influenced by events in Vancouver in response to the opioid crisis have engaged in acts of civil disobedience to provide drug consumption services in response to what they felt were delays to the development of sanctioned services. The opening of 'pop-up' supervised sites has occurred in parallel to efforts to develop more permanent services. The first site to open was in Moss Park in downtown Toronto in August 2017. Run by volunteers from the Toronto Overdose Prevention Society and the Toronto Harm Reduction Alliance, this service provided supervision for both injection and inhalation, initially from three tents. No action was taken by the City to shut down the illegal site and the Ontario provincial government donated equipment to the service (Arnone, 2017). Councillor Joe Cressy, Chair of the Toronto Drug Strategy Implementation Panel, captured the frustration of the local government with the delay in opening the newly sanctioned sites, reacting to the pop-up service:

> "We wish our sites were open yesterday, and frankly they would have been if it didn't take nine months for the provincial and federal government to give us the funding to do it.… The City of Toronto cannot open a site which is illegal, I certainly cannot as a city councillor and as a harm reduction advocate, cannot condemn it." (Nassar, 2017)

This act of civil disobedience in Toronto, and others across Canada, led directly to a change of policy. The federal government intervened in November 2017, by providing provinces with a CDSA exemption that would allow them to sanction overdose prevention sites on a three- to six-month basis as a crisis response. Approvals for five OPSs were granted by the Ontario government for sites in Toronto (de Villa, 2018). While the policy pathway to support OPSs was established, political support at the provincial level was withdrawn with the election of a new provincial government in June 2018. The Progressive Conservatives, under Premier Doug Ford, placed a freeze on new overdose prevention sites and called for a review of evidence, including of their links to rehabilitation services (Bueckert, 2018). The provincial government also demonstrated its capacity to be a key influence on policy in this area by suspending funding for any new sites. In response, activists opened an unsanctioned site in Parkdale in a further act of civil disobedience, opening the way for potential conflict between local government authorities and the provincial government (Jones, 2018). For further discussion on civil disobedience, see Section 6.4.2 below.

6.3.3 Current status

Opioid overdose deaths continue to rise steadily in Toronto. There were 303 deaths in 2017, up by 63 per cent on the 2016 figure and 121 per cent on the 2015 figure (de Villa, 2018 p.2). As of December 2018, there were four sanctioned supervised consumption sites operating in Toronto: The Works, South Riverdale Community Health Centre, Parkdale Queen West Community Health Centre, and the Fred Victor Centre. All sites offer supervised injection, and in addition, South Riverdale and Parkdale Queen West supervise intranasal and oral consumption (Health Canada, 2018). The Fred Victor Centre was the latest site to be approved. It is located opposite Moss Park and was intended to cater to the clients who used

the temporary Moss Park pop-up site (CBC News, 2018). Following the provincial government's review of overdose prevention sites, new guidelines were issued in October 2018. OPSs may continue to operate, but now must meet the federal requirements for supervised injecting sites in addition to further conditions, including proximity guidelines in relation to schools and parks. These requirements have not been welcomed by the Chair of the Toronto drug strategy implementation panel, Councillor Cressy, who described the guidelines as overly restrictive and said:

> "In the midst of the most significant health crisis in a century, we should not be restricting our ability to save lives, we should be scaling up our ability to provide life-saving health care." (Pagliario, 2018)

6.4 Contextualising the Canadian case studies

The purpose of this section is to set the two individual case studies in the broader political and policy context of the Canadian federal system, in order to identify relevant sources of policy change and stall through the lens of Evans' (2004) policy transfer framework. Particular attention is paid to state-based sources of policy change, given the complexity of the interactions of different levels of government in relation to drug policy generally and supervised injecting in particular. Following an examination of federal, provincial and local government roles, consideration is given to the impact of civil disobedience in both Vancouver and Toronto.

6.4.1 Political setting

International sources of policy change

Consistent with the cases in Australia, there is little evidence that international institutions such as the International Narcotics Control Board exercised a constraining effect in relation to policy transfer in Canada. The INCB did, however, attempt to put pressure on the federal government, stating in its annual report in 2003 in relation to the approval of Insite:

"The Board reiterates its view that such sites are contrary to the fundamental provisions of the international drug control treaties, which oblige States parties to ensure that drugs are used only for medical or scientific purposes." (International Narcotics Control Board, 2004 p.49)

The Board raised the issue again in its 2006 and 2007 annual reports (International Narcotics Control Board, 2008; International Narcotics Control Board, 2007). There is evidence that the federal government considered the risk of continuing to support supervised injecting in the mid-2000s. The *Vancouver Sun* reported that it had seen internal federal government documents that weighed concern with offending the international community as more serious than the repercussions of shutting down Insite against the wishes of the government of British Columbia (O'Neil, 2007). New Democratic Party Federal MP, Libby Davies voiced the fear that Health Minister Tony Clements would use the INCB's criticism to continue to attack Insite (Edward, 2007). The Harper Government was forthright in its opposition to supervised injecting; there is, however, no evidence that the actions of the INCB contributed significantly to their policy agenda.

State-centred sources of policy change

The different distribution of powers within the Canadian federal system when compared to Australia affects the degree of engagement and the capacity to act at different levels of government. Despite the importance of these structural relationships between the levels of government, autonomy is exercised through the impact of ideational factors such as political parties' ideological stances on drug use, and agency factors, such as the role of political leadership. The combination of these factors has influenced the degree to which drug consumption policy has been replicated.

National drug policy in Canada

Canada's first national drug strategy was launched in 1987 under the Progressive Conservative Government of Brian Mulroney. Health Canada has been the lead agency, reflecting the underlying principle that drug misuse is primarily a health issue. The first four

phases of the strategy to 2007 increasingly adopted harm reduction measures, although demand and supply reduction dominated. While all levels of government are engaged in activities that address substance use issues, at the federal level, funding has been directed largely towards supply reduction through enforcement and interdiction activities (Office of the Auditor General of Canada, 2001). Successive federal governments have adapted the strategy to reflect their ideological positions on drug use. In terms of policy transfer, these differing ideological stances have acted as key constraining and facilitating factors in the push to develop drug consumption rooms.

In 2007, the Harper Government re-badged the national strategy with the launch of the 'National Anti-Drug Strategy' (NADS), reflecting its 'tough on crime' position. While the strategy included prevention and treatment as priority areas, law enforcement continued to receive 70 per cent of drug strategy funding (de Beck et al., 2009 p.188). The NADS strategy was criticised for excluding federal support for harm reduction activities (Carter and MacPherson, 2013). Under the current Trudeau Liberal Government, the NADS has been replaced by a new 'Canadian Drugs and Substances Strategy' launched in 2016. The strategy deliberately restores the harm reduction pillar, alongside prevention, treatment and enforcement, and according to the Government, reflects its commitment to "a comprehensive, collaborative, compassionate and evidence-based approach to drug policy" based on public health principles (Government of Canada, 2016).

While Canada has 'national drug policy' in place, it has been contended that 'federal drug policy' would more accurately describe the approach, due to the lack of collaboration with provincial and territorial governments in the development and implementation of policy (Carter and MacPherson, 2013). This represents a difference to Australia, where drug policy appears to be better integrated across levels of government. In Canada, the provinces and

territories demonstrate considerable autonomy in relation to drug policy. As the 2008

Evaluation of the NADS noted:

> "The provinces and territories have different objectives and priorities: they focus on substance abuse in general rather than abuse of illicit drugs, support harm reduction, and take a more holistic approach to substance use issues (for example, many provinces have integrated or are integrating mental health and addictions)." (Evaluation Division Office of Strategic Planning and Performance Measurement, 2010 p.11)

Fischer et al. (2016) argue that the divergence of policy goals and approaches between these

levels of government has resulted in a bifurcation of drug policy between the two paradigms

of public health and law enforcement approaches to drugs, and that the lack of

'harmonisation' is undermining policy outcomes. The new Canadian Drugs and Substances

Strategy would seem to swing the federal pendulum back in favour of public health

approaches, more in keeping with policy approaches employed in the provinces (although

arguably not uniformly).

In terms of national policy in relation to supervised injecting, Health Canada was engaged in

developing recommendations in the late 1990s in relation to HIV and Hepatitis C risk.

Following a national consensus conference on the prevention and control of Hepatitis C,

feasibility studies for "community safe injection sites" were proposed (Health Canada, 1999

recommendation 4.2.1). In 2001, the Canadian Conference of Deputy Ministers of Health

tasked a Federal/Provincial/Territory Committee with investigating drug use in Canada. The

Committee's report, in endorsing harm reduction, recognised the successful experience of

other countries and set as an abiding principle that "Injecting drug use should be regarded

first and foremost as a health and social issue" (Federal/Provincial/Territory Committee,

2001). Within its framework for action was the recommendation that a feasibility study be

conducted of establishing a scientific, medical research project regarding a supervised

injection site in Canada. A working group was subsequently formed with approval from the

Ministers (Elliott et al., 2002). The issue was taken up by a House of Commons committee on

the non-medical use of drugs which reported in 2002. The committee's recommendation that the government remove any legislative barriers to the implementation of scientific trials and pilot projects was not adopted (Canada. House of Commons, 2002 p.89).

Federal government

National governments in Canada have influenced the ability of cities to host drug consumption rooms by their power to legislate in relation to possession of illicit drugs. This structural factor has been influenced by the ideational position of the Government of the day, as reflected in the varied legislative and political approaches in relation to supervised drug consumption. It is the federal government's constitutional authority in relation to criminal law that allows it to regulate drugs – licit and illicit. The *Controlled Drugs and Substances Act 1996* forbids "the unauthorised possession, manufacture, cultivation, trafficking, export and import of specified substances" and this prohibition extends to anything containing illegal substances, such as a used syringe (Elliott et al., 2002 p.36). To provide legal protection for both clients and staff of supervised injecting services, Health Canada developed guidelines for applications for an exemption under Section 56 of the Act which allows supervised injecting sites to be run for scientific purposes and thus be exempt from the application of the law (Bula, 2002). Through this process the federal government in 2003 was able to support the establishment of Insite. In Australia, by contrast, the equivalent legislative power is held at the state/provincial level and there has never been any federal legislation that provided an avenue to sanctioning SIFs; states have each had to create new laws.

Despite the existing legal provision, the change of Government in 2006 reduced certainty as to ongoing support for supervised injecting, with serious effects for the potential for scaling up of the policy. As one Advocate interviewed for this thesis noted:

> "...with the change of Federal Government to a Conservative Government the future of Insite looked increasingly dodgy given their stated antipathy towards harm reduction in general, but especially supervised consumption services, including the Health Minister of the day declaring [Insite] an abomination." (Advocate 3, Toronto)

Under the CDSA, provision to make an exemption lies at the *discretion* of the Minister of Health. It was the arbitrary nature of this process that Justice Pitfield criticised when upholding the right for Insite to continue to operate under the Charter (Boyd, 2013). The Federal Government, however, on the loss of the case, used its legislative powers to control the licencing process in relation to supervised injecting facilities through the introduction of the *Respect for Communities Act 2015* which established 26 criteria that applicants would need to address in seeking an exemption. As one interview participant described, even though there were doubts as to the constitutionality of the regime, "it had a chilling effect" (Advocate 3, Toronto), sending a message that new applications would not be considered favourably.

As the case studies illustrate, the surge of new applications for exemptions in 2017 after years of such limited provision of service came about prior to the new Trudeau Government repealing the *Respect for Communities Act*. This demonstrates that the legislation alone, as a structural factor, did not constrain the scaling up of supervised injection services. It was the political and ideological position held by Governments that signalled to communities and to Health Canada as the bureaucratic agency acting for the Government, what would be acceptable and therefore whether applications would be facilitated or blocked.

The provincial governments

With the formation of the federation in Canada, provinces retained categories of rights while ceding other powers to the centre. Health has largely fallen to the provinces to manage, although the revenue raising capacity of the federal government gives it the ability to engage both in terms of policy and funding allocations. The criminalisation of specific drugs necessarily involves the federal government in policy making (through their powers over

criminal law), despite ongoing efforts to re-orientate responses to drugs as a health issue. Provinces have had no legislative power to support the development of supervised injecting facilities, as the states have done in Australia, as they cannot override the issue of the criminality of possession of illicit substances. The provinces have, however, been able to lend support to those municipalities seeking to establish SIFs, politically as well as financially. The record on both fronts has been mixed. In the period from the establishment of Insite in 2003 until the present, there is little evidence that provincial governments actively supported efforts to replicate supervised injecting services, until the recent opioid overdose crisis.

Both British Columbia and Ontario have been almost exclusively governed by Liberal provincial governments since 2003. Change only came about for British Columbia with the New Democratic Party coming to power in 2017. Ontario remained under Liberal rule until the election of the Progressive Conservatives in 2018. The Premier of B.C. in 2003 was Gordon Campbell, a former Mayor of Vancouver and supporter of that city's first needle exchange program. He put his support behind the push for Insite, as then Mayor, Larry Campbell recalls:

> "I never felt a sense of hesitation on Gordon Campbell's part. He could have easily said it was a federal issue, but he didn't. He saw it as a health issue." (Campbell et al., 2009 p.176).

The B.C. government continued to support Insite throughout the turbulent years of the Harper Government, but (with the exception of the Dr Peter Centre) provincial level support for supervised injection did not translate into further services on the ground in other municipalities, despite proposals for services in other B.C. cities, such as Victoria and Prince George (Fischer and Allard, 2007; Fong, 2006).

For Toronto, on its slow journey towards its first supervised injecting centres, provincial support was never assured. On the release of the TOSCA report in 2012, with its recommendation for three sites in Toronto and two in Ottawa, the provincial government declined to support the proposals. Ontario Minister for Health, Deb Matthews is quoted as

saying that the government "was happy to receive good advice and that 'we make our decisions based on evidence'", while claiming, "Experts continue to be divided on the value of the sites" (Stinson, 2012). The following year, the new provincial government under Premier Kathleen Wynne maintained the stance, arguing the federal government's position would rule out the necessary approval being obtained and therefore the provincial government would not be moving ahead (Dale, 2013). As one interview participant said:

> "It was clear the environment was not supportive politically of moving any of this forward, either here, in Vancouver, in Ottawa, in Thunder Bay or London. No it wasn't. We had a Liberal provincial government but they were not particularly strong when we came out or when the TOSCA study came out; frankly they were a bit lukewarm to unhelpful." (Policy Maker 3, Toronto)

The tendency to defer to both the federal government and the municipalities belied the important role played by the provinces through their control of health budgets. One of the conditions that had to be met to receive an exemption was proof of sustainable financial support for the proposed project. The City of Toronto, in developing its application to Health Canada, was constrained by the slow commitment from the Ontario government, and in the end submitted their application in advance of the province pledging funds (Miller, 2017). In the view of another participant, the provincial governments were guilty of 'buck passing' between the municipalities and the federal government. See Theme 2 in Chapter Seven for further discussion of this issue.

The provincial governments' reluctance to engage in the issue of supervised injecting changed dramatically in both British Columbia and Ontario, as the extent and implications of the opioid crisis became apparent from late 2016 onwards. In British Columbia, the provincial government found an override for the arduous federal government process by differentiating between supervised injection services and overdose prevention. One Advocate explained the Minister of Health's actions:

> "… these illegal tents that came up in Vancouver last year showed the government, again, how easy it can be. And then, when our provincial Minister of Health issued a

> ministerial order on December 8th 2016, he actually said, "You know, I woke up in the middle of the night last night thinking about Sarah Blyth's tent". And then he passed the ministerial order, essentially making what she was doing, which was illegal, making it legal. He did that by calling it an overdose prevention site, instead of an injection site. Safe injection sites still require federal approval, overdose prevention sites do not. It was genius. And then within like five days we had 20 of them open across the province." (Advocate 1, Vancouver)

The province's actions proved to be politically effective in pushing the federal government to address the inadequacies of the legislative regime:

> "And it was really throwing down the gauntlet a bit to the feds at that point saying we'll just call it something different but we're going to go ahead and do it and what are you going to do about it? Of course this Government - supportive of harm reduction - was not going to pick a fight with the provincial government in the middle of an overdose crisis in order to defend bad law that they'd inherited from the Conservative Government. So I think it just helped add to the momentum for legislative reform and the need to actually streamline this process for these things. But it was a good move by the B.C. Government, for sure." (Advocate 3, Toronto)

In addition to repealing the *Respect for Communities Act 2015*, the federal government also provided the provinces with further legal protection in November 2017 by issuing a new category of exemption under the CDSA, which allowed the provinces to issue temporary licences for OPSs (as discussed above).

Again, legal protection alone has not been enough to allow services to operate; they remain dependent on ongoing political support, as the situation in Toronto has illustrated. The Ontario government of Kathleen Wynne reversed its initial ambivalence to supervised injecting, and announced in August 2017 that it would invest C$222 million in harm reduction and treatment measures, including C$23 million to expand the number of drug consumption sites across Ontario (Howlett and Giovannetti, 2017). However, a change of provincial government in July 2018 under the premiership of Doug Ford, as discussed above, has once again introduced uncertainty as to the ability of OPSs to continue to respond to the ongoing opioid crisis. In this way, the provinces remain key players in the development of supervised injecting policy, demonstrating the capacity to both constrain and facilitate the scaling of policy through the exercise of strategic selectivity of political preferences.

Local government responses

There have been similarities and differences in the roles played by local governments in Canada compared to Australia. Like in Australia, Canadian local governments have a close proximity to the issues confronting their communities concerning amenity and safety. Also like in Australia, they are dependent on support from other levels of government to create an enabling legislative and political environment to support supervised injecting. One striking difference between the four case study cities is the scale of the jurisdictions in Canada, where both Vancouver and Toronto have their own police forces and public health agencies. In Melbourne and Sydney, those agencies are under state government jurisdiction. This changes the level of engagement and the levers at the disposal of local governments in Canada to constrain or facilitate supervised injection.

The two Canadian case studies are marked by the different approaches they have taken, with drug issues in Vancouver being high on the political agenda while the City of Toronto has experienced a more bureaucratically- and research-led process. Arguably, the bureaucratically-driven process in Toronto reflects a lack of political saliency of the issue locally. In terms of agenda setting, it is apparent that there was a political concern with substance misuse in Toronto. The relative absence of injecting due to the dominant drugs of concern (alcohol and crack cocaine), however, may have reduced the impetus to consider SIFs as a policy solution. The dispersed nature of the street drug scenes may also have created a challenge for debating SIFs, where Insite was the primary example of a model. As a fixed site service, it was geographically bound and associated with the Downtown Eastside, for which there was no comparable scene in Toronto. It is not surprising that the TOSCA Report, reflecting the depth of the research underpinning it, specifically recommends a new integrated and dispersed model of services for Toronto (Bayoumi et al., 2012).

Agency factors at the level of local government have been apparent in both cases through the intervention of leaders in driving forward the issue (or attempting to block it). The leadership of mayors such as Philip Owen, Larry Campbell and Rob Ford has been crucial in determining the success or otherwise of policy proposals. Similarly, the leadership demonstrated by Toronto's Medical Officer of Health, David McKeown, demonstrates the role that can be played by agents in promoting ideas with the aim of embedding them in institutional structures in order to achieve change. Ultimately, local governments, while driving the ideational basis of the policy through the development of locally specific policy documents such as Vancouver's Four Pillars policy and Toronto's Drug Strategy, have remained dependent on the structural capacity of other levels of government to fully deliver supervised drug consumption services (MacPherson, 2000; Toronto Drug Strategy Advisory Committee, 2005).

6.4.2 Civil disobedience

Civil disobedience features in both Canadian case studies, although over considerably different periods of time and with different impacts on the process of policy development. The case study of Vancouver details the unsanctioned sites that were established by activists prior to the opening of Insite (Folz, 1999). They included the Dr Peter Centre's injecting room that operated within its private HIV/AIDS care clinic with the knowledge of authorities for fourteen years before it successfully applied to the federal government for an exemption (Hayle, 2017). In 2016, the Overdose Prevention Society established an unsanctioned drug consumption site in the Downtown Eastside in response to the rising death toll from fentanyl overdoses. This inspired twenty more sites to open across British Columbia, all of which initially operated outside the federal government's exemption regime, but with the support of the local and provincial governments (Shore, 2017). In comparison, Toronto's experience with civil disobedience was restricted to the establishment of 'pop-up' sites, inspired by the actions of the OPS in Vancouver (Arnone, 2017). The impact of civil disobedience on the

scaling up of services is further analysed in Chapter Eight (Section 8.3). The purpose of this discussion is to contextualise the experiences of Vancouver and Toronto in relation to civil disobedience by considering the 'top-down/bottom-up' nature of policy making in the two sites, and, the role of law enforcement.

In Chapter Five, the role of civil disobedience in Australia is assessed as having a relatively low impact in relation to the achievement of policy change in the two case study sites. In Vancouver in particular, civil disobedience has been more critical, serving the role of having a 'bottom-up' effect on policy change through not only the direct demonstration of services, but more importantly, the discursive process by which the concept of supervised injecting has been deliberated. In addition to civil disobedience, activists have been part of the policy transfer networks developing and circulating ideas; for example, VANDU members have held positions on the Board of Health. Toronto, in contrast, has illustrated a more 'top-down' process. Such a process is described by Schmidt (2011) in her discussion on discursive institutionalism: policy elites are seen to construct the ideas that are then communicated to the public by political elites. In discursive institutionalism, whether the change is top-down or bottom-up, the role of agents is key in the generation of ideas and to persuade policy makers, politicians and the public that 'new' ideas are necessary and appropriate.

In contrast to the focus on agency, law enforcement represents a potential structural barrier to the enactment of civil disobedience. Both Vancouver and Toronto have municipal police forces. The cooperation of local law enforcement has been a fundamental requirement for the effective operation of supervised injecting services, whether sanctioned or unsanctioned. As the discussion above of unsanctioned services in Vancouver has shown, there has been a significant degree of tolerance demonstrated by the police in relation to supervised injecting sites. One interview participant described the progressive approach taken by the Vancouver Police Department to drug use in general. She attributed this to a recognition by senior

management that they weren't going to arrest their way out of the problems associated with drug use, particularly because of changes made by judicial institutions:

> "And part of this impetus was the criminal justice system that decided that we weren't going to give significant sentences for drug possession any more. The criminal justice system, the judicial system seemed to recognise this as being more a health issue before we did. And so they started the conversation." (Practitioner 2, Vancouver)

The same participant was engaged with discussions with other forces across Canada and had encountered strong resistance to the ideas and institutional practices that have become dominant in the Vancouver force.

In Toronto, the team undertaking the TOSCA study researched the perceptions of the local police force towards supervised injection services. According to Watson et al. (2012), police in the study did not support supervised injecting services: they rejected claims that SIFs are effective and "made claims that appeared to filter evidence and privilege anecdotal reports which suggest that negative outcomes will result from SCS [supervised consumption site] implementation" (p.367). The lack of support from local police was confirmed through interviews undertaken for this thesis. One participant described the difficulty of gaining access to police and engaging with them (Researcher 4, Toronto), while another discussed his contact with the then-Police Chief, who was adamantly opposed to supervised injecting (Policy Maker 2, Toronto). This was confirmed by Policy Maker 3 who said, "The police chief at the time felt that we didn't have the same conditions as Vancouver and didn't warrant it [supervised injecting]". Given the strong stance taken by the police in Toronto prior to the opioid crisis, it is likely that civil disobedience would not have been tolerated in Toronto in the same way the unsanctioned sites were in Vancouver. In addition, it was argued of Toronto: "We've had very little of that kind of activism here" (Advocate 4, Toronto).

6.5 Findings and conclusions

The case studies of Vancouver and Toronto contribute key findings to this thesis' concern with what constrains and facilitates policy transfer in relation to the replication of drug

consumption rooms in Canada. While spanning a comparable period of time to the case studies of Sydney and Melbourne, the outcome of the scaling up of DCRs in Canada has been starkly different, although both countries have experienced comparable periods of stalled policy replication. Four major findings of the Canadian case studies are presented in this section. They are concerned with observations about the role of state-centred sources of policy change; the limits of policy-oriented learning and sub-national policy transfer; the role of crisis; and the significance of civil disobedience. Along with the findings of Chapters Five and Seven, these factors will be considered through the lens of the policy transfer framework in the later discussion on what has facilitated or constrained policy transfer.

As in the Australian cases, state-centred sources of policy change have proved to be very significant in the Canadian context. While the case studies have been city-based, multiple levels of government have played important roles in the policy development process, providing a strong argument for focusing on institutions and the formal processes and powers of government. Local governments, in particular, have been constrained by their dependence on provinces for funding and political support, and by the federal government for its ability to control the exemption process and thus the legality of the supervised injecting services. The need for coordination and alignment of goals has proved to be a significant constraining factor. The cases have also demonstrated the opportunity afforded by systems change, such as the election of new governments, for embarking on a new phase of policy development. Ideational factors have, however, shaped and influenced the workings and application of these structural forces. The ideological position of Governments in relation to drug issues has influenced the exercise of strategic selection in relation to the pursuit or otherwise of drug consumption services. Significantly, the case studies demonstrate the importance of a Government's framing of issues in shaping outcomes and facilitating change in the face of apparent structural constraints. The constraint posed by the *Respect for Communities Act 2015* on the scaling up of services under the Harper Government

significantly diminished with the change to the Trudeau Government in 2017. New services began receiving exemptions *under the old legislation*, illustrating that change was made possible through the interaction of ideational and institutional forces.

There was a thirteen-year period between the establishment of the first sanctioned supervised injecting facility and a second SIF exemption being issued under the CDSA in 2016. It was another year until a city other than Vancouver established supervised injecting services. The development of Insite in Vancouver was clearly influenced by experiences from overseas, demonstrating policy transfer occurred on an international-sub-regional pathway. Vancouver's experiences in turn had a national impact on policy development through the engagement of successive federal governments and the court rulings. In particular, the Harper Government's antipathy towards Insite curtailed the development of proposals and policies in other jurisdictions. Policy makers in Toronto looked to Vancouver, but also to experiences overseas in places such as Frankfurt. The constraints on policy transfer at the sub-regional level are explored in more depth in Chapter Eight, but two points specific to Canada are relevant to note here. Sub-national policy transfer was significantly limited by national factors. This was not the case in Australia where the federal government's involvement was restricted by the states having power over criminal matters.

National factors included the engagement of the courts in making determinations about the constitutionality of the federal government's policy approach in this area. The court cases amplified the evidence of the effectiveness of Insite, contributing to the public debate on supervised injecting. Despite this amplification, however, evidence continued to be contested in potential new locations, such as Toronto, where both politicians and stakeholders such as the police contested the scientific evidence that was in the public domain. This issue is addressed in more detail in the following chapters. It should be noted

here that the controversy associated with supervised injecting was a factor that curtailed opportunities for policy learning at the sub-regional level, inhibiting policy transfer.

Vancouver and Toronto experienced different degrees and forms of problematic drug use. In both sites, however, the increase in opioid related overdose deaths as a result of the increased availability of fentanyl created crisis conditions, placing pressure on all levels of government to respond. Crisis has been a critical factor in the rapid scaling up of services across Canada and is demonstrably a factor in both case study cities, where the increasing focus on opioid deaths has served an agenda setting function. These marked changes in Canadian illicit drug markets and the resultant levels of death contrast to the current situation in Australia, where street drug scenes have contracted (see Chapter Five). Interestingly, the nature of the risks associated with fentanyl, including the contamination of a wide range of illicit drugs in the market, has widened the focus of concern from street scenes such as the Downtown Eastside to recreational and 'hidden' users in suburban locations. While the risks associated with illicit drugs are often associated with public or street-based drug use, evidence, such as first responder call-outs for overdose, are showing that high risk drug use is geographically widespread (B.C. Centre for Disease Control, 2017.)

Finally, the case studies demonstrate that civil disobedience has been a significant facilitating factor in the scaling up of services. Arguably, civil disobedience has had greatest impact in Vancouver, as the acts of civil disobedience in Toronto occurred in parallel with attempts to develop services through official channels. However, the acts in Vancouver have had impact nationally, pushing the federal government to consider its approach. Policy changes at the federal level (for example, the issuing of CDSA exemptions to provinces to allow support for overdose preventions sites) have flowed to all provinces. The impact of civil disobedience on the process of policy change is considered in more depth in Chapter Eight.

In conclusion, although the chapter has focused on two city-based case study sites, the cases provided insight into the engagement in policy development of local authorities and stakeholders, as well as provincial and federal levels of government. The chapter has confirmed the importance of approaching the question of policy replication from multiple levels of analysis. It has demonstrated the impact on the policy transfer process of both structural factors, such as the distribution of powers in the Canadian federal system, and ideational factors, like the ideological stance on drug use held by different Governments. Two key additional factors have been prominent to understanding policy stall and change: the roles of crisis; and civil disobedience. These two factors have been crucial to catalysing policy change and serve as a significant point of contrast to the Australian case studies, as will be further explored in Chapter Eight.

Moving away from this chapter's descriptive-analytical approach, based largely on documentary sources, the following chapter employs thematic analysis of the interviews undertaken during the field visits to interrogate and identify patterns of meaning in order to further shed light on this thesis' concern with policy replication.

The challenges of replication: empirical findings
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7.1 Introduction

The two previous chapters present the experiences of the four case study sites over approximately a twenty-year period. They explore each city's attempts to respond to emerging problematic drug use, as well as the broader state or provincial and national contexts in which policy issues surrounding supervised injection have been debated and deliberated. The chapters address the structural, ideational and agency factors that have affected policy development, and focus on identifying the factors that either constrain or facilitate the replication of policy. The purpose of this chapter is to deepen our understanding of these issues by presenting findings from thematic analysis undertaken on interview data gathered from key stakeholders engaged in the policy process. The insights of participants into the challenges of replicating policy provide important data for developing an understanding of the significance of different sources of policy change. These findings are critical to the theoretical analysis undertaken in Chapter Eight.

Six main themes and their various sub-themes are presented, addressing a range of issues from the role of crisis; the proximity of political debate from the specific geographic locus of the problem; the ongoing effect of stigma and discrimination on public debate; and the contested role of evidence in the policy making process. In addition to exploring insights into ideational aspects of policy change, participants also provide views on the role played by institutions, and structural issues such as the interactions of different levels of government and the legislative process. Interview material from all four sites is presented together to explore the commonalities and differences that emerge in the different case studies.

7.2 Method

The analysis in this chapter draws on data from 30 semi-structured in-depth interviews conducted during field visits to Australia and Canada undertaken between April and June 2017. Following the granting of ethical approval and the development of city-specific

interview guides (see Appendix 2), invitations to participate were sent to key stakeholders.

Potential interviewees were identified through the documentary analysis undertaken as part

of the case studies and through consultation with informants known through existing

networks. Participants included former politicians, policy makers, public health practitioners,

law enforcement officers, researchers, lawyers and advocates. Interviews were recorded

with the permission of participants and transcribed before NVivo Software was used to aid

data analysis. The interviews were anonymised and are attributed below to broad

occupational categories which best reflect the primary role played in the policy process by

the participant, including Advocate, Researcher, Policy Maker and Practitioner. A list of

participants by case study location can be found in Table 4.4 above.

The analytical strategy applied to this project is derived from Braun and Clarke's (2006)

approach to thematic analysis, as discussed in Chapter 4 (Methodology). The first round of

open coding produced 67 codes. These codes were then reviewed and consolidated into

eight themes (Table 4.6). Through a third round of analysis, six themes were then identified

that provided the most relevant insights into the research question's central concern

regarding replication. It is these themes that are described below.

7.3 Thematic analysis findings

Table 7.1 provides a summary of the key findings from the thematic analysis before each

theme and its sub-themes are presented.

Table 7.1 Themes and sub-themes arising from stakeholder interviews in Australia and Canada of the challenges of replicating drug consumption rooms

Theme	Challenges
1. Problem definition and crisis	• Matching the 'problem' of street-based drug use to the 'solution' of drug consumption rooms • Crisis framing may be required for support to emerge • The differing roles of HIV and overdose as drivers (public risk versus individual risk) • Dynamic drug markets and changing needs over time
2. Interactions between different levels of government	• Engagement of federal, state/provincial, and local government in facilitating services due to division of powers • Alignment of all levels of government is crucial but challenging • Proximity to the problem. DCRs are a niche intervention providing services in a limited geographic area: the agendas of different levels of government reflect their proximity to the problem
3. Policy conflict between public health and law enforcement approaches to drugs	• Contradictory policy positions: governments need to exempt their own laws on drug prohibition to sanction services • The prioritisation of the politics of law and order weakens support for public health approaches • Relies upon a shift within law enforcement to recognise health implications and change policing strategies accordingly • The authority of public health approaches is partially undermined by the requirement for community approval for services
4. Politics and political leadership	• Site of interpretation and mediation of community concerns • The influence of electoral politics and political cycles on political parties' actions

	• Political leadership is an influential factor, often affected by the personal experience of the leader
5. Controversy and debate	• Strongly held attitudes towards drugs and drug use counter balance more progressive approaches in debate
	• Stigma and discrimination perpetuate a reluctance to support initiatives aimed at improving the health of people who use drugs
	• Moral and religious arguments are used by both opponents and proponents of drug consumption rooms
	• Neighbourhood amenity is a driving factor in the push for change but there is no consensus in communities that DCRs are the solution
6. The role of evidence	• Disillusionment about the use of evidence and its ability to effect change
	• Evidence as persuasive or serving a protective function for services
	• The debate is not framed as revolving around the evidence of effectiveness but engages at a more visceral level
	• The 'trial' status of projects has been used to stall replication

7.4 Theme 1: Problem definition and crisis

The impact of ideational factors is explored through this theme as the perception of the problem of drugs and the impact of crisis on opportunities for policy change are considered. Those making the case for drug consumption rooms must identify both the 'need' that exists (or the problem being addressed) and then demonstrate how the proposed 'solution' addresses that need. For replication to be achieved, there are two inter-linked considerations: 1) that need continues to exist that is not being met by existing interventions; and 2) that the problem or need identified is matched by the proposed solution. Each case study site had its own issues, and to complicate matters, the factors did not remain static

over time. The sub-themes concerning how the problem of drug use was perceived and how the solution was 'matched' to it, and the role of crisis in accelerating action on DCRs, are discussed below. It should be noted that the following analysis is based on the perspectives of study participants and does not attempt to either quantify or qualify 'need' through the objective analysis of public health data from the case study sites.

Identifying the problem

Drug consumption rooms have been, by and large, conceived as a solution to open street-based drug scenes where the visibility and associated problems of drug use such as overdose deaths and littering of paraphernalia are creating sufficient public issues that intervention is proposed. As such, they tend to be focused on a contained geographic area of activity. This is reinforced by the nature of the street drug market, which tends to cluster in certain areas. As many participants in the study observed, there is a strong tendency for people, having obtained drugs, to use them as soon as possible:

> "When you score your drugs, you want to use now. Because you've worked all morning picking bottles, breaking into cars, selling your body in order to score. You score, you're going to use as soon as you possibly can. If you happen to be close to the supervised injection site then you'll go use there... If you live three blocks, four blocks away, buy your drugs three or four blocks away, you're not going to go to the supervised injection site." (Practitioner 2, Vancouver)

In Melbourne, the local residents' campaign for a service concentrated on the 'factors' that were present in the area around Richmond to build a case for the 'need' justifying the proposed solution.

> "I mean, I met with residents in the Richmond area in Melbourne and they have made some strong representations to government. There's been quite a strong grassroots local campaign about the need for an injecting facility there based on the number of occurrences of public injection, the number of discarded injecting material, the paraphernalia they're finding the streets, number of overdoses in that area. It all points to the need for a specific facility for people who are engaging in drug use, injecting drug use in particular." (Policy Maker 5, Sydney)

Crisis

Where there was an identified problem of street-based drug use, yet resistance to introducing supervised injection as a possible policy solution, participants explored the role of crisis as a driver for change. The perception of crisis was also identified through the case studies as a potential catalyst for policy change. For example, the HIV epidemic was identified in Vancouver as a factor that effectively shocked people into responding, due to the scale and severity of the situation:

> "The crisis then was defined as HIV infection as well as overdose and they were able to use a figure, there was a figure of an 80 per cent conversion rate to HIV per year around 1997 that was the highest in the Western hemisphere. So that was able to be used as something that people could get their head around: this is as bad as Haiti, this is as bad as sub-Saharan Africa and then people could say well, we need to do something about this. And then of course the overdose deaths in the alleys." (Researcher 2, Vancouver)

A participant from Toronto credited the current opioid crisis in Canada with having created "greater openness" in her city to the introduction of supervised injecting (Policy Maker 3, Toronto). A researcher from Sydney considered whether it was the scale of the problem which prompted action:

> "You need a crisis...So is it then, is the answer then scale, is scale then the answer to all of it which is you need a drug problem of such scale that people can't ignore it and therefore communities have to respond?" (Researcher 6, Sydney)

Another participant recognised that the process of defining crisis was inherently political, and identified the importance of the act of framing a crisis and the use by activists of symbols to focus and distil arguments for change.

> "And I think the bigger issue is crisis. And sometimes crises are absolutely real and this one clearly is. But very often there's a politics to crisis about defining it, and building one, that definition and getting enough momentum behind the definition of something being a crisis versus something else...I mean it's about defining what is a problem, what is a crisis to be addressed and for whom and all that. But certainly people like Bud Osborn and VANDU and the other activists in the 1990s and the early 2000s were able to really make the crisis visible through really clever things like the thousand crosses on Oppenheimer Park. So something very visible really brings it to mind." (Researcher 2, Vancouver)

The perception of a crisis and the use of the language of crisis in the four case study sites has been linked to a concern with an escalation of a situation, whether it is increasing visibility of drug use and its effects, or increasing rates of overdose or blood borne viruses such as Hepatitis C and HIV. Some interviewees explored the idea of how these issues could be seen to affect parts of the community in different ways, resulting in varied motivations to act. One researcher in Melbourne observed how the arguments had changed over time, and that what once were issues that required a collective response were now seen to be more about individual risk. He saw a distancing and a narrowing of the focus on public drug use from previous times, suggesting a possible explanation for the lack of political will to introduce services in Melbourne:

> "We might argue that because that movement framed the issues as being relevant for everyone i.e. HIV/AIDS, public injecting on our streets, in your parks in your shopping areas, Hepatitis C: risk to everyone, Hepatitis B, it was more relevant for more of us. But it's different now. You know we don't hear talk about HIV or blood borne viruses now. We, with the exception of Richmond, don't hear talk about how public injecting is an issue that could affect you." (Researcher 8, Melbourne)

While the notion of crisis might prime policy makers for change, another participant identified the problems associated with making policy in response to crisis, rather than as a reaction to an immediate situation. In considering the current restriction in New South Wales (that a new service would require the passage of amended legislation), this participant argued:

> "But it would still be good here to have a change of legislation so that if a need did arise here, you wouldn't need to go through everything we had to go through. But getting reform, you know, when there's no crisis, from our point of view would be ideal because then you could really think it through. You know, we're not doing it all in the heat of the moment. But if you look historically at when the big changes happened, you know, reform-wise, it was almost always in response to a crisis. And yeah, it necessarily means you get this policy overreach or underreach, or you get this sort of politically expedient type of solutions, as with...you know not even decriminalising the provision of needles so that...30 years down the track we still have a very limited arrangement for needle syringe programs." (Practitioner 7, Sydney)

Temporal factors

The final sub-theme was the impact of time and change on the 'problem' that supervised

injecting facilities seek to address, and therefore the implications for replicability. Drug

markets are dynamic: types and composition of drugs can change; so too the patterns of use

both demographically and geographically. The fixed model of a supervised injecting site that

was trialled in both Canada and Australia may not be the best model as times change, or even

the right solution as new problems emerge. This issue was raised in both Canada and

Australia for very different reasons. In Canada, the arrival of fentanyl has had a devastating

effect on users of all kinds of drugs and different modes of consumption, due to

contamination of the drug supply (Belzak and Halverson, 2018). As one interviewee

explained, the problem now being faced in Canada needed a more comprehensive response

than just averting overdose deaths:

> "You know it's really tough. We've had a number of public health challenges related to
> drug use in this community including one of the worst epidemics of HIV seen in the
> western world. This thing scares me more than anything else because it's just the drugs
> that are in the supply are so, so strong. People will keep using it. I'm much more
> pessimistic than most people about the utility of a lot of overdose prevention
> interventions. … People are so desperate and in so much pain that they're not going to
> be like, "Oh there might be fentanyl in my drugs, I'd better not use today". … And so
> people keep rolling the dice and they keep dying. I think the solution is completely
> about rolling out those second, third, and fourth line opioid agonist treatments
> including injectable treatments. I mean injectable hydromorphone, injectable heroin;
> we need slow release oral morphine, we need more Suboxone, you need better
> methadone provision." (Researcher 3, Vancouver)

This concern was echoed by another participant who made the point that intervention on

overdose was always a post hoc activity:

> "Are we serious about this or not? You know? And all of our interventions you have to
> wait until someone overdoses. Let's wait until somebody overdose to really do
> something about it. We'll give them naloxone; we'll catch them in their chair in the SIS.
> But, I don't know. It doesn't make a lot of sense." (Practitioner 3, Toronto)

The deadliness of fentanyl and the comprehensive contamination of the illicit drug market in

Canada, a manifestly very real crisis, has spurred replication and innovation in service

delivery.

While Australia could also face the prospect of the arrival of fentanyl (McGowan, 2018), at present street-based drug use has contracted. This is particularly apparent in Melbourne; the five 'hot spots' of the late 1990s no longer present the high profile and visible problem that launched drug use onto the political agenda at that time. Sydney too, has seen considerable changes to its street drug markets through a combination of factors such as gentrification, drug market diversification and changes to the acquisition and selling of drugs with the proliferation of mobile phones. Participants in Australia recognised that with the passage of time, these changes affected both the sense of crisis and the degree of political focus on street drug issues, with implications for the replication of policy. As one participant succinctly said in relation to the advent of supervised injecting in Australia:

> "Well, I mean it arose as a specific kind of policy problem in a particular context that doesn't exist anymore, you know, substantial street base injecting, huge volumes of public needle discards, and a sense of crisis." (Advocate 4, Sydney)

Participants stressed that it was not so much the case that 'problem' drug use had disappeared, but that the nature and perception of it had changed. As one interviewee recognised, reflecting on these changes, the policy solution being offered through supervised injecting may no longer be seen to fit the policy problem:

> "So you had both the reality of people dying literally in the streets of opiate overdose. And also the community experience of that and those two things each convince different groups probably, to different levels. But together that was what created the policy opportunity. And that doesn't exist and it's not going to exist again, partly because of that thing about there's a decline in street-based injecting, partly because you know opiate abuse is now primarily a phenomenon of pharmaceutical opiates rather than heroin. More people die of pharmaceutical opiate overdose than die of injected heroin. Sorry, pharmaceutical opiate overdose of which many cases would be oral opiates. Supervised injecting facilities are not going to address that, you know. Now we've got more people dying of pharmaceutical overdose than heroin overdose so it's like what you said really, we don't have the same policy problem that that's the neat solution for anymore." (Policy Maker 6, Sydney)

7.5 Theme 2: Interactions between different levels of government

This theme explores the impact of structural and institutional impediments that arise from state-centred sources of policy change. It highlights the challenge of requiring political

support from three levels of government in order to initiate or sustain what is arguably a niche, local response to street-based drug use in a specific geographic location. The federal systems in Australia and Canada differ in terms of the division of powers, as the case studies above illustrate. Due to the criminalisation of drug use, both systems have required, to varying degrees, an alignment of support from governments at federal, state/provincial and local level. This has proved a significant challenge to the initial establishment of drug consumption rooms. Once the existence of DCRs has been accommodated through legislative means or exemption processes, the need for alignment has continued to vex attempts at replication. In addition, it is apparent that there is a tension regarding the need to debate drug consumption rooms at levels of government where there is a decreasing proximity from the immediate local area where services are proposed.

Levels of government

While not unique in policy making terms, the necessity that drug consumption rooms be considered by so many layers of government adds pressures in terms of timing and alignment of agendas. As one participant succinctly put it, "…in a country like Australia, and Canada, there's so many levels of government that maybe that's another kind of barrier because all those things need to line up in support" (Researcher 6, Sydney). Interview participants also recognised that political agendas at the national or state level may not be in alignment with local concerns. One Canadian practitioner in Vancouver explained how the federal government's attention had been focused on prescription opioids as the driver of overdose deaths, rather than the street drugs which were driving fatalities locally (Practitioner 1, Vancouver). In Australia, this issue has played out at the state level, where broader government agendas were seen as undermining local concerns:

> "However as far as the Victorian state issue is concerned, you know, I'm convinced that the state government looks at the whole state in terms of the messaging across law and order issues…And I'm convinced they are quite prepared to throw the local member under the bus as long as they don't lose, you know, so many percentage points in polling state-wide in law and order." (Advocate 6, Melbourne)

The need for coordination between levels of government to achieve policy change also introduced opportunities for higher of levels of government to resist pressure from local communities by arguing there was a lack of support elsewhere in the system. This was most apparent in Canada, where the federal government played such a prominent role to block local initiatives, first through its contesting of the court cases brought by local activists in Vancouver, and later through the introduction of the *Respect for Communities 2015* legislation. One Advocate felt this provided an opportunity for provincial governments in particular, with their responsibility for health funding, to delay making a commitment to local initiatives.

> "And that in fact has been a catch-22 that has delayed some of this and I think that speaks directly to the subject of your inquiry, particularly in a federal system where on one level the exemption from the drug laws that would enable you to run such a service without risk of prosecution comes from the federal government; in almost every circumstance any funding that you're going to be able to secure for such a service is going to come from the provincial and municipal level of government. It's become easy and we've seen that in several cases here in Canada including in Toronto and Ontario where there's this sort of buck passing between levels of governments. Not unknown in a federal system but certainly very much part of the dynamic that has played into delaying the scale up of these programs" (Advocate 3, Toronto).

Proximity to the problem

The necessity to engage in debate at both state/provincial and national level caused frustration for participants, particularly because the need arose on account of the criminalisation of drug use. In both Canada and Australia there were instances of local Councils keen to take action, but thwarted by their actions being *ultra vires*, making them reliant on higher level state authorities to determine whether or not they are permitted to act. This was the case in Melbourne where the Council of the City of Yarra was keen to proceed with a supervised injecting trial. An Advocate described their attempts to put up a proposal for an injecting facility in Richmond and North Yarra:

> "So we put that up and we put it to Council and we advocated to Council and we advocated to the state government and the state government were quite ambivalent about it. They weren't really interested. But the Council were very interested and they voted six to one in favour of trialling an injecting facility. And that was in May 2011. The state government said no." (Advocate 6, Melbourne)

Similarly, a participant in Toronto described the frustration that arose from the lack of tools available at the local level to deal with the issues that affected their communities and their urban environments. In describing the local drug problems and the city's inability to have an impact, he said:

> "And it got worse and worse and there were very little ways to deal with it because as long as it was within the criminal code, the city could do nothing because anything that's considered criminal, you can't regulate… except I worked awfully hard with the police and trying to find ways of dealing with it. But all I did was squeeze the rubber balloon, right? You apply the pressure at this end of the balloon and it goes away from those streets and just moves over two blocks, right? And then you squeeze there and then it comes back." (Policy Maker 2, Toronto)

These tensions led some participants to argue that supervised injecting should be determined at the local level. A participant from Sydney captured the conflict created by a higher political authority debating and making determinations on a problem from which they are removed, suggesting their lack of proximity to the location masks the need for action:

> "Which is why it should be a locally decided thing, I think, for a local, intense problem. Which is why it's silly for state governments to have to bother with this sort of thing, because of course, the Member for Yass or where ever is not going to have the appreciation of what it's like in Kings Cross, say. In the local area, all the politicians realised there was a problem that needed to be dealt with because it was on the doorstep and it was so palpable at the time. … But people in other areas are obviously not going to get that." (Practitioner 7, Sydney)

7.6 Theme 3: Policy conflict between public health and law enforcement approaches to drugs

Drug consumption rooms are public health interventions aimed at reducing harms associated with drug use, yet both staff and clients are at risk of prosecution under drug laws in both Canada and Australia unless specific exemptions are issued. This requires governments to hold contradictory positions in relation to their own illicit drug policies. Interview participants saw this issue affecting replication in a number of ways, both in terms of the political debate and the potential conflict created within and between the law enforcement and public health arms of government. Through this theme, the issue is explored both in terms of the impact

of competing ideologies within drug policy and the challenge DCR policy presents for the bureaucratic institutions of government.

Competing ideologies

In order to justify changing laws or issuing exemptions, a strong political argument must be mounted, given the controversy attached to drug use in general and drug consumption rooms in particular. While the broader arguments and discourse employed are discussed under Theme 5 below, two particular challenges were identified by interview participants as being significant for Governments in considering change. First, Governments appeared to be reluctant to make concessions to their own laws when there was overt campaigning under a 'tough on crime' banner, or when the position was generally seen to be antithetical to their ideological stance. Secondly, support for drug consumption rooms might be considered to be a 'slippery slope' for other drug policy reform that Governments were not prepared to address or embark upon.

In Australia, participants felt that there had been a general shift towards more conservative, hard-line positions by political parties, driven by concerns with crime, probation and terrorism, and that such 'tough on crime' stances were inconsistent with embarking on controversial law reform in the area of drugs (Policy Maker 5, Sydney; Advocate 6, Melbourne; and Researcher 8, Melbourne). One Policy Maker supported this by reference to the increasing focus on law enforcement as the primary political lens through which drug issues were addressed, which was felt to contrast to an earlier period in Australia where drug policy was addressed as a more bipartisan issue:

> "…the best example I can give is in the Federal Parliament. If there's a question on drugs that's raised it would be the Federal Police or Justice Minister who gets up to answer that question. I haven't seen for quite a while a Health Minister get up and answer a question about drug use. And that shows a lot about where the emphasis is on government policy…" (Policy Maker 5, Sydney)

In Canada too, the demonstrable difference between the Harper and Trudeau Governments in their ideological positions on supervised injecting had a material impact on the prospects for replication of services. Canadian participants referred to the Harper Government's antipathy towards the supervised injecting site in Vancouver, which according to one participant it fought "tooth and nail", first through the courts and then through the onerous legislative regime of the *Respect for Communities Act 2015*, which had a "chilling effect" on any attempts at replication (Advocate 3, Toronto). While Governments might support harm reduction as one pillar of government policy on illicit drugs, support for these measures is vulnerable when ideological shifts are made as a result of a change in the ruling political party or as a general shift towards more conservative politics across the political spectrum.

In addition, as a challenge to the dominant paradigm of prohibition, concessions for interventions such as supervised injecting are seen as a 'slippery slope' for Governments. As one participant argued:

> "And I think… one of these things that kind of casts a bit of a shadow over the debate is that, I think State Governments in particular, don't want to be seen as the one that made that decision which was the tipping point in terms of you other drug policy initiatives which we also need, like for example testing of drugs, heroin assisted treatment, needles and syringes in prison. So you kind of get sucked into that broader drug policy reform debate, even decriminalisation of drugs" (Advocate 6, Melbourne).

Law enforcement

The second aspect to this theme of policy conflict between law enforcement and public health approaches to drugs plays out in the agencies themselves or among their practitioners. The success of supervised injecting initiatives is dependent on the support and engagement of law enforcement. The effectiveness of both MSIC in Sydney and Insite in Vancouver demonstrates that partnerships can be forged that allow law enforcement and public health to work together on this issue. It also requires a cultural and managerial shift within law enforcement agencies to re-package or re-configure drug use as a health issue after years of addressing it as a criminal act. One interviewee, for example, described how

the successful working relationship between the Vancouver Police Department and Insite

was achieved due to a shift in culture and practice in the early 2000s as they began to

approach drug use and its implications from a health perspective:

> "All of our philosophy changed and it was a tough pill to swallow for a lot of cops who'd been working the beat for a long time and getting their bread and butter; it was, you know, possession charges or little street trafficking charges." (Practitioner 2, Vancouver)

In Australia, one participant discussed the challenge this posed within the police force:

> "Why can't we replicate this because it works? I think one of the things too is that people don't understand that the injecting centre is one small part of the overall health approach to drugs. And it should be a health approach. One of the terms I was using in the last couple of years in the police was we're after public health outcomes using law enforcement strategies and people look at you going, 'What are you talking about?'. Except for people from outside the police who go, 'He gets it'." (Practitioner 6, Sydney)

The challenge for replication of drug consumption rooms is that these changes may not have

permeated beyond the local command. There is a strong sense from participants that each

new instance of a DCR starts with new, local negotiations that can be very arduous. For

example, despite the police being key stakeholders and participants in the development of

the City of Toronto's broad drug strategy, access to the police by the needs and feasibility

research team was difficult:

> "It took us over a year to get in to see the Police Chief, just to talk to him." (Researcher 4, Toronto)

Public health imperatives

Public health authorities also face challenges with their engagement in supervised injecting,

particularly as the criminalisation of drug use complicates the pursuit of health objectives.

The politicisation of the issue leads to, for some, an onerous requirement to consult and

engage 'community', over and above what is normally expected for public health initiatives.

For example, one Researcher expressed his frustration at the requirement to give police a

'seat at the table' when discussing public health initiatives as he felt they did not have the

required expertise. He argued:

> "…I think the police and the enforcement community more broadly has had such a monopoly on drug policy for so long because we've criminalized the population that everybody thinks that they, somehow, have a really, really important voice in the design of public health interventions for drug users. And I think that's crap too. We don't tell them how to enforce people, enforce the laws. They shouldn't tell us how to deliver public health. Good luck going to a meeting about establishing a new, innovative service for drug users without cops there and without pandering to their concerns, without them sitting there and expressing their expert knowledge from their first-hand experience 'busting' people. They're suddenly experts on addiction." (Researcher 3, Vancouver)

Another participant from Vancouver echoed this concern but extended this frustration to the mandated need to also consult communities, which was captured in both the Supreme Court's ruling and the subsequent federal legislation introduced by the Harper Government. She asked:

> "So if it's a health issue and if this is a health service then why are we required to consult with the police station and the communities?" (Advocate 2, Vancouver)

The Supreme Court ruling's recommendations on community consultation vexed another Canadian participant on the grounds that this created a standard that was not required of other health facilities, suggesting that a shift to treating the issue of drugs as a health issue had fallen short.

> "The expressions of community support or opposition is actually less defensible in my view and in some ways is the more objectionable…because really it is just a naked indulgence of stigma and discrimination against people who use drugs or at least it enables Governments and Health Ministers to play to that by putting it right there in the judgment as something that the Minister must have regard to. I think that's really problematic because you would not see that with respect to other health facilities for people with other health conditions. So it very much is a reflection I think of the Court's own underlying discomfort on some level with the notion that these things even if the judgment ultimately was certainly a win for Insite and overall a positive contribution to the jurisprudence." (Advocate 3, Toronto)

7.7 Theme 4: Politics and political leadership

There was widespread agreement in the interviews in both Australia and Canada as to the centrality of politics in the deliberative processes surrounding drug consumption rooms, supported by statements like:

> "So, you know, I have very quickly learnt that it is the politics and the game playing that get things done in this area rather than anything else." (Practitioner 4, Sydney)

Opinions differed on the role of politics. For some the political arena was a genuine forum for mediating community concerns and views, while for others with a more cynical

perspective, the chasing of votes, and electoral and political cycles, overrode political will to act on controversial issues. Of critical importance to participants was the determining role played by political leadership in the process. These different factors all had an impact on the opportunities for replication to occur.

Political debate

Participants all agreed that drug consumption rooms specifically, and drug policy in general, are controversial for communities and therefore subject to considerable political debate. Interview participants reflected on the roles played by politicians in responding to community views. Strong arguments were put for the need for advocacy and active engagement in public discourse to shape those community views and provide politicians with a clear indication that there was support within the community for change. A supporter for increasing the number of drug consumption rooms in Sydney argued:

> "… there's so little leadership from within the political system, we need to demonstrate a constituency for change and also build power to apply pressure on politicians to make it easier for them to support the policies that we want than to maintain the status quo." (Advocate 4, Sydney)

The difficulties for politicians, however, were discussed by a Policy Maker who talked about the personal challenge of engaging in debate on drug policy "because of the strong and often diametrically opposed views of the community" (Policy Maker 6, Sydney). She went on to discuss the conflict created by advocating for a drug-related health service that is backed by strong evidence, but which does not appear to have the support of the local community:

> "But nonetheless I still found myself quite challenged by it and there were points where I thought am I really doing the right thing because the community who lived around it weren't very supportive of it and I could tell that there was a potential it would have a political impact on my future ability to hold my seat, and my seat was quite marginal." (Policy Maker 6, Sydney)

This quotation demonstrates the tension for politicians between their roles as representatives and their role in taking the lead to bring about change. The idea of representing a 'community view' is made more problematic by the question of how informed these views are (and indeed how informed they should be). This idea is explored further

below in the discussion on the role of evidence, but the political implications of this issue were drawn out by one Practitioner, reflecting on his own experience of initially approaching the question of drug consumption rooms with very little exposure to the issues:

> "Some people will object to these things just because they think that's what the community might want. And really the community quite often would be like some of the police, like I was, really if you don't understand it, it's very hard to have an informed decision about it" (Practitioner 6, Sydney).

Political calculations and electoral politics

While politicians and political parties are registering and responding to 'the community' in the process of deliberating policy, it is also apparent that decisions are being made based on calculations of their political capital and the risk of voter backlash – a factor that will be of greater or lesser significance depending on where a Government is in the electoral cycle. In New South Wales in particular, participants considering the successful establishment of MSIC thought it was significant that Premier Carr's Government was in its second term:

> "But you know…sometimes these things are also hostage to the political cycle. I mean Bob Carr…if it had have been the Labor Government in 2007 even, after that election, probably, it might not have made such a decision because our political capital was so much lower. I mean it was almost at a perfect point in the political cycle to be able to do something that was bold because we'd won one election, we'd demonstrated that we could do that. And yet we were not so tired and old as a Government that our political stocks were really low." (Policy Maker 6, Sydney)

The issue of political capital was also raised in relation to the lack of support within the Parliamentary Labor Party in Victoria, when there were signs of strong support from so many other stakeholder groups (Advocate 6, Melbourne; Practitioner 4, Sydney).

Another participant in Melbourne drew on the issue of proximity to the problem, as was raised in Theme 2 above, and discussed how electoral politics play out in marginal seats, removing decision making from the locus of the problem:

> "But I don't think that's how policy decisions get made…it's about single majority so I think what holds us back in the drug policy space is marginal electorates, swinging electorates and the swinging electorates are often in outer suburban areas. They've often got quite a conservative mix of people, a lot of them are actually faith based, so they can fall into a different sort of enthusiastic groups. And even if it's across the board 51 per cent in favour and 49, what really matters is where the swinging voters sit. And I think politicians get really swayed by the loudest voices in their local

community...there's not many people that argue for injecting facilities in Knox, but there's a lot of people in Knox that argue that the drug problem is too big and we need to wipe out the drug problem and those sort of things. Politicians put two and two together and think there's no votes for me in Knox if I support an injecting facility in Richmond. I think it's more grubby than just community sentiment more broadly. I think it's short term political calculations by politicians who are driven by electoral prospects." (Practitioner 8, Melbourne)

Political leadership

In many ways, the sub-themes discussed under the broader theme of politics show a tendency to run counter to each other, juxtaposing a notion of the political process as a forum to mediate community views with a view of politicians cynically calibrating their decisions with vote maximisation depending on where in the political cycle they sit. There was surprisingly little discussion with participants on the 'politics of conviction'. Where this did come through was in the recognition of the role of political leadership, a key 'agency' factor in the policy transfer process. The case studies in Chapters 5 and 6 illustrate occasions where political leadership appears to be decisive in breaking policy impasse on the issue of drug consumption rooms. These stories had a common thread, which was of a leader brought on a journey to realise the potential benefits of supervised injection. A Policy Maker from Toronto relayed one such story of the Mayor of Toronto, whose support was crucial in order to get the City of Toronto Council to adopt the recommendation of the TOSCA report to develop three supervised sites:

"And John Tory while he is a conservative, he is a social conservative, and had been and we knew through his radio show, had talked about the issue of supervised injection services, how he originally thought it was crazy, but over time learning about it and talking to people who are knowledgeable about it, could see that it could be part of a solution." (Policy Maker 3, Toronto)

In the interviews, some participants speculated on the role of personal experience in influencing whether leaders were prepared to tackle difficult drug policy decisions. For example, a participant from Sydney reflected on the particular family circumstances of key figures in Australian politics and the influence of this in enabling leaders to relate to drug use and drug users and therefore progress policy:

> "…but it's not a surprise, it's not a coincidence that Bob Hawke had a daughter who was a heroin user. I don't believe it's a coincidence that we have Bob Carr who had a brother who was known to have a heroin issue. Personal experience can help focus somebody's minds and help people understand the reality of what we're talking about and help break down that 'other'. You know whether you're talking about bloody anti-Muslim sentiment or anti-drug user sentiment I mean we really need to break down the 'other'." (Practitioner 4, Sydney)

This level of personal experience sits at odds with the more mechanistic drivers identified above such as political cycles and swinging voters. For the overriding concern with understanding challenges for replication, the level of engagement of political leadership, however that is achieved, is clearly critical.

7.8 Theme 5: Controversy and debate

This theme is concerned with exploring the discourse, ideas and narratives that underlie debate in communities and the ongoing opposition to supervised injecting, even in places where successful trials have been conducted. Participants were asked to consider the nature of the controversy surrounding supervised injecting, and why they thought the policy continued to be contested. The sub-themes identified were often interlinked, but four dominant concerns emerged: attitudes towards illicit drugs; stigma and discrimination; religious and moral arguments; and neighbourhood amenity and community aspirations.

Attitudes towards illicit drugs

The first sub-theme of attitudes towards drugs captures the prevailing discourse that sees drugs as bad or, in even stronger language, as 'evil'. It is through this framing of drug use as an undesirable act (confirmed by its illegality) that arguments are mounted against supporting an intervention which might be seen to be enabling or supporting further drug use. Participants in all four sites brought forth instances of this type of argumentation, acknowledging the challenge (noted in Theme 3) of the contradictory messages for the general public in simultaneously prohibiting and exempting use of the same substances.

> "I think it's very challenging. I think we forget that it is a very challenging idea for general public minds, the idea that there is somewhere where people can bring drugs

that they've obtained illegally, that they're probably committing a crime to pay for, and then they can go and use those drugs without any fear of repercussions or police intervention. And then they can move back out into the community drug affected. That's a very big leap for people to accept unless you work in this world where it's very normalised for us to think that that's completely fine." (Researcher 6, Sydney)

Some participants emphasised the act of enabling drug use by providing a place where the consumption of drugs could occur. The opposition to this was compounded, some participants felt, by the tendency for discourse around drug use to be against all drug use. This does not allow for a differentiation to be made between unproblematic drug use (whether alcohol and other drugs) and problematic drug use which would be the focus for an intervention such as a drug consumption room. A Policy Maker from Toronto captured these ideas when discussing what form opposition arguments took:

> "There's two related parts of it, of why people oppose interventions and that is because they think that drug use is bad - illicit drug use…It is against the law, and you are enabling an act. This notion of enabling is related. Somehow if you're encouraging people by having harm reduction services available even though evidence-wise flies in the face of that but, you know, 'Why are you helping people to kill themselves?', 'Why are you helping people to commit illegal acts?' And some people can't wrap their heads around that. And as long as drug use is criminalized that will continue. We cannot reduce the stigma that perpetuates that discriminatory viewpoint and get at the core of this which is, people use drugs for a whole host of reasons and most of which is non-problematic but for folks for whom it is, we do need some extreme measures." (Policy Maker 3, Toronto)

The criticism that drug consumption rooms 'send the wrong message' and unjustifiably enable the continuation of drug use is tied in with arguments that people should 'just stop taking drugs' and that treatment is a preferable option or solution. The effectiveness of treatment, however, is contested. As one participant addressing these concerns demonstrates, there continues to be a wide range of views in the debates and discussion around 'what works', and what therefore would be a better solution to deal with the problems that arise from problematic drug use:

> "But there is still like a good chunk of naysayers, right, that hate them, always will hate them… And they're just perceived to be taking it too far. That's, you know, why are you doing that when really people should go to treatment? … And I don't think anybody really understands that actually treatment is not very effective. I think there's this idea like a hospital; we put you in the hospital and you come out fixed, but that's not how treatment works. And I don't think your average Joe understands that, even though

they probably have seen it in their family, either through drugs or alcohol or even tobacco. That it requires many quit attempts and most people fail…Drug use has been criminalized for so long, and even though there's more support in the media, there's still that hard core war on drugs even though that is starting to crumble a little bit as well. So it's just, it's too far." (Researcher 4, Toronto)

Stigma and discrimination

The second sub-theme in this section is stigma and discrimination, which were identified by a number of interview participants as being instrumental in ongoing opposition to supervised injecting, therefore posing a challenge to the replication of services. For some interviewees, the stigmatisation of people who use drugs was seen to be at the heart of why more services were not provided. As one Advocate described, support for supervised injection entails an acceptance that you are not going to eradicate drug use and that is a position that was unacceptable for many people:

> "So why it would be so controversial I'm not sure, except in so far as you're even more explicitly, pragmatically accepting the reality of problematic drug use, which people don't want to do because it remains a stigmatized behaviour. So it's not something that should be encouraged. The more you're doing things that, quote, make it easy, for people to do the thing that we don't think that they should be doing, I guess the more discomfort and oppositional reaction you're likely to provoke." (Advocate 3, Toronto)

The criminalisation of drug use was linked to the ongoing existence of stigma with one participant making the comparison with the treatment of people with mental health conditions. He contended that where people suffering from mental health issues could access support, drug users were blamed for "not taking responsibility or making bad choices", with their criminality compounding the situation (Policy Maker 5, Sydney). Such stigmatisation was also attributed to a lack of understanding of drug use issues which maintains a divide between 'us and them', with the 'other' often being seen to be unworthy of help. One Practitioner felt that there was a need to frame the debates in terms of a conversation about "who belongs and who doesn't". While recognising the impact of prejudice, which he described as "that giant, block structure in the middle of that road", he also cautioned against being too judgemental, attributing such attitudes to a lack of exposure to the issues:

> "I would never want to take on saying to an affluent community, which is full of good people, but they're as conditioned as anybody because I know how conditioned I am and I don't hold a different ruler to anyone else and I don't think I have any insight, it's just where I work and eventually you build up insight into the area you work in, that's all. It's as simple as that. And so you have to have that kind of standard when you find people who don't get it, right? They're not bad people. I would have been in the exact same shoes, years ago." (Practitioner 1, Vancouver)

Religion and morality

The role played by religion and morality forms a third sub-theme. As the case studies in Chapters 5 and 6 illustrate, religious groups and stakeholders from religious organisations have both supported and opposed drug consumption rooms, illustrating a spectrum of beliefs from the conservative to the more radical. While some participants noted the role played by organised religion in trying to influence political decisions in relation to drug policy, they also acknowledged the significant role played by churches in service delivery as charities. This issue seemed particularly pertinent in the Australian case studies, although the tendency for religious identity to correlate with social conservatism was also noted in Canada (Researcher 2, Vancouver).

> "I think there's a variety of views within religious organisations because so often they're the organisations that are providing these services who are on the front line of dealing with people with drug and alcohol problems and they know what is needed and they know how desperate people can often be and therefore what sort of responses are going to work. But I think if you know looking at the community more broadly you know can you correlate religion and people who are religious, whatever their brand of religion with more conservative thinking? Yeah probably. So in that sense in the broader community, yes, maybe electorates that have a higher portion of people who are religious would be less likely to support a medically supervised injecting centre." (Policy Maker 6, Sydney)

Moral arguments have underscored the debates on drug consumption rooms in Canada and Australia, in both political circles and at the community level. At the centre of these debates is the interpretation as to what constitutes a moral position in relation to drug use and people who use drugs. Opposition arguments have centred around an association of drug use with immorality and general social conservatism, while arguments supporting interventions for drug users have been linked with values that highlight compassion and care for the vulnerable and marginalised. One of the implications of the strong association of drug use

and questions of morality is that evidence and concerns with impact and effectiveness may

be marginalised. Where arguments have been heavily based on a moral stance, it has been

difficult to find common ground in order to progress policy development.

The contested interpretations of these moral/religious positions were apparent from the

interviews, with comments such as:

> "…I can't even work out why as a religious person you'd be in opposition to saving
> lives." (Advocate 6, Melbourne)
> "…how do we get this idea that we can just turn our backs on people who are suffering?
> That's certainly not taught in any religion that I've been exposed to." (Advocate 4,
> Toronto).

Two participants raised the issue of love, and interpreting what it is to love, in relation to

understanding how we care about people and can best support people in need. An Advocate

from Toronto considered his own journey and engagement with harm reduction:

> "What is morality? It changes. It fluctuates. In my own life I've seen such changes. Most
> of which have been good, I think. You know as we become…better people our morality
> shifts and becomes more loving. The other thing is that I can't separate safe sites from
> harm reduction in general because it's a big piece of harm reduction but it's all about
> love. …But when I talk to other people…I often get the comment, 'This is why I started
> doing this work in the first place but I'd lost touch with'. The idea of love, the idea of
> we're here to make change. And it isn't just changing the person to fit the system, it's
> changing the system." (Advocate 4, Toronto)

Amenity and community aspirations

The final sub-theme related to controversy and debate is neighbourhood amenity and

community aspirations. Open drug scenes have a significant impact on public amenity

through discarded injecting litter; fear of the criminality associated with drug use and drug

dealing; anti-social behaviour; and the risk of people overdosing, sometimes fatally, in public

places. One Advocate from Melbourne gave her impressions of the current situation in a local

suburb, gained from her experience of walking through the area:

> "In Richmond, I mean the stories that the residents around there tell, it's just
> frightening. Yet at times I'll walk around there, and Fitzroy too, and you just see people
> in a huddle and then you walk a bit further and you've got to watch that you don't step
> on a needle and sometimes it's whole syringes. Other times it's just needles. And
> they're in the park, where there are children playing." (Advocate 5, Melbourne)

One Policy Maker in Toronto spoke of his interest in exploring the potential of drug

consumption rooms from the perspective of wanting to improve the amenity in his neighbourhood as it tried to come to terms with a growing open drug scene:

> "And so what I began to realise is that although there is a public health stream about the efficacy of dealing with the health concerns, there's also the neighbourhood health concerns and that's how I really got pulled into this. How do you help a neighbourhood cope? How do you make it safer for a neighbourhood? I'm not talking about getting rid of it, but how do you create a place where it's managed so that the neighbourhood isn't so negatively impacted by it. So that is where I ended up coming from." (Policy Maker 2, Toronto)

He was, however, confronted by opposition from local residents, who were not convinced that such services would improve the situation, but rather feared they would entrench problems that they were seeking to eradicate:

> "Neighbourhood associations were horribly opposed to the issue. ...No neighbourhood is going to say, 'Thank you, we want it' because they're sceptical about it being in any way ameliorating of the conditions in the neighbourhood. They just think it's going to be a magnet. It's just going to make it worse." (Policy Maker 2, Toronto)

Another participant felt opposition to drug consumption rooms stemmed from a reluctance to embrace a solution that required an acceptance that drug use is occurring and will continue to occur in a local community. He felt that the inherent acknowledgment of the presence of drug use would contradict more positive community aspirations:

> "I mean part of it's fear. Part of it's just a concern about what kinds of commerce/ public goods/ public institutions you want to see in your community. And somehow, for some people the fact that there's a consumption site in their community is a sign of failure. Somehow, you know, the community isn't working right. So I think that's where the resistance comes from. Those kinds of sentiments." (Researcher 1, Vancouver)

This quotation captures the complexity of the issue for communities deliberating the appropriateness of DCRs. Questions of what kind of community people want, and how they solve their problems, are demonstrated here not to be simply answered with technocratic proposals.

7.9 Theme 6: The role of evidence

The study participants diverged most on the impact of evidence on the prospects for replication of the successful models of drug consumption rooms. Some argued that building the evidence base to demonstrate drug consumption rooms work was critical for the services

and the policy decision making processes. Others expressed palpable frustration at the lack of impact of evidence on policy reform and were sceptical about the prospects for creating evidence-based policy solutions to street-based drug use in new areas of need. Another set of participants was more sanguine, reflecting on the need to approach policy change from multiple angles, including appeals to emotion, in order to effect change in a contested policy landscape.

The evidence base

Both Insite in Vancouver and MSIC in Sydney were established as trials and subject to extensive evaluation, as described in the case study chapters above. At the time of their establishment, there were over 45 existing facilities operating in Europe, but according to Dolan et al., there were "few thorough impact evaluations" – although their assessment of the studies that did exist concluded findings were "encouraging" (Dolan et al., 2000 pp.340, 344). Recalling the establishment of MSIC, a Practitioner reflected on the perceived benefits of proceeding as a trial:

> "… the wording also specified a trial in the original resolution. So that was a way, obviously, to reassure people that this was not cast in stone. It was also, I think, genuinely part of a commitment to evidence-based policy making that was very much the flavour of the Drug Summit. So at that stage, I thought that was both strategically a good idea and also would add to the evidence base, a great asset to have." (Practitioner 7, Sydney)

Many Canadian participants in the study were adamant that the intensive process of accumulating the body of evidence was critical to the survival of Insite in the face of the court cases, and therefore critical for the prospect of building future services. Commenting on the role of evidence, one Advocate said:

> "It's been central, I think. I think the evidence that was able to be marshalled on the record in the Insite challenge won the case. I think the legal arguments were important and, you know, needed to be the hooks on which to hang some conclusions and a remedy but if there hadn't been the solid evidentiary base it would not have happened, or it would have been far less likely to succeed, I think. And you see that and even the Court says in its decision, Insite saved lives, its benefits have been proven. You know that's the crux of the decision right there in those two sentences." (Advocate 3, Toronto)

Aside from serving a purpose formally in the courts, others emphasised the persuasive nature of the evidence on public opinion and politicians. In Toronto, both Researcher 4 and Policy Maker 3 argued that the 'hard data' developed to assess the need for services in Toronto and Ottawa played a significant role in building a persuasive case that resonated with politicians.

Impact on policy making

In contrast to these arguments, other study participants were dismissive of the relevance of evidence in policy making processes, citing their own experience or observations about the nature of the debates that occurred and the seeming limited impact of evidence on the arguments that were put forth. A Policy Maker in Toronto was adamant that his engagement in the issue was not dependent on receiving the imprimatur of the scientific community, while acknowledging that for others the authority of the 'scientific study' was persuasive:

> "You know, from my perspective, I couldn't have cared less. Right? Do it. There's a need to figure out how to fix this. You've got to do it. And I don't need a scientist to tell me that, right? It is that people are dying and we need to find a way to fix this problem. But there are an awful lot of people who are on the other side of the fence who need to be convinced and they need that scientific study. So it is important but it's not important for all of us." (Policy Maker 2, Toronto)

In this debate over drug consumption rooms, evidence is contested. Is it persuasive? How much evidence is needed? Is the quality of the evidence sufficient? Is it transferable? One participant, reflecting on his engagement in the issue in Melbourne in the late 1990s, argued that even with a less robust evidence base than currently exists, there was strong enough evidence to mount a convincing case for supervised injecting:

> "I think the evidence was strong enough in the 1990s to run injecting facilities and I think the evidence is stronger now, but it was definitely convincing in the 1990s." (Practitioner 8, Melbourne)

The ongoing requirement or pattern for supervised injecting facilities to undergo continuous trial is an additional challenge that suggests there is a tactical use of evidence at work. A participant in Sydney acknowledged that there was a responsibility for researchers to make their research accessible to policy makers, but she admitted she was "exhausted" by the ongoing situation where she felt evidence was not being used:

> "But it is very frustrating to think that, you know, in Melbourne for example, it is so obvious that they are now in a situation that we were in 15 years ago. And they could slide something in that would alleviate people's distress." (Researcher 6, Sydney)

There was also a notion that the controversy surrounding drug consumption rooms meant fairness was compromised, as the evidential requirements for supervised injecting went far beyond what might be 'normal' for a public health intervention, a factor that was attributed to the stigma attached to drug use and criminality. As one participant argued:

> "People don't listen to evidence and people aren't willing to listen to evidence. The studies are out there. Insite, again, evidence: like there isn't a more researched health experiment in the country, maybe even the world, than Insite. And yet we have one and we have to jump over Mt. Everest to get two. Evidence isn't the answer. They might want to see more evidence but they don't. They just want to see that it's not going to have an impact on their day-to-day life, that it's not going to increase crime or affect their feeling of safety because drugs are still a crime. They're not a health issue. If you had a clinic for diabetics that worked like a charm you'd have 60 clinics for diabetics that worked like a charm across the province. It's the criminality. It's the association with it being a crime that keeps this a dirty word, a dirty idea." (Practitioner 2, Vancouver)

Alternative arguments

In a final sub-theme under the issue of evidence, a number of participants referred to the visceral nature of the debate on drug consumption rooms and argued that to focus on evidence alone in making a case for offering services would be to miss an opportunity to engage with that debate directly. Researcher 2, for example, noted despite the rhetoric about evidence-based policy from influential drug reform groups in Canada, they too "know that that's not enough because it's always coupled with appeals to emotion, appeals to the humanity of the people who are using" (Researcher 2, Vancouver). A Practitioner in Sydney explained how she moved away from relying primarily on evidence to convince people, and engaged directly in questions of the ethics of not addressing preventable deaths:

> "And so I increasingly realized that. I was better off not using the evidence, the scientific evidence necessarily to argue the toss because that just sent people to sleep, but you know, arguing on that emotional level that was really what was fuelling them, so that then we were at least on the same page. So then I reframed, tried to reframe it as you know basically you people think it's alright to close the doors and have these people go back into the back streets …I would counter that to say well, you know, from a medical point of view that's unethical. You know we have to do everything we can to save life and I make no apology for that." (Practitioner 7, Sydney)

This insight demonstrates the consideration given to the role of argumentation and framing within the debate, which is an effective counterpoint to approaches which seek to privilege evidence as the decisive factor in policy making.

7.10 Conclusions

The purpose of this chapter has been to contribute to our understanding of the challenges facing the replication of drug consumption room policy by analysing data from key informant interviews. Through the application of thematic analysis, the interviews have yielded critical insights into the complexity of the policy making process. Ideational elements have been prominent. Running across the themes are the impact of ideology, framing and narratives, demonstrating the importance of the discourse that influences policy debates. The analysis has identified the impact of attitudes towards drugs and drug use, and the role played by stigma and discrimination in discussions on these issues. Perceptions on the role played by evidence have been diverse. Overall, conflict, not consensus, runs across the themes. Participants have also drawn attention to their perceptions of the 'workings' of government and the importance of considering institutional factors that affect policy making. Electoral impact, the division of powers between levels of government and proximity to the problem have all been highlighted. The following chapter will now draw on these findings and those of the case studies to interrogate the research question regarding replication of drug consumption room policy through the policy transfer lens.

Chapter eight
Policy transfer: understanding success and failure
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8.1 Introduction

The preceding three chapters present the empirical findings of this thesis on the experience of policy change in relation to drug consumption rooms in four cities in Canada and Australia. The contested nature of the policy has been illustrated through the debates around, and resistance to, the introduction of this idea into the policy domain. As the technical feasibility of the interventions has been established, the central concern of this thesis has been to understand the factors that have limited the diffusion of the policy over the twenty-year period from the late 1990s. Following a long period of hiatus, Canada has now experienced a national scaling up of drug consumption rooms. In contrast, in Australia, the two DCRs in Sydney and Melbourne remain one-off interventions in each state. The purpose of this chapter, therefore, is to draw these findings together under a coherent theoretical framework as a means of interrogating the key constraining and facilitating factors in relation to the replication of drug consumption rooms.

The review of the literature in Chapter Two identifies the limited application of policy transfer as a concept to explore change in the field of drug policy. Chapter Three presents the arguments for using the policy transfer framework to analyse the main findings of the case studies and the empirical findings from the thematic analysis of the interview data. I argue that the policy transfer framework offered an underutilised but appropriate means of addressing the challenges and barriers to the replication of drug consumption rooms, through its focus on multiple sources of policy change, multiple levels of governance and multiple agents interacting dialectically. Policy transfer is concerned with ideas and the sharing and transfer of knowledge; these are key factors in considering the question of why a demonstrably successful intervention struggles to be scaled up or more widely diffused.

The chapter is divided into three main sections. Section 8.2 rigorously applies the findings of the three previous empirical chapters to the four components of Evans' (2004) policy transfer framework, mapping the key case study findings and the outcomes of the thematic analysis.

The key constraining and facilitating factors are identified and analysed as to their significance. Section 8.3 then presents the outcome of a review of the empirical findings in order to identify any factors that do not appear to fit into the framework. It introduces the significant role played by civil disobedience as a driver for change in Canada: the site where policy diffusion eventually did occur, beginning in 2017. Acts of civil disobedience are compared across and within the case study sites, revealing that the actions of community activists have been important in bringing about this change in the context of a large-scale opioid overdose crisis. On the strengths of this analysis, I present the case in Section 8.4 for modifying the policy transfer framework to incorporate a fifth component that considers the broader role of civil society in the policy transfer process.

8.2 The application of the policy transfer framework

Evans' (2004) policy transfer framework focuses on four sources of policy change (or stall):

i)   global/international structures;

ii)   state-centred forces;

iii)   policy oriented learning; and

iv)   policy transfer networks.

This section analyses each of these in turn to assess which factors were significant in restricting and facilitating policy change in relation to the replication of drug consumption rooms in the case study sites. A summary of the key constraining and facilitating factors for each facet of the policy transfer framework is presented below in Table 8.1. The results of this analysis serve two key purposes. The first purpose is to provide a structured way to interrogate the specific question of the challenges of replicating drug consumption room policy. The second purpose of the analysis is to inform reflections on the applicability of the policy transfer framework to questions of drug policy.

Table 8.1 Key constraining and facilitating factors of policy change affecting replication

Source of policy change	Constraining factors	Facilitating factors	Links to Themes (findings)	Assessment of impact
1. Global, international and transnational sources	*Ideational* • Ideology of prohibition *Institutional* • International narcotic control treaties and institutions	*Ideational* • International harm reduction movement/ epistemic community	*Theme 3* Policy conflict	Weak
2. State-centred sources	*Ideational* • Ideology of prohibition • Conflicting policy agendas *Institutional* • Interactions of different levels of government • Role of parliament and legislation • Electoral cycles and politics	*Ideational* • Ideological change *Institutional* • Systems change (electoral) • Role of courts *Agency* • Political leadership	*Theme 2* Government interactions *Theme 3* Policy conflict *Theme 4* Politics and political leadership *Theme 6* Role of evidence	Strong
3. Policy-oriented learning	*Ideational* • Cognitive obstacles including policy conflict • Elite and public opinion • Persuasiveness of evidence • Stigma and discrimination	*Ideational* • Evidence-base • Crisis framing • Problem recognition	*Theme 1* Problem definition and crisis *Theme 3* Policy conflict *Theme 5* Controversy and debate *Theme 6* Role of evidence	Strong
4. Policy transfer networks	*Agents* • Ineffective elite mobilisation	*Agents and ideational* • Epistemic communities • Community consultation	*Theme 5* Controversy and debate *Theme 6* Role of evidence	Medium
5. Other (outside the framework)		*Agents* • Civil disobedience		Strong

8.2.1 Global, international and transnational sources of policy change

This thesis has identified both ideational and institutional structures operating at an international and global level that can be shown to shape the behaviour of state and non-state actors in relation to policy transfer in the case of drug consumption rooms in Australia and Canada. The impact of these factors, however, appear to be relatively weak in relation to both the constraint and facilitation of replication: these two aspects are considered in turn.

Constraining factors

At the global level, the key ideational factor impacting on the replication of drug consumption rooms is the internationally shared ideology of prohibition. As was demonstrated in the discussion on the theme of policy conflict in the findings of Chapter Seven, prohibition remains the fundamental basis of both Canada and Australia's illicit drug policies. The operation of DCRs directly challenge the laws that support prohibition by requiring an exemption to protect staff and clients from prosecution. The conflict that this creates for Governments was a definite constraint on replication, as demonstrated by the restrictive regimes they put in place to provide these exemptions. This is discussed in more detail in the section on state-centred forces below.

This international ideology finds institutional form through the international drug control conventions that are overseen by the International Narcotics Control Board. It was noted in the case studies of both Australia and Canada that the INCB monitored policy developments in both countries and made public statements condemning their actions (International Narcotics Control Board, 2000 and 2004). Under both Australia's and Canada's constitutions, there was provision for the federal government to intervene under its external affairs powers, should it determine the introduction of a drug consumption room would breach its international treaty obligations. The question of whether the interventions breached the

conventions remains contested due to treaty provisions which recognise the need for interventions to address the harms that arise from drug use (NSW Parliament, 1998; Totaro, 2000; O'Neil, 2007). In the case of Australia, successive Federal Governments took no action in relation to New South Wales' Medically Supervised Injection Centre or more recently Victoria's Medically Supervised Injecting Room. In Canada, the Harper Government actively opposed Insite in Vancouver, first through the courts and then through legislative means. However, with the power to legislate on criminal matters pertaining to illicit substances sitting at the federal level of government, there was no need for external powers to be invoked. International sources of policy change can be concluded, therefore, to have had only a limited impact on the stalled replication of drug consumption rooms in both case study countries. This argument is consolidated by the fact that the INCB itself took no direct action against either country beyond noting its displeasure through statements in annual reports (as noted above).

Facilitating factors

The findings of this study confirm the international sharing of knowledge that enables the idea of drug consumption rooms to travel with the support of an epistemic community. For example, Vancouver's four pillar strategy borrowed directly from European drug strategies. Toronto then drew on Vancouver's four pillar approach in the development of its own drug strategy that recommended the city council explore the introduction of DCRs (MacPherson, 2000; Toronto Drug Strategy Advisory Committee, 2005). In Australia, the extensive work undertaken by parliamentary and government-appointed expert committees, intent on scrutinising the appropriateness and viability of DCRs, drew on international research evidence (Parliament of New South Wales, 1998; Drug Policy Expert Committee, 2000). It is also possible to see the remarkable closeness in design of the MSIC and Insite facilities. McCann and Temenos' (2015) study confirms the professional relationships between

practitioners at each site. While this evidence demonstrates the international sharing of knowledge and the circulation of ideas to facilitate the establishment of centres, the impact in relation to the subsequent continued diffusion of the idea at a sub-national level is scarce. The idea persists, as we see in the case of the continued advocacy for a supervised injecting facility in Melbourne after the initial failure to secure the proposed five sites, but the scaling up of facilities is not achieved at all in Australia, and delayed for many years in Canada. In conclusion, the existence of an international harm reduction movement can be demonstrated to contribute to the circulation of ideas, but we must turn to other factors to identify stronger drivers (or inhibitors) of change.

8.2.2 State-centred sources of policy change

State-centred forces provide another level of macro-analysis for identifying factors that affect policy transfer. This study identifies both ideational and institutional factors that work at a structural level to constrain and facilitate the replication of drug consumption rooms. The impact of these factors has been significant in all four case study sites. In particular, the roles played by parliaments, legislation and electoral politics can be shown to have been effective in constraining change in this area and curtailing efforts that would have allowed the policies to have diffused or become more normalised. These institutional constraints have been supported by ideational factors such as the dominant ideology of prohibition. Following a discussion of these constraining factors, the key drivers that have facilitated change at the level of the state are identified. These fall under the headings of ideational, institutional and agency factors, and encompass opportunities presented by ideological change, electoral change and the role of political leadership.

Constraining factors

One of the most readily identified constraints that has mitigated against a permeation of policy in this area has been the necessity for different levels of government to support a

common policy objective. In both Australia and Canada, different levels of government become engaged in this issue as a consequence of the division of powers in the federal systems, which has resulted in the separation of responsibilities for criminal justice, health and local government. As a drug policy issue with a public health orientation, drug consumption rooms have straddled both health and criminal justice policy portfolios *and* layers of government, placing a level of complication on the development and passage of policy initiatives. This issue is explored in detail under Theme 2 of the previous chapter, which looks at the tensions and challenges that arise from the requirement to coordinate and cooperate across political and governance boundaries.

For the question of replication, of particular interest is the issue of the constraints placed on diffusion of the policy. In each case study country, at least one drug consumption room was able to be established, demonstrating their technical and legal feasibility. This study's findings show that legislation has been used very specifically to constrain expansion of service. In Australia, this took the form of enabling legislation in the two States only making provision for *one centre*, requiring any expansion of services to go before the Parliament again to debate amended legislation. In Canada, the Harper Government introduced the *Respect for Communities Act 2015* following the Supreme Court's ruling in favour of the constitutionality of providing drug consumption rooms. This legislation deliberately set burdensome requirements that discouraged applications under the existing exemption process (Hayle, 2015). In each of the countries, Governments have used legislation to set tight and constraining boundaries, sending a strong message that drug consumption rooms are exceptional services that are not to be normalised. This is in keeping with Evans and Davies' (1999) conjecture that policy ideas that do not align with the strategic concerns of the state are unlikely to be adopted – or in this case, scaled up.

The function of parliaments has also been critical, particularly in Australia, reflecting the important role played by institutions in resisting or blocking policy change. For example, despite the Bracks Government in Victoria campaigning on the introduction of supervised injecting facilities and gaining a mandate through its electoral victory, its Bill was defeated in a vote in the Upper House, where the Government of the day did not have a majority. Clearly, this is not out of keeping with the function of Parliament, but it reinforces that the policy process, particularly in contested policy areas, must be navigated. In seeking to understand outcomes, we must trace the institutional pathways along which policy travels (Lewis, 2005). The constraining role played by parliaments is also noted in the parliamentary committee process where bills are scrutinised prior to being taken to the floor for debate. As discussed in the case study of Melbourne, for example, despite the fact that 46 of the 49 submissions submitted to the 2017 Inquiry into Fiona Patten's bill proposed a medically supervised injecting centre in North Richmond, the Committee did not recommend supporting the trial (Parliament of Victoria, 2017). Earlier in NSW too, a Joint Select Committee of Parliament recommended against supporting the recommendation in the Wood Royal Commission to established supervised injecting facilities (Parliament of New South Wales, 1998). In both of these cases, the Committee's recommendations prevented legislation proceeding to debate on the floor of Parliament at that time.

The findings of this thesis demonstrate that the ideology of prohibition, which provided the rationale for the criminalisation of drugs, created tensions for states contemplating change in this area. Theme three in the previous chapter explores in some detail the policy conflict between public health and law enforcement approaches to drugs, and how drug consumption rooms sit at the interface of these policy domains. While harm reduction policies existed in both Canada and Australia, providing the rationale and ideational 'home' for DCRs, this study exposed the reluctance of governments to embark upon change in favour of health oriented policies if it made them look 'weak', particularly if they were in a phase of

campaigning on law and order issues or were simply ideologically disposed towards being 'tough on crime'. Part of the explanation for their reluctance was explained by electoral concerns but also by the potential of the 'slippery slope' that reform in one area of drug policy opened up should the paradigm of prohibition be challenged (see Theme 3, Chapter Seven). Drug policy appears to be a 'threshold' policy issue where Governments hesitate. As will be discussed below in the case of Canada, significant ideological change is required to overcome this constraining factor or change will be very difficult to achieve.

Facilitating factors

Several key state-centred factors for facilitating policy diffusion are identified here. The first is ideational and discusses the role of ideological change in Canada; the second is institutional, looking at both systems change as a result of elections and the role of the courts; and the third is agency related, focusing on the role of political leadership.

Drug consumption rooms in Canada began to be scaled up in the context of the overdose crisis as a result of the increase in fentanyl consumption, but prior to the extent of the crisis becoming apparent in late 2016, there had already been a shift in support at the federal level of government. The Trudeau Government won office in October 2015 and strongly signalled it would support the establishment of further DCRs. This encouraged organisations to submit or accelerate plans for applications for exemptions to run drug consumption rooms (Hayle, 2017). The Dr Peter Centre became the second site to gain official status in 2016, bringing the number of sites to two. By November 2017, 23 additional drug consumption rooms had been approved (Health Canada, 2017). What is significant is that the Harper Government's *Respect for Communities Act 2015* remained in place until May 2017. This meant applications for exemptions to be considered by Health Canada had to fulfil the arduous requirements of the standing Act. The legislation was identified by a number of study participants as a major barrier to the scaling up of supervised injecting, yet under the new Government,

organisations were able to successfully meet the requirements of the old legislation and were granted exemptions to operate. This demonstrates that the ideological stance of the new Government facilitated change without actually removing what has been identified as a structural impediment. This is consistent with Evans' (2004) argument that change can emanate from system change, which in this case introduced new ideological approaches as a result of electoral changes.

This ideological change was facilitated in Canada due to systems change brought about by the electoral victory of Trudeau. The findings of this thesis are somewhat ambivalent around the impact of electoral concerns in relation to replication. While Trudeau's win facilitated change occurring in Canada, as discussed above, the Bracks Government's plan for five centres in Melbourne was contested as an electoral issue, yet the legislation was defeated in the Upper House of Parliament, a result which undermined the ability of the electoral outcome to facilitate policy change. The discussion on the theme of politics in Chapter Seven demonstrated concerns with the political capital of Governments at particular points in the electoral cycle, as well as the vulnerability felt by politicians in relation to issues they felt divided their electorate. In all case study sites, a consciousness of the impact of addressing controversial issues on electoral prospects was raised. This is consistent with MacGregor's (2013) finding, in her study of British politicians' views of drug issues, that messages sent about drugs can be linked to short term political gain, as well as signalling overall positions in regards to sets of interests or values.

A key difference between the two countries has been the role played by the courts. In Australia, parliaments have proved to be the key fora for deliberation over the question of supervised injecting. In Canada, however, the finding of the Supreme Court that the denial of access to health services violated Charter rights emerged as a facilitating factor that provided a legal argument for the scaling up of services (Voell, 2012). According to Hyshka et

al., "Officials in several other cities have initiated or accelerated preparations for new facilities due to speculation that the ruling provides sufficient legal basis to expand supervised injection in Canada" (Hyshka et al., 2013 p.468). Whether this ruling did amount to an endorsement is contested on the grounds that the Supreme Court's decision related so specifically to Insite and its effectiveness (Boyd, 2103). The Harper Government, however, felt sufficiently compelled to react to the Court's ruling with the introduction of legislation designed to discourage service providers from seeking exemptions. That legislation proved to be short-lived and as discussed above, was not actually an impediment in a more politically supportive environment when the Trudeau Government came to power. No case was brought to test the constitutionality of the *Respect for Communities Act 2015*. The facilitating influence of the courts is perhaps best viewed in terms of the opportunities the long-running and high-profile court cases afforded to draw the general public's attention to the aims and outcomes of Insite, thus potentially cultivating more general support, or at least tolerance, for the concept of supervised injecting.

The final state-centred facilitating factor to be explored is political leadership. Through the case studies and the thematic analysis, acts of political leadership are identified as having been decisive in breaking impasses to allow policy change to occur. These acts of political leadership have often been captured as a 'change of heart'. Example include the emergence of Premier Bob Carr's support for supervised injecting at the end of the NSW Drug Summit, and the Mayor of Vancouver Philip Owen's conversion from opponent to supporter of supervised injecting facilities (Humphries and Totaro, 1999; Campbell et al., 2009). These acts of political leadership in coming out in support of controversial policy change can be demonstrated to have impact in initial policy change but cannot be shown to have resulted in replication or a scaling up of policy. For example, despite Bob Carr's engagement with the issue of supervised injecting having been decisive in bringing MSIC into existence, the legislative instrument that supported MSIC only made provision for one facility. In Victoria in

2017, Premier Andrews spoke publicly in support of supervised injecting and personally delivered the message as to the change in Government policy. Yet again, the legislation in allowing only one centre set strict limits, signalling the Government's support was narrow and specific, not in-principle support of the broader concept (Wahlquist, 2017).

In terms of policy transfer, it is useful to consider Hay's (2002) discussion of the intersubjectivity of structure and agency when attempting to assess the impact that these political leaders have had as agents through their conduct on the structures or context in which they operate. There appears to be a tendency to act conservatively and limit change. This supports an interpretation that acts of political leadership have been about 'strategic selection', with the contexts (structures) in which the leaders were situated generally favouring certain, more conservative, strategies over others (Hay, 2002). In explaining why scaling up did occur in Canada, we need to look to the role of crisis in breaking these more general patterns of preserving institutional stability. As Hay says, "Agents acting in a routine manner will tend to reproduce existing structures and patterns of social and political relations over time, while actors rejecting norms and conventions will tend to transform existing institutions and practices" (Hay, 2002 p.166). He argues that perceived crisis provides greater opportunities for institutional and ideational change than at other times. The critical role of crisis is further considered in the section below in relation to opportunities for policy-oriented learning.

8.2.3 Policy oriented learning

The third aspect of the policy transfer framework to be considered is the impact of policy-oriented learning on the question of replication of drug consumption rooms. Evans identifies four different forms of policy-oriented learning that are associated with the transfer of policy: copying, emulation, hybridization and inspiration (Evans, 2004 pp.37-38). This thesis' focus on the question of the replication of policy shifts the focus from the initial transfer of policy

to what facilitated or constrained the diffusion of the idea of supervised injecting. This allows an assessment to be made of significant policy learning issues beyond the other political and structural constraints and facilitating factors that have been identified above. The findings of the study identify a number of micro-level factors that have acted as barriers to the diffusion of the idea and the realisation of drug consumption rooms. They are i) cognitive obstacles, including the policy conflict between harm reduction approaches and prohibition; ii) ineffective mobilisation of elites; iii) the persuasiveness of evidence, and iv) stigma and discrimination. These are discussed before consideration is given to the facilitating factors that have appeared to support the process of replication in Canada: i) crisis framing and problem recognition; and ii) the use of the evidence base.

Constraining factors

Four key constraining factors affecting policy-oriented learning have been identified by the thesis. These are discussed separately below, but it should be noted that these constraints on the diffusion of policy are interlinked and reinforcing. The combination of factors strengthens resistance to the 'new idea' of drug consumption rooms, even in the face of evidence of the effectiveness of the interventions. These constraining factors include ideational and cognitive obstacles that affect the ability to mobilise the support of policy elites and affect the frames through which evidence is viewed. Ongoing stigma and discrimination towards drug use and drug users serve to reinforce an environment where the provision of services to drug users is viewed as enabling undesirable behaviour, rather than the dominant frame being one of providing care and compassion.

The third theme presented in Chapter Seven is policy conflict in relation to public health and law enforcement approaches to drugs. As was explored, the existing criminal laws present an obstacle to the operational requirement of a drug consumption room to offer clients a safe and legal place to consume illicit drugs. Political support for sanctioned drug

consumption therefore requires Governments to hold effectively contradictory positions on illicit drugs, making them vulnerable to political attack. In Australia, the restrictive legislation that was passed in both case study locations reflects the acknowledgement that supervised injecting was an extreme measure that would be tolerated but not normalised. This reflects there was no underlying change to the values being reflected in the general political stance on drug issues, and in fact, as was argued in the previous chapter, support for public health approaches to drug issues was vulnerable in times when Governments were seen to be focused on being 'tough on crime'. The 'success' of MSIC in Sydney could have resulted in policy learning that supported that knowledge being diffused to other places in New South Wales and nationally, but cognitive obstacles remained.

Ineffective mobilisation of elites is one of the potential obstacles to policy transfer identified by Evans (2004). Linking to the discussion on political leadership above, the findings of the study show that many politicians were reluctant to put their full support behind drug consumption rooms given the 'difficulties' associated with perceptions of drug use and its associated criminality. This quotation from an Advocate in Melbourne who campaigned for years for an injecting centre in North Richmond demonstrates the obstacles campaigners confronted in attempting to sway government in the face of competing demands:

> "We started to get feedback from Government to say…more people within Government are starting to recognise the issue or the need for an injecting room but the party room is at that point where they just don't believe there's enough community support or there's too many factors which could impact negatively on the Government. And that became quite apparent when we started to ask, well, what is it about the campaign or what aspect of what we are saying is not resonating with the Government and…the feedback that we got was that the Government wants to run an agenda around law and order. They believe that that's where the Opposition feels that the Government is weak." (Advocate 6, Melbourne)

In effect, supervised injecting was seen as a 'hard sell' and given the technical feasibility of DCRs (as proven in Vancouver and Sydney) this reluctance to support expansion or adopt the idea across sub-national jurisdictions does appear to be have been affected by an inability to

mobilise sufficient elite support. For more on this issue, see the discussion on policy transfer networks in section 8.2.4 below.

The findings in relation to the role of evidence are presented under Theme 6 in Chapter Seven and as argued there, study participants were divided as to whether evidence had a significant impact on the prospects for drug consumption rooms to be scaled up or the policy to become more diffused. The case studies in Chapters Five and Six also revealed instances of public figures being dismissive or disputing the findings of formal evaluations, perhaps the most notorious incident being Canadian Federal Minister Tony Clement calling into question Insite's effectiveness on the basis of contrary 'research' that proved to be non-peer reviewed research commissioned by the Royal Canadian Mounted Policy (Paulsen, 2008). The thesis has found that in all case study sites, evidence has been used selectively in the course of parliamentary, council and community debates on the issue of supervised injecting. The evidence of the effectiveness of the centres as presented in the scientific literature and evaluation materials has not proven to be persuasive in a way that has removed the level of controversy or concerns about the acceptability of the services. The role played by evidence in relation to policy learning appears to be consistent with Sabatier's notion that learning is a political process and the battle of ideas will be fought in accordance with core underlying beliefs. Sabatier maintains those core beliefs or values are difficult to change and therefore information that contradicts them will be resisted until a sufficient challenge arises that forced a revision of the belief system (Sabatier, 1988).

The fourth and final micro-level factor to be found to constrain policy learning is the ongoing existence of stigma and discrimination towards drug use and drug users. Stigma and discrimination were identified as a factor driving continued opposition to supervised injecting by participants in all four sites, as discussed under Theme 5, Controversy and debate, in Chapter Seven. Opposition to drug consumption rooms based on a view of drug users as

being undeserving of help, or that DCRs 'enabled' undesirable and criminal acts, affected the opportunities for policy learning and potential scaling up. For policy makers, this reinforced a sense of risk in relation to supporting something that could be held to be at odds with what the community wanted. The ongoing stigmatisation of drug use, reinforced by the criminality associated with it, has the effect of blocking the normalisation of the provision of such services to drug users. While they remain controversial and contested, political risk remains attached to them and the debate is removed from questions of their technical implementation. Policy learning in a controversial area is aided by a shift in underlying values or beliefs; ongoing stigma and discrimination mitigate against that change. This is supported in the literature by the work of Schneider and Ingram who argue that "Knowledge…is used when risks to policy makers are low and when knowledge reinforces either benefits to those socially constructed as "advantaged" or burdens those socially constructed as "deviant"" (Frantz and Sato, 2005 p.187). These ideas were also explored in the literature review in Chapter Two through the focus on 'deservedness' in the works of MacGregor (2013) and Stevens (2011). Hudebine's (2005) study of UK drug policy also captures these notions and he concludes that a duality emerges as the focus on social inclusion of a marginalised population sits at odds with the deviantisation that is achieved through repressive policies of prohibition.

Facilitating factors

The thesis identifies two key ideational factors that operated at the micro-level to facilitate the diffusion of policy: crisis framing and problem recognition; and the use of the evidence base. These are discussed below in relation to the scaling up of drug consumption rooms in Canada in 2017.

There has been a strong association with a notion of 'crisis' and problem recognition in all four case study sites, as discussed under Theme 1 in Chapter Seven. The findings captured in

Table 7.1 show that crisis framing is required for political support for DCRs to emerge, and that a challenge exists to match the 'problem' of street-based drug use to the 'solution' of supervised injecting. As the thesis demonstrates, Australia has not experienced a scaling up of supervised injecting and 17 years lapsed between the establishment of Sydney's MSIC in 2001 and Australia's second site in Melbourne. However, in 2017, the landscape changed considerably in Canada with the number of approved sites reaching 23, in addition to the emergence of multiple 'overdose prevention sites' operating outside the law (Health Canada, 2018). Here I will argue that it was the particulars of the crisis framing concerning the opioid overdose situation that increased the receptivity of policy actors to recognise the policy problem and take action. While this is discussed as a key ideational factor that facilitated policy-oriented learning, I also argue that without civil disobedience, that crisis framing would not have been sufficient to achieve the scale of change. The role of civil disobedience is further discussed in Section 8.3.1 below.

As was presented under Theme 1 of Chapter Seven, arguments to promote DCRs as a solution to street-based drug scenes have been concerned with issues of the visibility of the problem and associated amenity issues. There has also been a strong geographic factor linked to the nature of street drug markets and the fact that people will tend to use drugs in close proximity to the place of purchase (Reddon et al., 2013). As a high-profile facility, Insite in Vancouver was seen to be a solution to the specific and highly visible problems of street-based drug use in the Downtown Eastside. In one sense, this represented a barrier to the transfer of the policy, as confirmed by participants in Toronto. They identified resistance to the adoption of the idea of supervised injecting as the case had been made that their local dispersed drug scene did not appear to match the concentrated conditions of the DTES, generating arguments against adopting the model of Insite (Researcher 4, Toronto; Practitioner 3, Toronto; Policy Maker 4, Toronto).

The current opioid crisis in Canada, associated with the arrival of fentanyl into the illicit drug market, has some significantly different characteristics from the earlier public health crisis that was declared in response to overdose deaths and HIV prevalence rates in the Downtown Eastside of Vancouver. First, the impact has been national in scale, in comparison to the bounded problem associated with the DTES or other specific but limited locations in Canadian cities with street-based drug scenes. Secondly, fentanyl has widely contaminated the drug market and the risks associated with it are not contained within a specific category of drug, such as heroin, or a specific method of consumption, such as injecting. Thirdly, this widespread contamination of the market has resulted in new populations of people, outside of more traditional street-based drug market locations, being affected by overdose. Opioid overdose deaths have become a suburban phenomenon rather than an issue associated with street scenes, drawing new populations into the crisis (Belzak and Halverson, 2018). The effect has spread to all drug-using populations, challenging stigmatised notions that there is such a thing as a 'typical' drug user. This demonstrably different crisis presents an opportunity for the framing to shift the more familiar boundaries of 'us' and 'them', challenging the constraint of stigma noted above. It is perhaps more akin to the generalised threat of HIV that presented opportunities for more radical options to be tabled in the 1990s. In terms of policy-based learning, this crisis framing has reduced some of the constraining barriers and allowed for more widespread recognition of the problem being faced, and therefore acceptability of the 'solution' being matched to it.

As discussed above, the issue of the role of evidence remains ambiguous; this was included as a factor constraining policy-oriented learning. However, the case can also be made that evidence played a positive role in facilitating policy-oriented learning. As presented under Theme 6 in Chapter Seven, a number of Canadian participants argued strongly that the rigorous building of the evidence base of the effectiveness of Insite was critical for the prospect of building future services. In particular, the court cases concerning Insite, as

discussed in the Vancouver case study in Chapter Six, deliberated specifically on the *effects* of the intervention. The research evidence that was presented in the courts was crucial to the rulings that found in favour of right for people to receive this health care (or more specifically, that it would be a violation of Charter rights to be denied the service) on the grounds that the services provided at the centre were proved to reduce risk for injecting drug users (Small, 2012). The court cases were widely reported in the media and this contributed to a raised level of public awareness of the issue of supervised injecting and the strong arguments that could be made in support of the provision of such a service, thereby reducing cognitive obstacles to policy learning.

8.2.4 Policy transfer networks

The fourth component of the policy transfer framework is policy transfer networks. Evans defines policy transfer networks as "collaborative decision structures comprised of state and non-state actors that are set up with the deliberate intention of engineering policy change" (Evans, 2004 p.36). He argues that their significance lies in their ability to shape the policy outcomes that result from the transfer process. Under the policy transfer framework, emphasis is placed on the intentionality of the process of transfer – distinguishing it from policy convergence that may occur in an unintended way. The focus on the intentionality suggests agents play a key role in the process (Evans and Davies, 1999). Analysis of the networks is process-centred, but there are equally important ideational aspects with the focus on epistemic communities and the movement of ideas.

The sharing of knowledge about drug consumption rooms along a number of policy transfer pathways (for example, international to national, national to national, and local to local) has been documented in the drug policy literature (McCann and Temenos, 2015; Mendes, 2002; Dolan et al., 2000). In particular, there is evidence of visitors from European centres sharing their knowledge in both Canada and Australia prior to the opening of the first centres, and

of politicians embarking on study tours to view the operation of facilities in order to bring

first-hand experience to the policy debates (Campbell et al., 2009; Mendes, 2002; Interview,

Researcher 8, Melbourne; Interview, Policy Maker 2, Toronto). For example, Premier Steve

Bracks argued in the Victorian Parliament:

> "Overseas evidence is overwhelming. Anyone who has had the opportunity to travel
> and see some the facilities and talk to municipal officials, police and other
> organisations would bear that out…There has been a shift of drug use off the streets
> and away from public places, and the extent of public nuisance has been reduced. I
> saw some of the facilities in Switzerland, and to date no deaths have occurred in
> injecting facilities there." (Quoted in Mendes, 2002 p.143)

The findings of the case studies support the existence of policy transfer networks in all four

case study sites. Table 8.2 gives examples of events, processes or fora in which these

networks have operated and in which agents collaborated to pursue policy transfer in

support of drug consumption rooms. While this demonstrates collaborative activity in pursuit

of a policy agenda, the pertinent question in relation to this thesis' concern with replication

is what specific factors contributed to constrain or facilitate the diffusion of policy in this

area. Can the stalling of policy diffusion in Australia, and earlier in Canada, be attributed to

the failure of policy transfer networks? Conversely, how central were policy transfer

networks to the success of the more recent replication of policy in Canada? These issues are

considered in the sections below.

Table 8.2 Examples of policy knowledge sharing and work of epistemic communities in case study sites

Location	Event, process or forum	Agents of policy transfer
Sydney, Australia	Expert presentations to the Drug Summit, Nov 1999 Public forum for the 15th anniversary of the establishment of the 'Tolerance Room' organised by Unharm 2014 Stakeholder consultation, Statutory Review of Part 2A of the *Drug Misuse and Trafficking Act 1985*, 2016	Parliamentarians Bureaucrats Advocates Activists Researchers Public health practitioners Lawyers and court officials Coroners
Melbourne, Australia	Drug Policy Expert Committee, called to advise the Victorian State Government, 1999 Community Forums, organised by the DPEC, addressed by experts, various locations, 1999 Keynote address by Vancouver Mayor Larry Campbell to the International Conference on the Reduction of Drug Related Harm, Melbourne, April 2004 Coroner Hawkins calls expert witnesses on supervised injecting to her inquest into a heroin related death, 2017	
Vancouver, Canada	International Forum on Drug Treatment and Crime Prevention, gathering of international experts, June 1998 International Harm Reduction Association's conference hosted in Vancouver, 2006 International Society for the Study of Drug Policy's annual conference hosted in Vancouver, May 2018	
Toronto, Canada	Toronto Residents' Reference Panel on Supervised Injection Services, Final Report, July 2014 10th Anniversary celebration of the City of Toronto Drug Strategy including a community forum addressed by drug policy experts (including former Vancouver Mayor Larry Campbell), November 2015 Fourth International Law Enforcement and Public Health conference hosted in Toronto, September 2018	

Constraining factors

The most significant constraining factor on the actions of agents with the potential to influence policy outcomes appears to be ineffective or, at least, insufficient mobilisation of elites. There is extensive evidence of the existence of knowledge about drug consumption rooms in all four case study sites as documented in the case study chapters. With each attempt to introduce supervised injecting, there was intensive debate in the media, scrutiny by committees (whether the Boards of Health in Canada, or specifically convened parliamentary committees or expert panels in Australia), and feasibility studies such as the TOSCA report in Toronto or the Burnet Institute's study of street-based injecting in North Richmond (Bayoumi et al., 2012; Dwyer et al., 2013). In addition, the formal evaluations of Insite and MSIC provided credible evidence as to the objectives and effectiveness of DCRs (Wood et al., 2006; KPMG, 2010).

As was argued above in Section 8.2.3 on policy-oriented learning, this evidence did not prove to be persuasive enough to mobilise sufficient elite support beyond limited approval of single sites, until the recent changes experienced in Canada. Elites instead often made their decisions based on value judgements and in doing so, exercised considerable influence as to the 'unacceptability' of supervised injecting. This is illustrated by a speech in the NSW Parliament by MP Katrina Hodgkinson in 2010 on why she opposed legislation in support of the Medically Supervised Injecting Centre in Sydney. Ms Hodgkinson outlined her visit to MSIC and was fulsome in her praise for the staff and the service they provide to a client group with very specific needs, but then provided the following defence for her decision to oppose the legislation:

> "My primary focus must be on the message that I send to my electorate…I have outlined the many good things that are being done by the centre, but at the end of the day the message I must send back to my electorate is that it is never okay to start taking drugs. Drugs are bad. Drugs will do bad things to your body and to your mental health. It should never be okay to send children a positive message about drugs. It is

just not okay. Therefore, I will oppose the legislation." (Parliament of NSW, Legislative Assembly Hansard, 2010, p.26391)

Another example of the constraining role played by elites is the outcome of the parliamentary committee processes. Such committees play an important role in scrutinising potential legislation prior to it being debated in the Parliament, and their recommendations can determine whether draft legislation proceeds to debate or is withdrawn. An example of a lack of support from policy elites is illustrated by the outcomes of the Victorian Parliament's Legal and Social Committee's consideration of a draft bill to introduce a pilot drug consumption room in Melbourne in 2017 (see Chapter Five for further discussion). Despite 46 of the 49 public submissions to the inquiry arguing in favour of supporting an injecting centre in North Richmond, the Committee did not support the legislation proceeding to debate in the Parliament (Parliament of Victoria, 2017). This example relates only to a potential first centre in the State of Victoria, but demonstrates the road blocks confronting any scaling up of services. Nearly twenty years earlier, a Joint Select Committee of the New South Wales Parliament sat to consider the same issue. The Committee produced a 300-page report considering the state of injecting drug use in NSW; overseas research and experience; and health, social, economic and legal arguments for and against supervised injecting. Ultimately a majority of Committee members did not recommend proceeding to a trial, despite the Chair noting in her Foreword that support for the trial had come from "public health officials, the NSW Law Society, the Australian Medical Association, the Bar Association, and parents who have suffered the death of a child" (Parliament of NSW, 1998, p.xiv).

The introduction to this section posed the question as to whether the stalling of policy diffusion in Australia and earlier in Canada could be attributed to a failure of the policy transfer networks. The empirical findings of this study demonstrate the existence of concerted campaigns to bring about policy change in the case study sites, and equally demonstrate instances of the blockages presented by key political agents. In this simple

sense, those policy networks, or "advocacy coalitions" if conceptualised in Sabatier and

Jenkin-Smith's (1993) terms, have failed to dominate the battle of ideas or prove sufficiently

persuasive. However, this failure needs to be analysed in conjunction with the other findings,

identifying the limitations imposed by structural and institutional factors, that are discussed

in the earlier section of this chapter. In this way, we can better understand how the context

in which agents work has limited the opportunities for networks to succeed.

Facilitating factors

The facilitating role played by policy transfer networks was most evident in an epistemic

community that continued to keep the idea of drug consumption rooms in circulation in

Canada, where replication was eventually achieved. For example, a Policy Maker in Toronto

highlighted the role played by proponents of harm reduction and acknowledged the

influence of policy developments in Vancouver on the policy community in Toronto:

> "But also we have a very active and strong harm reduction community, and they're
> strong advocates. They've been talking about these issues for a long time, and they
> come to the Board of Health and they depute; and they come to city committees and
> they speak out, and they wanted to see more. I think certainly when Vancouver came
> forward with their drug strategy, and we started to talk at a different level about a new
> approach to the issue, it provided a good opportunity." (Policy Maker 3, Toronto)

Through research publications, conferences and the provision of expert advice, an active

research community kept the idea of supervised injecting 'alive' even during the difficult

political period of the Harper Government. As has been discussed, however, the evidence

produced by this epistemic community continued to be disputed and used selectively, so the

impact of the epistemic community on the more widespread implementation of supervised

injecting that occurred in Canada can only be assessed as having a medium impact on

facilitating replication.

As the case study on Toronto concludes, the process in that city was bureaucratically driven

through the work of the drug strategy task force and the actions of the Medical Officer of

Health, Dr David McKeown and his staff, in continuing to table the proposal for drug consumption rooms via the Board of Health. Through documentation such as submissions, reports and meeting minutes of the Toronto Drug Strategy Implementation Panel, the City of Toronto Council and the Board of Health, the work of a policy transfer network is the most transparent to trace of all the four case studies. The findings of that case study, however, are that progress was extremely protracted, with over twelve years lapsing between the initial tabling of the idea in the city's drug strategy and approval for services being granted in 2017. Again, this supports the finding that networks could facilitate ideas remaining in circulation as potential policy options, but those networks had to contend with the significant constraints that operated at different levels of governance.

Kingdon's (2010) multiple streams approach to policy change provides insights to the limitations of the impact of policy transfer networks. Toronto's experience appears to fit the argument that there was readiness in the policy stream but without sufficient momentum in the problem stream and the politics stream, the work of the policy transfer network was insufficient. For the problem stream, there was the question of whether supervised injection was an appropriate response or model for Toronto's dispersed drug scene and the relatively limited use of injectable drugs (Toronto Drug Strategy Advisory Committee, 2005; Porter, 2005). For the politics stream, the findings of the case study point to constraints emanating at the national level due to the Harper Government's stance (up until 2015), and at the provincial level, where the Government did not lend its support to the TOSCA Report recommendations for three sites to open in Toronto (Dale, 2013).

An additional facilitating factor in Toronto was the community engagement work undertaken by the policy transfer network. There is evidence of a sustained effort to work with communities at all stages of the development of the policy proposals, including through the research design of the TOSCA study, which included extensive surveying and community

forums. When the recommendations of the study were brought forward, they were couched in terms of their community acceptability, focusing on the feasibility objective of the study, rather than just the 'needs' component. Interview participants attributed the lack of apparent controversy within communities to this degree of engagement and consultation. For example, a Policy Maker from Toronto described the range of people and groups that came forward to publicly support the proposals being considered by the Board of Health:

> "At the time the Medical Officer of Health, when we came forward to the Board that was in July 2013, and as I say we had a sea of people. All different kinds of people, parents, faith leaders, community, lots of harm reduction folks, people who use drugs but scientists and treatment providers with a wealth of expertise and knowledge, from CAMH et cetera. They all deputed for it. The media was 95% I would say supportive. So there wasn't a huge backlash." (Policy Maker 3, Toronto)

In summary, policy transfer networks were able to act to facilitate policy replication, but they are assessed as only having a medium impact. They served to promote the idea of supervised injecting but relied ultimately on an engaged and mobilised policy elite and, specifically, the support of politicians, due to the legislative requirements needed to facilitate policy change.

8.3 Alternative sources of policy change: the role of civil disobedience

> "So it's confronting to think…you can have all the evidence in the world if you like but it doesn't always have the intended impact at the level of government decisions in this area.
>
> And so what does that mean? What do you do then as a policy response or as an academic who's paid to develop good knowledge and intervene in public debates about important public policy issues? Does it mean that you just continue to develop the evidence and bang your head against that wall or does it mean that you start thinking about alternative options for influencing public opinion, for changing government policy processes?
>
> Do those options include civil disobedience?" (Researcher 8, Melbourne)

The analysis above demonstrates the wide applicability and usefulness of the policy transfer framework for interrogating the factors which have been significant in constraining or facilitating policy change. Further implications of this will be discussed below, but one further piece of analysis was required to ensure a rigorous approach was taken to applying the policy transfer framework. Following the exercise of mapping the case study and thematic analysis

findings to the framework, care was taken to identify any theme or issue of significance that did not sit within the framework's components. One key factor emerged from this assessment: the role of civil disobedience, and by broader implication, the role of community participation. The actions of those who defy the law are clearly acts of 'agency' which challenge legal and political structures. Within the framework, agents of policy transfer are identified as being part of policy transfer networks. Civil disobedience, with its disruptive tendency, does not sit consistently within this conceptualisation of the original framework, with its emphasis on collaborative decision structures "set up with the specific intention of engineering policy change" (Evans and Davies, 1999 p.376). As a result, modification of the policy transfer framework may be required to address this limitation.

Acts of civil disobedience have been of a different scale and had a different impact in Canada than in Australia. Chapters Five and Six include discussions of civil disobedience in each case study site and the following summary recapitulates the findings. In Australia, there has been limited civil disobedience in relation to the provision of supervised injecting. In Melbourne, local groups set up a temporary public site in Collingwood in May 1999 (Mendes, 2002). The impact of this appears to be negligible as supervised injecting had the backing of a major political party, the Australian Labor Party, which campaigned on the issue during the Victorian state election that same year. In Sydney, an unsanctioned site was set up in the Wayside Chapel, also in 1999, as a deliberate act to draw attention to the issue in the lead up to the NSW Drug Summit (Wodak et al., 2003). This action was of higher profile, involving prominent people and engaging purposely with the media. While it can be concluded that it was an important action and served an agenda setting function, there have been no subsequent acts. Civil disobedience, therefore, has not played a key role in relation to policy replication or stall in Australia. The story in Canada, however, is significantly different.

Multiple cases of civil disobedience can be identified in Canada: the unsanctioned supervised injecting sites established by activists in Vancouver prior to the establishment of Insite; the Dr Peter Centre's long running unsanctioned site; and, the overdose prevention sites initiated in Vancouver in 2016, but expanded nationally in response to the opioid overdose crisis. The contribution of activists in Vancouver to the establishment and survival of Insite is explored above in Section 6.2.2, where unsanctioned sites are discussed. Activism, including civil disobedience, is acknowledged as an essential part of the Vancouver story (Osborn and Small, 2006; Small et al., 2006; Harati, 2015). The role played by activists was highly political and included participation in the formal structures of the body politic, such as holding membership positions on the Vancouver Board of Health (Campbell et al., 2009). The stalling of the scaling up of supervised injection during the 2000s, however, indicates that civil disobedience did not act as a facilitating factor to the further expansion of sites.

This can also be said of the act of civil disobedience quietly undertaken for fourteen years by the Dr Peter Centre in Vancouver (discussed in Section 6.2.2). From 2002, the Dr Peter Centre, a private HIV/AIDS care facility, offered a dedicated space where their clients could inject under the supervision of a nurse. The Centre disputed that their service was an act of civil disobedience. They justified their actions as being within the scope of registered nursing practice, and argued that to not provide service might therefore place their nursing staff in breach of professional standards contained in British Columbia's *Nurses (Registered) Act RSBC 1996* (Davis, 2007). They operated with the knowledge of, but without interference from, health or law enforcement authorities. In 2016, they submitted a successful application for exemption from the *Controlled Drugs and Substances Act 1996*, becoming the second official DCR in Canada. The Dr Peter Centre's claims to lawfulness were untested, therefore it cannot be said whether their model could have provided an alternative pathway to the scaling up of services by circumventing the arduous requirements of seeking Ministerial exemption. One article exploring the prospects for the scaling up of supervised injection in

Canada suggested organisations could consider working with their provincial nurses' association "to define supervised injection within legally binding definition of scope of practice" (Hyshka et al., 2013 p.471), but no evidence was uncovered in the course of this research that this had occurred. It can be concluded, therefore, that this second form of civil disobedience had only a minimal impact on the replication of services in Canada.

In 2016, a new wave of community activism did change the political landscape for the scaling up and replication of drug consumption rooms. The establishment of the unsanctioned overdose prevention sites – first in Vancouver in September 2016, but then in other locations across Canada, including Toronto – represented a significant turning point in the policy transfer process, and one that is not adequately captured by the policy transfer framework. Details of the actions of the Overdose Prevention Society are provided in Section 6.2.3, including the support the Society received from both local and provincial governments, despite operating in direct defiance of the requirements of the *Controlled Drugs and Substances Act 1996*. My analysis is that the establishment of overdose prevention sites proved to be a tipping point for the issue of supervised injection in Canada, triggering a paradigm shift in the approach towards drugs in Canadian politics.

As this was not the first time that activists had engaged in civil disobedience, what factors were different in 2016-2017 that enabled acts of civil disobedience to contribute to the scaling up of drug consumption rooms? First, the spatiality and scale of the crisis was critical. Arguably, the national public health crisis declared in 1997 opened the way for consideration of supervised injecting; however, there was a sharp focus on the Downtown Eastside of Vancouver as the epicentre of the epidemic. While the Downtown Eastside experienced the initial impact of the opioid crisis in the last few years, the threat posed by fentanyl has not been contained in the DTES but has affected all provinces with rising overdose deaths being

recorded nationally. A recent synthesis of all publicly available opioid-related surveillance or epidemiological reports found that:

> "This is not a problem restricted to persons who use illegal or street drugs; rather, this is national public health crisis that affects people in communities across Canada, across all ages and across all socioeconomic groups." (Belzak and Halverson, 2018 p. 224)

The impact of civil disobedience must be understood in terms of the specific crisis context in which it has occurred, rather than as an isolated factor.

Secondly, while there has been a remarkable degree of tolerance of illegal sites in Canada over many years, as the case studies demonstrate, 2016 marked a turning point when government authorities at the local and provincial level provided direct material support to the unsanctioned overdose prevention sites, providing physical resources such as tents and supplies, and in the case of Vancouver, covering some salary costs (personal correspondence, Sarah Blyth, April 2017). In British Columbia, overdose prevention sites were endorsed through a Minister Order issued by the provincial health minister, Terry Lake. The province argued that overdose prevention sites did not *supervise* drug users, but only *monitored* use, and therefore would not be subject to the strictures placed on supervised injection sites such as Insite (Lupick, 2016b). This support came at a critical time. Although the new Federal Government had signalled its broad support for supervised injecting, the legislative architecture of the Harper Government remained in place, presenting a potential obstacle to the expansion of supervised services until 19 months into the Trudeau Government's period of office (Woo, 2017). Terry Lake attributes his decision directly to the impact of activist Sarah Blyth, who co-founded Vancouver's Overdose Prevention Society:

> "In the face of the crisis, she had such an impact on me that I thought, this is crazy: We've got someone out there by herself, you're saving lives, and it's our job to do that very thing." (St Denis, 2018)

The effect of this endorsement of activism by the provincial government was to break the impasse created by the previous requirement to coordinate support at three levels of

governance, while overturning the major structural obstacle presented by the existing legislation.

Civil disobedience in Canada in 2016-2017 can be seen to have impacted the process of policy replication in four ways, making it a significant factor that must be accounted for in order to further understand policy change. Firstly, it contributed to the framing of the opioid crisis by drawing attention to the extent of the crisis and the desperation of people, particularly through the media profile of key activists such as Sarah Blyth. In this way, it served an agenda setting role. Secondly, it challenged politicians to justify the existing laws when the state did not appear to be inclined to enforce them. Ultimately it broke the impasse created by the 'buck passing' observed between different levels of government. Thirdly, it served as a catalyst, speeding up the 'slow wheels' of government by demanding change and, in effect, shaming governments into providing services. Finally, the overdose prevention sites demonstrated the ease with which services could be delivered, demystifying the process of providing assistance for drug users made vulnerable by the increasingly unreliable drug supply. Through these impacts, civil disobedience served as a challenge to the state to reform its legal apparatus, a move aided by the increasing receptivity of policy elites to the 'solution' of supervised drug consumption in the face of a worsening public health crisis.

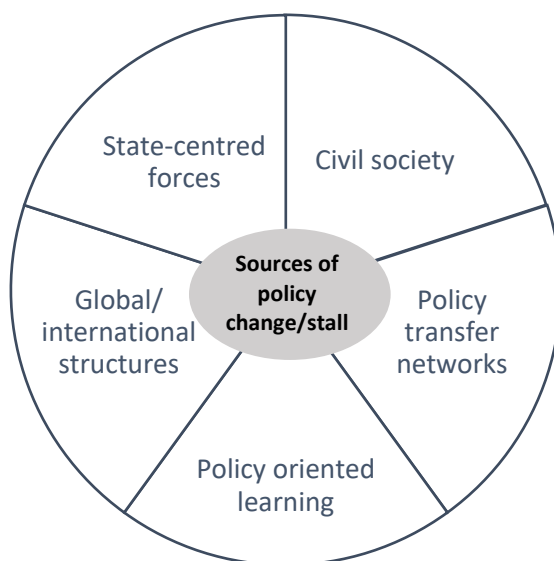## 8.4 Appraising the policy transfer framework

It is a finding of this thesis that the policy transfer framework has proved to be a robust tool for interrogating the factors which both constrain and facilitate policy transfer. Its particular strength lies in its capacity to capture the complexities of the policy process, through its focus on multiple levels of governance and the roles of both structural and agency factors. By mapping the empirical findings of the case studies and the thematic analysis of the semi-structured interviews to the framework, it was possible to identify the key facilitating and constraining factors that influenced opportunities for the replication of drug consumption

rooms in the cases under examination. State-centred factors were shown to have been particularly significant, confirming the need to examine structural and institutional factors in the process of policy change. The framework's focus on policy-oriented learning is useful for examining the influence of ideational factors. What this analysis demonstrated is the interconnectedness of many factors; for example, the role of ideology in setting boundaries for policy ideas. It is evident from the findings that policy ideas have to travel institutional pathways and that there is a tendency towards conservatism. Where replication did not occur, this reflects limited change to the underlying values that dominated political decision making on the broad question of how to approach drugs, with prohibition remaining the dominant ideology. A factor that mitigates against this tendency towards conservatism is crisis or, more specifically, the framing of crisis. This study confirms Hay's (2002) argument that crisis can serve to reveal the gap between the cognitive templates under which policy makers operate and the experience of the material world. When significant gaps emerge, 'new' ideas – or as in this case, existing ideas that had not gained full acceptance (as demonstrated by the legislative constraints imposed on their execution) – are more fully embraced, allowing for diffusion.

It is also, however, a finding of this thesis that there is a significant factor facilitating change that is not satisfactorily captured by the policy transfer framework. Civil disobedience has been identified as having been critical to the process of change in Canada, serving an agenda setting function in the context of crisis, as well as acting as a catalyst to the often slow processes of government. In addition, the acts of civil disobedience in setting up unsanctioned overdose prevention sites contributed to policy-oriented learning by demonstrating from pitched tents the simplicity with which services could be offered, serving to demystify the processes by which vulnerable drug users could be supported.

It is my contention that the policy transfer framework, as conceived by Evans and Davies (1999) and Evans (2004), does not adequately capture the role played by broader community participation in the process of policy transfer. The framework is weighted towards capturing top-down policy change. Its conception of policy transfer networks, acting with deliberation to engineer policy change, does not capture the more maverick actions of agents working to provide direct services – regardless of the policy environment. However, the impact of these agents on the more formal processes by which policy is developed and delivered through institutions has been found to be significant in the cases where there was successful policy diffusion (Vancouver and Toronto). I therefore propose that the policy transfer framework could be usefully augmented by the addition of a fifth component that identifies the role of civil society as a source of policy change or stall. This proposed new framework is presented in Figure 8.1. By focusing on both facilitating and constraining factors, the addition of the actions and participation of civil society lends more scope and depth to efforts to understand why some policy ideas are adopted and why some fail to progress. In particular, it would provide a vital lens for better coming to grips with the role played by opponents and not just by activists or advocates who support and promote policy reform.

Figure 8.1 Modified policy transfer framework: sources of policy change and stall

8.5 Conclusions

Utilising the policy transfer framework, this chapter has presented analysis identifying the factors that constrained or facilitated the diffusion of policy in relation to drug consumption rooms. This framework has proved to be a useful heuristic for interrogating and comparing the factors that affected policy change in the different sites. The analysis has enabled the identification of the factors or circumstances that, working in combination, facilitated policy replication in the case of the Canadian sites, and those factors that constrained policy replication in Australia. The patterns of the two countries' experiences in relation to the slow uptake of drug consumption rooms were very similar until the changes that occurred in Canada from 2015 onwards.

The major factors identified as working together to bring about significant change are a combination of state-centred factors and opportunities for policy learning to occur, which increased the receptivity to the idea of supervised injecting among policy elites. Those specific factors were ideological and systems changes brought about by the election of a new

Federal Government in Canada, and the combination of crisis and the community response through civil disobedience with the opening of unlawful overdose prevention sites. For the case study sites in Australia, where there has been no general diffusion of the policy, it has been shown that there has been very limited change at the structural and institutional level. This is reflected in the restrictive nature of the legislation that was introduced in both states. There has been a failure to mobilise policy elites to support the *idea* of supervised injecting, as it remains too firmly in conflict with the dominant ideology of prohibition. More generalised support for supervised injecting would have required a shift in the underlying values, which does not appear to have occurred amongst policy elites. Unlike in Canada, there has also been less persuasive crisis framing, reflecting the dynamics of the street-based drug market which has been evolving over the last decade.

Evans' (2004) policy transfer framework has been found to be very useful for exploring the question of policy replication in relation to drug consumption rooms. In particular, the framework's focus on both structural and agency factors and the dialectic relationship between them has allowed this study to explore the multiple influences on the policy making process and make comparisons across sites. Analysis using this framework has confirmed the sometimes marginal role played by evidence in the policy deliberation process, while allowing for a range of key constraining and facilitating factors to be identified. As the literature review in Chapter Two identified, comparative studies are not common within drug policy scholarship. This thesis demonstrates the usefulness of applying concepts from policy transfer to explore comparative research in this field. A finding of my comparative analysis is that civil disobedience, in the context of crisis, is a major factor that has affected policy outcomes in relation to drug consumption rooms. This outcome has been significant as it has highlighted that the role of civil society and community participation has been underplayed in the current formulation of the policy transfer framework. This has led to the

recommendation of a modification to the framework to reflect the influence of agents acting outside the intentional, albeit ad hoc, policy networks conceived by Evans and Davies (1999).

In the final chapter, I will reflect further on the question of civil society's participation in policy making, and the applicability of policy transfer concepts to the field of drug policy, as I draw together the key contributions of this thesis and their implications for future research.

Chapter nine
Conclusions
● ● ● ● ● ● ● ● ●

9.1 Introduction

This thesis aimed to identify the barriers, challenges and facilitating factors that impact the replication of drug consumption room policy in Australia and Canada. At the commencement of the research in 2015, both countries' experiences of introducing drug consumption rooms were broadly similar: single government-sanctioned sites introduced in the early 2000s had not been replicated. This was despite the services having been formally evaluated as successfully meeting their objectives. The research was concerned with identifying challenges or barriers that had affected the replication of services, and sub-national transfer of policy to other regions where similar problems with street-based drug use might have made drug consumption rooms a potential policy solution. During the course of the study the policy paths of the two countries diverged as Canada embarked on a significant scaling up of services across the country in 2017. These circumstances led to a modification of the initial research question to focus on the stalling and diffusion of drug consumption room policy.

Drug policy is multi-faceted, being concerned with criminal law, law enforcement, health and education. Drug consumption rooms are an intervention that seeks primarily to address the health and well-being of drug users, while reducing risks and exposure to the harms of drug use for the general public where open street-based drug markets exist. As discussed in the Introduction to this thesis, a considerable body of literature has focused on the evidence of the effectiveness of drug consumption rooms. The aim of this thesis has not been to assess the validity of these scientific claims. An underlying assumption of this research is that policy is the result of multiple influences. This position is a rejection of the privileging of evidence as would occur through the adoption of an evidence-based policy paradigm. To further our understanding of the policy making process, we must look beyond the production and weighing of evidence, and seek to understand the different sources of policy change and the relationship between them. From this standpoint, perceptions, regardless of the validity of

the information they are based on, can have a causal effect (Hay, 2002). For this reason, the research has focused on the interaction of these factors rather than the production of further evidence as to the effectiveness of DCRs.

Chapter Two presented a review of the existing literature from a post-evidence-based policy perspective, focusing on ideational and social constructionist approaches to understanding drug policy. This review identified that while drug policy scholars have been drawing on theoretical frameworks from policy studies and political science, the literature on policy transfer had only been utilised in a limited way. This is despite its ability to accommodate comparative research and to interrogate the relationship between multiple levels of government and multiple sources of policy change. Through the adoption of a policy transfer framework (Evans, 2004), this research explains how the interactions of structural and ideational factors can either constrain or facilitate sub-national policy transfer processes, helping to increase our understanding of the challenges of replicating drug consumption room policy in Australia and Canada.

The conclusions of this thesis are presented in four sections. Section 9.2 provides a summary of the main findings of the research. Drawing on the structural, ideational and agency factors that affect policy development, two scenarios are compared: policy stall, and policy diffusion which results in the scaling up of interventions. Section 9.3 considers the empirical and theoretical contributions of the research. The fourth section discusses the limitations of the research. This is followed by Section 9.5 which proposes future research directions.

9.2 Summary of the main findings

Scenario one: policy stall

In both Australia and Canada, it was demonstrated that state-sanctioned supervised injecting facilities were technically and legally feasible. However, policy learning that would have supported the diffusion of the intervention was constrained, particularly by state-centred

structural sources of policy change and ideational factors. Structural factors, such as the division of powers under the federal systems in both states and the criminalisation of drug use, resulted in the engagement in policy development of multiple levels of government. Policy change required a high level of coordination and an alignment of goals which proved a challenge, particularly in Canada, through the initial period. A commitment to policy change was required at levels of government that were geographically removed from the areas experiencing the amenity issues arising from street-based drug use. Local community concerns had to compete with broader political agendas and the concerns of parliamentarians for whom drug policy reform was considered a risk with their electorates. In Australia, legislation was used deliberately to limit the provision of service to single sites, reinforcing the message that supervised injecting would be tolerated under specific conditions but not normalised or diffused. This use of legislation contradicted the emphasis on policy learning that was implied by framing of the interventions as trials and focusing on evaluations to ensure continuation was linked to evidence of effectiveness.

The tendency towards conservatism, in relation to drug policy change that has been reinforced institutionally, has strong ideational elements. The four case studies all record that policy makers and stakeholders were exposed to ideas from overseas, initially through study tours and through inquiries, research reports, parliamentary debates and media reports. Once the initial services were established in Sydney and Vancouver, evidence arises of sharing of knowledge and experience across domestic jurisdictions. However, these ideas proved insufficiently compelling to result in the lasting structural change that would support ongoing policy diffusion. The research identifies two key ideational factors that contribute to this in cases of policy stall. The first is the policy contradiction that arises between the dominant paradigm of prohibition and the sanctioning of supervised injecting. The second is the ongoing existence of stigma and discrimination regarding drug use and drug users. In addition, the research confirms findings of other drug policy scholarship that evidence, while

important, is only one contributing factor in the policy development process (Stevens and Ritter, 2013; Stevens, 2007; Ritter, 2009; Lancaster, 2014; Lancaster and Ritter, 2014; MacGregor, 2013; Monaghan, 2011).

Ultimately, where policy has stalled, it has been the consequence of politics and the actions of politicians. This conclusion is consistent with MacGregor's (2013; 2017) findings of drug policy making in the United Kingdom. The cases in Australia demonstrate that the debate on supervised injecting has been dominated by parliamentary institutions and therefore would have relied on the mobilisation of policy elites to support more deeply embedded change. As such, there is no evidence of a change to the underlying values amongst those policy elites that continue to support a prohibitionist ideology. Supervised injecting has proved a 'threshold' issue politically. Support waivers in the face of the competing, politically expedient agendas that arise periodically, under banners such as 'tough on crime'. This is despite evidence that community support for supervised injecting may be high. Finally, in both countries, there has been a significant temporal element. In Australia, the changes to street drug market scenes in major cities have affected the nature of the issue, reducing the 'match' between the policy problem and the policy solution. In Canada, as discussed below, the changing problem presented by its dynamic drug market has also required new policy solutions. In summary, the cases of policy stall show us that while the idea of supervised injection has continued to circulate, it cannot be said to have attained a level of acceptance which will see the interventions 'normalised' as a public health provision. The scenario below outlines what this research allows us to learn from the alternative scenario of policy diffusion and scaling up.

Scenario two: scaling up

The rapid scaling up of drug consumption rooms in Canada during the course of research for this thesis presented something of a natural experiment, introducing an unexpected

comparison to the previous stable, stalled states of supervised injecting policy in both Canada and Australia. Analysis of this occurrence identified three findings from the research that facilitated change in Canada.

The first is crisis. The opioid overdose crisis ushered in by the arrival of fentanyl in the illicit drug market rapidly changed the scale and scope of the problem, requiring a policy response. Drug consumption rooms represented a (partial) solution with their capacity to reverse opioid overdoses through the administration of naloxone. Political resistance or objection to the idea of supervising drug use became less tenable in the face of increasing death rates and the exposure of the widespread nature of the problem. As fentanyl penetrated a range of drug markets, including the recreational drug market, the problem could no longer be framed as one that only affected marginalised communities such as those in the Downtown Eastside, mobilising broader political support.

The second factor that facilitated change was structural and lay with the institutional change that occurred with the election of the new federal government in Canada in 2015. As explored in Chapter Six, national factors had a significant impact on the capacity of cities to provide supervised drug consumption and affected the capacity for sub-national policy transfer to occur. The systems change brought about by the election of the Trudeau Government worked to bring about a more supportive policy environment. Federal drug policy was re-framed to support harm reduction and the restrictive legislation of the Harper Government was rescinded. However, it was the ideological position of the new Government and the signalling of their intent that allowed drug consumption rooms to begin to scale up. This occurred prior to the formal change of legislation, demonstrating the power of the interaction between ideational and structural forces in achieving policy change.

Finally, the third factor is the role played by civil disobedience. Despite the rigorous process of evaluating the effectiveness of Insite in Canada, evidence did not prove decisive in

persuading policy elites to expand supervised injecting beyond the initial site in Vancouver, limiting policy transfer. The persistence of activists, as evidenced in Vancouver, kept the idea of drug consumption rooms in circulation, demonstrating their potential through the unsanctioned provision of services and by continuing to keep the issue on the political agenda. In terms of replication, the advent of the overdose prevention sites in 2017 proved catalytic, forcing governments at local, provincial and national levels to acknowledge of the scale and severity of the problem. Furthermore, the OPSs demonstrated the simplicity, in many ways, of the solution. Politicians and policy makers responded to the actions of community activists, first through material support and then through systemic policy change that supported the provision of more sustainable and regulated services. In Australia, the policy process was dominated by control that emanated from the top down, reflecting the embedded institutional interests of the elite. In Canada, the challenge to institutionalised power came from the bottom up, driven by a community's response to crisis.

9.3 Contributions of this research

As the scoping review presented in Chapter Two demonstrates, drug policy scholarship is a vibrant field addressing complex issues in a contested policy landscape. This thesis has aimed to make distinct empirical and theoretical contributions to this body of scholarship. Specifically, it has addressed two gaps that were identified in the review of the literature: the dearth of comparative studies; and the limited application of policy transfer concepts to understanding policy change in the drug policy field. These are addressed in turn below.

Despite the limitations set by the research question guiding the scoping review, it is nonetheless surprising that only four studies were identified that utilised a comparative methodology. This thesis, therefore, advances our understanding of policy making by the choice of case studies that have provided opportunities for comparative analysis at both national and sub-national levels. In doing so, this research makes a contribution to the body

of comparative drug policy literature. In addition, it provides an opportunity to interrogate the relationship between national policy and local policy and implementation: another gap identified by the scoping review. The choice of case studies at the outset was guided by a replication logic (Yin, 2014) based on a change/no change criterion where Sydney and Vancouver had initial services but no replication, and Melbourne and Toronto had no services despite attempts to develop policy in support of drug consumption rooms. The unfolding situation in Canada, which could not have been anticipated, provided contrasting comparative cases. The timing of the research enabled reflection on policy change in real time, but set against a backdrop of a twenty-year period lending the analysis depth and breadth. The inclusion of Australian case studies also makes a timely empirical contribution to drug policy literature. There has been very limited scholarship considering the cases of both Melbourne and Sydney and virtually no focus on the issue of policy diffusion or scaling up of services. This research therefore addresses this gap and contributes insights into evolving perceptions of the problems presented by street-based drug markets and their impact on local communities. It may also serve to inform future policy debates as to the need to develop new, more flexible models of service delivery in the Australian context.

In terms of original theoretical contributions, this research can lay claim to three distinct advancements relating to the utilisation of the policy transfer framework. The first concerns the capacity of policy transfer to act as a bridge between divergent theoretical approaches being employed in drug policy scholarship. The second relates to the theoretical contribution to policy transfer scholarship through a proposed modification to the policy transfer framework. Lastly, the findings of this research on the critical role played by state-centred sources of policy change present a challenge to the claims within policy mobility literature (Temenos, 2017) that we have entered a post-political condition, strengthening the case for an ongoing need to look to structures and institutions in order to understand policy change.

This research was conducted on the underlying premise that in order to gain insight into policy change and development, we must look beyond the evidence-based policy paradigm to understand the dynamics of policy making. Within drug policy literature, there has been a divergence of approaches attempting to do this, which was explored through the focus on ideational and social constructionist approaches in Chapter Two. This research identified that the concept of policy transfer had been underutilised in the drug policy field, and therefore aimed to test out the utility of the policy transfer framework. Chapter Eight demonstrated the value of this conceptual approach in accounting for multiple sources of policy change and identifying both constraining and facilitating factors that impact policy replication and diffusion. This research has illustrated the value of exploring both structural and agency factors and the dialectic relationship between them. Importantly, it is the capacity of the policy transfer approach to appreciate the role played by structural and institutional forces, while accommodating constructionist concepts (narratives, problem construction, ideas) that adds value. This research has demonstrated the potential of policy transfer concepts to bridge the gap between the often divergent theoretical stances taken in drug policy literature, contributing the capacity to develop a fuller understanding of policy making in this contested domain.

In addition to the contribution to drug policy scholarship, this research has engaged with the broader policy transfer literature by proposing a modification to Evans' (2004) policy transfer framework. Through the rigorous process of mapping the empirical findings of the case studies and the themes identified from analysis of the interview data, a significant source of policy change emerged that was not satisfactorily captured by the framework. I contend that the framework is oriented to capturing top-down policy change. However, this research demonstrates the challenge posed to institutional power through the bottom-up actions of activists and community groups, including through acts of civil disobedience. As these actions of civil society have proved significant in explaining how policy change is catalysed, I have

proposed a fifth source of policy change, civil society, be added to the policy transfer framework to aid in the identification of facilitating or constraining factors for future studies of policy transfer.

Finally, the conclusions reached in relation to the role played by state-centred sources of policy change pose a challenge to policy mobility scholars, such as Temenos (2017), who maintain that power lies with agents, not within institutions or structures. Chapter Three introduced the work of policy mobility scholars who were concerned with the circulation of knowledge and the movement of policy ideas and their adaptation in local contexts (McCann, 2008; McCann and Temenos, 2013; Temenos, 2016; Temenos, 2017; Longhurst and McCann, 2017). Their approach is consistent with a constructionist ontological position. The findings of this research reinforce that institutions must be studied in order to understand policy development. Structural forces are demonstrated through the exercise of power through institutions such as parliaments which have a tendency to constrain political possibilities through conservatism. Ideas matter, but they are mediated through institutional processes. This was apparent through the use of legislation to deliberately constrain change and opportunities for policy learning in the case studies of Sydney, Melbourne and Vancouver. As Hay (2002) argues, agents are also important, but the contexts in which they operate must be acknowledged. Such a position is at odds with Temenos, in particular, who argues that the capture of political structures by neoliberal forces requires we look elsewhere to understand change. While this research shares an interest with Temenos in the role of activists and civil society, and is arguing for the acknowledgment of civil society as a source of policy change, it does so while remaining deeply committed to understanding the structures or contexts in which such forces can catalyse systemic change. This point is also relevant for embarking on further dialogue within drug policy scholarship where constructionism is becoming increasingly influential (Lancaster, 2014; Lancaster, Duke and Ritter, 2015; Fraser and Moore, 2011; Stevens, 2011).

9.4 Limitations

Despite the consideration given to the framing of the research question and the research design, several limitations of this thesis are noted.

First, the choice of case studies in Australia and Canada cannot be said to be representative of the experience of the diffusion of supervised injecting policy, noting the majority of DCRs are in Europe. This issue was examined in Chapter Four and an argument made for the appropriateness of these cases for this comparative study, including the ability to work in English and the broadly similar experience of both countries, at least at the outset of the research. Nonetheless, caution should be applied regarding the generalisability of the findings. The use of comparative methodology, however, has ensured rigour in terms of providing a counterpoint for the reflections on the findings of the research, noting that these conclusions apply specifically to Canada and Australia.

A potential criticism of the study is the lack of systematic evidence to build a case that scaling up is warranted. This issue is addressed several times in the thesis by stating that the research question is concerned with the policy process and does not set out to resolve the question of scaling up from an epidemiological or public health standpoint. The framing of the research question did not close off the possibility of finding that sub-national and sub-regional policy transfer did not occur because there was insufficient demand for services. As the Australian case studies demonstrate, changes to drug markets over time have affected the nature of the problem of street-based drug use that DCRs have the potential to address. This research has drawn conclusions based on perceptions of stakeholders, as an underlying assumption of the research is that ideas, whether factually based or not, have causal power in relation to policy change. However, it is important to acknowledge that research that specifically addresses the need for services, particularly from a public health standpoint, is a valuable complement to the findings in this thesis.

Lastly, limitations related to the collection of data should be noted. Interviews were conducted in four field locations in two countries. Effort was made to approach a range of participants who had been engaged in the policy making process, as identified through the development of the case studies, documentary analysis and through contact with key informants. Despite attempts to include people who had specifically opposed drug consumption rooms, none agreed to participate. As a result, the interview data does not reflect as full a range of views as intended. To counteract this potential bias, specific attention was paid through the documentary analysis to public statements from opponents, particularly through media reports and parliamentary debates. Nevertheless, the lack of opponents' views from the interview data does pose a limit to this research. While there was no opportunity to make return visits to the field sites in the course of the research, a future remedy would be to spend more time in developing suitable contacts and networks in advance of entering the field.

9.5 Future research directions

The contested nature of drug policy generates a host of questions that warrant ongoing research. Stemming directly from the findings of this thesis, four specific issues are identified that would merit further enquiry.

The opposition to drug consumption rooms highlights that the idea of supervised drug consumption has failed to be persuasive for many people, resulting in ongoing political contestation and a lack of normalisation of the provision of such services. Yet, as Justice Wood argued in New South Wales in 1997, given the public provision of needles and syringes it seemed short sighted to waiver on providing sanitary conditions under which people could inject (Wood, 1997). A comparative study of attitudes towards, and the debate around, needle syringe programmes compared to DCRs would provide some valuable insights into what factors have contributed to the apparent public acceptance of needle syringe

programmes, to inform the framing of arguments for drug consumption rooms. Further, such research would provide an opportunity to delve more deeply into the nature of opposition to DCRs, thus addressing one of the identified limitations of this research.

The second broad area of proposed future research relates to questions of the role of representation, public participation in policy making and deliberative democracy as considered through case studies of DCR policy making. This research identified that the political debates concerning DCRs saw politicians holding positions on the appropriateness or otherwise of DCRs that did not align with apparent community support for such services. While this thesis has identified a number of factors that have influenced politicians (such as perceived electoral backlash and proximity to the problem), there would be value in considering this issue in more depth, particularly through more extensive interviewing of politicians than was able to be undertaken for this thesis. Such research could further develop the work of Treloar and Fraser's (2007) exploration of why positive community attitudes towards harm reduction and NSPs fail to translate to political action, and MacGregor's (2011) work on the role of politicians in the development of drug policy. Empirical findings could contribute to theorising on participation in policy making, governance, the potential for deliberative democracy and the question of whose voice is heard – a pertinent concern in a domain where civil disobedience has proved influential (Ritter, 2015; Ritter et al., 2018; valentine, 2009; Houborg and Frank, 2014).

The third proposed research area relates to the suggested modifications to the policy transfer framework that were outlined in Chapter Eight. The recommended adaptation of Evans' (2004) model arose directly from the findings of the thesis in relation to policy transfer and policy replication. The idea of delineating civil society as a separate domain of policy change from the agents in a policy transfer network reflects a concern with re-balancing the policy transfer framework to better reflect both top-down and bottom-up change. This

modification also speaks to the concerns addressed in the paragraph above on representation and governance issues. It would be appropriate to now subject the modified framework to analysis and case studies beyond drug consumption rooms and drug policy to test the value of the proposed change.

Lastly, to return to a concern regarding drug consumption rooms and policy transfer, it is proposed that there would be value in further interrogating the issue of specific models of DCRs (for example fixed, mobile and integrated) from the perspective of the ideational impact of 'models' as a fixed and potentially constraining idea in a dynamic environment. Data collected in the interviews suggests that some participants were concerned that the focus on setting up pilot sites with stringent evaluation requirements may have constrained the transfer of the idea to other sites that did not match the specific conditions; for example, of the Downtown Eastside in Vancouver. This idea warrants further exploration and could engage with McCann's (2011) notion of exemplars from the policy mobility literature.

9.6 Conclusions

This thesis set out to understand the challenges and barriers which have constrained the scaling up of a life-saving public health intervention: drug consumption rooms. In the process, an opportunity arose to examine the conditions and factors that have facilitated the diffusion of policy. I have argued that evidence of the effectiveness of supervised drug consumption has not proved sufficiently compelling for the policy idea to become mainstream. It continues to compete with conflicting political agendas and dominant ideologies that support the architecture of drug prohibition, impeding policy transfer. In Canada, crisis has galvanised a community into acts of civil disobedience that have succeeded in bringing about change, both locally and at provincial and national levels. This thesis has demonstrated that the context or structures in which ideas emerge and circulate matter if change is to be effected. Ideas do, however, have a causal impact and can bring about change at the institutional level through

the actions of agents. Thus a dialectic relationship exists, both constraining and facilitating policy change. The tendency towards conservatism within institutional structures can slow the pace of change, which is an undesirable outcome in the face of preventable suffering and death. Where positive policy solutions exist, communities should be encouraged to continue to speak up and, if necessary, demonstrate through their actions the feasibility of providing life-saving community-based services. Such actions can serve to galvanise the courage of those with the power to provide sustaining institutional protection through the policy making process.

Appendix 1 Ideation, social construction and drug policy scoping review charted data, 2016

Author, Year	Journal/Book/Thesis	Country	Theoretical approach	Drug policy/issue	Method	Data source
Alexandrescu (2014)	*Crime, Media, Culture*	UK	Narratives and frames	Mephedrone, media and moral panic	Discourse and media analysis	Online published news items
Amundson et al. (2015)	*Sociological Spectrum*	US	Social construction of target populations	Construction of welfare recipients as drug users	Documentary discourse analysis	Media, press releases and speeches
Bewley-Taylor (2014)	*International Journal of Drug Policy*	Afghanistan	Policy transfer	Development of the Afghan national drug strategy	Narrative policy analysis and historical reconstruction	Documents and interviews
Bright et al. (2008)	*Addiction Research and Theory*	Australia	Discourse analysis	Identification of dominant discourses on drugs	Media analysis	Newspaper articles and media
Bright et al. (2013)	*International Journal of Drug Policy*	Australia	Narratives and frames	Kronic, dominant discourses, moral panic	Media and discursive analysis	Online published stories, google trends analysis and survey data
Butler (2013)	*Drugs: Education, Prevention and Policy*	Ireland	Policy transfer	Drug courts in Ireland	Case study	Documents and interviews
Clarke (2016)	*Critical Social Policy*	US	Narratives (Narrative Policy Framework)	Needle exchange programs in California	Narrative analysis	Documents, media, committee recordings and interviews
Dingelstad et al. (1996)	*Social Science and Medicine*	Australia	Social construction (problem construction)	Drug debates and interest groups	Case studies	Interviews and research texts
Dwyer and Moore (2013)	*International Journal of Drug Policy*	Australia	Social construction, Science and Technology Studies	Methamphetamine and public discourse	Discourse analysis and ethnography	Web content, media, policy documents, grey literature, research texts and ethnographic material
Elliot and Chapman (2000)	*Drug and Alcohol Review*	Australia	Social construction of target populations	Construction of drug users and the ACT heroin trial	Qualitative content analysis	Newspaper articles
Euchner et al. (2013)	*Journal of European Public Policy*	Germany and Netherlands	Frames and frame shifting	Morality framing of gambling and drug use in the Netherlands and Germany	Case studies and documentary analysis	Parliamentary and government documents
Everett (1998)	Book chapter	US	Social construction (problem construction and public arenas model)	Sentencing of crack cocaine offences in the US	Narrative reconstruction and media analysis	Documents and media
Fitzgerald (2013)	*Critical Public Health*	Australia	Narratives (Narrative Policy Framework) and framing	Safe injecting facilities in Australia	Narrative analysis	Interviews, policy documents, parliamentary records, research texts and ethnographic material

Fraser and Moore (2011)	*International Journal of Drug Policy*	Australia	Social construction (problem construction)	Amphetamine-type substances policy, representation, knowledge and evidence	Policy analysis	Policy documents
Gunaratnum (2005)	Report	Australia	Kingdon's multiple streams	Safe injecting facilities in Australia	Case studies	Media, press releases, parliamentary records, reports and research texts
Hallam (2006)	PhD Thesis	Australia	Sabatier's Advocacy Coalition Framework	Drug policy and harm reduction in Australia	Case studies	Media, press releases, parliamentary records, reports and research texts
Houborg and Frank (2014)	*International Journal of Drug Policy*	Denmark	Kingdon's multiple streams and Callon's 'framing' and 'overflowing'	Drug consumption rooms in Denmark	Critical discourse analysis	Media, legislation, government and NGO documentation
Hudebine (2005)	*Addiction Research and Theory*	UK	Policy paradigms and problem construction	Harm reduction and drug policy in the UK and perceptions of drug users	Cognitive policy analysis	Policy documents, reports, research texts and interviews
Hughes et al. (2011)	*International Journal of Drug Policy*	Australia	Frames	Australian news media reporting of illicit drug issues	Media content analysis	Newspaper articles
Hughes et al. (2014)	*International Journal of Drug Policy*	Australia	Policy theory (Kingdon and Sabatier)	Legal thresholds for drug trafficking	Critical legal and historical analysis	Policy documents, legislation, parliamentary records, government inquiries, policy reports and research texts
Kolind et al. (2016)	*Drugs: Education, Prevention and Policy*	Denmark	Science and Technology Studies, 'enactments' and actor network theory	Drugs in prisons	Critical analysis	Interviews and participant observations
Kübler (2001)	*Journal of European Public Policy*	Switzerland	Sabatier's Advocacy Coalition Framework	Harm reduction policies in Switzerland	Tests ACF's policy change hypothoses; case study	Documents
Lancaster et. al. (2011)	*Drug and Alcohol Review*	Australia	Media/ communication theories	Impact of media and effect on drug policy	Models of media effects	Research texts
Lancaster (2014)	*International Journal of Drug Policy*	General	Social construction (problem construction)	The evidence-based drug policy endeavour	Discursive analysis and commentary	Research texts
Lancaster and Ritter (2014)	*International Journal of Drug Policy*	Australia	Social construction (problem construction and representation)	Australia's national drug strategy documents	Critical discourse analysis	Documents
Lancaster et al. (2014)	*Policy Studies*	Australia	Kingdon's multiple streams	Methamphetamine and public discourse	Case study	Research texts, summit papers, grey literature, government reports, policy announcements and media
Lancaster et al. (2015)	*International Journal of Drug Policy*	UK and Australia	Social construction (problem construction)	Recovery agenda in the UK and Australia	Comparative policy analysis	Reports
Lawrence et al. (2000)	*Aust & NZ Journal of Public Health*	Australia	Frames	Media coverage and the ACT Heroin Trail	Media content analysis	Newspaper articles

Lybeker et al. (2015)	*Policy and Internet*	US and Mexico	Social construction of target populations and narratives (Narrative Policy Framework)	New media and the portrayal of issues on the US-Mexico border	Media analysis	YouTube videos
MacGregor (2013)	*Drugs: Education, Prevention and Policy*	UK	Social construction (problem construction) and narratives and frames	Political perspectives of drug issues in the UK	Thematic analysis using grounded theory approach	Government and policy documents, media, interviews and participant observation
McCann (2008)	*Environment and Planning A*	Canada	Policy transfer and urban policy mobilities	Drug policy in Vancouver	Case study	Documents, media and interviews
McCann and Temenos (2015)	*Health and Place*	International	Policy mobilities	Drug consumption rooms	Case study	Government and policy documents, research texts, reports and interviews
Monaghan (2011)	Book	UK	Sabatier's Advocacy Coalition Framework; models of evidence use and the 'processual' model	UK cannabis classification system and evidence	Case study	Government and policy documents, research texts, reports and interviews
Monaghan (2010)	*Social Policy and Society*	UK	Models of evidence use and the 'processual' model	UK cannabis classification system and evidence	Theory building	Government and policy documents, research texts, reports and interviews
Moore and Fraser (2013)	*Qualitative Health Research*	Australia	Social construction (problem construction)	Addiction treatment policy	Case study	Interviews
Neill (2014)	*World Medical and Health Policy*	US	Social construction of target populations	Social construction of drug users and impact on drug policy in the US	Historical narrative	Research texts
Ritter (2009)	*International Journal of Drug Policy*	Australia	Evidence-based policy	Use of evidence in drug policy making	Empirical research	Interviews
Ritter and Bammer (2010)	*Drug and Alcohol Review*	Australia	Policy making theories (multiple)	Impact of research on drug policy making	Descriptive and analytical	Policy documents
Roumeliotis (2014)	*Addiction Research and Theory*	Sweden	Social construction (problem construction)	Knowledge utilisation and ideology in Swedish drug policy	Discourse analysis	Public reports
Small et al. (2006)	*International Journal of Drug Policy*	Canada	Social construction (problem construction), narratives and cultural change	Safe injecting facility in Canada	Narrative account	Research texts
Sobeck (2003)	*Administration and Society*	US	Sabatier's Advocacy Coalition Framework, bureaucratic politics framework and the institutional analysis and development framework	Group membership and participation in the drug policy making process in California	Case study comparing different policy frameworks	Meeting minutes, observations, reports, interviews and surveys
Stevens (2007)	*Critical Social Policy*	UK	Narratives and frames and 'evolutionary' theory of evidence selection	Bias in the use of evidence in policy development	Theory building	Policy documents

Stevens (2011)	Book	UK, US, Sweden and the Netherlands	Narratives and frames, evidence and policy making	Bias in the use of evidence in policy development; harmful consequences of drug policy	Empirical research	Government and policy documents, observations, and ethnography
Stevens and Ritter (2013)	*Drugs: Education, Prevention and Policy*	General	Narratives	Drug policy development and evidence utilisation	Editorial to IJPD special edition	Research texts
Tammi (2005)	*International Journal of Drug Policy*	Finland	Social construction and elite networks	Drug policy development in Finland	Discourse and network analysis, case study	Policy documents, reports, proceedings, committee member notes, media and interviews
Temenos (2016)	*Space and Polity*	International	Policy mobilities	Conferences, networks and drug policy reform	Empirical research	Documents, interviews and observations
Tieberghien (2014)	*International Journal of Drug Policy*	Belgium	Research utilisation and the media	Drug policy debates in Belgium	Discourse analysis	Newspaper articles and policy documents
van Tooren (2016)	*Evidence and Policy*	Australia	Social construction (problem construction) and frames	Compares role of evidence in drug policy and child protection	Case studies and discourse analysis	Policy documents

Appendix 2 Interview guides

Drug consumption rooms case study (Sydney) - semi-structured interview guide

1. Introductions; ensure the interviewee is aware of the purpose of the research. Signing of the consent form.
2. Establishing the role and experience of the interviewee regarding drug policy development and specifically, safe injecting facilities (SIFs) in Sydney.
3. Overview of the nature of street-based drug use in Sydney and its consequences for public health and public security.
    − An assessment of the need for safe injecting services in Sydney, including beyond Kings Cross, and more broadly in NSW.
4. Identification of the main stakeholder groups which played a significant role in policy debates about the setting up MSIC in Sydney and proposed new facilities.
5. The role of evidence in the policy debate.
    − How evidence was introduced into and used in the debate.
    − What was the role of local evidence? International evidence?
6. Perception of the primary arguments that were raised to oppose the introduction of a safe injection facility.
7. Perception of the role and influence of the media in the debates in Sydney.
8. What role was played by different levels of government?
    − Local/State/Federal
9. The role of legal and legislative processes in relation to the MSIC.
    − What impact did the attempt to challenge the MSIC in court have?
    − Why does the legislation only allow for one safe injecting facility?
10. Identification of key factors that might account for there only being one safe injecting facility in New South Wales. Have there been any critical events that have affected potential replication?
11. Impact of the decision to design and manage the first safe injecting room as a scientific trial on further expansion of safe injection facilities in Australia.
12. Exploration of the notion of 'normalisation' of safe injection services.
    − What factors might support normalisation; what factors might mitigate it?
13. Identification of ongoing challenges.
14. Any further reflections.

Drug consumption rooms case study (Melbourne) - semi-structured interview guide

1. Introductions; ensure the interviewee is aware of the purpose of the research. Signing of the consent form.
2. Establishing the role and experience of the interviewee regarding drug policy development and specifically, safe injecting facilities (SIFs) in Melbourne.
3. Overview of the nature of street-based drug use in Melbourne and its consequences for public health and public security.
    − An assessment of the need for safe injecting services in Melbourne and more broadly in Victoria.
4. Identification of the main stakeholder groups which played a significant role in policy debates about the setting up of safe injecting facilities in Melbourne.

5. The role of evidence in the policy debate.
   – How evidence was introduced into and used in the debate.
   – What was the role of local and national evidence? International evidence?
6. Perception of the primary arguments that were raised to oppose the introduction of safe injection facilities.
7. Perception of the role and influence of the media in the debates in Melbourne.
8. What role was played by different levels of government?
   – Local/State/Federal
9. The role of legal and legislative processes in relation to the MSIC.
   – Have proposed facilities been the subject of any legal action or threat of legal action?
   – What has been the impact of the recent Coroner's verdict recommending a facility in Richmond?
   – Why was the original (failed) legislation not reintroduced?
10. Identification of key factors that might account for there being no safe injection facilities in Melbourne? Have there been any critical events that have affected potential replication of Sydney's MSIC?
11. Impact of the decision to design and manage the first safe injecting room as a scientific trial on further expansion of safe injection facilities in Australia.
12. Exploration of the notion of 'normalisation' of safe injection services.
    – What factors might support normalisation; what factors might mitigate it?
13. Identification of ongoing challenges.
14. Any further reflections.

Drug consumption rooms case study (Vancouver) - semi-structured interview guide

1. Introductions; ensure the interviewee is aware of the purpose of the research. Signing of the consent form.
2. Establishing the role and experience of the interviewee regarding drug policy development and specifically, safe injecting facilities (SIFs) in Vancouver.
3. Overview of the nature of street-based drug use in Vancouver and its consequences for public health and public security.
   – An assessment of the need for safe injecting services in Vancouver, including beyond DTES.
4. Identification of the main stakeholder groups which played a significant role in policy debates about the setting up of SIFs in Vancouver.
5. The role of evidence in the policy debate.
   – How evidence was introduced into and used in the debate.
   – What was the role of local evidence? International evidence?
6. Perception of the primary arguments that were raised to oppose the introduction of safe injection facilities.
7. Perception of the role and influence of the media in the debates in Vancouver.
8. The role of legal and/or legislative issues in relation to attempts to introduce SIFs in Vancouver.
   – What has been the impact of federal law on the province in this policy area?
   – How did the 2011 Supreme Court ruling influence the policy process locally?

9. What role was played by the province in relation to the City of Vancouver achieving its policy goals?
10. Identification of key factors that might account for the gap in time between the opening of Insite in Vancouver and the extension of safe injection facilities elsewhere.
    – What were the critical moments that spurred action; what were the critical moments that stymied action?
11. Impact of the decision to design and manage the first safe injecting room as a scientific trial on further expansion of safe injection facilities in Canada.
12. Exploration of the notion of 'normalisation' of safe injection services.
    – What factors might support normalisation; what factors might mitigate it?
13. Identification of ongoing challenges.
14. Any further reflections.

Drug consumption rooms case study (Toronto) - semi-structured interview guide

1. Introductions; ensure the interviewee is aware of the purpose of the research. Signing of the consent form.
2. Establishing the role and experience of the interviewee regarding drug development policy and specifically, safe injecting facilities (SIFs) in Toronto.
3. Overview of the nature of street-based drug use in Toronto and its consequences for public health and public security.
    – An assessment of the need for safe injecting services in Toronto.
4. Identification of the main stakeholder groups which played a significant role in policy debates about the setting up of SIFs in Toronto.
5. The role of evidence in the policy debate.
    – How evidence was introduced into and used in the debate.
    – What was the role of local evidence?
6. Perception of the primary arguments that were raised to oppose the introduction of safe injection facilities.
7. Perception of the role and influence of the media in the debates in Toronto.
8. The role of legal and/or legislative issues in relation to attempts to introduce SIFs in Toronto.
    – How did the 2011 Supreme Court ruling influence the policy process locally?
    – What has been the impact of federal law on the province in this policy area?
9. Identification of key factors that might account for the gap in time between the opening of Insite in Vancouver and the opening of similar services in Toronto.
    – What were the critical moments that spurred action; what were the critical moments that stymied action?
10. Impact of the decision to design and manage the first safe injecting room as a scientific trial on further expansion of safe injection facilities in Canada.
11. Identification of lessons learned from the national experience that are being applied to the development of services in Toronto.
12. Exploration of the notion of 'normalisation' of safe injection services.
    – What factors might support normalisation; what factors might mitigate it?
13. Identification of ongoing challenges.
14. Any further reflections.

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