Beyond failure: The generative effects of unsuccessful proposals for Supervised Drug Consumption Sites (SCS) in Melbourne, Australia

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Abstract

Focusing on the 20-year history of unsuccessful proposals for Supervised Drug Consumption Sites in Melbourne, Australia, this paper highlights the generative effects of apparent 'failure' in policy-making and policy mobilization. Rather than framing thwarted proposals as categorical failures, we show how they altered parameters of policy acceptability, invigorated policy and practitioner networks, facilitated the development of allied programs, and, recently, inspired a successful SCS proposal. The paper argues that apparent policy failure and the potential for policy change must be evaluated and conceptualised in terms of variously long historical timeframes. In doing so, the paper contributes to ongoing debate over the conceptual and empirical status of failure in policy mobilities literature.

Keywords: Failure; harm reduction; drug consumption; policy-making; policy mobilities; Melbourne

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Introduction

On 31 October 2017, Daniel Andrews, the premier of the Australian state of Victoria, made an unexpected announcement: overturning his previous opposition, he announced the impending approval of a 'Supervised Injecting Room' in North Richmond, an inner-urban neighbourhood of Melbourne. "This is a change in policy […] no question about that", he stated, "[but] it's a change that is very much needed" (quoted in Barlow 2017: n.p.). The facility will become Australia's second Supervised Consumption Site (SCS)[1] at its planned opening as a time-delimited trial in 2018. The change in policy coincided with a sharp increase in overdose deaths, centred in North Richmond, echoing the circumstances that surrounded the establishment of Australia's first SCS in 2001: the now internationally renowned Medically Supervised Injecting Centre (MSIC) in Sydney.

News coverage of the Melbourne SCS plan emphasised that the recent advocacy efforts of several organisations and individuals had been decisive in the Premier's decision. A coalition including local business owners, medical professionals, police, community organisations, independent members of parliament, and the state coroner had created significant pressure in the years preceeding the decision (Towell and Preiss 2017: n.p.). Yet, the recent announcement cannot be disentangled from a much longer history of advocacy for SCSs in Melbourne. Greg Denham, executive director of the Yarra Drug and Health Forum, a key organization in the pro-SCS coalition, paid tribute to those whose efforts, over 20 years, paved the way for Melbourne's long-awaited SCS. "Despite many 'ups and downs'", he stated, "those committed to the cause […] never lost confidence […] that one day the 'planets would align' and such a centre would be set up" (Denham 2017: n.p.). Given the history of that struggle, however, it is likely that Denham and his allies will neither assume that the new SCS will be opened until they actually see it in operation, nor will they believe that advocacy for SCSs is only about establishing one particular type of facility for the consumption of drugs. As we will demonstrate, the effects of SCS advocacy—even when such advocacy appears to 'fail'—are multiple and, often, highly unpredictable.

Since the 1990s, people who use drugs (PWUD), allied advocates like Denham, service providers, and policy-makers have developed and identified models that address the harms of illicit drug use in ways that counter dominant criminalization approaches and their accompanying stigmatization of PWUD. These harm reduction models include needle and syringe distribution, methadone prescription, and more advanced interventions like SCSs, which have been accepted as effective and replicable models by public health practitioners (EMCDDA 2017). Harm reduction is a philosophy and set of practical interventions developed to reduce the health, social, and economic harms of illicit drug use (e.g., from overdose and bloodborne disease, to drug-related litter, to the high costs of emergency room visits), without necessarily expecting reduced drug consumption or demanding abstinence.

SCS have been operating in European cities, including Bern, Frankfurt, and Amsterdam, since the mid-1980s and are also operating in Canada. They are either legally sanctioned or they operate in a legal grey zone. People bring drugs they have obtained elsewhere and consume them using equipment provided by trained staff. Drugs are consumed by injection, inhalation, or intranasally, depending on the regulations governing individual sites. They are observed by staff during and after consuming and they are often offered advice and resources. Despite the dangers of the unregulated drugs involved, there have been no deaths in the over 100 SCSs operating in 11 countries since 1986 (Global

Platform for Drug Consumption Rooms, n.d.). The model is a travelling one, mobilised among cities in Europe and elsewhere by public health practitioners, PWUD, and their allies in response to shared problems associated with concentrated drug use in inner-urban and suburban locations – places drug policy researchers have described as "'drugscapes,' areas of cities […] produced by social isolation and underdevelopment, where certain patterns of drug use are more likely to occur [and where] geographies of containment are created, enforced and reinforced" (Tempalski and McQuie 2009, 7). Yet, SCSs differ from place to place depending on locally-specific drug use characteristics, regulatory frameworks, and public health problems (McCann 2008, 2011b; McCann and Temenos, 2015).

Sydney's MSIC has been an important, if geographically isolated, reference point in global discussions of SCSs. In the lead-up to its establishment in 2001, the MSIC was expected to be one of three Australian SCSs, but similar initiatives in Canberra and Melbourne did not come to fruition. Thus, the Australian experience offers an example of the successful mobilization of the SCS model from its European heartland to the Southern Hemisphere, and a paradoxical example of what, until Premier Andrews' 2017 announcement, might be called a 'failure' of attempts to mobilise and proliferate the SCS model across a wider range of cities. How do we understand the apparent inability of a globally-circulating model to be embedded and operationalised in a particular locality? In this paper, we address this question through the 20-year history of SCS proposals and their effects in Melbourne. In doing so, we make two contributions. First, we conceptualise policy 'failure' in terms of its complex social, political, spatial, and, particularly, temporal contexts. Second, building on this perspective, we analyse 'failure' in one historical moment to address how the politics of policy-making and the derailing of particular proposals may generate subsequent outcomes nonetheless.

As we argue in the next section, failure cannot be taken at face value or understood as a discrete condition. Highlighting the generative possibilities and pathways of apparent failure in policy-making and policy mobilization contributes to the ongoing debate over the conceptual and empirical status of 'failure' in policy mobilities literature. To substantiate this argument, we provide an account of the politics of the Melbourne case in the subsequent section. This discussion explores the generative effects of SCSs proposals that did not come to immediate fruition. Rather than framing such thwarted attempts as categorical failures, we show how they not only inspired the recent apparently successful campaign for an SCS, but, over the past 15 years, they also altered the parameters of policy acceptability and invigorated policy and practitioner networks. The generative effects we discuss may be linear (a policy fails, actors learn from the failure, and a new modified policy is created) but we would suggest that, in most cases, policy-making and policy 'failure' are defined by complex causalities and overdetermination. Therefore, the specific ways in which policy 'failure' generates new strategies are contingent on the socio-spatial context in which policies are debated and reworked and, thus, they must be analysed and conceptualised in and through specific cases. In Melbourne, the post-'failure' outcomes led to the establishment of other services that many local actors believe were different, but appropriate, applications of harm reduction principles to their specific local situation. We conclude the paper by emphasising the political aspect of policy-making and policyfailing (Wells 2014) – a theme that is evident throughout the paper but that is worth emphasizing in terms of its consequences for the analysis of policy mobilities.

Our discussion is based on analyses of documentary materials and key informant interviews. We reviewed documentary materials, including news media articles, government documents, and activist publications, from the last 20 years. Recurring themes were identified and the materials were used to provide an overview of defining debates and important actors. The documentary research supported a subsequent set of semi-structured interviews with 10 actors who were involved in policy debates and service delivery in the late 1990s, when SCSs were first proposed in Melbourne. Interviews were conducted in Melbourne in June 2016. Interviewees ranged from harm reduction advocates, social service workers, health researchers, a lawyer, a former police officer, and a senior politician, among others. Interviews were recorded and transcribed, then analyzed for recurrent themes in tandem with thematic analysis of documentary materials (Boyatzis 1998, Rice & Ezzy 1999). The analysis is further informed by one co-author's long-term international study of SCSs (Longhurst and McCann 2016, McCann 2008, 2011, McCann and Temenos, 2015).

Failure and beyond

Accepting, to a greater or lesser extent, the premise that "[m]obility is an inherent characteristic of policy" (Freeman 2012, 20), the policy mobilities literature seeks to characterise, conceptualise, and empirically investigate the ways in which policies and policy knowledge travel, how these travels create ever-incomplete similarities among diverse places, how policy-making is political, and how it is often as much a global as a local process (McCann 2011a; McCann and Ward 2011). In a recent discussion, Ward (2017) provides a valuable summary of the key elements of the policy mobilities approach. The literature foregrounds the ways in which places are produced through relations that run through and extend beyond them, as well as by the territorialised politics within them. While multiple types of relations constitute places, studying policy-making as relational place-making is a valuable contribution to both the study of place and policy. Drawing on the wider mobilities literature (Sheller and Urry 2006; Adey et al 2014), the policy mobilities approach also takes seriously the interstitial spaces and activities among sites of policy development and adoption. Transit and translation, in this sense, are productive activities and, therefore, policy mobilities simultaneously involve mutations, both of the policies being circulated and of the places through which they circulate. This is a social process, so the literature has focused heavily on the various actors involved, from politicians, policy professionals, representatives of global organizations, and consultants, to social movement and community activists, among others. The focus on 'transfer agents' in mobilizing policy emphasises "the embodied and performative nature of the work done [and] the importance of how people communicate and interact" as well as "the various objects, spaces, technologies and times that facilitate" mobilizations (Ward 2017, 13). These actors work in, through, or in reference to institutions and informational infrastructures, particularly for the swift proliferation of hegemonic policy models (Peck and Theodore, 2015), but also for models that move at moderate speeds and, occasionally, for the spread of counterhegemonic ideas (Massey 2011). Therefore, actors involved in promoting or questioning policy mobilization are continually engaged in some form of politics. Problematisation, comparison, 'solutioneering', and persuasion, are all elements of the 'supply side' politics of policy mobilities, taking place both at a distance and, crucially, in what Temenos (2015) calls the "convergence spaces" of conferences, fact-finding trips, etc.

(see also Cook and Ward 2012). As we will see, the impulse and imperative to mobilise policies is often met by resistance or skepticism, among other potential barriers.

The development of the policy mobilities literature over the last decade has been marked and facilitated by a rich 'rolling conversation' (Peck 2011) among various interlocutors. The literature has been challenged to better historicise the processes it studies (Harris and Moore 2013), to focus both on the topologies, as well as topographies, of invention/adoption among locally-based urban actors who "arrive at" new policies (Robinson 2013, 2015), and to broaden its scope beyond neoliberal policies and beyond the global North (Bunnell 2015). Yet, perhaps the most persistent critique has been around the question of 'failure'. Is the literature 'successist' (i.e., focused on success while blind to wider complexity)? Can it adequately account for policies that do not get mobilised, that come to nothing, that have unexpected or negative effects after they are implemented, or that continue to be mobilised after having fallen flat?

'Failure' as a focus of the policy mobilities literature

Given its constructivist orientation, 'failure' and 'success' are conceptualised as socially produced, spatially situated, and power-laden in the policy mobilities literature.[2] Failure and success are not natural, nor entirely distinct. They are relationally interconnected (McCann and Ward, 2015). For example, Ward (2006, 70) notes that policies are "'made' into […] success[es]," and, he continues, "there is nothing natural about which policies are constructed as succeeding and those that are regarded as having failed." Over its first decade, the literature has continued to acknowledge the role that constructions of failure play in the practice and politics of policy-making, while largely pursuing a very reasonable attention to policies that have moved and been implemented as the best way of fleshing out the conceptual contours of the approach (Baker and Temenos 2015).

As a result of this dominant orientation, the appearance of failure in the literature has largely been in the form of critique. Critics have questioned what they see as an over-attention to successful examples of policy implementation and to the mobilization of successful policy models. Jacobs (2012, 419), in one of the earliest critiques, calls for more attention to "[s]ites of failure, absence and mutation" (see also Clarke 2012). This argument has emerged in parallel and, frequently, in combination with charges of problematic 'presentism' (McFarlane 2011; Jacobs and Lees 2013; Harris and Moore 2013), a term that can be read as connoting either an overt focus on the contemporary (neoliberalised) period (Bunnell 2015) or, more pertinently to our discussion in this paper, a tendency to be attracted to cases where policies associated with one place are present elsewhere, suggesting their successful implementation. More recently, these critiques have gained momentum. "[I]t is necessary to pay attention to […] interruptions, exceptions, and stalled attempts at policymaking," Wells (2014, 475) argues. These are "moments in which policies are defeated, stopped, or stalled," she continues. Stein et al (2017, 36) go as far as to identify a "success bias" in the literature. They also "argue that it is necessary to examine failure, resistance and contradictions [by] focusing on breaks, cuts, stoppages and detours." Lovell (2017, 4), for her part, argues that "policy mobilities research is overwhelmingly about policies that do work and are 'present' – publicly promoted and discussed as successes."

Clearly, policy mobilities researchers should take failure seriously. After all, there are numerous cases where policies fail on their own terms. Stein et al (2017) study the uneven fortunes, and frequent failures, of Business Improvement Districts in Germany, for example. They emphasise the various contextual conditions that can stymie the smooth 'transfer' of a neoliberal policy fix. They rightly stress that policy mobilization is a "contested, fractured and often inherently contradictory process marked by unpredictable outcomes" (Stein et al 2017, 28). Lovell (2017a) discusses a failed smart electricity metering program in the state of Victoria, Australia, and how, despite failing on its own terms, was discussed in other states, and then nationally, as a cautionary case to be explicitly disavowed. Some policies plainly do not achieve their stated or implied aims. Worse still, they can motivate consequences and reactions that further exacerbate the problem they are meant to address. Failure is an apt term to describe the reality of such occurrences.

Contextualizing, temporalizing, and differentiating failure

Policies are "embedded within […] particular social and cultural worlds or 'domains of meaning' [that they] create as well as reflect" (Shore and Wright 2011, 1-2). Therefore, studies of the limits of policy mobilization must extend beyond *prima facie* understandings of what failure is and analysis of these limits should avoid fetishizing, simplifying, dichotomizing, or reifying failure. Analyses can address how the effects of an attempt to implement a policy model are defined, either on their own terms or by their differential impacts on a range of interests and constituencies in specific social, spatial, and temporal contexts. As we will suggest in the following paragraphs, this nuanced approach is already evident in recent writing on failure in the literature. It is a promising orientation to which we hope to contribute through our case study, by considering the long-term after-effects of attempts to introduce the globally-mobile SCS model to Melbourne. A consideration of the complex effects of those thwarted attempts allows us to address what failure meant and did not mean in this specific case. The case also allows us to show how researching a relatively long historical timeframe influences our understanding of policy advocacy, policy mobilization, policy-making, and policy failure. In turn, it raises questions about which concepts and terms are most appropriate rubrics under which to address the fate of policy models in certain contexts.

These questions have been raised by others. For example, the brief and provisional critiques of the policy mobilities approach by Jacobs (2012) and McFarlane (2011) suggested that there was more to policy-making and policy mobilization than had been captured in the literature, which was very much in its infancy when they wrote. It is telling, for example, that Jacobs (2012, 419), who critiques a tendency to focus on the repetition of policies rather than on their differentiation, argues that "[s]ites of failure" *but also of* "absence and mutation are significant empirical instances of differentiation." She then calls for analysis of "the motives and politics of action-in-the-name-of-differentiation, reaction, rejection, de-activation, detour, redirection and failure" (ibid.). The point, then, would be to pursue a 'differentiation-focused' agenda in the study of policy mobilities.

Longhurst and McCann (2016), for example, examine the politics of harm reduction in Surrey, BC, Canada, a suburban municipality in Greater Vancouver. At the time of the study, the implementation of harm reduction models in the city was staunchly resisted by local politicians and police, despite being central to overarching Provincial health strategies.

This resistance was set in particularly stark relief by Surrey's proximity to Vancouver, a city globally recognised as a successful model and mobiliser of harm reduction approaches. While Surrey's recalcitrance could be interpreted as evidence of a failure of the model's mobilization, the study suggests that definitions of 'failure' are influenced by changing social and political contexts and by the ways in which research into the case is temporally delimited. Thus, the Surrey case supports a conceptualization of *constrained* policy mobility in which barriers, boundaries, and frontiers of mobilization are understood as spaces of alliance building, debate, persuasion, experimentation, and persistence as key actors wait for political and other circumstances to change. This argument has subsequently been borne out as a huge increase in overdose deaths and continued pressure from activists and public health officials led to the establishment of two SCSs in Surrey, despite the objections of local business and political leaders (Britten 2016; Reid 2017).

The timescale of one's analysis is, therefore, crucial in the study of policy mobilities and policy failure. Furthermore, it is problematic to entirely separate success and failure in these sorts of analyses (McCann and Ward 2015). Wells' (2014) notion of "policyfailing," addresses both these points. Policymaking and policyfailing are two sides of the same coin, she argues: "systematic regulatory failing is endemic to governance and likely constitutes the actual essence of policymaking efforts" (ibid., 479) and, she continues, 'policyfailing' is "an ongoing and unstable process rather than […] an unequivocal achievement" (ibid., 488). Just as no policy model is forever, an apparent policy failure is not necessarily an end-state. The fate of a policy and the effects of failure are matters of power and politics, as Wells (2015) argues elsewhere. Competing agendas, not only between proponents and antagonists of a particular policy but also among these 'camps', can both make a policy fail and also complicate, reformulate, and redirect its post-failure future. In Chang's (2017) study of an early attempt to build a model eco-city in Dongtan, "failure matters" because the context of her study is defined more widely (spatially and temporally) than simply a focus on the story of Dongtan, from its planning to its failure. Rather, by tracing the legacies and travels of Dongtan's failure, she is able to show its influence on a subsequent eco-city development elsewhere in China. Complicating the division between success and failure, while echoing Wells in her discussion of unpredictability and process, Chang argues "that a model may not be successful in its implementation but remains successful in its mobility" (ibid., 1721). Moreover, Chang's research shows that failure can generate and facilitate further learning, innovation in, and differentiation of policy. She notes that McFarlane (2011, 373-374, our emphasis) sees failed initiatives as helpful to learning because they can initiate "new habits of working and challenging regimes of truth, as well as building capacities of engagement [with] the potential of transformation, and of the emergence of a *different* kind of city."

As we have shown, the policy mobilities conversation has long been marked by attempts to develop a critical and nuanced approach to all aspects of policy-making and policy advocacy, including the question of failure. A number of scholars have pushed beyond thinking in terms of stark and unequivocal failure (set against studies that *supposedly* look for and find stark and unequivocal success). Instead, they explicitly refer to and grapple with questions of differentiation, mutation, fragility, unraveling, instability, emergence, detour, redirection, reaction, rejection, de-activation, and absence. This constellation of terms, drawn from the works discussed above, suggests that scholars are unpacking and differentiating failure in their analyses. It also highlights the centrality of

time and temporality in politics and policy-making, as has been recently noted by anthropologists (e.g., Harms, 2013; Abrams, 2014) and geographers (e.g., Anderson, 2010; Wood, 2015; Bunnell et al, 2017) among others. In what follows, we approach an example of apparent failure in this way and add to the ongoing conversation by examining its long-term generative effects, where these effects are understood to be complex, non-linear, overdetermined and operating in co-constitutive relationships with their socio-spatial contexts.

Crisis politics: The fate of SCS proposals in Melbourne (1997-2002)

The most intense period of advocacy and public debate around proposals for SCSs in Australia occurred between 1997 and 2002, amid a sharp increase in rates of heroin overdose and overdose-related death in large Australian cities. In Canberra, Sydney and Melbourne, distinct but interconnected coalitions of community groups, politicians, health practitioners and researchers sought to respond to the unfolding public health crisis with a range of harm reduction initiatives (Dietze et al 2001). These included the expansion of existing initiatives, such peer education and needle/syringe exchange programs, but also involved moves to implement new harm reduction initiatives, such as drug/alcohol recovery spaces, heroin prescription, and SCSs.

Proposals for SCSs were the focus of state-level political debates —in the Australian Capital Territory (ACT), New South Wales, and Victoria, respectively—because of the central role that state governments play in funding drug treatment services and creating the legal environment for SCSs to operate. In 2000, the proposal for a SCS in Canberra was wrecked on the shoals of budget negotiations between the sitting government and independent members of the ACT legislature (Gunaratnum 2005). A public referendum was later considered but never held, and no significant attempts to implement a SCS have been made since. As we have noted above, the proposal for an SCS in Sydney was successful and the resulting Medically Supervised Injecting Centre (MSIC) opened in 2001 as a pilot program. It was subsequently given a longer mandate and at the time of writing (June 2018) continues to be the only operating SCS in Australia. Sydney's MSIC is widely regarded—domestically and internationally—as a highly effective public health intervention (KPMG 2010). For a time, proposals for SCSs in Melbourne seemed to have sufficient momentum to lead to the creation of at least one. However, this was not to be, until the recent announcement of a plan to open one in North Richmond. "The policy process [in the late 1990s and early 2000s involved] a lot of actors and [was] politically complicated too," one senior health researcher recalled (Interview 8: health researcher). This complex process can be broken down, heuristically, into three phases.

Phase 1: The 'heroin crisis'

The first, from 1997 to 1999, was characterised by the emergence of what was commonly called a 'heroin crisis', which created political opportunities for advocates to suggest new public health initiatives and approaches. Melbourne's heroin-related deaths had increased from 49 in 1991 to 268 in 1998 and cases of non-fatal overdose increased significantly, resulting in "widespread recognition of the urgency of the problem of heroin overdose" (Dietze et al 2001: 437). Increases in heroin-related harms were generally thought to have

resulted from a 'glut' of inexpensive, relatively pure heroin, high-risk drug use practices, and the emergence of open drug markets in several locations. The visibility and scale of heroin-related harm and the related 'disorder' observed in public spaces encouraged, at least for a time, a view that the heroin crisis was one of public health, rather than criminality or individual fault (Fitzgerald 2013). A senior figure within the Melbourne drug treatment sector described the situation:

> The mayhem of open drug markets was a new thing that we'd never had before and then the failure to actually maintain public amenity in relation to injecting equipment was important. There were needles strewn about […] playgrounds and on beaches and public transport and shopping centres. […] There was a level of sympathy in the community as well. The *Herald Sun* is a tabloid [Rupert] Murdoch paper and they used to run the overdose toll next to the road [accident death] toll [on the front page]. They were milking it in a way, but on the other hand, at least they were actually paying attention to it. (Interview 5: drug treatment professional)

The first SCS proposals came in 1997 as the heroin crisis worsened. In August 1997, the City of Greater Dandenong, in outer Melbourne, released a report advocating for the introduction of 'Safety Clinics'. One month later, Eddie Micallef, a member of the Victorian state legislature, proposed an SCS in the suburb of Springvale, within the same municipality. These proposals signalled the start of a protracted period of debate, research, policy development, and electoral positioning that incorporated state government and several municipalities within the metropolitan area. Individual councillors from the City of Melbourne and the City of Maribyrnong signalled their support for an SCS within their jurisdictions, while the City of Port Phillip and City of Yarra voted in favour of trial sites. One interviewee noted that "it took a year or two until the idea made its way into the state government political process—then it just gathered steam" (Interview 8, health researcher).

Separate from local and state government, a group of people associated with Wesley Central Mission, a church in the Central Business District, took it upon themselves to construct an SCS—at significant financial and reputational risk—by refurbishing a building on church grounds. Sensing that the political winds were shifting in support of one or more SCSs, their initial intention was to open the facility once local planning approval was granted and enabling legislation at the state level had passed (Interview 9: harm reduction advocate). When conservative Liberal Party premier Jeff Kennett's support for SCSs appeared to soften in the lead-up to the September 1999 state election, the Wesley Central Mission group met with the premier's staff and threatened to open the facility as an act of civil disobedience (a strategy used, over the years, by SCS advocates in Europe, Canada, and in Sydney (Wodak et al 2003)):

> We walk in and we meet [an advisor to Premier Kennett]. There's nine of us and one of him, God bless him, and we say we've made a decision: we're opening [the SCS] without regulation or legislation. We don't care what the consequences are. I've never seen a man's face change colour so fast. He leaves the room and is gone for forty minutes. He comes back in and he says, 'if […] you don't do it [until] after the election, we will pilot one [if elected]'. (Interview 9: harm reduction advocate)

With an assurance from the premier, and widely-held expectations that the Liberal Party would be returned to government at the upcoming election, the Wesley Central Mission group agreed to wait and, as a result, a fully-functional SCS sat unused in the city centre.

Meanwhile, the opposition Labor Party sought to differentiate itself from Kennett's Liberal Party government and to capitalise on emerging professional and public consensus regarding the acceptability and necessity of SCSs. As part of their election platform, Labor announced a trial program with not one, but five SCSs across the Melbourne metropolitan area, pending community consultations in the areas surrounding the proposed site of each trial. In September 1999, opposition leader Steve Bracks led the Labor Party to an unexpected electoral victory, which saw the party form a minority government with the support of three independent members of the Legislative Assembly (the lower house of state parliament). The Legislative Council (the upper house) remained under the control of the Liberal and National parties.

Phase 2: The Labor Party's support for SCSs

The Labor government's subsequent attempt to implement trial SCSs, in the period from 1999 to 2000, marked the second phase in Melbourne's history of SCS proposals. With the SCS trial sites high on the new government's agenda, advocacy efforts quickly intensified on both sides of the issue, and the positions of politicians, community groups, and others hardened. Disagreement among Christian groups was particularly pronounced. Father Peter Norden, director of Jesuit Social Services, came out in support of SCSs, claiming that it was "very immoral for Christian people to stand by [during such a crisis.] Safe injecting rooms are not about encouraging heroin use, they are about keeping people alive" (cited in Duffy 1999: 32). Melbourne's Catholic Archbishop George Pell took a different stance. Noting that involvement by Catholic organisations was "misdirected compassion", he reportedly used his influence in the Vatican to have a decree issued by the Congregation for the Doctrine of the Faith to ban Catholic groups from involving themselves in SCSs (Duffy 1999: 32). Opinion was also divided in the local city councils, particularly the City of Melbourne, whose councillors were airing their disagreements in the media on whether to support or oppose the proposed SCS in the city centre (Strahan 1999: 9).

With signs of an increasingly fractious public debate, and concerns about the new government's fragile parliamentary majority, Premier Bracks' "approach to governing became one of very small steps and a very conservative approach" (Interview 1: health researcher). He outsourced policy development and consultation to an independent Drug Policy Expert Committee, comprised of key actors within Victoria's drug research and drug treatment fields. The Committee was charged with conducting public consultations on the proposed SCS trial and providing wide-reaching recommendations for the implementation of SCSs and other harm reduction initiatives to address the heroin crisis. Instead of providing a release valve for the discontent of certain segments of the public, however, the consultations provided more opportunities to call the appropriateness of SCSs into question. Advocacy groups sprang up in response to specific trial sites. In one inner suburb, a supportive group, called Footscray Cares, and an oppositional group, called Footscray Matters, were heavily involved in efforts to sway local political and public opinion. While survey results released by the Drug Policy Expert Committee in April 2000 showed support from 64% of residents in the vicinity of the trial sites, rancorous public meetings and, at times, sensationalist media coverage amplified the impression of a deeply divided populace. As the Liberal opposition health minister at the time noted:

> in my mind, when Labor floated this idea they made a fatal political error: they announced where the sites were going to be. Politically, we'd pressed them on that […] The community went ballistic. (Interview 7: politician)

Phase 3: From legislation to rejection

Nonetheless, in May 2000, the Labor government moved ahead by introducing a bill in the Victorian Parliament that, if passed, would have enabled five SCSs. This was the third phase of the process, which lasted until the five-site proposal was formally abandoned in 2002. While introduction of enabling legislation into parliament marked a significant milestone in the path toward implementation, it quickly became apparent that oppositional forces were growing and, in doing so, sapping much of the political momentum out of the proposed trial. In May 2000, the City of Melbourne rejected an application for planning approval by Wesley Central Mission for its SCS and, in June, the City of Greater Dandenong and Victoria Police both refused to support trial SCSs.

At the same time, the 'heroin glut' had turned into a 'heroin drought' that would last until early 2001. Partly attributable to the United States-led war in Afghanistan, the sudden and prolonged shortage of heroin produced dramatic changes in Melbourne. Street-based drug markets were far less active and heroin-related harm reduced markedly. From December 2000 to January 2001, heroin-related deaths fell by 82% in the state of Victoria and non-fatal heroin overdoses declined by 52% in Melbourne (Dietze et al 2004: xi). In the eyes of the public and key decision-makers, these changes merited the downgrading of the current situation from a previously recognised crisis to a more normalised state of affairs. Without widespread recognition of exceptional, critical circumstances, the justifications for radical proposals, such as SCSs, lost their potency:

> Once you didn't have what people regard as an unacceptable number of heroin related deaths, then they said 'well, you know, why would you have injecting rooms?' 'Why would you have places where people can go use their drugs, because that'll just encourage them'. It went back to some of the old arguments. (Interview 2: drug treatment service manager)

This point was echoed by another interviewee, who remarked that, "harm reduction strategies generally are more supported when there's a sense of emergency and the broader community is at risk" (Interview 6: advocacy organisation manager). The same interviewee noted that, during the heroin drought,

> the heroin trade became very much behind closed doors [and it] probably became more complex and more difficult to police and those street drug markets that had been in the city, and other places were generally pushed towards places where [they] could better survive.

As a result, by September 2000, the opposition Liberal Party decided to oppose the government's enabling legislation, and in November, the Legislative Council rejected the bill. The future of the proposed SCS trial remained in limbo until the lead-up to the state election in late 2002, when it was abandoned by a Labour government facing an impending 'law and order' themed election campaign by the opposition Liberals.

Generative effects of SCS proposals in Melbourne

As we have already argued, failure is a real element of the politics of policy. As a model that ran counter to the hegemonic approach to people who used illicit drugs in Australia, SCS proposals had an extremely slim margin for error. Their fate is an example of the fragility Lovell (2017b) points to as a feature of policy assemblages. If we consider that there was little disagreement about the effectiveness of SCSs at the time, that they were proposed during a widely recognised public health crisis, and that there was, for certain time, bipartisan commitment to implementing one or more SCSs, the proposals for SCSs in Melbourne had much going in their favour. Labor's change of heart in 2002 marked a failure for proponents of the model and, in the immediate period, SCSs did not come to fruition.

Yet, a different set of insights emerge when we look back over the intervening 15 years, scoping out from the specific moment when the SCS proposals unravelled in Melbourne. With a longer historical view, it is apparent that simply labelling the fight for SCSs as a failed attempt at policy implementation would be both limited and limiting. It would assume, first of all, that there was a coherent, singular goal among harm reduction advocates in Melbourne at the time and that all these varied actors were true to that goal. While some actors were advocating solely for SCSs, others were arguing for a range of harm reduction programs that included SCSs alongside primary health facilities, heroin prescription, expanded drug treatment programs, and expanded needle/syringe exchange programs. This tends to be the case in harm reduction advocacy efforts: advocates usually support a continuum of care. As one interviewee noted, it is "a little bit more complicated than just saying, 'Oh, injecting rooms didn't get up [and running]'" (Interview 1: health researcher). Furthermore, many of the key advocates were pushing for SCSs in multiple Australian cities at the time and they framed their goals as nationally-scaled rather than Melbourne-specific. Therefore, for another interviewee, framing Melbourne-based advocacy as a failure makes little sense:

> It wasn't a Melbourne thing for us […] We needed to get one in Australia […] If you want to look at the victory of it, we [now] have the research that can contribute to the literature [because of the Sydney SCS]. I was very happy. (Interview 9: harm reduction advocate)

Secondly, designating the Melbourne case as categorical failure obscures a substantial amount of policy-making activity that continued after the fact. The unravelling of SCS proposals had discernible and lasting impacts. Focusing too narrowly on a single moment of setback presents a real risk of framing failure as the inert and passive 'other' to generative and active success (Wells 2014; McCann and Ward 2015; Peck and Theodore 2015). Instead, we can pursue the notion of 'generative failure'. Peck and Theodore (2015: 140) note, for example, that "neoliberal interventions tend to 'fail forward'". Indeed, their work suggests that failure-induced policy experimentation is a central feature, rather than an exception or fatal flaw, of contemporary policy-making. While neoliberalization is not the focus of our discussion, *per se*, we suggest that an attention to the generative effects of setbacks and rejections is a useful way of nuancing the ongoing 'failure debates' around policy mobilities.

We sought out the Melbourne case because it provides an opportunity to critically interrogate the implication, in many critiques of the policy mobilities approach, that policy failure has no impact and, therefore, no importance to policy studies, except as a cautionary tale or a case from which to draw negative lessons. Our intention was to return to the scene,

some 15 years after Bracks' Labor government abandoned the implementation of SCSs, to assess whether there were any generative effects associated with the unsuccessful SCS proposals. We found two main ways in which the proposals were generative.

Detour, redirection, and the generation of other programs

The first way that failed SCS proposals were generative was that serious discussion of them, research into them, and even the physical 'modeling' of one of them in the city centre expanded the parameters of policy acceptability for other harm reduction initiatives. This expanded universe of potentially acceptable options led, most immediately, to the establishment of five primary healthcare facilities for people who use drugs, the first of their kind in the state of Victoria. Located in the five locations that had been ear-marked for SCSs, the facilities—which provide services such as needle and syringe distribution, peer support, counselling and drug treatment—were funded by the budget allocation that had been reserved for the SCSs. These programs were a concession to proponents of SCSs, and their contribution to the health of people who use drugs and others in Melbourne has been significant. Indeed, several interviewees believed that, in retrospect, these centres were a better long-term response to drug-related harm than SCSs might have been. The dissipation of mature street-based drug markets and drug use in the wake of the heroin drought and the emergence of street scenes in different locations, meant that many of the SCSs would have, in the words of two interviewees, seemed like 'white elephants' (Interviews 1 and 10) because of their under-use. Another interviewee explained,

> You might see [the primary healthcare centres] as the consolation prize […] I'm more of the view that it was a better outcome. […] the market changed so much in Melbourne in 2001. Barely after the [SCS trial] Bill was voted down, the heroin overdose rate dropped […] People talk about the heroin drought. It was a shifting market. […] The public injecting scene practically disappeared overnight. (Interview 8: health researcher)

Moreover, the executive officer of a peer-run harm reduction organisation for people who use drugs explained that, in the centres,

> the clinical staff [are] supported by peer workers: trained people who were also injecting drug users […] it really was quite specific and unique to these primary healthcare facilities. It doesn't exist anywhere else [in Victoria] to this day (Interview 10: harm reduction advocate).

The interviewee explained that this approach allowed for a movement away from a "purely clinical model of healthcare" to a less alienating and more inclusive model that draws people who use drugs closer to the services they need to survive.

SCS proposals created an environment in which less radical proposals seemed palatable, in other words. In this way, advocates of SCSs employed a strategy—knowingly or not—that is commonly associated with libertarian and conservative think tanks (Peck 2006). They advanced a radical demand, in the form of SCSs, that cast less controversial harm reduction initiatives as reasonable and feasible, thereby shifting the parameters of policy acceptability. While the primary health centres represent a direct and tangible outcome of the failure to implement SCSs, it is also reasonable to surmise that SCS advocacy—in creating what Peck (2006: 681) refers to as a "shift in the ideational climate"—had more

diffuse impacts on the perceived acceptability of harm reduction initiatives. High profile public debates about the implementation of SCSs were more than debates about SCSs. By their very nature, they were about how drug use ought to be thought of and acted upon. They called upon politicians and the general public to question received understandings of drug use and people who use drugs. It is very likely that several years of public advocacy for SCSs contributed to the general acceptance, on the part of significant segments of the public, of much of the harm reduction 'policy toolkit'.

Capacity-building, engagement, and the generation of ongoing harm reduction networks

The second way that failed SCS proposals were generative was by acting as a focal point for the invigoration of harm reduction policy activism and policy networks. The urgency of the late 1990s heroin crisis compelled a range of people from various professional and personal backgrounds to become public advocates for harm reduction. Particularly noticeable was the extent to which SCS proposals galvanised community-based organisations, some of which continue to play prominent roles in harm reduction advocacy. The Yarra Drug and Health Forum, for example, rose to prominence through its advocacy for SCSs in the late 1990s. "There was some effective mobilization of community action groups as key participants in the drug policy debate," one interviewee noted. "There were," he continued,

> the opposition groups, but there were also some coalitions and supportive groups. … [T]he debate that happened did breathe a bit of life into [the Yarra Drug and Health Forum.] We saw a higher order of participation in drug policy in Melbourne and Victoria in the action groups participating, including users. (Interview 8: health researcher)

After a brief period of inaction following the abandonment of the five SCS trial sites in 2002, the Yarra Drug and Health Forum has been central to all subsequent calls for SCSs in Melbourne. The most recent attempts in the neighbourhood of Richmond, led by the Forum, are informed by the institutional knowledge of prior attempts.

Beyond the catalysing effect that SCS proposals had on community-based activism, the proposals also prompted the creation and strengthening of connections with harm reduction researchers and activists across Melbourne, but also nationally and internationally. News coverage and the accounts of interviewees suggest that the late 1990s and early 2000s was a period of intense policy activity. Fact-finding trips to Switzerland and other countries in Europe were common among many of the key people within the SCS debate, and experts from those places were brought to Melbourne as part of the lobbying effort. Recounting the visits by Robert Haemmig and Franz Trautmann, two key figures in early SCSs in Europe, an interviewee talked about the lasting relationships—professional and personal—he had maintained with colleagues in the international network of harm reduction advocates (Interview 9: harm reduction advocate). Many people who were involved in Melbourne SCSs debates remain involved in research, activism and 'formal' politics, and they are enmeshed in drug policy networks nationally and internationally. The future trajectories of numerous people were forged in the context of a particularly heady period for drug use in Melbourne. In concert with a range of other factors, SCS proposals have moved people toward the pursuit of harm reduction goals and inserted them into evolving networks of harm reduction expertise and activism.

Conclusion

Policy mobilities scholars have begun to grapple with the conceptual and empirical status of failure as a complement to analyses of successful and successfully-mobile policies. Focusing on the 20-year history of apparently failed SCS proposals in Melbourne, we have contributed to this collective effort by attending to the long-term, generative effects of a thwarted attempt to replicate the globally-circulating Supervised Consumption Site model in this particular place. While acknowledging that failure is real, in the sense that policies and policy mobilisations can fail on their own terms, we take the position that 'failure' is also constructed within evolving and relational contexts. Failed attempts at policy mobilisation can spawn allied proposals, offer valuable lessons and experiences in the careers of different policy actors, and forge consequential connections within professional and activist networks from the local to the global. Thus, as Perrons and Posocco (2009, 132) argue,

> failure opens up key trajectories of globalising processes to critical scrutiny and investigation, as the ''global" is understood, interpreted and experienced through stoppages in flows, cuts in networks and new forms of exclusion. Further, this focus on failure also suggests the importance of a close consideration of the configurations of the social which underpin the failure of globalising processes, the historical trajectories leading to them and the range of important re-alignments and specifications [that] enrich more abstract and generic accounts of globalisation.

Certainly, the effort to establish SCSs in Melbourne, and in the other Australian cities, tied harm reduction advocates there into global circuits of knowledge (McCann and Temenos 2015; Van Beek 2004). But their failure was also generative. It influenced the individual careers of harm reduction advocates and experts, and supported the further development of local, national, and global networks of policy and activist knowledge and a longstanding commitment to the cause (Denham 2017: n.p.) of harm reduction that has influenced the character and practice of drug policy, drug treatment, and drug activism more generally. Therefore, the disappointments harm reduction advocates experienced in the early 2000s are balanced by an optimism derived from their subsequent resilience, flexibility, and pragmatism. When looked at as a form of 'slow policy-making', failure looks different from 15 years in the future.

The recent decision to open an SCS in North Richmond provides a poetic conclusion to 20 years of SCS advocacy in Melbourne. Yet, the story we have told suggests that it is another stage in a continuing political struggle to fully apply a public health framework to the wellbeing of people who use drugs. It emphasises the political nature of policy mobilization, policy-making, policyfailing, and policy change. These processes involve ideological struggles between different interests and coalitions as they seek to define the appropriate future for a place and its citizens. They play out in often complex and sometimes contradictory ways (Wells 2015) and are part of the differentiation of policies, places, and social relations (Jacobs 2012). The frontiers of a policy model's circulation may be defined in terms of failure, therefore, but rather than seeing failure as decontextualised, discrete, and functionally inert, it must be understood in social, political, spatial, and temporal context. If "frontiers have a complex geography whose very outlines are the products of contestation," as Leitner, Peck, & Sheppard (2007, 311-312) argue, then the case of SCSs and harm reduction in Melbourne suggests that care must be taken in how we

define our terms and the scope of our study if we are to adequately assess the character and consequences of failure in specific cases of policy-making.

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Endnotes

[1] We use the 'Supervised Consumption Site (SCS)' in this paper as a generic term that refers to a range of facilities "where illicit drugs can be used under the supervision of trained staff" (EMCDDA 2017, 1). The specific character of these sites depends on the contexts in which they operate. In Australia, among other places, the focus is on injection. Therefore, terms like 'Medically Supervised Injecting Centre' or 'Supervised Injection Facility' are used. The argument we make in the paper would apply to a range of consumption facilities, however, so we use this generic term. Other generic terms exist: 'Drug Consumption Room' (DCR) is common because it encompasses locations where inhalation and intranasal consumption are permitted (Global Platform for Drug Consumption Rooms, n.d.). Yet, it does not emphasise the importance of supervision. 'Supervised Consumption Facility' is a common substitute as a result. But 'facility' tends to suggest a particularly formalised institutional setting, which is not the case everywhere. The alternative, more geographical, 'site,' which has recently become common in Canada (Health Canada 2017), overcomes the narrow connotation of 'facility' and emphasises how the specific character and location of an SCS in a particular neighbourhood has a great deal to do with its effectiveness.

[2] Our use of scare quotes around 'failure' and 'success' thus far in our discussion indicates the indeterminacy of the terms and the need to critically unpack them. Having made the point, we will largely dispense with the quotation marks.