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# Mobilizing drug consumption rooms: inter-place networks and harm reduction drug policy

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ABSTRACT

This article discusses the learning and politics involved in spreading Drug Consumption Rooms (DCRs) globally. DCRs are health facilities, operating under a harm reduction philosophy, where people consume illicit drugs in a supervised setting. Approximately 90 are located in almost 60 cities in 11 countries. They are intensely local attempts to improve the lives of specific populations and urban neighborhoods. DCRs are also global models that travel. This article examines the relationship between DCRs as facilities that are fixed in place and DCRs as globally-mobilized models of drug policy and public health practice. Drawing on research from seven countries, we apply concepts from the policy mobilities literature to analyze the travels of the DCR model and the political strategies involved in the siting of these public health service facilities. We detail the networked mobilization of the DCR model from Europe to Canada and Australia, the learning among facilities, the strategies used to mold the DCR model to local contexts, and the role of DCR staff in promoting continued proliferation of DCRs. We conclude by identifying some immobilities of DCRs to identify questions about practices, principles and future directions of harm reduction.



## 1. Introduction

In the early morning of September 29, 2011, celebrations broke out among hundreds of people gathered at Insite, a legal Drug Consumption Room (DCR) on Hastings St. in Vancouver, Canada's Downtown Eastside neighborhood. Users of the facility, its staff and managers, neighborhood residents, and allies from across the city, cheered news from Ottawa that the Canadian Supreme Court had ruled that Insite would no longer operate on a trial basis, as it had done since 2003, but would now be a permanent part of the city's health care system. The small health care and social services facility is the most prominent physical manifestation of Vancouver's four-pillar drug policy, which combines prevention, treatment, enforcement, and harm reduction in its approach to drug use. Like DCRs elsewhere, it serves a largely economically impoverished, homeless, or marginally housed population of people who use drugs (Broadhead, 2003). They inject heroin, cocaine, and morphine, among other drugs and suffer from, or are threatened by, a combination of blood-borne diseases, particularly HIV/AIDS and Hepatitis C, high overdose risks, other medical issues related to drug use and poverty, as well as concurrent mental health issues and marked social stigmatization and marginalization (Marlatt, 2002; Merkinaite et al., 2010).

Following harm reduction principles, Insite is intended to be about protection. Like its counterparts elsewhere, it provides clean equipment and a protected place "for the hygienic consumption of previously obtained drugs, in a non-judging environment and under the supervision of qualified personnel" (Akzept, 2000). It also offers low threshold access to primary health care services, counseling, and referrals to drug treatment, other social services, and housing opportunities. Research has shown that harm reduction policies are successful when implemented, and it is generally considered to be best practice in public health service provision for people who use drugs (Heller and Paone, 2011; MacArthur et al., 2014; Marlatt and Witkiewitz, 2010; Percival, 2009). These findings are replicated in the case with Insite (Urban Health Research Initiative, 2009).[2] In 2010, for example, there were over 200 overdoses at Insite but there have been no fatalities since the site

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[2] The published evidence from the BC Centre for Excellence in HIV/AIDS Scientific Evaluation of Supervised Injecting at Insite is extensive. Space does not permit a full listing of the papers here. The referenced summary report and the following webpage provide full access to the findings: http://uhri.cfenet.ubc.ca/content/view/57/92/.

opened. Five thousand referrals were made in 2010 to social and health services, most of which were to drug treatment programs (Vancouver Coastal Health, 2010).

Yet, the jubilation that September morning revolved around another protection – legal protection – that Insite offered its participants and that its staff and operators were themselves granted by an exemption from section fifty-six of Canada's Controlled Drugs and Substances Act. That exemption had always been temporary: Insite was established in 2003 as a time-delimited research trial and extensions to the original exemption, allowing staff to witness and instruct on safer drug use, had to be continually fought for in the courts, the media, and through political channels stretching from the city to the national level. The early-morning crowd at Insite celebrated the end to its legal uncertainty and the Supreme Court's guarantee of protection for the DCR.

Insite, then, is a physical manifestation of local politics and policy-making, but one influenced by decisions at others scales. Vancouver's harm reduction approach is only possible because of policies and legal decisions made at provincial and national levels. Moreover, Vancouver's approach to drug policy could not have developed in the late 1990s and early 2000s without connections between the city and other places, like Frankfurt, Geneva, and Sydney, which provided models of how harm reduction drug policy might work (McCann, 2008). A non-judgmental approach to drug use that aims to reduce physical, social and psychological risks to individuals who use drugs and to society as a whole, harm reduction is a public health approach that, while considered best practice by public health professionals and social policy advocates, remains a highly contested set of policies and practices at all levels of governance. Vancouver's harm reduction drug policy, with Insite at its core, is a global product as much as one born out of great suffering, remarkable political activism, and sustained evidence gathering and analysis in the city itself (Wood and Kerr, 2006; Boyd et al., 2009). Harm reduction drug policy can therefore be usefully understood as a global assemblage of expertise, practices, and design elements that are arranged in locally specific configurations. By extension, DCRs can be conceptualized as fixed, locally embedded public health facilities that, paradoxically, also travel.

This article analyzes DCRs as both public health facilities that are fixed in particular places and also "the DCR" as a globally mobilized model of drug policy. We argue that inter-place networks are crucial to the proliferation and operation of DCRs as public health services and we suggest that an attention to the spatial relations involved in policy-making offers insights into how DCRs are advocated for by proponents of harm reduction as a set of "policies,programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption" (International Harm Reduction Association, 2010).[3] Harm reduction, as a public health drug policy is predicated on the philosophy of scientific method and legitimized through data-driven debates. However the literature on harm reduction has not explored the global, networked nature of evidence sharing and its use in legitimating harm reduction strategies.

This study begins to do so by examining how successful models of harm reduction drug policy are understood and translated across diverse cities within a global network of harm reduction managers and advocates. Building on an ongoing qualitative research project spanning DCRs in Europe, Canada, and Australia, the article employs an "assemblages, mobilities, and mutations" approach to studying harm reduction policy (McCann and Ward, 2012b,2013). We focus on the DCR model to unpack the political debates that affect landscapes of public health service provision in cities. In order to do so, we discuss how the DCR model is mobilized and assembled in particular places by a range of actors, how its mobilization involves change, or mutation, both of the model and of the local contexts in which it is embedded, and how existing DCRs and their staff are crucial elements of the politics of mobilizing and "demystifying" the DCR model. The article concludes by highlighting elements of DCRs that have not moved so readily in order to raise some questions for future discussion about the practices and principles of harm reduction.

## 2. Inter-place connections, policy mobilities, and drug policy

Introducing their concept of the "drugscape," Tempalski and McQuie (2009, 7) emphasize the localness of marginalized people who use drugs' experience in "places … produced by social isolation and under-development, where certain patterns of drug use are more likely to occur." While highlighting the local/social/economic isolation of there drugscapes, they also recognize that their territorial embeddedness is only one side of the coin (see also Ashton and Seymour, 2010; Atun and Kazatchkine, 2010, Burris and Burrows, 2009; Carlson, 2001; Coffin, 2002). On the other side are relations that connect local politics and policy-making to other scales, places, and contexts such as national regulatory bodies and their international counterparts.

This notion of "scapes" as "scalar dynamics" or configurations of forces and relations that are multiple and simultaneously local, regional, national, and global (Appadurai, 1990, 301; Mitchell, 2000, 276–277) also emphasizes that the territories where public health policy is formulated and implemented are not clearly bounded. Critical studies of policy thus conceptualize the world as constituted by a dialectic of fixity/mobility or territoriality/relationality (McCann and Ward, 2010) that produces policies which cannot be easily defined as *either* local *or* global. Instead, policy, including harm reduction policy, is framed by mobilities – the social process of circulating models and expertise among places and the often-political struggles around tuning these models to specific local contexts. In this regard, if Tempalski and McQuie's (2009) call for the development and retention of inclusionary services (like DCRs) in local drugscapes is to be fully addressed, attention must be paid not only to local contexts of drug use but also to how they are constituted in relation to wider circulations of public health knowledge and advocacy for the siting of health service facilities.

### 2.1. *Movements: public health policy as mobile, mutable,* & *political*

The "policy assemblages, mobilities, and mutations" approach (McCann, 2008, 2011a, 2011c; McCann and Ward, 2011, 2012b, 2013; Peck and Theodore, 2010; Temenos and McCann, 2013) offers an opportunity to analyze how knowledge and models of harm reduction are developed in specific places, mobilized by policy actors of various kinds, changed as they move, and assembled in new, but related, forms in other places. The mobilization of policy is a complex, power-laden social process, involving numerous practices, networks, and sites. An attention to how policies are assembled from resources in a particular place and also from "parts of elsewhere" (Allen and Cochrane, 2007) is important to understand the actors, motivations, and global policy networks that shape policies and how the spatial relations at the heart of inter-place movements of policy models develop through face-to-face interactions at meetings, conferences, and site visits

[3] While this article focuses explicitly on DCRs as a harm reduction public health service, we wish to emphasize that there are many forms of harm reduction services (and policies that govern those services) that operate across a continuum of health and social service provision, and do not always or exclusively focus on people who use drugs.

(Cook and Ward, 2012) as well as being forged at a distance, often through the Internet. These teaching, learning, comparison, and emulation practices are crucial to the practice and politics of policy-making and to political campaigns aimed at reshaping existing policies (Temenos and McCann, 2012).

The concept of mutation highlights, first, that the flow of policies through places, institutions, and communities provokes change. Second, policies themselves change as they travel, through interpretation and reinterpretation, and as they are molded to new contexts. Third, the adoption of a new policy involves interests of various types, as it will serve the interests of some while threatening or bypassing others. Thus, policy mobilities are always about power and politics. Therefore, our analysis of DCRs is, in part, an attempt to close the gap between studies of public health and urban politics. As Michael Brown (2009, 23) argues, "those who conceptualize 'urban politics' rarely consider public-health departments as an interesting apparatus of the state. … Public health in all its wide and shifting forms is an important part of urban political geography that we should consider more fully." Harm reduction certainly highlights this health-politics connection. It is an organized, if loose, coalition of individuals and organizations working both inside and beyond state institutions at local, national, and global scales to improve the health of people who use drugs, to make rights claims, and to change legal regulations, governance practices, and social attitudes toward users (Bluthenthal, 1998; Wieloch, 2002; VANDU, 2004, 2010; Friedman et al., 2007; Newcombe, 2007; Tempalski, 2007; Brown and Watson, 2009).

## 3. Follow the policy: methodological considerations and public health mobilities

"Following" is one way to uncover how policy models are created and mobilized (McCann and Ward, 2012a; Peck and Theodore, 2012). Following policies largely entails following networks of people, their ideas, their experiences, and their persuasive stories, as expressed in interviews, in written form (consultants' reports, think-tank discussion papers, reports from fact-finding visits, conference summaries, PowerPoints, etc.), and in videos, podcasts, and so on. This methodology focuses on how local policy actors and their global counterparts learn from and teach each other models and best practices in order to reshape specific places. It entails studying how key actors, concepts, and techniques are gathered into co-presences in particular "drugscapes." It is also about identifying how certain types of "absent presence" – DCRs, their staff, their users, and other experts in other cities elsewhere in the world – also affect local policy-making, as actors in one place mold strategies learned from other places into a locally workable model.

It is possible to push this approach further and to think literally about following the *thing* – the DCR as a physical facility or building form (Jacobs, 2006) – as it moves around. It is possible to trace how the general form moves from place to place by tracing formal similarities in different places and verifying the analysis through interviews with key actors. Moreover, it is possible, through interviews with key actors, to specify certain parts of DCRs – the organization of the rooms in the facilities, the character of the consumption booths, certain procedures, and so on – that have moved from one site to others. Following the thing in this way delineates the global connections that tie together and constitute DCRs in specific cities. It also uncovers the local contingencies that produce certain elements of the model and make those elements particularly attractive to other places.

This article is based on five years of research by the authors into the local contexts and public health politics affecting the implementation of DCRs and the networked, global mobilization of the DCR model. The focus is not one particular site but, rather, the "case" being studied is the operation of a *dynamic network* of people and institutions stretched across the globe, constituted by particular nodes, such as DCRs, and also conferences, meetings, and institutions that contribute both to the making of local public health landscapes, and also to the production of a globalized politics of health service provision. Knowledge about DCRs is mobilized through these global networks. Our main objective in utilizing this method is to map the relationships between local landscapes of DCRs and globalized policy elements that travel among harm reduction networks that, as Olds (2001) and Murdoch (1997) note, span different spatialities *and* change over time. Our related objective is to "[follow] the source of a policy – its discourses, prescriptions, and programs – through to those affected by the policy" (Wedel et al., 2005, 40; McCann and Ward, 2012a, 2013; Peck and Theodore, 2012). The focus of the research is the processes of learning and inter-personal advocacy involved in the dissemination of the principles, practices, and physical architecture of DCRs.

Our purpose is to use this analysis to encourage a dialogue between geographical analysis of policy-making and the literature on harm reduction and drug policy. That this conversation has begun is clear in a recent special issue on geographies of drug policy in *The International Journal of Drug Policy* and a forthcoming special issue on legal geographies of drug policy in *Space and Polity* (Cooper and Tempalski, 2014; Williams and Wharf, forthcoming). McLean (2012, 296) points out that spatially informed analysis of health services for people who use drugs "point[s] to the need for a (re)expanded definition of harm reduction… that addresses the social inequalities shaping already constricted geographies of survival." The landscapes of public health service provision for people who use drugs are entangled in ongoing political debate over how to manage people in the city. Harm reduction health services such as DCRs can be "meaningfully understood to emerge from within an ongoing politics of socio-spatial order in the 'new city'" (Fischer et al., 2004, 358).

Scholars of drug policy and harm reduction have called for a shift in "the focus for change from individuals alone to the social situations and structures in which they find themselves" (Rhodes, 2009, 194; see also Burris and Burrows, 2009, McKeganey, 1995; Moore and Rhodes, 2004; Russell and McVeigh 2001; Pauly, 2008; Rhodes et al., 2010). Similarly, health geographers have been attuned to critical engagement with landscapes of health and wellbeing for some time (Brown, 2009; Curtis et al., 2010; Kearns, 1993; Keil and Ali, 2008, Martin and Pierce, 2013; Mayer and Meade, 1994; Parr, 2008; Williamson, 2004). Much of this work focuses on health outcomes, but recently there has been a call to look at the social and structural processes that make up the landscapes of health and well-being and that shape health outcomes. As Pierce et al. (2012, 1050) argue, "the multifaceted politics of health facility siting should be an explicit component of health geography analyses, particularly as a means for understanding the interface between geographies of health and urban development."

In order to contribute to this focus, we use a methodology aimed at following mobile policies across "translocal fields of power" (Ong, 1999, 159) that can, on occasion, involve literal following, as when one of the authors participated in a 2008 tour of DCRs in Frankfurt by members of EXASS Net (EXASS Network, 2008). This method also often involves the retrospective tracing of the travels of policy models. First, this research involves a review of key documents produced by harm reduction advocacy organizations at international, national, and local levels, government documents, and news reports to identify the institutional drivers and practical connections shaping policy emulation among places.

The second, and core, element of the approach involves semi-structured interviews with key actors involved in harm reduction

policy-making and in operating DCRs to explore their experiences of and strategic approach to operationalizing and mobilizing the DCR model. This analysis draws on 66 interviews with managers of DCRs in cities in Germany, the Netherlands, Switzerland, Australia, Canada, Luxembourg, and Spain.

The decision to focus primarily on managers rather than on front-line staff, ensures that participants would be able to speak of their experiences as teachers or learners and to reflect on their own direct involvement in local politics around the establishment of DCRs (Bondi, 2005). All the interviews were recorded and transcribed. Redundancy – the recurrence of similar perspectives in numerous interviews and an exhaustion of the pool of potential interviewees recommended by previous participants – was used as a measure of the generalizability of the findings to the population of DCR managers and advocates as a whole.

The third element of the methodology is direct observation through participation and observation. Site visits to 12 DCRs in nine cities (Frankfurt (3), Amsterdam, Geneva, Zurich, Sydney, Vancouver (2), Luxembourg, Barcelona, and Bilbao) in the seven countries identified above were employed to develop a first-hand understanding of the operation of the facilities. In the Frankfurt and Vancouver cases, this was augmented by participating in tours with others visitors to the sites, to gain an understanding of how DCR operators discuss the successes, failures, and ongoing challenges facing the health care facilities. Participant observation was also deployed at conferences organized by Harm Reduction International and the Harm Reduction Coalition to investigate how they act as temporary nodes of knowledge mobilization within global networks. Field notes and photographs were used to document this participant observation. Coding for themes that were expected, based on preliminary research (e.g., the importance of first-hand experience of already-existing DCRs) and emergent or unexpected themes (e.g., a learning relationship between Sydney and Vancouver) that recur (Boyatzis, 1998, Rice and Ezzy, 1999). While qualitative research does not make general claims about entire populations, this research's use of redundancy as a measure of generalizability and its coverage of 7 of the 9 DCR countries provides a basis for broad claims to emerge from the analysis.

## 4. Drug Consumption Rooms: Fixed, mobile, and political

Studying the spatial relations involved in policy-making sheds light on how siting harm reduction services, in particular DCRs, involves both place-specific material considerations and the knowledge and support of globally differentiated harm reduction services in other places. This is done through the process of policy mobilization, the advocacy, spread, and implementation of particular elements of policy models (drug policies, policy exemptions), and of physical technologies of the policy (DCRs). Space does not allow a full detailing of our research findings, thus we provide illustrative quotes that highlight key elements of a policy mobilities approach to the politics of DCR policy-making.

### 4.1. Mobilizing and assembling DCRs

Vancouver's DCR is the product of intense work by a remarkable coalition of local advocates, including people who use drugs (Kerr et al., 2004; Osborn and Small, 2006; Kerr et al., 2006; Wood and Kerr, 2006; Boyd et al., 2009). One important element of this work was the use of models and expertise from cities in other parts of the world to persuade local politicians, policy-makers, police agencies, and the general population that a harm reduction approach would positively impact the city's injection drug-related health crisis (McCann, 2008). The earliest official report to Vancouver council by a city planner who systematically detailed a harm reduction approach (MacPherson, 1999) explicitly focused on Swiss and German models of care. From the beginning, Vancouver's policy has been an assemblage of expertise and resources from close-by and far afield. Indeed, some of the elements of its current approach to drug use, including its focus on non-judgmental, low-threshold care, attempts to maintain good relationships with local police, and the explicit adoption of the Swiss "pillars" of enforcement, prevention, treatment, and harm reduction, are all evident in the report.

MacPherson's fact-finding trip to Frankfurt included visits to the La Strada, Konsumraum, and Eastside DCRs. His description of La Strada's injection room is striking in the way that it closely mirrors many of the elements of Insite when it opened four years later, including the process of entering and receiving equipment, the provision of individual places to inject, and the use of the café – or "chill room" in Insite parlance, a social space to monitor and make contact with participants:

> [It] is a fairly sparse well-lit room approximately 15 feet square with 7 tables for people to use to inject their drugs (one person per table). Individuals receive a small sterile kit from a staff member who records some basic statistics and the individual proceeds to the room. … After the user injects they are encouraged to hang around in the café section of the centre for a while. This allows more supervision of their behavior and a chance to maintain or increase contact with them. (MacPherson, 1999, 14)

Vancouver's subsequent *Framework for Action* report (MacPherson, 2001), which became the basis for its current policy, explicitly references evidence, including information about DCRs, from cities elsewhere, including Liverpool, Swiss cities, and Frankfurt.

The development of a local policy approach is never the work of one person. Indeed, cities in an age of globalization have managed to resist the desire for serial reproduction, and instead stand as assemblages of their particular situated social and political histories that interact with global trends of social policy and urban development (Massey 1991; Horvath, 2004). Therefore a model is not simply transferred from one place to another place. Rather, the process is one of drawing together multiple actors and elements from various places. Thus, as the policy-making process went on, Vancouver became part, not of a single pipeline of ideas from Frankfurt, but of a networked geography tying together numerous cities across the Atlantic. Furthermore, in the period between the new policy's adoption in 2001 and the opening of Insite in 2003, attention also turned across the Pacific, to Sydney's Medically Supervised Injecting Centre (MSIC).

While European cities provided Vancouver's harm reduction advocates with an overarching philosophy, a way of talking about the benefits of a harm reduction approach to Vancouver's citizens and politicians, and examples, evidence, and numerous models and operating procedures, Sydney's MSIC, which opened in 2001 under similar legal scrutiny as Insite, provided details of daily operating protocols. As a key figure in MSIC's founding put it,

> We had a lot of contact with the Canadians before [Insite] opened up. … [W]e shared a lot of our protocols … [A]s part of the license application process, we had to have very comprehensive internal management protocols before we opened the doors. So we did end up sharing all those protocols with Canada who were similarly needing to have that sort of thing. (Interview, Sydney, June 2011)

An analytical lens that focuses on how local health policy is produced through relations with other places, highlights this inter-local "sharing economy." The elements shared may include philosophies and justifications, protocols and practices, or physical things, from particular types of syringes and filters to architectural

elements and the organization of interior spaces (cf. Jacobs, 2006). Tracing how elements of policy travel aids our analysis of how harm reduction's global circulation is produced through specific practices and politics in local drugscapes.

The organization of facilities like La Strada in Frankfurt, located in a walk-up building in the city's railway station quarter, with a contact café and injection room on the ground floor and various rooms with services on the floors above is reflected in the organization of Insite and the related Onsite detox facility above. Not only does it show a continuum of harm reduction services within a singular care facility, but the similarities between MSIC and Insite speak to trans-Pacific connections that shape philosophies and technical practice of health care provision for people who use drugs. Both DCRs have three stages, each in a separate area of the facility: waiting and reception, injection room, and after-care or "chill" room. "We had … an architect come from Canada who looked at the space and rather liked the three-stage nature of it," recalls the MSIC representative. "That came from here" (Interview, Sydney, June 2011).

### 4.2. Mutation: shaping global models and local contexts

While harm reduction is a model of public health policy that is based in general principles, its origins and implementation are uneven and place-specific (HRI, 2012). Open drug scenes are local problems that can motivate politicians to accept change, and policy mobilization in the context of health policy for people who use drugs necessitates the molding of general models to specific circumstances. Advocacy for new policies always involves the identification of local problems that need innovative governance solutions and the definition of solutions that, while frequently drawn from afar, are locally sensitive. The Taunusanlage park in Frankfurt, Zürich's Platzspitz park, the steps by the Nervión river in Bilbao, and the intersection of Hastings St. and Main St. in Vancouver are all examples of such drugscapes. They became defined as political problems and harm reduction advocates strategically used these places to push for new approaches to policy, approaches based in public health and public order rather than steeped in criminalization.

In the center of Bilbao, a city renowned for its tourist-oriented redevelopment, "the problem on the streets was so visible … and drug consumption in the center of the city didn't match the idea of Bilbao. So … that moved [the] administration to agree with the DCR" (Interview, Bilbao, October 2011). The motivation to establish a harm reduction approach in Bilbao was situated in relation to flows of global capital, and economic development in the local urban context. Similarly in Zürich,

> There was the historic main station. There's a museum where there's a monument … where you would have all the tourists around for sightseeing and then you would have this huge park which was a big open drug scene. … So it was like during that time they really started to act. They had to. … [Politicians concluded that what] "we have to do really is to take pressure off … the public road, like get people off the streets." (Interview, Zürich, June 2010)

In other cities, like Vancouver and Sydney, worries about tourism and the city's image were less prominent. In those cases, the public health harms to IDUs and to others who might encounter drug-related litter were emphasized. In both these cases, the politics of molding the general harm reduction model to specific places involved coalition-building among various impacted communities. Furthermore, in all the cities, local adoption was only possible because other levels of government had a "specific orientation towards harm reduction" (Interview, Bilbao, October 2011) that allowed regulations to be adjusted and funds to flow to new harm reduction initiatives like DCRs.

In cases like Sydney and Vancouver, where DCRs were highly controversial and existed at first as temporary trials under great public scrutiny, it was essential to mold the general principles and practices underlying European DCRs (a category which is itself internally differentiated) to these conditions – in essence, to make the facilities as unassailable as possible (Van Beek, 2004). Like Insite, Sydney's MSIC has undergone extensive and rigorous evaluation (MSIC, n.d.), a situation that both framed its operation and helped it weather scrutiny and criticism. As the MSIC representative puts it,

> [A]t the beginning … journalists [were] saying, you know, "Which model? Was it the Frankfurt model or …?" and I said, "Well now it's the Kings Cross [neighbourhood] model!" So the model is actually quite different to any of the European rooms. By this stage too it was apparent that we were going to be under 24-hour seven-day-a-week media and political scrutiny… So it needed to be… a model that could deal with the high profile. (Interview, Sydney, June 2011)

Furthermore, MSIC's founders also chose to name their facility a *Medically* Supervised Injecting Centre, which they believed would both reflect their approach situated in a clinical model of care and justify their operation politically.

> [In Europe] they are very informal [in how they run DCRs] and they were very much more social welfare focused models rather than health models and I didn't think that that [social welfare] model … would be acceptable [in Sydney] … but I was also a bit more ambitious anyway for the clients. … I think that we're still a little bit more assertive as far as wanting to move people along and get them into treatment .(Interview, Sydney, June 2011)

Another local contingency in the development of the "Kings Cross model" – and one that would become a model for Vancouver – involved the three-stage organization of MSIC, as discussed above. This was the result of the building they were able to rent: "the premises also dictated the way the service was going to be operated at this location. So all of those things sort of had an impact on the type of model" (Interview, Sydney, June 2011). Sydney, then, highlights a number of ways in which what gets "imported" as a model in one place and what emerges from that place as a model for others must be both molded to and also abstracted from specific contexts. Thus, attempts to use models of harm reduction facilities from elsewhere to address problems in cities must be very sensitive to local politics, the character of drug use, built environments, and the governance of public health in each place. This argument is contrary to the 2012 Insite court ruling, for example, which, while welcome in many ways, stipulates that any new facilities across Canada must be implemented exactly as the existing Insite facility has been. Attention to local drugscapes then must also be attentive to appropriate harm reduction interventions, including harm reduction service provision beyond DCRs, such as public education, syringe exchange, or opioid substitution therapy.

### 4.3. DCRs as sites of persuasion and learning

If DCRs are sites shaped by the molding of generalized models into concordance with local priorities, it is important to note that they also play an important role in shaping those generalized models. Specifically, DCRs are powerful points of reference and exchange in the circulation of harm reduction among communities of public health practitioners, policy-makers, and advocates

worldwide, even as the DCR model itself has become part of that global circulatory system (McCann, 2011b).

Furthermore, DCRs are destinations for "policy tourism" (González, 2011; Cook and Ward, 2011) – where policy actors travel to experience, first-hand, particular policies and practices and to learn directly from practitioners. Staff in the DCRs that tend to be most visited, like Vancouver's and Frankfurt's, think carefully about how they convey their stories. As an Insite manager puts it,

> If there are people coming to try and get ideas and influences and take them back to their jurisdictions, … I want something to stick four weeks or six months from now. And I know that's not going to be very much. … And what I try and get to stick are a few concrete images. … And you want to be able to answer; you want to be able to give people what they want to know. (Interview, Vancouver, November 2010)

The persuasiveness of their storytelling is reinforced by the fact that their audience is *in place*. During visits, they are able to explicitly show, not just tell, how DCRs operate. There is an explicit intention to "demystify" the operation of the rooms, both for traveling delegations and also, importantly, for local residents and politicians. As the MSIC representative puts it, "[W]e have community tours on a regular basis. That's been important to demystify [MSIC]. People actually seeing the physical room, it reassures people … [S]howing people the very clinical nature was massive. To reassure people that this really is a health service" (Interview, Sydney, June 2011).

Yet, tours of DCRs are not only about public education and political persuasion, they are also sites of learning and support for like-minded peers, including operators of other DCRs. When asked if his visits to DCRs in Barcelona were valuable to him, a manager of Bilbao's room said,

> Yes, absolutely. Not just [the] place but how the DCR is thought to be working. The ideological background, because *it's not the same everywhere* … how according to different situations a DCR is thought to [work] compared to [how it is] working. (Interview Bilbao, October 2011)

This is a point emphasized by a member of the organization that runs Insite and one of the first people from Vancouver to visit German DCRs,

> [W]hen you tell people that you've actually seen [a DCR], they lend greater credence to what you're saying. … Personal experience cannot ever be underestimated, right? You know, it normalizes it. (Interview, Vancouver, June 2007)

The lesson learned on that trip was subsequently reflected in a mock-up of an Insite injecting booth that has been taken to conferences and other events to provide a personal experience even for those unable to travel to Vancouver.

On the "supply side" of these professional encounters, staff at Sydney's MSIC express willingness to welcome visitors: "I think its really important. You know seeing is believing; you can only learn so much I think, from afar. I think its really important having people visit. … [Y]ou learn something every time you go, you see something that a service is doing and you ask questions" (Interview, Sydney, June 2011). Similarly, in Vancouver, a city that has now become a destination for policy tourists looking to learn, Insite staff are keen to continue to engage in global circuits of knowledge about harm reduction. Rather than a one-way stream of expertise flowing west across the Atlantic, an Insite manager argued that "the Atlantic situation's been reversed and we [now] have a lot to offer Europe" (Interview, Vancouver, November 2010).

## 5. Discussion

In this article we argue that harm reduction policy-making is characterized by an inter-local "sharing economy" in which global models are strategically used in decision making processes regarding the appropriateness and siting of health services for marginalized people. Our analysis suggests that the social/geographical process of mobilizing DCRs involves a commitment to knowledge exchange by DCR managers and other harm reduction advocates, whose educational effectiveness is place-based. It is partly a result of their own intensely local experiences and their ability to highlight their own credibility while transcending the particularities of their specific places. It is in these places and encounters that local models are articulated into more generalizable and mobile lessons. Thus, through the work of DCR advocates, the localness of specific models becomes a major resource underpinning the model's ability to spread globally and to affect places elsewhere.

By paying attention to how public health responses to local drugscapes are mobilized in global networks of harm reduction, this article begins to highlight how local evidence can be usefully applied to harm reduction policy advocacy and implementation in other places. Yet, the exchange of knowledge is neither the complete story, nor should it be seen as a transparent process – one that is free of power relations and imbalances. Politics at scales from the local to the national and international are crucial to drug policy. It conditions the character of implementation, funding, and even what is considered to be a valid topic for discussion in policy discussions. At a more micro-level, politics defines the composition of delegations that visit model programs elsewhere and defines which actors are able to attend conferences and other knowledge-exchange events. Knowledge exchange and politics are, thus, two sides of the same coin, but space does not permit a full discussion of the politics that condition the networks of knowledge exchange regarding harm reduction and DCRs (but see McCann, 2008, 2011; Boyd et al., 2009; Ashton and Seymour, 2010; Temenos, Forthcoming). The politics of DCRs' mobilization is evident in how they have not spread to many parts of the world, like Russia, for example. Indeed, even when they have traveled, they do so partially and unevenly. Paying attention to things that do not move at all, that seem to only move in certain directions, or that appear to be left behind is instructive in highlighting the connections between knowledge exchange and politics of various sorts. One procedural and one philosophical element of DCRs illustrate this point about "differential mobilities" (Sheller, 2011, Temenos, 2014).

First, DCRs in different contexts allow different forms of consumption. Sydney and Vancouver are explicitly *injection* sites, while some sites in Europe allow inhalation. The reasons why *consumption*, more broadly than injection, has not moved from Europe to the "outpost" DCRs elsewhere may reveal not only differences in locally available substances and cultures of use, but it can also speak to regulatory restrictions placed on the establishment of DCRs. Certain methods of consumption – injection versus inhalation, for example – are associated with different levels of risk (Rhodes, 2009). Injection is seen as a higher risk activity with more dangerous health and other material effects (blood-borne disease, used syringes), and therefore in some places it has been deemed acceptable to medically intervene using harm reduction public health practices. Even within facilities that allow injection drug use, certain forms of injection, such as jugular or femoral injection, are not uniformly permitted. These differences and immobilities raise questions about the political frontiers of harm reduction: should the scope of consumption in existing injection sites be broadened, should various spatial models of DCRs (from "store-fronts" to rooms within larger health care facilities) be established to cater to different populations in specific cities, or should the regulations governing the opening of new sites be

written flexibly, to accommodate new consumption methods and newly popular drugs in the future?

A second set of DCR characteristics that have not traveled so much from their "heartland" in the Netherlands, Germany, and Switzerland, relate to the social orientation of harm reduction practices. Harm reduction philosophy is predicated on reducing medical and social risk to people who use drugs and to society, but, given its social movement origins, it is also a philosophy that seeks to empower people who use drugs. Within the philosophical context of what harm reduction means as practice, concerns about the growing emphasis on the medicalization and professionalization of harm reduction (at the expense of models of harm reduction based in social service or even more grassroots paradigms) are regularly expressed (e.g., Roe, 2005; Schatz et al., 2010; VANDU, 2010; McLean, 2012.) Therefore, differences among DCRs in terms of their related role as drop-in centers, the involvement of peer-support workers, and their level of formal protocols and procedures might prompt discussion about the overarching principles of the harm reduction movement: What is lost and what is gained by a DCR model that incorporates, or does not incorporate, a wider set of functions and types of participation beyond consumption? Should DCRs be seen as one-stop multi-service health-care and social-service facilities or as single-function sites within neighborhood-wide networks of care? How is risk perceived and evaluated in local contexts? We suggest that these and other questions and strategies can be brought to light through an understanding of harm reduction and DCRs as fixed and mobile, local, political, and globally interconnected.

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