# Addiction in the City: Analyzing Supervised Consumption Site Development Processes

by

Joyce Rautenberg

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## Table of Contents


TABLE OF CONTENTS 2
ABSTRACT 4
ACKNOWLEDGMENTS 5

**1 | INTRODUCTION 6**
1.1 Harm Reduction 8
1.2 Established Public Health Benefits 11
1.3 Canadian Context 13
1.4 Limitations and Biases 15
1.5 Concluding Thoughts 16

**2 | THE RESEARCH PROBLEM 19**
2.1 Research Problem Background 19
2.2 Research Questions 21
2.3 Research Methodology 22
2.3.1 Previous Research Methodologies 22
2.3.2 Semi-structured Interviews 23
2.3.3 Working with Data 26
2.3.4 Ethics 27
2.4 Scope of Work 28
2.5 Significance of Project 30

**3 | THEORETICAL APPROACHES 33**
3.1 Participatory Planning 34
3.2 Communicative Action 35
3.3 Multiplicity and Transdisciplinary Approaches 38
3.4 NIMBY Theory 40
3.5 Concluding Thoughts 46

**4 | EXPERIENCE WITH DEVELOPING SUPERVISED CONSUMPTION SITES 47**
4.1 Functions 47
4.2 History 48
4.3 Challenges and Opportunities 50
4.4 Potential Networks 54
4.5 Concluding Thoughts 57

**5 | CONSTRUCTIONS AND ANALYSIS: WHAT I HEARD AND IDENTIFYING UNDERLYING THEMES 59**
5.1 What I Heard 59

5.1.1 Motivation 60
5.1.2 Considering Context 62
5.1.3 Communication 66
5.1.4 Considering Politics: The Role of Government and Political Buy-in 71
5.1.5 Importance of a Larger Harm Reduction Network 75
5.1.6 Summary: Tracing the Trajectory of Development Processes 78
5.2 Identifying Themes 79
5.2.1 Social Justice 80
5.2.2 Inclusion 82
5.2.3 Rethinking 'the community' 85
5.2.4 Transdisciplinary Work 89
5.2.5 Summary: Uncovering the Themes Behind Development Processes 92
5.3 Concluding Thoughts 93

**6 | CONCLUSIONS: LESSONS LEARNED AND RECOMMENDATIONS 95**
6.1 Implications for the Planning Profession and Theory 95
6.2 Recommendations and Lessons Learned for Future Communities 99
6.3 Recommendations for Further Studies 106

**7 | WORKS CITED 107**

APPENDIX 1 | INTERVIEW QUESTIONS (POLICYMAKERS, RESEARCHERS AND SITE STAFF)
APPENDIX 2 | INTERVIEW QUESTIONS (PLANNERS)
APPENDIX 3 | INFORMED CONSENT FORM

## Abstract

Considering planning and development of supervised consumption sites in an urban setting will enrich future processes in communities that are interested in implementing their own sites. The literature does not link planning and supervised consumption sites, so this thesis endeavours to bridge the gap in the research. This project brings an experiential knowledge component and promotes a qualitative understanding of addiction. Uncovering the potential roles of planners and policymakers in planning and developing supervised consumption sites is the overarching goal.

Drawing on precedents and utilizing interview methodologies, knowledge was shared about the various challenges and opportunities in developing the sites. The interviews were summarized into constructions, or my interpretation of what I heard; then they were distilled into key themes that should be considered for future planning. The theme of supervised consumption sites as part of a larger network emphasizes the chances for planners to get involved, and to generate new knowledge with communities. The project concludes with the implications for theory and practice in the planning profession and a list of lessons learned for interested individuals, neighbourhoods and different levels of government.

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## 1 | Introduction

Growing up in Vancouver, I was very familiar with the Downtown Eastside (DTES) neighbourhood – perceived as the seedy underbelly of the world's 'most liveable' city. This neighbourhood has been painted as a haven of homelessness, addiction, prostitution and crime – a mark on the pristine landscape of glass condominiums, mountains and the sea (Woolford, 2001). I became increasingly interested in the complexities of this area, constantly asking questions about the visible and concentrated presence of public drug use and homelessness. After decades of struggling with how to handle the ongoing public drug use and an emerging HIV/AIDS epidemic in the neighbourhood, some policymakers came to terms with the idea that an enforcement approach would not solve the addiction 'problem'. In 2003, Canada's first safe injection site facility, Insite, opened its doors. What happened afterwards? Despite quantitative evidence compiled by researchers from the BC Centre for Excellence in HIV/AIDS that demonstrated decreased public drug use and fatalities by overdose (Wood et al., 2004), the site became a media spectacle that attracted legal backlash and incited a furore in some Vancouver residents (Campbell, Boyd and Culbert, 2009). Nevertheless, Insite operated for eight years until the Supreme Court put an end to their legal woes in 2011, with a ruling that allowed the facility to remain open. The court requested an exemption to federal drug laws from the Minister of Health (CBC, 2011). This landmark court decision set a precedent for other Canadian cities – sparking a shift in approaching addiction within a harm reduction framework, as opposed to purely enforcement[1]. For the purposes of this thesis, I will refer to the sites as 'supervised consumption sites' unless referring to a specific site. This is to acknowledge that each site offers various services and initiatives to work with different types of illicit substance use. I do not want to make assumptions on what methods of drug use are most prominent in each context. Consumption indicates that the sites will be used for taking drugs without identifying the means.

Addiction is a complex issue that is primarily viewed through a medical or public health lens. A

[1] With respect to 'enforcement', I am referring to the approach that focuses on incarceration, criminalizing drug use and abstinence-oriented treatment and education. In a brief prepared for Parliament of Canada, the author states that in "the mid-80's, there was a growing acknowledgement of the serious limitations of law enforcement and education in reducing the demand for drugs" (Riley, 1998, not paginated).

variety of studies show that supervised consumption sites are beneficial – to both the individual and general public health (Beyrer, 2011; Hedrich et al., 2010). Data and numerous statistical analyses demonstrate the reduction in public drug use, disease/infection transmission, overdoses and fatalities, and an increase in accessing healthcare and support services (including housing and employment) as a result of a supervised consumption site presence (Wood et al., 2004). However, most of the information published in North America is heavily reliant on quantitative methodology and may not provide a deeper understanding of the social aspects of these sites in communities. Rather, the evidence of success is demonstrated by medical benefits and the perceived impacts on public order. While important in articulating the need for a safe injection site, experiences from community members' perspectives are particularly relevant because experiential knowledge draws attention to how the facility affects daily life in neighbourhoods. Often, the biggest hurdles in getting approval for a contested site are fierce neighbourhood opposition groups and battling preconceived notions based on stigma and myths. This project will explore lessons learnt from other communities for planners to utilize when implementing safe injection sites and facing community opposition. This will be achieved through site visits to Germany, Switzerland and Vancouver – precedents where supervised consumption sites appear to be accepted and integrated within the community and have demonstrated positive health and public realm outcomes.

The thesis unfolds as follows. The remainder of this chapter sets context for the rest of the project. I discuss the foundations of harm reduction, reiterate established public health benefits, provide a background of how supervised consumption sites may function in a Canadian context, and outline any limitations and biases. Chapter two outlines the research problem, which includes research questions and methodology, scope of work, and the significance of the project. Chapter three and chapter four provide a summary and analysis of the literature surrounding planning and community engagement, anticipated challenges in contested spaces, and existing research about supervised consumption sites. Chapter five details the results from the fieldwork: what I heard from the interviews and the arising themes that ground the discussions. Finally, chapter six concludes with lessons learned for the planning profession and recommendations for future interested communities.

### 1.1 Harm Reduction

It is worth mentioning that this thesis operates within a harm reduction framework. That is to say, this project advocates for a more holistic approach as opposed to just enforcement. Supervised consumption sites are firmly entrenched in a harm reduction-based intervention setting, which articulates the need to reduce harms and promote positive health outcomes instead of calling for a quick solution to the 'drug problem'.

The key components of harm reduction are defined as: raising awareness, working with populations, providing the means for change and gaining endorsement (Stimson, 1998). Harm reduction began to gain notoriety in the 1980s, after it was introduced as an innovative method in working with the global AIDS crisis – its roots are in HIV prevention, which is the primary reason why countries in the European Union were ready to adopt harm reduction-based policies in 2004 (Rehm et al., 2010; Davoli et al., 2010). In general terms, harm reduction "falls under public health perspective" where the goal is to "reduce immediate harms" (Davoli et al., 2010, p.438). The question of abstinence, or stopping drug use altogether, is not prioritized and left completely up to the user (Davoli et al., 2010). This then will be the basis of how severe a drug problem really is (Rehm et al., 2010, p.79). Harm reduction departs from this line of thinking, focusing on mitigating the users' harms and negative health outcomes thereby opening possibilities for creating inclusive spaces for drug users. Because this is seen as so controversial, the success of harm reduction interventions (such as safe injection sites and needle exchanges) are often dependent on support from the community and all levels of government (Stimson, 1998). Furthermore, because of the quantitative nature of the discipline and the need for evidence-based success, the efficiencies of harm reduction interventions are difficult to demonstrate. Comprehensive studies that look at both quantitative and qualitative research can be difficult to implement; this could be largely due to lack of funding (Stimson, 1998). The argument for the need to present evidence through evaluations with carefully and clearly articulated interpretations is that data can often be manipulated and used in opposing arguments (Rehm et al., 2010). In sum, "harm reduction measure is an outcome of use, not use itself. The intervention is to reduce negative outcomes

regardless of whether or not use is reduced" (Rehm et al., 2010, p.83).

In dichotomous terms, harm reduction is the 'other' approach to working with addiction and in conflict with an enforcement point of view. Drug policy and harm reduction interventions are often presented as two opposing sides: appealing to societal morals and values, and espousing public health benefits and scientific data. Drug users are either seen as criminals responsible for their own actions or viewed sympathetically as individuals who need medical help and social support (Davoli et al., 2010). Enforcement has largely been the dominant tactic in dealing with the 'drug problem', with harsh laws that often end up punishing the drug user. It has been argued that this approach criminalizes addiction instead of treating it as a health concern, which serves to stigmatize users and subject them to discrimination (Palepu and Tyndall, 2005). Researchers have also put forth that a strong "enforcement presence leads to riskier behaviours" and severs any potential relationship between the user and health/social support (Ompad and Fuller, 2005, p.143). With the previous emphasis on enforcement, it is no wonder why harm reduction has been relegated to numbers and data presented as a "rational" argument to counter a moralistic viewpoint. There may be a real concern that harm reduction-based intervention may not be taken seriously otherwise.

The Four Pillars approach is an example of harm reduction in practice. These principles are employed in Switzerland's national drug strategy, and formed the basis of Insite's establishment in Vancouver. Chantal Collin, as part of the Political and Social Affairs Division, prepared a report for the Senate Special Committee on Illegal Drugs detailing the specifics of Switzerland's federal drug strategy which details the four pillars of harm reduction (Canadian Library of Parliament, 2002). This would go on to inform the *Four Pillars Drug Strategy* in Vancouver (Hathaway and Tousaw, 2008). The four pillars include: harm reduction, law enforcement, treatment and prevention (Hathaway and Tousaw, 2008). In Switzerland, drug policies vary across cantons (jurisdictions similar to provinces) but they must align with the federal policy. It is interesting to note that the harm reduction pillar emphasizes decreased health and social risks, but also highlights the importance of access to housing/shelter, food and showers/laundry facilities (Collin, 2002). As

well, the enforcement pillar no longer criminalizes drug users themselves, but is targeted towards illicit drug manufacturing and trafficking (Collin, 2002). In sum, harm reduction has become an integral part of drug policies in Europe and Canada. In order to promote a coherent relation between theory and practice, it is essential to acknowledge that the Four Pillars will not be able 'solve' drug problems (Collin, 2002). Furthermore, the sites "must also be seen for what they are. Expectations need to be realistic, [supervised consumption sites] cannot address all aspects of harm" (Hedrich et al., 2010, p.322)

However, this is not to say that harm reduction is the perfect approach without any flaws. Harm reduction has been critiqued within scholarly circles, especially the processes in which interventions have been implemented. Some academics have explored the notion of what it means to be viewed as a 'drug user' and reduced to the status of a subject of a political and moral debate (Moore and Fraser, 2006) rather than to be viewed as an individual. Drug users are typically seen as relinquishing basic rights and "recipients or objects of intervention" (Hathaway and Tousaw, 2008, p.13). This had led to attention being drawn to the split in interventions intentions and practice (Fischer, Turnbull, Poland and Haydon, 2004). In particular, harm reduction projects have been accused of functioning as another means of government control: the shift from enforcement to harm reduction is merely a way to regulate users' behaviours in a 'empowering' manner (Fischer et al., 2004). This raises questions on how safe injections function in contemporary discourse, whether harm reduction projects serve as a means to further marginalize drug users. These sites could be interpreted as a way to push concerns around addiction to the periphery so they are no longer in view. These criticisms mean that ideas around harm reduction should not remain stagnant. Harm reduction can stay critical and current if proponents adopt a reflexive stance and projects are open to vigour, research and improvements (Moore and Fraser, 2006). Another possible critique of harm reduction is the danger in placing labels and assigning characteristics to users and sites, which ignores the diversity and various challenges that drug users and communities may have. It should not be implied that all drug users have the same experiences or that harm reduction projects will address all challenges associated with drug use; "notions of agency and empowerment do not have much impact if they are not accompanied by

policy and practice that attempts to address political and economic conditions that contribute to marginalization of drug use" (Moore and Fraser, 2006, p.3041). Perhaps this could be an opportunity for planners to enter discussions.

The notion that harm reduction should ideally operate within a larger framework provides opportunities for planners to become involved in the conversation around addiction. Public health officials have posited, "harm reduction interventions may sometimes be most effective when provided as part of a package of care instead of a stand alone facility" (Davoli et al., 2010, p.445). Specifically, it has been argued that if supervised consumption facilities are part of a wider policy discussion involving a variety of stakeholders, the sites will be more efficient and hopefully accepted (Hedrich et al., 2010). This could be because the "current system's failure to acknowledge material constraints on individual agency diverts policy and practice away from structural issues" (Moore and Fraser, 2006, p.3036). In Frankfurt, supervised consumption sites are part of a larger social framework in a response to these structural issues. Visible reductions in public drug use in a community setting were observed; researchers believed this was linked to the strong support network drug users were able to access (Hedrich et al., 2010). These links included access to housing, treatment programs and counselling/community centres. As Insite is relatively new, the levels of community and social program partnerships are not as established as the European examples. However, efforts have been made to build a detox centre on the floor above the supervised injection site, and transitional housing on the third floor to accommodate those who will enter treatment (Campbell, Boyd and Culbert, 2009). Planners could possibly play a role in fostering these community connections and be involved in discussions establishing a larger drug policy framework within a neighbourhood or city.

**1.2 Established Public Health Benefits**

Supervised consumption sites are a relatively new concept in North America, with Insite being the only sanctioned facility. Much of the research (that is published in English) is medically oriented – the studies primarily discuss public drug use and the associated health risks in an inner-city context (Wood et al., 2004a). Studies reiterate five main public health benefits: improved health

and social functioning, decreased fatalities by overdose, decrease in drug related litter and discarded needles on the street, decreases in the instances of HIV/AIDS and Hepatitis C, and accessible medical care and drug treatment (Wood et al, 2003). Studies demonstrate that users associated with high risk HIV transmission behaviours are more willing to use supervised consumption sites; users will benefit from greater healthcare access, reduced unsafe needle sharing and usage, and exposure to safer injection practices (Wood et al., 2003). As scientific research holds certain legitimacy, authors have found it necessary to adopt conventional research approaches in arguing that these sites are medically beneficial. Researchers present statistical analysis and scientific trial findings to substantiate their claims. Such data are more likely to convince federal officials and policymakers that supervised consumption sites are a legitimate form of addiction treatment.

It is necessary to acknowledge the negative aspects of supervised consumption sites. Some politicians, policymakers and neighbourhood residents may feel that it is a moral dilemma. By operating these facilities, society is implicitly condoning illegal drug use. There is a common misconception that the government is providing free drugs, fuelled by provocative statements made by the media. For example, MacLean's magazine's headline "Are we ready to subsidize heroin?" promotes this myth and distracts from the main issue at hand (MacQueen and Patriquin, 2011). This is one reason why I believe there may be an emphasis on quantitative research: researchers and policymakers may think that scientific rationale is needed in discussions around harm reduction, as it appears to provide a sense of 'logic' that highlight public health and public order benefits in the face of fierce moral opposition and media frenzy. However, these so-called 'logical' arguments can also be traced back to morals – such as reducing harms and improving the quality of life for drug users. A comprehensive argument that encompasses a broad spectrum of knowledge can effectively counter opposition. These ideas are not free from morals, nor should they claim to be. In terms of logistical critiques, the wait times associated with the injection facilities an increasing concern (Kimber et al., 2003). This leads users to abandon line-ups and use publicly, because the withdrawal symptoms are kicking in (Small et al., 2011). As well, drug users are not allowed to share drugs or assist one another with injection – as this is not covered under

the exemptions to the federal drug laws – which also causes users to leave the site and inject elsewhere, usually in public (Small et al., 2011).

### 1.3 Canadian Context

In Canada, Insite in Vancouver is the only sanctioned supervised consumption site. Other Canadian cities have expressed interest in opening their own sites, and this project is tailored primarily towards a Canadian context (although recommendations could likely be adapted for other international cities). I would like to draw attention to two landmark verdicts, one from the Supreme Court of Canada and one from the Federal Government of Canada, that have strong implications for what the future holds for supervised consumption sites and harm reduction in the country. These recent decisions demonstrate that this project may hold some relevance in Canadian and urban addictions discourses, and perhaps will have some implications on the planning field as well.

In 2011, the Supreme Court of Canada announced a ruling that would have lasting consequences for the future of supervised injection sites (at the time of this project, there have been no plans to incorporate other drug use methods into the facility or proposed facilities) across the country. When Insite first opened in 2003, it was allowed to operate as an exemption to the Controlled Drugs and Substances Act for three years (CBC News, 2011). This meant that drug users and the facility itself would be exempt from drug possession and trafficking charges under the Act. However, the facility "was granted two extensions but the Conservative government made it clear in 2008 that it did not support another exemption, and court proceedings were launched to try to save the clinic" (CBC News, 2011, not paginated). When this happened, the Portland Hotel Society, Dean Wilson and Shelley Tomic (two drug policy activists) decided to take legal action and pursue a case with the British Columbia Supreme Court (Bernstein, 2011). This went to the Supreme Court of Canada, where the plaintiffs argued that refusing to grant the exemption would contradict the Charter of Rights and Freedoms. On September 30, 2011, the Supreme Court ruled that Insite would be granted an immediate exemption, and would not be subject to prosecution under the Controlled Drugs and Substances Act (Makin, Dhillon and Peritz, 2011). Furthermore, the courts

stated that shutting down Insite would undermine the positive impacts it had on the community and the benefits for drug users (Makin, Dhillon and Peritz, 2011). The Supreme Court put forth that "not allowing the clinic to operate under an exemption from drug laws would be a violation of the Charter of Rights and Freedoms" (CBC News, 2011, not paginated). Finally, the ruling argued that public safety and health were part of federal drug laws; failing to grant the exemption would contradict this objective (CBC News, 2011). This court case set a precedent for harm reduction facilities in Canada, and arguably set the stage for sites to open in other cities (Bernstein, 2011).

Despite the victories gained in pushing forward progressive drug policies in Canada from the Supreme Court decisions, the federal government is currently tabling Bill C-65, the *Respect for Communities Act,* which gives more power to communities at a local level to influence decisions on opening supervised consumption sites (Gwiazda, 2013). It appears that the additional criteria for reviewing an exemption application will make it significantly more difficult to establish sites, if passed. Some of the criteria, as proposed by this new Act, include: reports from engagement sessions with medical professionals and local community groups, demonstrated financial stability, scientific evidence that states a need for a consumption site, impacts on community safety and stakeholder participation such as letters or communications from government, health authorities and police (Health Canada, 2013). Drug policy groups across Canada are describing the bill as "irresponsible" and promoting NIMBYism (Canadian HIV/AIDS Legal Network, Canadian Drug Policy Coalition and Pivot Legal Society, 2013). The Act is accused of creating barriers and hurdles to opening the sites, and ignoring the rights of drug users. The groups (Canadian HIV/AIDS Legal Network et al, 2013, not paginated) go on to say:

> …the government's bill would make people's access to supervised consumption services dependent on whether police or other members of the community feel they are warranted. People who use drugs are entitled to needed health care services just like all other Canadians. It is unethical, unconstitutional and damaging to both public health and the public purse to block access to supervised consumption services which save lives and prevent the spread of infections.

Although encouraging community participation in planning processes is very important, it is clear that this Act will not serve the concerns of marginalized groups well. In addition to promoting

a NIMBY-type attitude within communities, the voices of drug users and other vulnerable populations may be lost in contentious debates within neighbourhoods. As this Act was in the media after I finished my research, I was unable to bring it up during discussions with the interview participants. Despite the intentions of the Bill, I believe there may be increased opportunities for planners to work with communities and bring about change at a local level. As well, due to the timeliness of the Bill, it seems that the issue of addictions and harm reduction is at the forefront of health policy. I believe this reinforces the need for greater partnerships between planners and policymakers, and utilizing experiential and community-based knowledge.

**1.4 Limitations and Biases**

As this thesis aims to draw attention to the experiences of individuals who worked to plan and develop supervised consumption sites, and also participants who are part of a larger network, it is a limitation that I was unable to involve drug users or drug users' groups in this research. Especially in Vancouver, the drug users' groups were instrumental in getting support and momentum for the opening of the sanctioned site. However, I am aware that I am an outsider in the drug using community, and recognize that my time and resources were limited in establishing relationships and building trust with marginalized individuals. I realize that many of the drug users and groups feel that they have spoken enough about Insite and its history, without seeing further action or increased positive social outcomes that should follow in the DTES community. It has been ten years since the site opened, with no plans to open another one or increase other support systems. After speaking informally with members of the DTES community and personal contacts within the City and other stakeholders, I understand that Insite cannot be seen as just a facility – but as one aspect of a wide network.

Another limitation when pursuing the interviews abroad was timing. Unfortunately, I travelled to Europe over the Christmas holidays where many staff and policymakers were on vacation. This meant that some individuals did not respond to e-mails or telephone calls, and were simply too busy to allocate a significant time period to talk with me. However, due to the school schedule and the timeline of this thesis, that was the only time I could have made the trip. I would

recommend that future interested researchers do not travel during this holiday season, as many people are gone for long periods of time.

I would also like to point out the language barriers associated with the scope of this project. Although the participants in Europe spoke perfect English, my German was not up to an academic or professional standard. This may have hindered potential interview opportunities with people who were not comfortable speaking English in an interview setting. As well, the issue of language came up in regards to the literature review. I am primarily drawing on North American or English-based sources, which may not represent an accurate view of the research across Europe. This is true especially in terms of the existing literature surrounding supervised consumption sites.

Finally, I would like to acknowledge that the lessons learned and recommendations should be considered in context. Not all of the information will be applicable to each community or individual groups. Not all drug users have the same needs or experiences, and specific policies may serve to marginalize these individuals even further.

**1.5 Concluding Thoughts**

Once an understanding of the different policies and development processes has been addressed, there may be a useful application of "lessons learned" for Canadian cities. Different levels of government and communities across Canada (especially inner-city neighbourhoods in urban cores) struggle with developing effective policies in regards to addiction and public drug use. Access to healthcare, housing and neighbourhood revitalization are all variables that need to be looked at when considering how to work with drug users. Although it is important to recognize contextual differences (legal frameworks and societal relations will vary from place to place), there may be overarching themes that can be shaped into useful planning tools. Developing an effective but socially responsible drug policy and addiction framework is vital in a Canadian context, as our national drug strategy is supposed to be based on harm reduction principles (Hathaway and Tousaw, 2008; Elliott et al, 2003). Due to the recent changes in the Controlled Drugs and Substances Act, it becomes even more necessary to learn from others that were in similar

situations.

As major cities continue to grow in Canada, an effective drug and addiction strategy will need to address the changes in drug use and social issues. This will hopefully complement mental health and other health care strategies. It is clear that the enforcement approach is not successful in preventing or treating drug use, especially in a public setting (Hedrich et al, 2010; Hathaway and Tousaw, 2008). The presence of supervised consumption sites as part of a larger harm reduction framework has demonstrated reduced drug use and improved access to healthcare and housing for users, which benefits the neighbourhood as a whole (Wood et al, 2004). Planners will have an important role to play in facilitating discussion and participatory processes between public health agencies, all levels of public policymakers, people struggling with addiction, and local residents who are impacted by safe injection sites. This project considers the planning and development processes in Berlin, Zurich, Frankfurt and Vancouver, where the sites are already established. The primary research shows that German and Swiss addiction frameworks consider social aspects of addiction and have developed support systems to help drug users reduce harms and improve health outcomes. In Vancouver, the partnerships between the different levels of government and stakeholders are not as developed as the European examples – this could be due to the different political structures or the fact that Insite is relatively new. Perhaps the examples in Europe could support decision-makers in advocating for a more integrated approach.

Other Canadian cities are talking about establishing safe injection sites. For example, there is interest in Montreal in opening three safe injection sites despite concerns over location (*The Globe and Mail,* 2012). As well, scholars have started to determine the possibility of opening safe injection sites in Toronto and Ottawa (TOSCA, 2011). The City of Toronto Drug Strategy has developed a Supervised Injection Services Toolkit (2013), which outlines the needs and opportunities for implementing sites in the city. Unfortunately, this toolkit was published before the recent tabling of the *Respect for Communities Act* – however, many of the points raised are relevant and make a strong case for the need for a site. To supplement this toolkit and other research done by different cities, this thesis could possibly be used to engage neighbourhood

residents with planners and policymakers to develop a harm reduction framework that works in their specific context. Ideally, the information presented in this thesis could contribute to assisting stakeholders achieve success in developing such a site.

## 2 | The Research Problem

I am interested in researching the planning and development processes of supervised consumption sites because so far, it seems that planning has not been discussed or mentioned in the existing literature. Although addiction is often framed primarily as a medical and public health issue, the siting and operations of such a facility should involve collaboration with planners. I argue that supervised consumption sites are a planning concern, as planners may be responsible for working with zoning by-law amendments and facilitating community consultations. Social planners can contribute based on their experience in working with marginalized groups to foster discussion around issues such as homelessness, urban health and access to food and transportation. The literature positions discussions around harm reduction and safe injection sites firmly in the public health and medical domain (Wood et al., 2003; Rehm et al., 2010; AK Konsumraum, 2011; Beyrer, 2011). There appears to be a dearth of scholarly articles linking addiction and planning, even though planners could provide knowledge and insight into the addiction context in a community. What makes sense and adds up numerically in a positivist, statistically-minded world may not translate into a real-life situation. This thesis raises questions on how planners can bridge the gap in collaboration and make room for experiential knowledge and technical skills in working with communities.

### 2.1 Research Problem Background

First, most of the literature discussing supervised consumption sites and addiction uses quantitative methods to evaluate outcome goals. This does not address the different ways people perceive “success”. Drug users’ experiences are quantified into categories, as data is generated through positivist measures such as surveys and analyzing statistics and database information. These methodologies do not take into account the various challenges and opportunities drug users and other community members may perceive when implementing supervised consumption sites. Statistics and data may provide a background understanding of drug use in a space, but qualitative approaches are needed to ensure all voices are represented. What one user or community may

judge as 'successful' may be different to another individual. This also applies to members of the community, site staff, researchers, addiction service workers and businesses located within the neighbourhood. More experiential knowledge is needed to provide a richer understanding of how urban addiction impacts neighbourhoods, and uncover the positive or negative relationships the sites may have with communities.

In addition to the challenges of focussing only on quantitative evidence, the terminology is largely medical or health jargon heavy – making policies and information inaccessible to people outside of these professions. While there is an emphasis on the medical and public health benefits, there is an absence of research on the impacts that supervised consumption sites have on community at the neighbourhood level. Although the previous chapter describes positive impacts such as decreased public drug use and drug related litter, the research focuses primarily on public health outcomes. The challenges and opportunities this presents will be discussed in Chapter Four. This information is usually represented quantitatively, including correlation analyses that show causal linkages the presence of consumption sites and positive health outcomes. This does not necessarily address the importance of context, or the relationships embedded in communities. These studies have set categories, such as public order outcomes and measuring HIV/AIDS increases, which are determined by researchers and do not include input from community members (Zeisel, 2006). This can be limiting, especially it indicates what researchers think is important instead of also including the priorities or relationships that community members may place emphasis on. The focus on what to learn next should be looking at context, learning from community-based knowledge, identifying challenges and priorities with community members, and utilizing these ideas for effective community engagement.

There has also been a growing body of literature concerning NIMBY (Not-in-my-back-yard) in relation to addiction facilities. Lois Takahashi posits that NIMBY is not as simple as just an exclusionary tactic, but embedded in a larger socio-spatial relation framework (1997). Stigma towards addiction facilities does not occur spontaneously; rather community members may have preconceived notions on the people who may utilize the facility. This thesis is underlain by the

position that by researching neighbourhoods in Europe where safe injection sites are an established part of the urban fabric, counterarguments to NIMBY can be developed. Community engagement can build on participatory processes and articulate how seamlessly sites can be integrated into the neighbourhood. Looking at planning and development processes in other cities can be beneficial for developing innovative communication strategies, but engagement and planning work should reflect the specific context of the proposed neighbourhood/location.

**2.2 Research Questions**

The purpose of my research is two-fold. By researching planning and development processes, I aim to highlight the usefulness of qualitative and experiential research and knowledge to understand addiction in an urban environment. I take this one step further and argue that planners are important to supervised consumption site establishment processes, as scholars that may be well versed in qualitative methodology and as practitioners with developed communication skills. In addition, planners can be effective mediators: bridging the gaps in understanding between public health officials, policymakers, politicians and marginalized communities. The planning field is inherently interdisciplinary, so planners will be able to utilize their broad perspectives to work with a variety of people and groups. This project hopefully provides a deeper understanding of how supervised consumption sites function within a larger harm reduction-based framework. This will become the foundation of my argument for planners to become increasingly involved in this complex web. The study is driven by the following questions:

1. Who were the major stakeholders involved in implementing safe injection sites in Switzerland, Germany and Vancouver? What were the planning processes like?
2. What lessons can be learned from Swiss and German site development processes for application in a Canadian context?
3. What are some of the similarities/differences in Vancouver's Insite planning process? How can current practices be improved?
4. What are some of the implications facing Canadian cities that are interested in planning and developing supervised consumption sites? What are some potential

lessons learned for the future?

## 2.3 Research Methodology

The following sections outline how my chosen research methodology endeavoured to answer the research questions. Although the research questions guided the interview processes, participants were encouraged to share other experiences or bring up ideas of what they perceived to be important to the discussions.

### *2.3.1 Previous Research Methodologies*

There is a gap in the literature in terms of qualitative research, including discussions around planning and development of the sites, or considering local context and knowledge when researching supervised consumption sites. The focus on prioritizing quantitative methodology is seen in studies relating to Insite, where the researchers looked at immediate public health benefits. This was done through measuring a set of indicators six weeks prior to and twelve weeks after Insite's opening (Wood et al., 2004a). However, this does not necessarily reflect the same priorities the drug users or DTES community members envisioned when the site opened. Although this could be a useful starting point – especially as the research suggests correlation between a safe injection site presence and a noticeable decrease in public drug use and related litter (Wood et al., 2004b) – simply counting the numbers is not enough to develop a fully formed understanding of why a facility may be beneficial. One of the examples cites compiling statistics on suspected drug dealers is highly arbitrary – researchers cannot make assumptions on who is a drug dealer unless they approach individuals and ask about their profession. This perpetuates stigma attached to individuals that frequent the DTES, which is counterproductive to treating addiction and encouraging community development. Safe addiction sites are meant to assist individuals with risky addiction behaviours and promote a safe environment for drug users and the neighbourhood – studies should also address neighbourhood residents and businesses' experiences, as well as exploring how effective sites are in referrals to treatment and stable housing. This will provide a greater understanding of how sites can benefit a community as a whole, rather than focusing solely on the users.

To supplement the findings that demonstrated Insite's effectiveness in decreasing public drug use, researchers conducted studies that measured client, staff and community satisfaction. Clients' responses were tracked through questionnaires, which indicated positive attitudes towards their experiences with the site (Wood et al., 2004b). The researchers utilized focus groups to determine levels of staff satisfaction. This can be an effective method to gain a deeper understanding of experiences – the staff members could have similar common traits (such as work responsibilities, schedules and backgrounds), and the groups would provide a safe and supportive environment to share their stories. In the groups, the focus was on how to improve services – however, this conversation should expand to include planners, policymakers and a legal advisory team. Many improvements cannot be made without legal ramifications. As demonstrated by the diverse range of literature (which is discussed in Chapters Three and Four), addiction is a complex issue. Working with drug users and facilities requires a multidisciplinary approach, as communities and neighbourhoods are also affected. As well, significant changes to housing and service provisions would call for working with planning and other professionals.

Researchers attempted to engage community members via street recruitment of residents and business owners to participate in surveys about their satisfaction with Insite (Small et al., 2011). However, this approach is quite limited. The recruitment process only targeted people walking on the street, which eliminates many residents at home or business people working. The data generated through the survey approach would also be limited. Individuals are asked to categorize their perspectives and experiences based on concepts and themes the researchers have developed. Ideally, the surveys should have been conducted in conjunction with focus groups or interviews to generate richer data. Residents and business owners may have different experiences or perspectives that the researchers did not consider when developing their survey questions. A survey is an effective starting point, but a qualitative approach is needed – especially if the goal is understand multiple perspectives.

### *2.3.2 Semi-structured Interviews*

The interviews are based from what I learned from the readings, and served to reaffirm, negate or add to what was already published. On all trips, I utilized semi-structured interviews as my primary research method. This allowed me to cover key themes and topics I wanted to address, while giving the interviewee the opportunity to address any key themes and identified gaps they wished to contribute. The semi-structured nature of the interviews is necessary, as the literature briefly discusses the comprehensive support networks available to the drug users. However, information about details and how the programs work is not published – especially not in English or North American literature. This made it difficult to pinpoint exactly which key themes to address. Discussions with people working with addictions and policymaking not only benefitted my own study, but also may be useful for other neighbourhoods considering implementing sites. After the details are published in English, this will hopefully enable greater accessibility to information especially in a North American context. I also chose interviews as my research method in order to develop a fuller picture of how individuals perceive their situation and surroundings – participants discussed their thoughts and what they believed to be important (Zeisel, 2006). Furthermore, data generated from the interview supplemented my own analysis of how supervised consumption sites operated within a neighbourhood and what planners' roles were, and could be (Zeisel, 2006).

The interviews were semi-structured. A list of topics and questions were prepared in advance and submitted for ethics approval. However, semi-structured interviews allowed for better discussion – especially as English was not the primary spoken language. Probes were used in some instances to confirm understanding and encourage further insight (Zeisel, 2006). Three different interview guides were developed to cater to the various informants – researchers, policymakers/planners and consumption site staff/non profit advocacy groups – to fully uncover each person's specific role within the framework. Data generated through these discussions were transcribed and analyzed using qualitative approaches.

Participants were selected based on their job experience, and whether their experience could inform my research topic. I sought out members from the research community, consumption site staff and non-profit addiction organizations to develop a broad understanding of

how supervised consumption sites function. My goal was to compile a variety of perspectives (academic, health, professional and support staff) to fully understand addiction as a multi-disciplinary issue. After making contacts internationally and locally, I heavily relied on the snowballing technique to garner more participants. This tactic "generates unique social knowledge" due to the dynamic nature of knowledge construction through each individual (Noy, 2007, pg328). The referral aspect of the snowballing technique was beneficial, as I did not have the connections in Germany or Switzerland to recruit relevant participants. I interviewed individuals in Zurich, Berlin and Frankfurt.

Due to my work experience and familiarity with the Vancouver context, it was easier to determine interview participants. These individuals were selected based on their expertise and roles in Insite's development process. The participants included planners, community organization members, and researchers. I was determined to include members from the drug user community, and made efforts to arrange interviews when I was in Vancouver. However, I was unable to secure any meetings or get confirmations for interviews. I wanted to be mindful of the contentious relationships that researchers and vulnerable communities may have, and respect boundaries. Some participants indicated that drug users' groups were "sick of talking about Insite without any action taken", and felt that they were research subjects without any benefits to their community. I would like to emphasize the importance of building a trusting relationship in marginalized communities, which takes time. Unfortunately due to the short timeframe of this project, I was unable to take the necessary steps to do so. This is a significant limitation, where I could not include experiences from drug users who were instrumental in the development processes in Vancouver.

I recorded the interviews using software on my laptop computer, which were one to two hours in length. However, I would like to note that some interviews took place in public spaces where I was unable to record. In these cases, I asked the questions and took notes. I do not use direct quotes for these participants, but paraphrase ideas instead. Two participants also submitted written responses in point form, as they were unable to meet for an interview. These paraphrases

were offered to the participants, who agreed with my interpretations of what they were trying to say.

*Figure 1. Interview table*

| **Site** | **Type of site** | **# of interviews** | **Type of participants** |
|---|---|---|---|
| Zurich | • City of Zurich<br>• Substitution therapy facility | Three | • City staff member<br>• Harm reduction medical specialist<br>• Public health nurse |
| Berlin | • Non-profit organizations that were responsible for implementing and running the sites | Three | • Non-profit organization staff members<br>• Former researcher with non-profit group |
| Frankfurt | • City of Frankfurt | One | • Former City staff member |
| Vancouver | • City of Vancouver<br>• Non-profit organization<br>• Research institution | Four | • Former and current City planners<br>• Non-profit organization staff member<br>• Researcher |

### *2.3.3 Working With Data*

All interviews were recorded and transcribed. I also took notes throughout the interview discussions. After the interviews, interview participants were given pseudonyms to maintain confidentiality in my notes and saved files. I organized notes chronologically – but I also remained aware of how I organized my assumptions and influences (Mason, 2000). When reading my data, I was conscious of utilizing an interpretative approach first – asking questions about meanings and relationships. After I became aware of links and my own thought patterns, I then assumed a reflexive reading. This required me to place myself as part of the data, and consider my role in asking questions, conducting the interview/focus groups and how I am interpreting my notes/transcriptions (Mason, 2005). In terms of analyzing any supplementary documents, I was also aware of my biases and perceptions – and consider what role I played in interpreting the data.

I am part of the data generation process and tried to acknowledge this in my interpretations.

When working with my interview transcriptions, I aimed to follow the coding process as explained by W. Lawrence Neuman. The first step is 'open coding': I organized data into themes. These themes were not predetermined, but were generated from the data results. I would like to note that the themes were fluid, and changed throughout second and third readings (Neuman, 2005). The second reading, 'axial coding', focuses on the generated themes. This was compared with the first coding results. I also thought about relationships and tried to determine if any more questions arose from the themes. The third step is 'selective coding', which considered the existing themes and compared them to the previous codes and initial reading. I also compared this session with my notes written at the time of discussion. I selected cases that highlighted my themes and used them as examples in the thesis document (Neuman, 2005). For instance, I utilized block quotes from interview participants if it encapsulated the theme I was trying to convey. This process ensured that I read my transcriptions thoroughly and that I was aware of the data generation process and how I am implicated. There were some challenges in going further past what I thought I heard, and making connections into themes. This became easier once I thought about links to the literature, and was able to write first about the interviews themselves – then moving into discussions of the themes.

*2.3.4 Ethics*

In order to generate data to support my thesis, I interviewed researchers, consumption site staff and planners/policymakers that work within the harm reduction/consumption site setting. I chose harm reduction as my focus, as typically supervised consumption sites operate within this framework. These interview participants did not fall under the vulnerable group category as outlined by the Research Ethics Board at the University of Manitoba. Key informants were identified and contacted via their information available on websites. Some contacts referred other prospective interviewees based on their relevance to my research topic. Written informed consent was obtained from all the participants before each interview. The majority of the interviews were conducted in person. Informed consent forms were e-mailed before hand. I briefed the

participants on the purpose of the thesis before the interviews, and they were made aware of the topics and questions that I asked. Participants were permitted to withdraw from the interview at any time, without questions asked. Confidentiality was be maintained by using code names for participants and storing all data in password-protected files and folders. All paper documents were locked in a secure briefcase and/or cabinet that only the researcher had access to. General job descriptions were used to ensure confidentiality is maintained. After the interview and analysis are completed, participants had the opportunity to review a brief description of my interpretation to ensure accurate representation. All notes and recording devices were stored according to the University of Manitoba Research Ethics Board guidelines.

**2.4 Scope of Work**

This thesis examines planning and development processes of supervised consumption sites and associated support networks in four cities using qualitative methods. The data is generated through semi-structured interviews and meetings with various stakeholders. These individuals spoke about the roles of public health officials, policymakers, planners and other key players. They provided insight on the various benefits and opportunities that the supervised consumption sites added to communities. I made three separate research trips to gain a better understanding of how the sites functioned in the communities, and to speak with individuals about their experiences and knowledge of how the consumption sites developed. I travelled to Zurich, Switzerland and Berlin, Germany to examine precedents/better practices and gain more information about how the sites were developed. The Swiss and German sites have been operating for nearly twenty years, making it the ideal time for a comprehensive analysis. I also interviewed a participant from Frankfurt, Germany; unfortunately the timing and weather prevented me from making a trip there. I also went to Vancouver and explored current practices, while inquiring about the planning and development aspects of the site. The aim was to understand how stakeholders worked to address addiction in a Canadian setting without solid political backing at a federal level. This visit raised questions on how current practices could evolve and continually improve. I wanted to take these lessons learned, and contribute to sharing knowledge and experiences that may enable other Canadian cities to achieve success in opening their own sites.

Zurich was the ideal city to begin research, as there are four safe injection sites located there – out of twelve in the entire country of Switzerland (Hedrich, 2004). As Zurich is the financial centre of Europe and home to some of the most expensive real estate in the world, it was interesting to see firsthand how safe injection sites function in such an exclusive setting. As well, learning about the different political and referendum structures made for a unique comparison to other cities. Switzerland's residents are also known for their conservative tendencies (Csete, 2010); further research and discussion was needed to explore how a controversial measure of harm reduction operated, and how the city achieved a level of tolerance and support from residents and business owners. Although there were concerns that the Swiss harm reduction model tended to 'medicalize' addiction over advocating a more holistic approach – meaning that issues around poverty and marginalization are brushed aside – the argument can still be made that the Swiss model was the first to establish a safe place for drug users to go, and this led to discussions around harm reduction all across Europe (Csete, 2010). The Swiss experience was informative, especially when comparing the work in Zurich to the other sites. Through these experiences, guidelines could be provided for rethinking drug policy and planning processes in a Canadian setting – particularly in working in contested spaces with resistance from the community, politicians and media scrutiny.

Sites in German cities were also valuable examples for comparative analysis. As of 2003, there were twenty-five facilities in Germany located in fourteen different cities (Hedrich, 2004). I chose Berlin as my starting point, as there were many links to research institutions and various non-profit groups that work with addiction are based here. I did not manage to make it to Frankfurt, although the different interviewees from Zurich and Berlin were quite familiar with the processes in Frankfurt and were eager to share their knowledge. I was also able to speak with an individual that was key to the development of the sites in Frankfurt. The German precedent is important to study, as the sites emerged after many years of discussion with various stakeholders – e.g. health authorities, neighbourhood residents and business owners, and police staff (Hedrich, 2004). One researcher mentions Germany as an example of successfully garnering political support

for the sites (Hedrich et al., 2010). For example, planners can be part of a 'network' that facilitates public engagement sparking discussion around addiction in neighbourhoods, in addition to involving members of various sectors and addressing local concerns. Germany is singled out for the health service providers' "skilful public relations work" which led to "increased acceptance" of supervised consumption sites within German neighbourhoods (Hedrich, 2004, p.68). In terms of understanding how these sites operate within a larger framework and working with participatory processes, Germany may be the ideal precedent.

Finally, I thought Vancouver would be the obvious starting point for a Canadian precedent, as Insite is the only sanctioned site in North America. Insite presents a useful example to learn about partnerships within a complex municipal and health authority framework. Planners and policymakers play different roles than in Europe, so it is easier to draw out lessons learned that might be more applicable in a Canadian context. Further information can be gleaned about the planning processes, programming and working in an interdisciplinary environment. There are talks about establishing safe injection sites in other Canadian cities, such as Toronto and Ottawa (TOSCA, 2011). This project could possibly be used to engage neighbourhood residents with planners and policymakers to develop a harm reduction framework that works in their specific context.

**2.5 Significance of Project**

As the American Centre for Disease Control states, "urban planning and public health share common missions and perspectives" (2006, not paginated). This is echoed in Canadian planning literature: Thomas Adams, an influential Canadian planner in the 1900s, writes that "civic improvement" should include efforts to maintain "housing, town planning, and public health" (1916, p.10). This statement links the importance of having access to stable housing and positive health outcomes to 'good' planning. To further link planning and public health, the Chief Medical Officer of the Commission of Conservation in Canada led planning initiatives before Adams arrived (Caldwell, 2011). Planning was based on the premise of creating attractive and clean spaces for people to enjoy their livelihood and live in healthier conditions. I would like to draw attention to

the discrepancy in collaboration, especially if planning and public health were closely linked from their onset. However, I would like to acknowledge recent initiatives by the Canadian Institute of Planners; a Healthy Communities project was created to address the relationship between the built environment and planning (Canadian Institute of Planners, 2013). This project looks at how the relationship that planning has with health issues – including the effects of climate change, chronic diseases and the increasing costs of healthcare (Canadian Institute of Planners, 2013). It does not appear to address the social aspects of healthcare, or focus on any programs that work with addiction or related diseases. As issues around addiction and social issues are marginalized in current discourses around 'healthy communities', the focus of the literature on scientific methodology and medical models also serves to ignore the role of planners in working with addictions and drug users. It also does not acknowledge that addiction is increasingly understood in an interdisciplinary context. My project aims to consider community health perspectives and working with marginalized individuals at the community level – while centring the focus on what planners can do. In other words, I hope to further bridge the gap between planning and public health – there is room for both quantitative and qualitative approaches. I endeavour to utilize experience-based knowledge and propose alternative methods to learning and generating data (Sandercock, 1999).

In terms of the project's significance within a Canadian setting, I would like to align my research objectives with the Canadian Institute of Planners' Code of Practice. It stipulates that planners have the responsibility to "practice in a manner that respects the diversity, needs, values and aspirations of the public and encourages discussion on these matters" and to "identify and promote opportunities for meaningful participation in the planning process to all interested parties" (CIP, 2004, not paginated). When planning with vulnerable populations, there should not be questions of who is deserving or undeserving of planning. Unfortunately when working with marginalized groups, this is often the case. Experts are called in to develop policy to "solve a problem" but rarely engage drug users, homeless individuals or others on the periphery of society in planning processes. Planners have a moral obligation to consider drug users as community participants – supervised consumption sites are just one example of how to promote social

inclusiveness. The literature consistently proves that harm reduction, especially supervised consumption sites, work. Planners should empower others and themselves to facilitate discussion around harm reduction strategies – learning from precedents in Germany is an effective way to fulfill our ethical obligation and include others. Hopefully, my research will demonstrate that strategic engagement can be applied in Canada.

Finally, my thesis will corroborate studies that support the position that drug policy and harm reduction frameworks can be established and fully functioning without detriment to neighbourhoods. Especially in the German and Swiss cases, residents were satisfied with the reduction in public drug usage and risky behaviors (Hedrich, 2004). Planners can work with various stakeholders to discuss addiction, show successful precedents and engage in policy interventions with the community. My project can be used as a tool for planners to work with resistant communities in the future, similar to the State of California's *From NIMBY to YIMBY* document. As well, this thesis can serve as a basic foundation of conducting qualitative assessments of supervised consumption sites – in an attempt to add to this void in the literature.

## 3 | Theoretical Approaches

Perhaps like the research problem and subject matter itself, the theme of working together across disciplines will run through this thesis continuously. Zeisel distinguishes 'transdisciplinary' approaches from 'intra' or 'inter' disciplinary – instead of treating disciplines as separate entities, transdisciplinary work does not "reflect one discipline or join different disciplines" (2006, p.77). These kinds of approaches are open to strategies and thoughts from across disciplines, and adopt a reflexive stance when working in various contexts to meet a common objective (Zeisel, 2006). The literature review aims to be transdisciplinary in nature. The *Theoretical Approaches* section lays the groundwork for analyzing the more medicalized and scientific reports, and attempts to provide different perspectives in looking theoretically at supervised consumption sites. The *Experience with Developing Supervised Consumption Sites* will summarize past and current literature specifically discussing supervised consumption sites, synthesizing writing across disciplines to provide a comprehensive background of the different challenges and opportunities. The literature review will hopefully function as one step in bridging the gap between theory and practice. In order to critically analyze the existing research, an understanding of the theory that informs my perspective is needed.

I will begin by discussing participatory planning and communicative action as the planning theories that ground my research. I mention participatory planning because I identify with the original intent of involving participation in planning processes. However, I recognize this planning paradigm has shortcomings and I believe that communicative action is one theory that can overcome these challenges. I will explore what issues are at stake and provide different perspectives on participation and working with marginalized communities. Then, I build on the basic theoretical approaches by emphasizing the need for collaboration between the public health/medical and social science disciplines. This calls for an epistemological shift in what dominant approaches and public health models perceive to be the "right" way in working with addiction. Finally, I will discuss NIMBYism and the profound effects on stalling or stopping human service facilities from opening. However, it is important to engage in a critical discussion of how

NIMBYism functions and dissect alternative viewpoints to move past a simple 'us vs. them' mentality. These discussions are framed by how adding planners to processes and conversations may be beneficial or important in empowering marginalized groups to be heard in engagement processes. This will hopefully address a small fraction of the many challenges of working with supervised consumption sites in a multidisciplinary context.

### 3.1 Participatory Planning

As indicated in the introductory chapter, harm reduction means working with various communities, raising awareness of reducing harms from drug use and empowering processes that allow for meaningful change (Stimson, 1998). Adopting this perspective has consequences for planning, such as differences in conveying information about drug addiction and the processes for developing priorities for supervised consumption sites in communities. However, there are limitations in terms of linking theory and experiences in planning processes that can guide putting harm reduction into planning practice. Participatory planning is one planning theory that is noted for its intent to ensure all voices are heard and allow for equal participation (Rabinowitz, 2013). This approach is a means of encouraging alternative ways of knowing and making room for qualitative methods. This signifies a shift from rational-based planning, where planners were viewed as 'experts' that were able to make decisions for the 'greater good'. However, participatory planning is not always the 'best' approach: scholars have critiqued its effectiveness particularly in working with traditionally marginalized groups because marginalized individuals may not wish to participate due to past experiences of exclusion, and that there still may voices that dominate the processes (Rabinowitz, 2013). Participatory processes should not remain stagnant, but constantly evolve according to contexts.

Participatory planning often involves prioritizing working with communities and ensuring that all perspectives get the opportunity to be considered. In contemporary settings, working in an urban neighbourhood means that vulnerable populations are given the chance to participate and express their opinions. The basic premise is that no viewpoint is 'better' or 'correct'. Despite the efforts of participatory planning to empower individuals to voice their opinions and promote social

inclusion, some scholars remain sceptical of the effectiveness and the means to conduct participatory processes. Currently, participatory planning has had to incorporate increasing diversity and the resulting complexities each situation presents (Hou and Kinoshita, 2007). As a result, current planning practices may not be culturally or contextually appropriate to truly empower marginalized groups to be comfortable in voicing their opinions (Umemoto, 2001). This is corroborated by claims that participatory planning has been accepted and formalized in municipal planning that it no longer seeks to challenge existing paradigms but becomes another box in a regulatory checklist (Hou and Kinoshita, 2007). Questions are raised about the effectiveness of working with a community, if the process is institutionalized. This could potentially act as a barrier to include marginalized groups, especially if they are wary of institutions to begin with. Furthermore, if the community is encouraged to speak freely and marginalized/diverse groups are not participating, planning processes run the risk of reproducing stigma and exclusionary practices. It must be acknowledged that individuals in communities have the power to discourage differences of opinion, despite the best efforts of planners (Hou and Kinoshita, 2007).

Scholars have criticized participatory planning for putting emphasis on interaction and communication, rather than identifying and exposing unjust systems and social relations (Hou and Kinoshita, 2007). It has been argued that the focus of planning should be its political nature, and planners need to break down systematic barriers to assist in empowering marginalized groups (Reardon, 2010). Without these actions, critics believe that change cannot occur (Umemoto, 2001).

### 3.2 Communicative Action

Judith Innes writes about communicative action, a concept related to participatory planning, addresses its obstacles in planning practice and links it to the interpretative line of thinking (1995). She stresses that planning is inherently “interactive” and planners are “embedded in the fabric of the community” (Innes, 1995, p.183). Planners are exposed to community and political relations, and have the power to influence or make decisions (Innes, 1995). Communicative action has the

possibility to generate new ideas and pose questions about planners' roles, planning processes and directions for the future.

Planning processes gave planners a sense of power and important ability to implement decisions. During the time of a positivist and rational planning paradigm, planners were expected to make decisions on behalf of the 'public good' and 'fix' problematic situations (Innes, 1995). Although this could be viewed as something positive, particularly if planners were to strive to enact social change and advocate for marginalized populations, the danger is that it assumes that a group of people is knowledgeable enough and is able make decisions of behalf of society. Communicative action and participatory processes do not make attempts to define what is good for the 'public' as an undifferentiated unit, or what is 'right' for society. Rather, the focus is on how socially constructed processes define and promote certain ideals of 'good' and 'justice' – these processes occur through interactions between people and/or institutions with knowledge and power and are (re)produced through discourses in everyday life (Healey, 2003; Reardon, 2010). It becomes vital to examine how actors, planners and other stakeholders shape the processes. Communicative action and participatory processes acknowledge that in any situation, people have the ability to influence the outcome of any process (Reardon, 2010).

Communicative action is recognized as an effective way to engage communities and promote a 'democratic' way of planning. Patsy Healey argues that communicative action "brings diverse forms of knowledge to bear on governance struggles" and "enrich[es] understanding of the way actions now may play out through complex relations in space and time" (2006, p.336). That is to say, communicative action considers multiple perspectives and the planning profession is becoming aware of how their attitudes and ideas shape how processes turn out. Judith Innes also suggests participatory processes and communicative action acknowledge the notion of 'wicked problems' (Rittel and Webber, 1973; Innes, 1995). These are defined as problems in society that cannot be solved due to the changing contexts and evolving challenges (Innes, 1995). Processes of defining problems constantly shift, therefore implementation of proposals cannot resolve the issues. Drug addiction and homelessness can therefore be called wicked problems, as

the literature of harm reduction exemplifies the differences in opinions. There cannot be a 'one size fits all' solution, simply because addiction is not understood in the same way by every single individual. The theory of communicative action understands the wicked problem concept, and thus focuses on determining "what planners do, not what they should be doing" (Innes, 1995, p.185). This is also reflected in the purpose of this thesis: I will not be concluding that planners in Canadian cities should be doing exactly what planners are doing in Europe. Rather, I will emphasize what has worked abroad and whether there are any applicable practices after determining the context and what planners do in each city. The appeal of participatory processes is that it is recognized that not all consensuses are representative of what could be construed as real (Innes, 1995). Planners can work to understand the deeper relations behind reaching a consensus and re-design processes accordingly. They can also determine how their role shaped the decision.

There are emerging issues that need to be considered in planning processes. These issues will ideally be part of the reflexive process in improving participatory planning. Public health researchers have advocated for decisions to be made at the municipal and local level to shape policies – this shift would be crucial for planners to examine their planning processes. If health decisions based on services and access are localized, planners will need to understand their roles and increase in decision-making power. As well, it is important to recognize the "rising role of the shadow state" (DeVerteuil, 2000). This means the non-profit sector is increasingly able to make decisions about important healthcare and social services, without the same scrutiny of government public services. This raises many questions on what is considered a 'public service' and who is really making decisions. Planners will need a grasp on external actors outside government agencies who wield power in affecting health outcomes. This relates back to the concept of examining relationships and history, and the need to understand these situations when entering a new planning context. Researchers have emphasized cultural diversity as another factor that will influence planning processes. Karen Umemoto explored planning processes that affected indigenous groups in Hawaii, and recognized the culturally specific way planners conduct processes (2001). The primary challenge was to incorporate different forms of knowledge

(indigenous and Western); she found that "discussing challenges of participatory planning [with the different groups] can lead to more thoughtful practices" (Umemoto, 2001, p.29).

In future planning, participatory processes should be consistently re-evaluated and have room for innovation to adapt to changing contexts. Patsy Healey optimistically states that "planners should not be afraid to reinvigorate the planning project with a utopian edge" and use their influence to "assert the idea of a good city and society" (Healey, 2006, p.338). Those sceptical of participatory planning suggest ways to deformalize processes: allowing for spontaneous activities suggested by the community may encourage deeper engagement and more dialogue (Hou and Kinoshita, 2007). In complex situations, this gives the community a chance to face stigma and develop their own understanding. Communicative action strategies could address the shortcomings of participatory planning. For example, interactions between community residents and drug users can hopefully create new meaning to what it really means to be a 'user'. Planners who utilize inclusive and participatory processes can ideally shape policy to re-examine roles of actors and continually re-evaluate processes to adapt to the situation. Brendan Gleeson and Robin Kearns (2001, p.78) summarize in one quote what the future of participatory and inclusive processes should look like:

> Community is no mere social container, but an entity that is constituted by the very negotiations and compromises that occur through engagement in civic life… A new service landscape [will] cherish the diverse values and interests of carers and care recipients. If we are serious about care, we must engage and value the interests of all who care.

### 3.3 Multiplicity and Transdisciplinary Approaches

The notion that urban issues need qualitative consideration equal to scientific and technical methods is nothing new. Leonie Sandercock calls for an "epistemology of multiplicity," which emphasizes different ways of understanding and gaining knowledge (1999, p.170). Planners have a responsibility to be inclusive of all groups and ensure all members of the public have their voices heard. However, concerns and discussion can often be overlooked when only looking at data and attempting to draw conclusions via numbers and statistics. Sandercock puts forth five concepts that will enable planners to approach processes thoughtfully and expand on a new understanding

of knowledge: in particular, this thesis will attempt to achieve two of these goals through *dialogue* (talking and listening effectively) and *experience-based local knowledge* (1999). As Sandercock concludes, "our task is ultimately people-centred rather than document-centred" (1999, p.178).

There is a general understanding in planning and social science circles that disciplines are slowly shifting from a positivist/rational-thinking paradigm to that of critical thinking and reflexive understandings of how scholars are implicated in their research (Reardon, 2010). As well, it is becoming more accepted to use qualitative methodology as the notion of the 'right' evidence in form of numbers and statistics is dissipating. However, in public health and scientific discourses, the concept of integrating qualitative research is not as prevalent. Even current studies by the European Monitoring Centre for Drugs and Drug Addiction are scientifically minded, favouring hard evidence and displaying charts as what is 'real'. It seems in this context, quantitative methodology is still privileged. This is clearly demonstrated in the remark that one of the problems facing the harm reduction approach is the lack of "rigorous evaluations" – Vancouver is cited as an example of integrating evaluation practices in the safe injection site pilot project, which implies that other sites should do the same (Hedrich et al., 2010).

There are opportunities to create dialogue and ideas between public health and planning disciplines, despite the gaps in conveying information. Although the means to generate knowledge may differ, the two fields share similar issues at stake. Health services research is fundamentally transdisciplinary, as it draws on knowledge generated by scholars and practitioners in planning, policy, medicine, public health and health services management. Research has not fully address the relationship between cities and health; urban health research proposes a more rigorous evaluation of service delivery by municipal governments (Gusmano and Rodwin, 2005). Adding qualitative research that examines the impacts of income, gender and race at a neighbourhood level could supplement understandings about how environment impacts health – planners could then synthesize both kinds of knowledge to develop policies that fit the context. Specifically, there are many issues at stake when discussing addiction and planning. Danielle Ompad and Crystal Fuller state "drug use has been historically conceptualized as an urban problem" (2005, p.127). As

well, addiction in an urban context needs to be understood in conjunction with other social policies (Ompad and Fuller, 2005). For instance, housing plays a big role in examining the cycle of addiction. Anita Palepu and Mark Tyndall argue that homeless individuals experience many barriers in accessing health and social supports because they lack an address or stable housing (2005). Besides social policy, planning processes around zoning by-laws and building codes affect how the built environment impacts health (Perdue, 2005). An example of this can be brought back to discussions around NIMBYism – if a zoning by-law prevents a human service facility from being built in an area zoned 'residential', this affects many clients' access to services and therefore impacts their health outcomes. Planners can bring different forms of knowledge to work with public health staff on more efficient forms of health services and modes of delivery (Palepu and Tyndall, 2005).

Overall, it becomes a question of why planners should care. Individuals can bring about a shift in considering alternative ways of knowing. The public health discipline has already acknowledged that urban centres bring about an opportunity for interdisciplinary collaboration to discuss new kinds of programs and services (Ompad and Fuller, 2005). Planners bring contextual information and can spark discussion on innovative services and access to healthcare. Encouraging alternative ways of generating knowledge can lead to improvements in design and development processes. As Palepu and Tyndall emphasize, context is important (2005). Drug users are usually seen as a marginalized group: bridging public health and planning perspectives could ideally empower individuals in achieving positive health outcomes and greater civic participation. Disciplines must "operate outside traditional models of delivery" and promote a "holistic approach" which allows for a variety of perspectives and inputs (Palepu and Tyndall, 2005, p.570). Multiplicity is one way to increase collaboration between various fields, ensuring that one methodology is not privileged over another.

### 3.4 NIMBY Theory

Understanding NIMBY is crucial to this thesis. Even though sites are integrated into European neighbourhoods, there has been evidence of opposition in Canadian cities (Wood et al., 2004).

Without realizing how NIMBY works, community engagement may be a futile exercise. Christopher Smith also explores NIMBY in relation to addiction treatment spaces in Toronto. The Corktown neighbourhood heavily opposed the siting of a methadone treatment clinic, utilizing a number of tactics – including blaming municipal politicians, fighting the "exploitation" of addicts and then finally, vilifying the users (Smith, 2010). Lois Takahashi argues that understanding the deeper reasons behind vehement community resistance is crucial if planners and policymakers want to succeed in engagement (1997). This thesis aims to achieve that deeper understanding, how resistance was overcome and the results of the siting decades later. California's Department of Housing and Community Development also offers a number of strategies to go "from NIMBY to YIMBY" – the premise of which is to use precedents and dispel myths in working with communities (2006). The results of this thesis could possibly be a tool in planning with contested spaces in neighbourhoods.

There are a number of ways that NIMBYism can be understood. Michael Dear articulates NIMBYism as a mindset of residents who are protective of their neighbourhood/community (1992). This may be simply an internal thought or community members may utilize "protectionist attitudes and oppositional tactics" to vocally express their disagreement (Dear, 1992, p.288). NIMBYism can be applied to many land use discussions, such as building supportive housing or siting a landfill in a certain neighbourhood. For the purposes of this thesis, I looked at articles that discussed NIMBYism in relation to human service facilities. These arguments could theoretically apply to supervised consumption site development processes where NIMBYism is a factor. Joanne Wynne-Edwards detailed a number of ways on how to work with NIMBYism when trying to build affordable housing (2003). She states that NIMBYs are worried about the proposed intervention affecting property values, increasing traffic and crime rates and high concentration of services in one neighbourhood (Wynne-Edwards, 2003). It can be argued that the rise of NIMBYism stemmed out of deinstitutionalization policies and the lack of available community housing – people recognized the need for shelter but were unwilling to accommodate these facilities in their own communities (Wynne-Edwards, 2003). However, Dear points out that NIMBY is not always negative or self-interested: suggestions of viewpoints can create design or service delivery

improvements, especially if clients are give the chance to voice their opinions (1992).

The primary motivation for NIMBYism in relation to human services facilities can be described simply as the fear or apprehension of the 'other'. Andrew Woolford explores the notion of "tainted space" in his essay on visual and cultural representations of HIV/AIDS and drug users in Vancouver's Downtown Eastisde (2001). He argues there is a "symbolic" divide in cities between the "infected" and "non-infected" – "the infected are usually located in communities outside the moral space of the city" (Woolford, 2001, p.27). This is especially true in the Downtown Eastside, where Insite is located. This neighbourhood is frequently distanced in discussions around Vancouver as a whole; it is treated like it is a separate entity. Woolford suggests that language in the media and everyday discourse plays a role in further stigmatization of marginalized individuals in this area, which can influence people's perceptions (2001). Through these discussions and media portrayals, the homeless are viewed as not part of 'their' community and thus can be displaced. These prevailing attitudes enable communities to "take back public space which was stolen by deviants" (Fischer et al., 2010, p.359). As inner-cities are believed to be more accepting of these individuals than suburban or outer-city neighbourhoods, inner-city residents may be concerned about the 'saturation' of services in their community (Dear, 1992). This is commonly called "service ghettos", or a concentration of social supports in one area. However, no matter what neighbourhood residents live in, there is an inherent desire to "distance ourselves from guilt…when faced with suffering we tend to isolate the sufferer regionally and see ourselves as separate" (Woolford, 2001, p.49).

Several scholars, particularly with respect to human service facilities, have studied the process of NIMBYism. The general consensus was to seek out counterarguments to common NIMBY arguments, in an effort to aid communities and organizations to work with opposition groups (Abraham and Maney, 2009). The research discusses how real estate transaction studies disproved worries around declining property values and increased risks of crime and threats to safety (Dear, 1992). Past research has also uncovered other fears associated with the NIMBY mindset. For instance, apprehension around the proposed intervention's clients and their

behaviours were explored. Residents and community members appeared to be particularly resistant to substance users and individuals living with HIV/AIDS (Takahashi and Dear, 1997). Researchers sought to understand how opposition groups perceived fear and how to design participatory processes to assuage their concerns. Michael Dear outlined four factors that influenced responses from communities, which could be used in developing counterarguments to NIMBYs: client characteristics, the type of facility, background and context of the host community, and other programs operating in the host community (1992). He argued that these four themes could predict how communities would react to future proposed programs or interventions. Lois Takahashi and Michael Dear also discussed the notion of the service ghetto: NIMBYs could also be concerned about the high concentration of services, despite efforts to minimize barriers to the facility users (1997).

Research around understanding NIMBY processes also focused on case studies: analyzing the process and outcomes of previous NIMBY situations, then creating checklists and recommendations for future developments. In particular, Margaret Abraham and Gregory Maney examined two instances where NIMBY opposition threatened efforts to establish a domestic violence shelter and an official hiring day site for day labourers (2009). The shelter was successfully built, but the hiring day site did not come into fruition. The researchers sought to explore the reasons for this, analyzing NIMBY responses using frameworks set out by Dear and Takahashi. Overall, the conclusion was that both situations were highly contextualized and NIMBY labels had the potential to reinforce divisions within the community, especially racial and class stereotypes (Abraham and Maney, 2009). It became increasingly important to involve the community during each step of the implementation processes, and for policymakers to be aware of the contexts in which they were working in. NIMBYism was also present during the early days of Insite's implementation: some business community members in the Downtown Eastside were initially opposed to the site (Campbell, Boyd and Culbert, 2009). These individuals were worried about Insite attracting more users to the area and detracting visitors to the historical Chinatown, especially since the local Chinese shops and restaurants were in decline. There was a real fear around losing the sense of Chinese community, and not so much a moral opposition to the site.

This demonstrates the NIMBYism is complicated and there are always contextual reasons for opposition arguments. However, once the Chinatown merchants noticed that there were lower instances of public drug use around the shops and restaurants, they became less resistant to the ideas. Planners and policymakers should fully uncover why people are opposed to a facility, instead of assigning an arbitrary, all-encompassing NIMBY label.

Out of these studies and articles, toolkits and resources were developed to address the so-called NIMBY problem (State of California, 2006; Pivot Legal Society, 2011). Scholars reiterated a number of suggestions for planners working in contested space, such as emphasizing the need to understand the types of arguments that may arise (Dear, 1992). There were also a variety of factors proposed that would predict how a community would react to certain facilities, as well as a range of strategies on how to work with communities (Dear, 1992). Participatory processes were deemed as the 'best' way to address NIMBY concerns, as it appeared that encouraging each individual or group to voice their concerns/oppositions would bring about the most meaningful change (Wynne-Edwards, 2003). Other organizations such as Pivot Legal Society (Vancouver) and the Legal Action Centre (USA) provided legal alternatives and interpretations to anti-discrimination laws as a means to counteract NIMBY, should the conflict escalate to a litigation scenario. The Legal Action Centre gave explanations around how zoning ordinances and by-laws could act as a barrier to building a facility; either it was exclusionary in nature or a planner/policymaker could interpret the by-law to deny variances (1995). This information was available in plain language, which made complicated by-law information accessible to the general public. Pivot Legal Society also came up with a NIMBY toolkit that suggested ideas on how to engage NIMBYs and policymakers in discussions around building supportive housing in BC's Lower Mainland. Besides including attractive graphic work and using clear language, the report also summarized local legal frameworks and ideas on how to navigate planning approval processes in Vancouver (2011). Interestingly, reports (Abraham and Maney, 2009) and toolkits (State of California, 2006; Pivot Legal Society, 2011) emphasize the need for myth busting and education, implying that people respond best to evidence. This means communities may respond better if they are aware of successful precedents and the processes interventions were developed through.

It is becoming more apparent that land use arguments and human service facilities implementation processes are too complex to be simplified into a "rational common interest" paradigm (Gibson, 2001). This raises questions on how to move past the dichotomous nature of NIMBYism. As Vincent Lyon-Callo discusses in his article "Making sense of NIMBY: poverty, power and community opposition to homeless shelters", there is more to opposition than ignorance or lack of compassion (2007). He explores the processes of NIMBYism in relation to opening a winter shelter in Massachusetts, utilizing content analysis and discourses in an effort to understand the deeper reasons behind opposition. It was clear that the residents could not be categorized under a simple 'ignorant' label: rather the NIMBY arguments stemmed from class relations that had not been acknowledged before (Lyon-Callo, 2007). Residents feared the 'dumping' of services in their neighbourhood signified that city officials saw their community as 'unimportant' – further research uncovered that residents were worried about gentrification pushing them out of their working-class neighbourhood (Lyon-Callo, 2007). It can be argued that a concentration of services in one area implies that the neighbourhood is not valued, as perceived by community members. NIMBY cannot be understood and predicted through checklists or indicators. Scholars and community organizations need to dig deeper to uncover complexities in each context, instead of relying on indicators and predicting arguments that may arise (Gibson, 2001). In fact, working within a singular NIMBY framework could reinforce stereotypes and reproduce caricatures of 'the homeless' or other marginalized individuals (Lyon-Callo, 2007). In order for meaningful change to occur, individuals should not be relegated to 'bigot' or 'drug user' stereotypes.

Both Lyon-Callo and Gibson advocate for rethinking planning or policymaking decision processes. Individuals in positions of power need to adopt a reflexive stance, and remain increasingly critical of their role in complex situations (Lyon-Callo, 2007). Gibson argues that there can no longer be a "dream of rational, expert-controlled technocracy" and planners and policymakers need to give up the notion of an "uncontested claim to the civic good" (Gibson, 2001, p.399). In this proposed framework, planners and policymakers need to re-examine their roles in development processes. It appears that these individuals should encourage discussion and

debate around processes of human service facility development (Gibson, 2001).

In line with moving past the traditional NIMBY framework, this thesis will not conclude with a list of recommendations or a checklist for communities thinking about establishing supervised consumption sites. Rather, analysis will focus on processes of working with addiction and planners' roles in this ever-evolving context. The conclusion will put forth ideas for planners' involvement in harm reduction intervention processes. It will remain essential for stakeholders to be critical of their own processes and roles (Abraham and Maney, 2009). Going into a community with a basic understanding of context and relationships is a useful start, and has the possibility of encouraging participation (Takahashi and Dear, 1997). In the future, NIMBYism should not be just another label that signifies exclusion – but a way to stimulate discussion and critical thinking (Takahashi and Dear, 1997).

### 3.5 Concluding Thoughts

As there are no examples of literature linking supervised consumption sites to planning, I looked at literature that focuses on participatory processes that I believe will be important for developing these sites in the future. I recognized the spirit of participatory planning, but acknowledged the shortcomings of this particular paradigm. I suggest that communicative action can overcome some of these identified challenges, but caution against making the engagement processes too formalized. I explore the notion of 'multiplicity' and 'transdisciplinarity' to draw attention to the multifaceted nature of developing supervised consumption sites. I emphasize drawing on local and experiential knowledge, while promoting collaboration and generating new knowledge that transcends disciplinary boundaries. Finally, I discuss NIMBY theory in relation to human service facilities to highlight the contentious nature of developing such sites. I analyse the dichotomy that NIMBY presents in communities and look at how these labels can promote further discussion. These theories inform how I approach my research, and lay the groundwork for identifying implications for the planning profession and the roles of planners in these processes.

## 4| Experience with Developing Supervised Consumption Sites

Supervised consumption sites operate under a harm reduction framework – the facilities are used as a means to work with addiction with the premise of reducing harmful activities and consequences of drug use. As discussed in the introductory chapter of this thesis, harm reduction lies at the crux of a moral dilemma: advocates believe that addiction should be viewed as a medical condition which requires a supportive network and access to treatment and healthcare, while 'prohibitionists' favour an enforcement approach which criminalizes drug consumption and promotes abstinence-oriented programming. The existing research on supervised consumption sites suggest that using enforcement strategies is not an effective way to deal with drug problems, making the case that harm reduction strategies (when working with drug users) are the most sustainable option in the short and long term (Beyrer, 2011). This portion of the literature review examines what has been written about supervised consumption sites, and concludes with the argument that existing literature can be understood in conjunction with planning theory in terms of supporting the planning and development of these sites. For this thesis, I will focus specifically on Zurich, Frankfurt, Berlin and Vancouver – while discussing the general implications on the countries as a whole.

### 4.1 Functions

Supervised consumption sites are set up as low-threshold facilities, under the objective of maintaining stability and survival of drug users (Federal Ministry of Health, 2003). They are defined as "protected places for the hygienic consumption of pre-obtained drugs in a non-judgemental environment and under the supervision of trained staff" (Akzept, 2000, quoted in Hunt, 2006, p.1). The sites are geared towards drug users with a history of consumption, and most have a mechanism in place to assess individuals and restrict entry (Hunt, 2006). There are three different kinds of supervised consumption sites: integrated, which means the sites operate within a larger framework of support services and partnerships; specialized, meaning that the sites are specifically for consuming drugs; and informal, which is typically run by peers or former drug users (Hedrich, 2004). For the purposes of this thesis, the sites I refer to are mostly integrated –

however, the site in Vancouver is primarily referred to as supervised injection site.

Switzerland, Germany and the Netherlands are the three most widely cited examples of effective and legal drug consumption room operation. These three countries are often mentioned in reports – sites in other cities have modeled their own harm reduction frameworks on these precedents (Hedrich, 2004; Akzept, 2006). As of 2003, there were fifty-four drug consumption rooms in operation in Europe (Kimber et al.). However, supervised consumption sites are understood differently in international contexts. The literature discussing precedents in Europe makes the distinction between safe injection sites and drug consumption rooms. Safe injection sites cater primarily to injection drug users, and operate in an Australian and Vancouver setting. In Europe, they are more commonly known as drug consumption rooms – this allows for flexibility in terms of how the user chooses to consume drugs. There are provisions for a 'smoking room' and a sterile counter if the user's preferred method is to consume through the nasal cavity (Dolan et al., 2000). However, due to Canadian drug law, exemptions were only granted for injection drug users within the facility. The literature makes it clear that contextual drug use activity should be considered – safe injection facilities and drug consumption rooms should reflect the local drug use culture (Small et al., 2011).

**4.2 History**

Supervised consumption sites were not always the sterile and legal spaces they are now. In the 1960s and 1970s, 'shooting galleries' were informal gathering places where drug users would congregate and use/buy drugs (Dolan et al., 2000). These were not legally sanctioned and did not include medically trained staff. Public and visible drug use made these galleries highly problematic, as well as the drug-related litter and residue that remained afterwards (Dolan et al., 2000). The earliest precedents for legal and medically supervised sites were in the late 1980s/early 1990s in Switzerland, Germany and the Netherlands; they were established in an effort to fight a rampant and escalating HIV/AIDS epidemic and public drug use activity. Each country set out specific regulations, but the underlying goal was the same – to view addiction as an illness and move away from an enforcement/criminalization approach. Studies continuously showed that the sites were

working (Kimber et al., 2003).

The first supervised consumption site was set up in Switzerland in 1986. There was a large open drug scene in Zurich that attracted media attention, and also a focus on the HIV/AIDS epidemic (Hunt, 2006). Although there were concerns about public health, the issue around public order and safety was the driving force behind setting up a consumption site (Eastus, 2000). In 2001, Swiss consumption rooms also recognized the changes in drug use modes and implemented inhalation rooms (Hunt, 2006). In terms of legalities, opening a supervised consumption site did not appear to contradict the national drug policy. The legislation stated that addiction facilities must "improve the hygienic conditions under which consumption takes place and provide medical supervision and no dealing takes place" (Hedrich, 2004, p.15). The original open drug scene in Zurich attracted a number of 'drug tourists', where drug users from other cities in Europe came to the Platzspitz, or 'Needle Park' as it was referred to (Hunt, 2006). This led officials to decide on restricting the consumption sites to local residents only. Entering the site is controlled by identity documents with proof of residency (Hunt, 2006). Although this restriction may not address the larger social issues at hand, it demonstrates the importance of local context in making decisions.

In Germany, the first sites were in Frankfurt, Hamburg and Bremen – which operated under some legal ambiguity (Akzept, 2011). As there was an unofficial (sanctioned by the municipality but not on a federal level) site running in Hamburg, the City of Frankfurt and other local stakeholders took that as enough of a legal precedent to start their own 'health' room that would offer a space for drug consumption in 1994 (Akzept, 2011). As Frankfurt had one of the largest open drug scenes in Germany at the time, it was imminent that the sites would open after Hamburg started theirs (Akzept, 2011). There was also a need for the site as overdose rates were increasing quickly and to respond to the nuisance complaints by city centre businesses and residents (Hunt, 2006). In 2000, there were amendments made to the Narcotics Act that made the sites legal across the country albeit under stricter and more controlled regulations (Federal Ministry of Health, 2003). Nevertheless, these sites set a precedent for other sites in Germany to open. As of 2009, there were 25 consumption rooms in 16 German cities, with the most sites

located in Frankfurt and Hamburg (Akzept, 2011). Interestingly, Berlin's fragmented drug scene called for a mobile drug consumption van – a different model than the stand-alone consumption rooms in other cities. However, this reiterates the importance of considering how the consumption rooms need to function in order to serve the drug users' needs and neighbourhood concerns.

In Vancouver, Insite opened on September 22, 2003 in the heart of the DTES neighbourhood. This location was chosen due to the proximity to the concentrated pocket of public drug use, homelessness and visible sex trade workers in the DTES (Small et al., 2011). There is an estimated five thousand injection drug users that reside here, with many more coming to purchase and inject (Wood et al., 2004a). Furthermore, just within the DTES boundaries, it was estimated that seventeen percent of drug users are HIV positive – as well, over eighty percent have Hepatitis C (Small et al., 2011). As addiction straddles the line between a criminal and a public health concern, the federal government approved a three-year pilot project that would be exempt from Canadian drug laws – the government called for a comprehensive health and social impact evaluation (Wood et al., 2004a). Some of my interview participants pointed me in the direction of considering how the closing of the Health Contact Centre in the DTES has influenced the importance of Insite. The Health Contact Centre, run by the Vancouver Coastal Health Authority, was the first point of contact for many DTES residents and an important link to basic healthcare and community services (Vancouver Courier, 2010). It appeared that closing the Health Contact Centre in 2010 was meant to direct more resources towards Insite (*Vancouver Courier*, 2010). As Insite was not set up to be a community health hub, it may be useful to look at the European precedents to learn from the integrated consumption model.

### 4.3 Challenges and Opportunities

There have been several evaluations completed for drug consumption rooms in Europe. As well, Insite was required to have an evaluation and research component as part of the pilot project. In these evaluations, there have been some discussions around the challenges and opportunities of implementing supervised consumption sites. These discussions also address potential

recommendations to improve operations. This research is helpful in understanding what services are available to drug users within the facility, and the links to other resources. It also provides comparisons between sites, and lessons learned from an operational perspective. It appears that the literature is primarily focused on the logistics of the sites and outlining service and operational details. There is a noticeable gap in presenting information about drug users' experiences, or even stories from staff or policymakers about the planning processes or the daily running of the sites. This is how I would like to frame the discussion of the challenges and opportunities presented in the literature: not only working with what the researchers suggest and write, but critically examining throughout what implications the research presents. I want to draw attention to what is being said, and implicitly what is not being said – and how this shapes exchanging knowledge among individuals on a local, national and international scale.

One report from the Federal Ministry of Health surveyed drug users and generated information from policymakers to identify challenges and opportunities in each site in Germany (2003). Some challenges included limited services, small size of facility, neighbourhood complaints, the difficulties of working with different kinds of drug use and long waits (Federal Ministry of Health, 2003). The challenges have not been overtly described in Zurich, but the focus appears to be on measuring risk behaviours in drug users utilizing the consumption sites (Hedrich, 2004). This could also be attributed to the focus on quantitative methodology in the literature written in English.

I now turn to a number of studies focus on the processes that led to the establishment of Insite and the associated challenges (Beyrer, 2011; Marshall et al, 2011; Mate, 2008). It was a controversial topic in North America, which could explain the larger amount of information available about a singular site – compared to the few articles about numerous facilities in Europe. The challenges in the literature tended to focus more on the legal aspects of opening Insite (Elliott et al., 2002). Literature from the Canadian HIV/AIDS Legal Network outlined the legal implications of Insite, putting forth a new framework that would enable law and policy changes to allow for a safe injection site to operate legally (Elliott et al., 2002). Insite still remains a legally contested

space, as it is technically viewed as a pilot project. The Canadian HIV/AIDS Legal Network argues that Canada's drug strategy is based on a harm reduction framework (Elliott et al., 2002). As this was published before Insite opened its doors, the authors posit that policymakers and the law are obligated to try to implement safe injection facilities. This is based on the premise that sites are legally operating elsewhere.

In terms of the literature itself, the research acknowledges the challenges in evaluating and monitoring the drug consumption sites and their 'expected results' (Hedrich, 2004). Two reasons identified were the level of influence of the drug consumption site, and that the length of time to monitor the effects of the site may not be enough (Hedrich, 2004). As well, research explains that the findings of the scientific evaluation may not apply to all drug users using the facilities – they recognize that not all results will be the same across drug users and in different communities (MSIC Evaluation Committee, 2003). Interestingly, there is no mention that the indicators used in evaluation research may not be applicable in all scenarios. As well, the criteria used to measure 'progress' is arbitrary – progress has different definitions to each individual and community. Statistics are useful in demonstrating how many people use the site and public health benefits, but should ideally be supplemented with experiences from drug users and community members. This would lead to a richer understanding of how the sites have impacted the public realm and the well-being of drug users and neighbourhood residents. This will be helpful in presenting a comprehensive picture of supervised consumption facilities function in their surroundings, and what to consider in future planning and development processes.

There is limited writing on the topic of opportunities. Generally speaking, I believe it is easier to identify problems because individuals are constantly exposed to and experiencing what is not working, and can speak about what does not work. However, it proves to be more of a challenge when faced with the task of identifying opportunities; it can be daunting to rethink current practices and put forth recommendations. An opportunity exists within supervised consumption site research to identify research projects that can either confirm or provide evidence that casts doubt. One such example is the apprehension that drug users would actually use Insite. However,

studies conducted before Insite's opening established willingness to use the facility. The research was based on an extensive survey/client monitoring process. Researchers tracked clients' visits and drug use patterns on a database – after six months of operation, there were over 1300 entries recorded (Wood et al., 2004b). Drug users were identified based on drug of choice and usage patterns. Researchers performed follow-up surveys and blood sample testing after six months (Wood et al., 2003). The literature demonstrates there was willingness for drug users to utilize the site. As well, studies reflected on precedents in Europe and determined that the same public health benefits, as well as a decreased public presence, would be seen in Vancouver. However, there is an emphasis that addiction needs to be understood within a specific context (Small et al., 2011). Insite needs to be considered as its own entity: observed and recorded benefits will enable policymakers and planners to adapt to changes and concerns.

In the literature concerning supervised consumption rooms in Europe, opportunities included setting minimum standards for facilities across programs (Federal Ministry of Health, 2003). This could include rules around hygiene, facility cleanliness, established referrals, rethinking opening hours, and considering a social impact assessment on future site locations (Federal Ministry of Health, 2003). The last suggestion is particularly interesting, as a social impact assessment could mean drawing attention to other social issues such as housing, food security and accessibility – broadening the discussion is another opportunity for the sites to serve a more comprehensive role for drug users and neighbourhood stakeholders.

Opportunities in presenting research and literature could be considered as well. In addition to increased qualitative research and incorporating experiential knowledge, more information on planning and development processes should be documented to provide a background in understanding the functions and operations of a facility. Some of the strengths of the research, especially in Europe, include displaying information in tables and charts, which make comparisons and quick communication easy to follow. I believe this makes information accessible to those not in an academic setting. Sharing information and generating new information with community members should be a priority in future research, in order to add more perspectives on this topic.

### 4.4 Potential Networks

Supervised consumption sites function alongside other resources (counselling, healthcare professionals and links to housing and employment) to provide drug users with a clean and sterile place where they can inject with new equipment while supervised by a nurse, and coordinating referrals to treatment and detox facilities when the drug users are ready.

The sites are attached to food options, counselling services and an onsite clinic (Dolan et al., 2000). I observed that the research on the sites does not discuss the specific partnerships with other service providers, or how these partnerships were created. The literature also does not delve into the importance of service provision in conjunction with operating a consumption site, as these facilities may often be the first point of contact for drug users. When discussing other services, the research lists the services provided and provides a snapshot of the target population (Hedrich, 2004; Hunt, 2006) – but does not go into further detail about how these networks function to provide positive health and social outcomes for drug users. Access to housing, social services and other supports are some of the most beneficial aspects of supervised consumption sites (Akzept, 2006). There may be opportunities to further uncover potential networks, and forge new relationships.

In terms of service delivery within a larger harm reduction network, most of the supervised consumption sites I looked at for this thesis would be defined as "integrative" (Hedrich, 2004) with the exception of Insite. Most of the sites are stand alone facilities, which offer drug users a break from living on the street and a chance to have a snack, do laundry and talk to people (Akzept, 2011). However, many of these sites are connected to other services, provided within a larger network. This includes referrals to counselling, detox and other primary health care (Akzept, 2011). There are also harm reduction supplies available in the centres, and food services. Interestingly, the ways the sites operate are different in each case study. In Switzerland, the supervised consumption sites offer a place for drug users to drop in and use drugs, and act as points of contact for users who are interested in further accessing health services (Hedrich, 2004).

The research does not describe who provides services, or what is available to drug users. In Berlin, there are two mobile sites and three drug consumption rooms to serve the fragmented drug scenes. The mobile sites provide an interesting opportunity for outreach, and a useful platform for reaching drug users who may have mobility challenges or are apprehensive of accessing services. The mobile van can also provide a safe place to use drugs in an environment the drug user is somewhat comfortable in. In Frankfurt, there are three drug consumption rooms and one facility that is fully integrated with other services under one roof (Takács, 2006). This 'one stop' facility is called the Eastside, and is located in an industrialized area in Frankfurt. In addition to the consumption rooms and medical services, the facility offers employment programs, emergency shelters and long-term housing (Takács, 2006). In Vancouver, Insite operates as a 'specialized' facility, in that it exists as a supervised injection site. However, harm reduction supplies are offered to drug users and the program has expanded to include Onsite, which provides temporary shelter for clients who are entering detox treatment (Vancouver Coastal Health website). As Insite is operated in partnership with the Portland Hotel Society, there are a myriad of services that are available to drug users such as housing, food programs and specialized health services (Vancouver Coastal Health, n.d.(a),). Therefore, I would classify Insite as an 'integrative model' rather than 'specialized' as outlined in the literature (Hunt, 2006).

Supervised consumption sites offer potential networks that can also include opportunities for social interaction and positive social impact. In Frankfurt, drug users experienced a sense of exclusion "despite the fact that about 80,000 commuters passed by the open drug scene daily… the drug users were still in complete social isolation" (Nickolai, 1997, not paginated). I came across one article that included drug users' stories about using Insite, where they expressed feelings of safety and that somebody cared (Vancouver Coastal Health, n.d.(b)). Unfortunately, this seems to be the only available document that highlights the experiences of drug users and why they chose to use Insite. Involving drug users can foster a sense of belonging, especially if their voices are being listened to and documented.

The German model addresses the relationship between social inclusion and addiction as

well. The establishment of the centres often involves the community in participatory processes – a strong referral network is set up which includes housing, assistance with finding employment and access to social services and healthcare, and encourages community integration (Dolan, 2000). Community involvement can improve relationships between residents and drug users. Establishing housing and links to employment ensures that users are not back on the street after completing treatment. Planners should be involved as much as possible in these participatory processes, to facilitate a collaborative atmosphere and empower marginalized individuals (Garrison, 2003).

In terms of positive social and community impacts, Wood et al. expressed that "while it must be stressed that limited quantitative data are presently available, various reports have credited [supervised consumption facilities] with a number of public health and community benefits" (2004b, not paginated). Some studies found that safe injection sites had positive impacts on improving public order – researchers argued that this would promote a stronger sense of community, encourage tourism and alleviate neighbourhood opposition (Wood et al., 2004a). These benefits are due to the fact that users have somewhere safe to go. Improvements to health and access to housing have been linked with recovery in some individuals (Dolan et al., 2000). Evidence suggests that due to the efforts of safe injection sites and partnerships with other social services, the facilities are engaging with their targeted clientele (Kimber et al., 2003). The decrease in public drug use and risky behavior leads to sites being accepted in the neighbourhood – and has also "contributed to neighbourhood improvement and stabilization" (Kimber et al., 2003, p.231).

There are always opportunities for innovative work in service delivery and models in supervised consumption sites. In Berlin, the sites offer first aid and emergency overdose training to drug users in case they are in that situation outside the facility (Akzept, 2011). Health education and developing trusting relationships are ways to empower drug users to make choices with knowledge they may not have had access to (Vancouver Coastal Health, n.d.(b). Researchers found that drug users are more interested in their personal health, and are more likely to access health services and supports if they feel that their needs will be addressed in a supportive environment (Akzept, 2011).

### 4.5 Concluding Thoughts

Supervised consumption sites inevitably have an impact on their surroundings in a neighbourhood, which is why planners should be involved in establishing drug and addiction policy. Planners can look at the community context and help to generate recommendations that consider function and partnerships with potential networks. As harm reduction and addiction are controversial topics, planners have an added responsibility to work within communities and balance the needs of the neighbourhood and drug users. Most of the literature and drug policy work is geared toward a medical and/or public health audience, but as I summarize below, planners can use these resources to advocate for marginalized populations while still effectively engaging with the community. Addiction can no longer be pigeonholed as simply a medical or enforcement issue – it is complex and needs to be discussed in an interdisciplinary context.

As emphasized throughout this chapter, there are significant gaps that need to be addressed through further research. Considerations on social benefits and inclusion would be worth considering as supervised consumption sites can act as a 'meeting' or 'contact' point for individuals who have been severely marginalized or excluded from society. Planners have the ability to consider the bigger picture, but also facilitate discussions between residents, stakeholders, site staff, and drug users. Knowledge of other success stories in terms of positive social and community impact along with reiterating public order and health benefits would be an effective negotiating tactic.

As well, most of the literature is scientific-focused due to the high level of legitimacy society places on data and numbers. Qualitative research on safe injection sites and addiction should be expanded to involve people's experiences – users, residents, community participants, and healthcare professionals. Knowledge is understood differently across cultures and contexts – planners, policymakers and researchers should be aware of this, and make efforts to recognize this (Sandercock, 1999). The emphasis on bridging qualitative and quantitative evidence and research is a recurring theme.

In terms of future directions, the literature points in two directions. Researchers in Vancouver are pushing for a quantitative study of Insite's community and health impacts (Small et al., 2011). Researchers posit that this can take place in the future, likely ten to twenty years after its inception (Dolan et al., 2000). Australian and European researchers emphasize they wish to see further studies of accessibility – in terms of availability to women and different cultural groups (Kimber et al., 2003). It speaks volumes that these countries are already considering links between social inequalities and site accessibility, signalling the need for the issue to become more interdisciplinary. In sum, the literature documents the premise behind implementing safe injection sites and details the progress that has been made since the opening of the first site in the late 1980s. Hopefully, lessons can continue to be learned from successful precedents. As well, ideally there will be a broader variety of literature around safe injection sites in the future involving multiple disciplines and professionals.

## 5| Constructions and Analysis: What I Heard and Identifying Underlying Themes

As I read through my transcribed interviews and performed the three-step coding process as described by Neuman (2000), I grappled with the difficulty of separating the chapters by findings and analysis. Although I was aware of my role as a researcher and what biases and perspectives I brought to the interviews, it became clear that summarizing what I *heard* in one chapter and then writing about *my* thoughts in the next was not an effective way to develop an argument. While generating themes and making notes, I was subconsciously writing down questions as well – comments about the relationships between concepts, or asking how each theme related to the broader implications on the planning profession. I was always searching for the lessons that could be learned, and keeping in mind the themes brought about from the literature review. Did what I hear correspond with what I read? Why or why not? I also reflected on my reactions to reading the transcriptions. I would immediately take notice if I disagreed with a particular participant, and thought about how my own values influenced my perceptions of what the person was saying. How was I connecting the dots among participants, and to what I believed in?

I began reading through my notes chronologically, and quickly realized that the previous interviews influenced how I approached and understood the next interview. After listening to the interview recordings and reviewing the transcriptions, I noticed emerging themes and the overlaps among them. I approach this chapter by discussing what I *heard,* or the open codes, and the significance of these concepts on developing supervised consumption sites in the *What I Heard* section. The *Identifying Themes* section attempts to uncover the relationships between the open codes and consider my role as part of the data generation processes. These open and axial codes will inform the concluding chapter, which details the implications of my analysis for the planning profession and the role of planners in implementing supervised consumption sites.

### 5.1 What I Heard

The coding process led to the following themes: motivation, considering context, communication,

the role of politics, and the importance of a larger harm reduction network. These themes attempt to encapsulate my interpretations of the interview participants' experiences, in relation to establishing and operating supervised consumption sites in their communities. When asked to look back and reflect on the development processes, the participants first explained why they thought the sites were necessary and what the objectives were (motivation). Then, they reflected on the processes that were instrumental in getting the sites set up – which largely dealt with issues around communication and working within the community context. The interviewees repeatedly emphasized how critical it was to achieve political support and how policymakers' roles were shaped by political influence. Finally, they reiterated how supervised consumption sites should operate within a larger harm reduction network.

### *5.1.1 Motivation*

I asked the participants questions about what led to the opening of the facilities, and in all cases there were many motivating factors. It was reiterated that a large open drug scene would get public and political attention: there were questions raised about how planners could learn more about drug use in a particular area. As well, how planners could promote local and experiential knowledge as part of development processes. In this discussion around motivation, I endeavour to look at what aspects are important and how they motivate politicians and politicians to take action. It is clear from the literature that the drug situations triggered a breaking point in each city and forced some kind of intervention. However, I am reminded that not all motivation stems from a compassionate place. I question whether planners can be aware of motivating factors, while still maintaining a sense of social justice.

After all of the interviews and reading the literature, the theme of public order was brought forth as the primary motivating factor.

> Zurich 3: It's an important thing to see that establishing the contact centres in Switzerland. I'm not sure if it would have been possible if it wasn't that strong of a public order issue.

Another participant from Zurich goes on to reflect:

> Zurich 2: Since 1995, we haven't had an open drug scene since. The contact centres are very, they play a very big part in giving drug users an alternative to be in the public space. It's always been a public order issue.

A participant from Frankfurt recalls how the drug open scene in the financial centre of the city prompted discussion when the international implications came to light:

> Frankfurt 1: It's a financial city. In the early 90s, we were having an open drug scene, in the middle of the city in a part that is surrounded by banks. But as it happened, in that area, Frankfurt also wanted to have the European Central Bank. One of the driving factors, it's not the major one, was that everybody was saying, if you want to have the ECB here, it's really awful to have this open drug scene … People were in danger, there were people dying almost everyday. And so it was pretty obvious, from a social and health aspect but also with a little push from Frankfurt wanting to have the ECB. So that was the situation in the early 90's, everybody was thinking 'what can we do about that'?... One of the major drivers in this whole harm reduction approach was the public safety and the public order aspect. It was not enlightened made decision. It was having too many complaints, of crime and whatever, so that was really it.

Concerns around how drug use would affect life in the public realm were also brought up in other cities. It should be kept in mind that Zurich and Frankfurt opened their sites over twenty years ago, so public order was likely the only motivation that would get public and political approval. Perhaps a more altruistic approach was not yet fully realized at that time. However, public order is crucial to consider as motivation. When public drug use is so rampant, there are bound to be effects on the neighbourhood and community that may have other consequences. The topic of public order and drug use has been researched (Graham, 2007; Fischer et al., 2004) and raises important questions. For example, whose interests are being served, and whose are ignored. Also, consider if or how the notion of public order works to further marginalize drug users. Perhaps there could be ways to promote public safety without perpetuating the 'junkie' or 'criminal' stigma.

Besides public order, public health was an issue that sparked the development of the consumption facilities.

> Zurich 2: And it was the end of the 1980s, the AIDS epidemic, public health problems. This made people and the city try to think of a very pragmatic approach to the drug problem. By the end of the 80s, they [Zurich] said no to any abstinence-oriented strategies.

> Vancouver 4: We've got homelessness [in Vancouver], there were some reasons and underlying causes of the push behind the site. It was kind of the perfect storm scenario. What happened was that there was deinstitutionalization, where mentally ill people, well you know, the facilities shut down, many of these people found their way to SROs, places that were less expensive… there was poor housing, high HIV rates, other things like law enforcement that were driving them away from, they were injecting in unsafe conditions, extremely unhygienic. And all the overdose rates. People were agitated and wanted to make the politicians understand that this is a serious problem and we have to do something about it. If you have seen Fix [movie about opening Insite] you've seen Dean coming into City Hall with the crosses symbolizing the people who died of overdoses.

Especially in Berlin and Vancouver, the public health aspect was a heavy focus. In Berlin, the idea of opening up the consumption rooms came out of the AIDS epidemic and organizations working with HIV/AIDS and youth. The drug scene in Berlin was not as large and visible as the other European counterparts, but there was a significant movement in the late 1980's to deal with the AIDS crisis and interventions to promote prevention for youth and children. In Vancouver, there was a crisis in the 1990s that became a health epidemic and the Downtown Eastside was declared a national emergency due to soaring HIV/AIDS and Hepatitis C rates. Along with the persistent public drug scene, the high disease and mortality rates provided enough traction for making the case for an officially sanctioned supervised injection facility. All of the cities realized that an abstinence-oriented approach would not work, and there needed to be creative ways to work with the problem immediately. The focus on prevention would be too late to help the population who were already struggling with health challenges along with addiction. The link between public order and public health can be made, signifying the public's concern that the epidemic would spread if public 'order' was not maintained.

### *5.1.2 Considering Context*

Relating back to the literature, there has been a shift from a 'rational' planning approach to a more holistic and participatory paradigm. This move signifies the importance of context and experience in planning processes. All participants had challenges coming up with 'solutions' to 'the' drug problem, emphasizing the fact that context is the priority and policymakers needed to consider what the local

issues were first. Context can mean the political climate, social issues, and the economic landscape, among various other things. Specific policy recommendations must be tailored to meet the setting. It needs to be reiterated that there is no 'one size fits all' solution. Cities may find similarities in some contexts and learn from others, but ultimately local experiences and knowledge should be the foundation of policy and planning. As well, the notion of planners as experts is likely not the way of the future. Planners bring a unique set of skills: but instead of being prescriptive, these skills should complement community knowledge and skills. Furthermore, a planner in this type of development scenario will be one of many stakeholders – making it important for planners to keep the focus on how ideologies and relationships shape context, and how to share experiences to create new knowledge within neighbourhoods.

Despite the differences in community context, participants identified some recurring things to consider when working within a local neighbourhood setting. The first was looking at what the drug scene was like, and the necessary actions to address the problems within it. Participants share their experiences:

> Zurich 1: This Platzspitz [in Zurich], they have to close it. There was more than, there was around 500 people in there. These people were living there in this park, and about more than 1500 or 2000 people that walked through in one day. Just to pick up or use the drugs there, maybe they go home after or go to work. It was a big problem for the city. For years, this open drug scene was around the river and in the middle of the city.

> Frankfurt 1: You can't imagine what it was like [in Frankfurt]. There was about one thousand people in a public park in the city buying and selling drugs, shooting up.

In Vancouver, there was a large open drug scene concentrated within three to four blocks on Hastings Street in the Downtown Eastside neighbourhood. In the literature review I discussed how the media portrayed, and continues to paint, the community as a downtrodden area inhabited by homeless people, drug users and sex workers. What the press does not acknowledge is that these scenes are very similar to the images of Zurich's Platzspitz and the large park in Frankfurt's financial centre twenty years ago. The difference is that these large open drug scenes in Europe invoked a sense of urgency and prompted policy officials to think of *something* to address public drug use. In contrast, the push for an official supervised injection site came from the community – as a protest

to the lack of response from the government in re-examining Canadian drug policy and working with addictions. There was even a peer-run unsanctioned supervised injection site operating before Insite came into existence. This illustrates that the situation was so dire that the community took the drug issues into their own hands and came up with their own harm reduction strategy.

> Vancouver 4: There was an unofficial site though, it was on Carrall Street. When people talk of North America's first injection site, they are often corrected by people who knew there was an unofficial one running before. They had to close it down because the police came. That trial was a very good way to understand, it's possible, we've done it. The community could say to the politicians that we could do it, we just need your support.

Even in Berlin, the drug scene was not as large-scale as Zurich or Frankfurt. However, the concentration of drug use around train stations was enough to provoke a response from non-profit organizations and local government. Currently, the drug scenes in Zurich and Frankfurt are nowhere near the large numbers of users that injected in public during the late 1980s. In Vancouver, there is still a visible concentration of drug users on Hastings Street. However, public drug use has drastically reduced, and the significant concentration remains a commentary on the lack of housing more than an outdated drug policy. In Berlin, the scene around the Kottbusser Tor train station has dwindled since the opening of the drug consumption rooms. Smaller scenes continue to move around the city in an effort to evade the police.

The type of drug use should be considered in context. Many participants indicated that the type of drugs used affects how individuals use the facilities. Consumption rooms may be considered next in Vancouver, as opposed to an injecting facility – which reflects how services must respond to the ever-changing nature of drug use. In Berlin, there are increasing instances of crystal meth uses, which present a new set of challenges for health and medical professionals. This reiterates the importance of keeping up with context, as drug policy should be ever changing. This is perhaps why communication and collaboration remain key themes: regular meetings ensure that facilities adapt to new drug problems and health issues. Interdisciplinary collaboration will also foster ideas and learning on how to work with different types of users. In all of the European countries involved in

this study, roundtable discussions and meetings identified the need for inhalation rooms to be added to the consumption sites to reflect the different means of taking drugs and constantly adapting to safer practices.

From a planning perspective, the location of such facilities is also highly contextual and needs to be selected in the early stages of development processes. Each participant had thoughts on how the location was selected and what was important when deciding where to put a site. They more or less agreed on basic concepts to take into consideration. In Zurich, there are two larger sites in the centre close to the Platzspitz. During my own experiences in the city, I inadvertently walked by both sites without realizing what they were. It was clear that the City staff and policymakers took into consideration the location and neighbourhood, and designed the site to fit in with the surroundings. There are also two smaller sites in the periphery to prevent congestion at the two main city centre facilities. In Berlin, the facilities are site specific near train station where drug use tends to be concentrated. However, due to the movement of the drug scenes, there are also mobile consumption vans that go to emerging spots to distribute fresh harm reduction supplies and offer a quiet and safe place to quickly inject. Frankfurt also offers two choices: there are four stand-alone consumption rooms located near train stations. There is also the East Side facility located on the outskirts of the city which offers housing, drop-in shelters, access to services under one roof, employment options, and also a daily shuttle service from the main station area for drug users living in the city centre. Insite in Vancouver is a stand-alone injection facility with links to detox, treatment and temporary housing upstairs located in the heart of the drug scene in the Downtown Eastside.

One interviewee explains why it is so important to have the facility right in the middle of the drug scene.

> Vancouver 4: Especially for the drug user, it has to be NOW. Five minutes later is too late. To go on a bus and go to the west side, it's just not happening. And even now, the site has been opening seven days a week for 18 hours a day, and it's just not enough.

Another interviewee mentioned a low-key injection room in a larger medical facility (Dr. Peter) that provides services for patients with HIV/AIDS. Although the primary focus is on treating HIV/AIDS,

there is still a small room for drug users. This clinic is located inside St. Paul's Hospital, a large institution in the middle of downtown Vancouver. This brings up questions on where people will use the facilities the most and how far they are willing to travel. Looking at the Dr. Peter model, having a small site within a larger facility or hospital could be a feasible idea for cities that may not get enough political support for a full-on injection site.

### *5.1.3 Communication*

Communication, as part of exchanging knowledge and conveying ideas, was the key theme that every interviewee emphasized. Although communication could arguably be another chapter, or even a thesis topic on its own, my aim is to draw attention to how communication shaped the planning and development processes in my selected sites. From my experiences, I learned that communication could be understood in multiple ways. For the purposes of this thesis, I will focus on the importance of communication with neighbourhoods, communication among stakeholders, and explore what communication strategies planners could potentially utilize when working within this framework. As I went through the coding process, I struggled with the distinctions between collaboration and communication – as they were used almost interchangeably through the interview processes. It became clear to me that the aspects of collaboration I was choosing to focus on really reflected the importance of communication. This could involve how communication shapes opportunities for sharing knowledge and further learning among stakeholders, and what the implications are for establishing partnerships.

Although communication between stakeholders and community members are the focus of this section, I would like to recognize that communications from the press and media also wields considerable influence on how people perceive drug consumption facilities. After attending a press conference in Vancouver where a research institution presented their findings from a drug policy report, I noticed that the media coverage focused almost exclusively on the scientific evidence. Despite the presence of two community members on the discussion panel, news reports did not do much to address the input from folks from the Downtown Eastside or concerns put forth by the audience. To me, this further signifies the importance of fair and just communication – planners

should find a way to 'legitimize' community and experiential knowledge in such a contested situation.

All interviewees expressed that communication was a crucial part of the engagement processes, and this communication needed to be regularly maintained. In Zurich, it was the communication that was key in gaining support from the public and politicians. As Switzerland has a unique political system (which will be discussed further under 'the role of government' theme), the public can decide whether to pass or reject any laws or regulations. This meant that public support was essential not only to pass the federal drug policy, but also to implement sites in certain neighbourhoods.

> Zurich 1: You have to deal with the public, you have to deal with the people who live there. Even you have to, you have to make communications, inform them at an early stage … it means you have to be in constant communication with the neighbours. It's very important.

This sentiment was shared in Frankfurt: communication was described as a two-way street. Not only did the municipal government and political figures have to communicate these new harm reduction strategies in an abstinence-oriented environment, but also to take communications from the public seriously. Interestingly, politicians decided to target a mass audience in order to get the harm reduction message across. One interviewee reflected on how neighbourhood engagement happened on a large scale, at train stations to share information and impact the largest amount of people possible. Communication was quick and brief, but the ideas were clear. People taking the trains into work faced open drug scenes around the stations on a daily basis at the time, so it was an effective location to gain the public's attention and support on an issue that was right in front of them.

In Vancouver, communication was also on the City agenda. Although the idea of a sanctioned injection facility was community-driven, it was important to promote communication at a municipal level. One interviewee (Vancouver 2) recalls how the municipality hired a communication consultant. They note how it was particularly effective, as she presented a balanced approach outlining the benefits to the public realm and public health in the Downtown Eastside. Community

groups also rallied together to share their stories: another interviewee spoke about how drug users groups humanized the issue of addiction. These experiences helped personalize the challenges many residents in the Downtown Eastside faced on a regular basis.

As discussed at the beginning of this section, I noticed that the concept of collaboration in the interviews often indicated the importance of honest and fruitful communication, in an effort to learn from others and exchange ideas. When participants used the words 'collaboration' and 'communication', they were used to convey similar ideas. I argue that communication is what frames the whole discussion around planning and developing supervised injection sites. Open and active conversations happened between stakeholders. A lack of collaboration means communication is one-sided and not presented in a just or comprehensive way. Participants spoke about working and talking to each other at length – whether it was a means for learning and sharing knowledge, or working with diverse groups of people – and the importance of cooperating together and aiming towards an identified goal. As planning is inherently tied to a variety of disciplines, communication across departments and other fields could lead to more innovative and comprehensive policies. Addiction is a multi-faceted issue that includes health, social and land use challenges; forming partnerships and discussions across disciplines is necessary to facilitate effective strategies.

Before any sites were proposed or implemented, there were learning and knowledge exchanges in each process examined here. Although each city has their own unique strengths and challenges, the interview participants were interested to learn from others. Vancouver policymakers and politicians found it important and useful to listen to Swiss and German policymakers share stories and "evidence" about how harm reduction works. One participant shares:

> Vancouver 4: We learned from them [Swiss government] and came up with our own Four Pillars drug strategy here in Vancouver. But the Insite, there was already momentum happening from what I showed you [images of open drug scene] and from the community's side.

Similarly, when Berlin's non-profit organizations started their plans for drug consumption

rooms, they looked to precedents in Frankfurt, Hamburg and Zurich. In Frankfurt, they brought in health professionals from Amsterdam to get the processes going and to increase awareness around the harm reduction movement. Increasingly, throughout the interviews, I noted how the discussions would diverge into conversations not related to the questions – reinforcing the interview function as a knowledge exchange. Participants abroad were very interested to learn about addiction in Vancouver, my hometown, and Winnipeg, where I was completing my Masters program. They were also happy to show me around the sites, provide me with information brochures and pamphlets, share harm reduction toolkits and demonstrate how the methadone dispensary worked. It was an incredibly interesting experience to see firsthand how the sites were run and situated, and take note of how the facilities interfaced with the neighbourhoods.

Communication across various stakeholders, departments and disciplines was the next step. It was implied that collaboration was a means for starting and moving the planning and development processes forward. As one of the interview participants put it,

> Berlin 2: Taking drugs is an issue of health, education and other things. All these movements go together.

In Frankfurt, the Monday Group roundtable meetings were the catalyst of opening up the first drug consumption room in the city. The police, who were getting frustrated with worsening drug scenes and the lack of improvement through enforcement methods, instigated this group. They brought it to the attention of the mayor, who invited everyone involved or affected by the drug scene in Frankfurt to this roundtable. The attendees ranged from the public prosecutor, the health department, the police, non-profit groups and the newly formed (at the time) drug policy group. These conversations resulted in trying a variety of harm reduction approaches. First the ideas included methadone substitution therapy on an outreach basis, and an emergency bus and needle exchange. However, there were still too many people dying and the drug users' health statuses were not improving. Medical emergencies were only treated if the bus was nearby. So the roundtable participants decided:

> Frankfurt 1: We need to have places where people can go with their own drugs and do what they do anyway, but do it in a safe environment. Then we decided to draw up some kind of scenario.

This example of large-scale collaboration with many diverse participants was a common theme in other cities. A participant in Zurich emphasized:

> Zurich 2: So having the contact centres is one thing. Then try and run it in a way that all the stakeholders are satisfied is another thing. And the key to that is really the collaboration of different players.

This was echoed in Berlin:

> Berlin 1: When we started with these facilities, we did not want to do it on our own. We believe in networking, and to stabilize and do things further, you have to look for partners. We wanted to do this project with other organizations.

Berlin's similar roundtable group continues to run every six months; some of the members were part of the first site development process. Stakeholders are encouraged to anticipate and prevent problems, openly discuss anything related to drug policy.

> Berlin 1: Sometimes stakeholders will talk about other issues, not just relating to drug consumption rooms, but about drugs and harm reduction in general. For them it's a great opportunity to talk and brainstorm when they meet together.

These roundtable and meeting groups appear to have multiple purposes, not only to ensure regular communication but also to continue to learn from each other. Another potential benefit of holding these regular meetings with stakeholders is the opportunity to pass down knowledge from experienced individuals to newer members of the group.

The interviewees continuously highlighted communication and working with the police. There is a very fine line of what is legal and illegal when it comes to using drugs and supervised injection facilities. All cities mentioned that it was crucial to reach an understanding with the police, to prevent officers from waiting outside the facilities and confiscating drugs or arresting people. There needed to be a common objective of reducing the harms from drug use and promoting public health, while keeping in mind the neighbourhood's concerns. In Berlin, the police were instrumental in building trust and relationships between the non-profit organizations and the

politicians. The police chief reframed the discussion around drugs throughout the police force, which was sparked by the collaboration at the roundtable sessions. In Zurich and Frankfurt, the police assisted with information sessions and public engagement meetings to provide support and achieve political approval. For instance in Frankfurt, the police organized a public forum inside one of Germany's largest banks: this not only 'legitimized' the issue, but encouraged collaboration with the finance and business industry in the neighbourhood. In Vancouver, a planner agreed that the police played an essential role in gaining political support. They believed that communicating common interests and ideas with difficult stakeholders, such as the police, was just as important as working with other groups with common interests.

> Vancouver 4: Delve a little further into collaboration. Not just any collaborating, but working from, potentially, challenging partners. The police, to work with them is vital. If we didn't have that, it would be very difficult to get that exemption from [the Controlled Drugs and Substances Act].

*5.1.4 Considering Politics: The Role of Government & Political Buy-in*

The interviewees recognized the importance of political support in getting processes going, not only in a logistical capacity but also to change laws and define funding structures. Politics and planning are inevitably interconnected, as planners and/or their recommendations are ultimately subject to the approval of Council. Further exploration of government and addiction facilities could make for interesting research in a political science and legal context. I would also like to mention that the roles of planners are very different across international contexts – planning is understood in a more technical and design sense in Europe. However, a discussion around the roles of government and gaining political support still merits further consideration. Planners in all disciplines and sectors can benefit from learning to communicate effectively with government, and being aware of their implicit power in presenting information to the public.

I will start by outlining a basic discussion of the different political structures in the cities I looked at and the roles each level of government plays in this particular issue. Perhaps the most striking is the pronounced role of the public in Switzerland's political system, where policymakers and politicians can propose laws and changes but they are ultimately subject to referenda as the public gets the final vote on whether or not to approve them. The benefit of this is that the

community gets so much say, but the danger is that marginalized groups may be further silenced. This means that policymakers, planners and politicians must be extremely conscientious of how they present information and arguments, and aware of their power to sway the majority. The City of Zurich manages the consumption rooms, and works alongside other departments to develop initiatives that address other aspects of drug use. This allows for a comprehensive drug strategy, and staff are able to implement projects relatively quickly that address the needs of the neighbourhood. Healthcare is privatized in Switzerland, with insurance companies funding many of the substitution therapies or counselling services. However, all recipients of social assistance have automatic access to health insurance that is subsidized by the City.

> Zurich 2: The main pillars like harm reduction and repression [enforcement], they are main pillars of the City. The City is very much in charge of most of the facilities, like all the low threshold facilities. However, there are also private institutions that provide meeting places, counselling and stuff like that. The City runs the contact centres, which are very low threshold, and heroin prescriptions, which would be a treatment. They [other departments] also have another outreach service, which is a mixture of social work but with sort of repressive [enforcement] ends. Like they go and communicate rules in the public space. So for example, they make sure that the public spaces like the Bahnhof [train station], it's not monopolized by certain groups. The aim of this outreach service is to ensure the co-existence of different groups, in one space.

In Germany, the federal government was not involved at first so the idea started at a local level. In Berlin, advocating for the opening of the site came from the non-profit sector combined with police and Department of Health support. The City eventually approved the site with support from the state. In Frankfurt, the proposal was a product of the Monday Group roundtable discussions. This group involved politicians, municipality staff and other stakeholders – they were able to operate the site without waiting for federal approval.

> Frankfurt 1: With the roundtable recommendations, it went into local Parliament and were decided on positively. Then we started doing it. On a national level, there's not much going on that really helped us on the ground in our city. So we took the liberty and we have, as a municipality, implemented it our way.

Currently, sites in Germany are run by non-profit organizations with support from the municipalities and states. The federal government passed a law delegating drug policy responsibility to the states,

which has resulted minimal involvement limited to small funding or supporting research.

In Vancouver, the jurisdiction is challenging to differentiate. While passing laws relating to drug policy (under the *Controlled Substances Act*) is federal responsibility, health is primarily under provincial jurisdiction. There are also smaller regional health authorities, such as the Vancouver Coastal Health Authority, which assumes medical responsibility and some degree of management of Insite. A City planner says:

> Vancouver 4: It was the community's constant rallying and push for this, and then the city's acknowledgment, in a nutshell, that's what it is. The city does not fund this, the city advocates for health related issues. It's not part of their mandate, but it advocated for it to the province and to the feds.

However, in terms of land use, the City has the authority to reject or renew permits. As land use and zoning is a North American concept, this topic did not come up in the European interviews. A participant (Vancouver 2) explained that every health facility needs a permit, so there is usually a public hearing. The mayor at the time expedited the permit process, which meant that the municipal election acted as a public process for the citizens concerned about this issue. Another interviewee (Vancouver 1) recalls how the City played a role in getting the development process going, but like in Germany the operations and logistics aspects are run by non-profit organizations.

Political support is instrumental in reframing discussions around the legalities of the sites, and how support at a municipal level can have the power to change laws. It was repeatedly stated that support at a local government was the most important aspect. In Zurich, the participant reiterated how important the public opinion is and how the city council is primarily responsible for providing budgets and taking care of the logistics. In this case, political and public support is often synonymous.

> Zurich 2: The first step, politically you need the majority. When you plan a contact centre, you have a certain amount of money you can spend it on, and you need an institution like the city council or executive that suggests how to spend the money. Before you start planning, you have to get that public approval. It's hard to get a site that's appropriate for this kind of facility. Most people don't want drug addicts in their neighbourhood. As soon as we have a site, which we think we can use, it's a problem to talk to the people who live or work there. They can make objections, they can stop the

process…usually it's a very long process. Typical Swiss politics, the public has lots of opinions.

In Germany and Vancouver, it was crucial to get local government support to develop the site and ensure it would run legally. In Frankfurt, this largely had to do with the role of the public prosecutor. It was not technically legal at a national level, but he was able to interpret the law and find loopholes to get the site running without doing anything that could be construed as criminal. Berlin looked to Frankfurt and Hamburg for legal precedents, however the responsibility of revamping drug policy was soon passed to each state. In Berlin, the state attorneys played an important as well – during roundtable discussions, they made sure each step was legal. Vancouver was a similar situation, the mayor Philip Owen provided critical leadership at the time as an advocate and facilitator. The participants in Vancouver all recalled the challenges in getting the federal government on board, citing many hoops to jump through but eventually the site was able to run as an exemption to the *Controlled Substances Act* as a 'research pilot project' that required consistent evaluation. The mayor and local government kept pressure and a sense of urgency on the federal government, and were pivotal in establishing and maintaining a strong connection between City staff and the community.

The role of governments is also tied to questions about funding. In Zurich, the City provides the majority of the funding for the site and the canton (province) makes a small contribution. The federal government only gets involved if there are research opportunities. In Germany, it is a mixture of municipal and state money but the federal government contributes as well. In Vancouver, the funding is primarily from Vancouver Coastal Health and some money from the province. The federal government pulled the research funding when the exemption was set to expire. There have been no federal contributions since. Although the funding is public, the services are run by non-profit organizations in Germany and Vancouver.

Ultimately if the government makes the decisions, it can be asked if any of this has to do with planners. A participant from Vancouver states that the roles of planners can fluctuate depending on the politics of the day:

> Vancouver 4: A lot depends on the political climate. What roles planners can play depends on what the politician's focus is. As community planners, our role would be how to facilitate these processes where people who are experiencing issues can voice their concerns and how we as planners can take it forward given the climate of the day.

*5.1.5 Importance of a Larger Harm Reduction Network*

The participants all reiterated that increased and improved access to services and housing is one of the main benefits of consumption sites. Not surprisingly, the interviewees believed that obtaining housing was one of the most important first steps in harm reduction. As well, all of the programs offered links to shelters, housing, medical and support services. To me, this signifies that supervised consumption sites should be understood as an important piece of a larger harm reduction model. The existing literature also refers to how sites are often integrated into a wider network of services (Hedrich, 2004; Hunt, 2006; Akzept, 2011). This becomes a planning issue when a more comprehensive approach is needed when dealing with health and housing. Simply providing medical care or a place to inject is not enough; the partnerships with other organizations or municipal programs are as much part of the process as developing the site. That is to say, solidifying a larger harm reduction network needs to be considered and implemented as part of the development processes. Perhaps this is another way for planners to join the conversation.

Homelessness and lack of housing is a significant challenge facing drug users. As this is often linked to addiction and perpetuating the cycle, the importance to access to housing as part of the harm reduction network came up frequently. Housing came up in every conversation, but the importance of shelter and having a safe place to live was not discussed in relation to a larger harm reduction network in the research. It also appears that housing came after developing the sites, but eventually became part of the accessible services for drug users. Across the case studies, it was apparent that the municipal governments and policymakers had some involvement with housing programs. Participants from Zurich say:

> Zurich 2: The City is very much involved in housing. Housing programs are very important. We have assisted housing programs where people, we provide rooms and they are allowed to use drugs in there too. But they have, during the day they can go to the contact centres. At night, they have their room where they can be, and that's an important factor. They have much better health. Nothing is so damaging than being

> being homeless, being on the street, healthwise. That's why you really need to have housing programs.
>
> Zurich 1: We have social workers here [at the clinic], they look for people who are on the street, outside. Like what you call an outreach worker. They also look for flats. We have in Zurich, flats that the government provides. People with drug problems can have a room there, live there in a stable place.

When the drug consumption rooms first started operating, the idea was to integrate the drug users into the city's housing markets but this soon proved to be nearly impossible. The focus evolved, as the drug user population's lifestyles and needs changed along with the idea for expanding the housing continuum to include longer-term options. In Berlin and Frankfurt, the City or non-profit organizations provide housing programs. Drug users who use the consumption sites have access to the different types of housing in the city. For instance, the building next to a Berlin site offers housing for older individuals with HIV/AIDS. A staff member explains that many people that reside in this building also struggle with addiction (source). In Frankfurt, the East Side facility is the only site that offers housing in the same building. A participant (Zurich 3) draws attention to older drug users or individuals who face mobility challenges, and the benefits of not having to travel to their accommodations or support services.

Housing is also a significant challenge and barrier to quality of life in Vancouver. All of the participants reiterated how the lack of housing in the neighbourhood has contributed to much of the social problems in the DTES. An interviewee says:

> Vancouver 4: Homelessness is very closely related to addiction, and addiction is closely related to homelessness. It's such a big issue in Vancouver.

As rental housing in Vancouver becomes increasingly unaffordable, one participant (Vancouver 1) believes that linking social housing with drug use services can mitigate potential gentrification. Another participant (Vancouver 2) agrees, stating that it is very important to keep social housing in the Downtown Eastside to maintain easy access to services. They go on to state that more work with housing needs to be done, as obtaining decent housing is an important way of reducing the harms associated with drug use. As the City has a housing department that works closely with the

community, there could be further opportunities to promote and develop good quality housing.

Partnerships and collaborative programs with various services are other important components of establishing a larger harm reduction network in conjunction with opening a supervised consumption facility. All participants agreed that access to services and maintaining relationships with other organizations should be a priority. In some instances, partnerships meant increased funding and services available under one roof as opposed to doing it alone.

> Berlin 1: Our sites in Berlin, we are low threshold, we focus on short term interventions and try to support people changing something in their lives. We will connect them with other institutions. For instance, we don't have therapy. We have to form a lot of networks.

As the site in Berlin is specialized in offering medical and nursing care in conjunction with offering a safe place to use drugs, it becomes important for them to partner with different organizations so drug users have access to a wider network of support. Links to services also promote partnerships between the disciplines, which emphasizes the importance of collaboration and learning from each other.

Access to services also means developing innovative approaches to service delivery. In Frankfurt, the use of the shuttle services to transport drug users from the main station to a large-scale facility was one way to address the challenges in accessing services located all over the city. In Berlin, the mobile consumption van was an innovative way to target the nomadic and emerging drug scenes. Having a mobile van also saves costs on developing stand-alone sites all over the city, which may not be able to keep up with the ever-changing drug scene. In addition to service delivery, many participants thought that alternative methods and services to complement the consumption room functions were worth further consideration. For instance, most participants highlighted the importance of access to substitution therapy. One participant in Zurich reiterated that substitution therapy was a crucial part of harm reduction:

> Zurich 1: I think it's important that they have substitution with methadone, opiates, whatever. This is really important. If you want to reduce crime or infections, this is one

way to go about it. That they can also have a better life.

It appears that this type of treatment needs to be further integrated into drug services and housing programs, as an alternative to just offering detox programs.

Deciding where to put services and housing is one of the challenges that planners and policymakers may face when working with marginalized populations. Despite the participants agreeing that these services should be readily accessible to drug users, there was some disagreement on the locations of these facilities. In Vancouver, the participants thought housing and services should be located within the Downtown Eastside so the community members would not feel displaced. The interviewees all stated that social housing was extremely important in the community, as homelessness is a huge concern in the area. However, the participants in Europe argued that too many services in one neighbourhood could have an adverse effect. Homelessness is also not as visible or rampant in these cities, to the extent of Vancouver. In Europe, the policymakers stated that infrastructure for housing and services should be developed in conjunction with sites. For instance, housing was placed in the larger East Side facility in Frankfurt to address homelessness in the city centre. This serves to reinforce how housing and service development/delivery will vary across neighbourhoods, and should be considered according to the needs of the people and community.

*5.1.6 Summary: Tracing the Trajectory of Development Processes*

This thesis focuses on looking at the development and planning processes of supervised consumption sites. I asked the participants questions about their roles in the development processes or their understanding of how the sites came into fruition. I wanted to understand *how*, but also *why* the sites were established. The participants spoke about what they thought was important in getting the processes going, and what needed to happen in conjunction with establishing the sites. Although I did not write out predetermined themes, I had some thoughts that stemmed from the literature review. For instance, the research gave me some ideas on why these sites were established and the general objectives of the facilities. The research also briefly touched on 'integrative' models of supervised consumption sites, but did not go into detail about what

services were attached to the sites or why it was necessary to do so. I decided to interview participants, not only to confirm what I read in the literature, but also to listen to their experiential knowledge. I thought it would be interesting to hear the different perspectives of the motivating factors and contexts that the participants were working in. The 'findings' sections are organized somewhat chronologically, and reflect the trajectories of the development processes. The motivation and context sub-sections give an idea of what the participants were exposed to, and the factors that prompted action. The communication and political support sub-sections detail how the processes began, and what was instrumental to maintaining a sense of urgency in reducing harms and public drug use. Finally, summarizing the importance of a larger harm reduction network emphasizes social service and housing development processes that need to occur in tandem with implementing the sites.

**5.2 Identifying Themes**

This part of the analysis draws on what the interview participants said, and what I perceive to be common threads linking the ideas together. I want to acknowledge that separating the findings and analysis section does not mean that they should be understood as two different entities. The themes in the previous section were based on a sorting type of analysis, where the open codes were created by what I heard from the interviews. The analysis in this section focuses on discourse analysis approach and generating axial codes: I looked at the underlying meanings of what people said to understand *why* they said it. The axial codes consider the relationships among the open codes, and put forth broader themes that will ideally create a deeper understanding of the open codes.

Besides the data generated from the interviews, the analysis was also informed by the literature review. I interpreted the data while constantly referring back to planning theory and keeping in mind the potential implications for the planning profession. I considered my part in generating the data, and the reasons for my interpretation of the relationships among the open codes. I understand the goals and objectives I have outlined for this thesis will influence how I generate data. For instance, the axial codes that I identify reflect what is important to me when it

comes to analysing the processes around developing supervised consumption sites. I also wanted to be mindful of my reactions, and especially how I reacted to concepts or statements that I did not agree with. Overall, the themes of social justice, inclusion, rethinking the 'community' and transdisciplinary work are an important component of analysing the open codes I generated in order to understand the planning and development processes more fully. I believe these axial codes uncover the deeper relationships and meanings behind what was said and heard during the open coding process. These themes are important to me, as it appears that they have been overlooked in the past. This set of codes could apply to shaping the role of planners in developing consumption sites in the future.

### *5.2.1 Social Justice*

Supervised consumption sites are different than most medical facilities; opening a health clinic would not provoke the same reaction or outcry as a supervised consumption site in a neighbourhood. I wanted to determine what made these sites so unique and how they addressed drug users' needs in an alternative way. Supervised consumption sites can be understood as a socially just intervention in reducing harms and promoting quality of life for drug users. They recognize the rights of drug users, and by situating themselves within a neighbourhood, their presence acknowledges that drug users are part of the community.

Although public order and public health are the most commonly cited reasons for opening a supervised injection site, there are compelling reasons to consider social justice as motivation when reading deeper into what is being said. Social justice is not often discussed as motivation, because there may be a belief that it would take away the 'legitimacy' from a case to open up a sanctioned site – which echoes how 'expert' knowledge often takes priority over local and experiential knowledge because those are not seen as legitimate ways of knowing (Sandercock, 1999). I started to think about the issue of social justice in relation to how Insite in Vancouver opened. Because the push came from the community in Vancouver to create the space, this could be interpreted as a reaction to the lack of response to the health and housing crisis in the DTES. It appears that the protests and action from the Downtown Eastside is a call for social justice; a demand to be

humanized and seen as a person that needs help and support. Looking at social justice as motivation during development processes personalizes the situation, and considers the rights of drug users as well.

In addition to social justice being recognized as a motivation for opening up the site, fighting for social justice could be a means to improve the inequalities in health services and (lack of) housing conditions, which is reflected in the need for establishing a comprehensive harm reduction network and considering the context of the neighbourhoods. Many participants spoke passionately about how they thought it was 'wrong' and 'terrible' that drug users were on the street, living and using, without any support and left to die. One participant (Zurich 3) went on to note that "you would not believe the conditions the drug users were in, the open drug scene was just…nobody should live like that". Although the interviewees, especially in Europe, viewed themselves as just supporting a 'pragmatic' approach to working with drug use, there was still an underlying sense of doing the 'right' thing and an inherent understanding that these initiatives that would improve the lives and well-being of marginalized groups of people. The participants reiterated how important it was for the drug users to have adequate housing (Berlin 3, Vancouver 1, 2 and 4) and access to health services – which reflected the contextual challenges of each site.

I believe social justice can be understood as a positive impact from Insite onto the DTES community. What is most noticeable to me when I walk around the DTES is the diversity in the neighbourhood. It appears that Insite celebrates the differences in the community, and provides a platform for marginalized individuals to participate in a safe space. When the site was developed, it was treated as a real victory for the community (Vancouver 1 participant). This serves to remind passing visitors and residents that there is a strong sense of social justice in the neighbourhood, that recognizes differences and is committed to improving the quality of life for as many individuals as possible (Fainstein, 2011). Every neighbourhood is different, and social justice can be an effective concept to stimulate communication and conversation – not only among community members but also as something that brings stakeholders together to discuss how to improve these situations.

Despite the interviewees reiterating the importance of public order as the main reason for opening the supervised consumption sites, there appears to be an inherent sense of social justice in Europe that may not be so readily stated. I realize that without any precedents or previous information to work with, the innovations in drug policy and the willingness to try new ideas led to largely positive effects in the European cities, creating a sense of safety that was not only felt by the public, but the drug users as well. This was corroborated in instances where social justice was not explicitly stated as a goal of the sites, but the systems evolved to respect the drug users and offer them dignity and the right to make their own decisions about their health and life.

> Zurich 2: There was a move towards what we call an urban compatibility strategy. It's the main strategy we have, to follow the drug policy that aims to always balance both interests of the people who take drugs and need support, but also to focus on the issues and the problems of the public, they don't want to have any bad side effects of the drug problem. Sometimes you have two contradictory views. It seems like you have drug users on one side and the public on the order. You have to make measures and facilities, it's like a compromise. No drug use in public, it's very unhealthy, bad for the health of the drug users and it also bothers the people that live there in the neighbourhood. We established the contact centres where they can use drugs under safe conditions and it also takes the pressure of the public space… In the 80s, one would say the aim is to get them off the drugs and abstinence-oriented approach. To get them out. I mean it's really become much different. They would take them out of the city and put them in therapy and get them away from drugs. The aim was to reintegrate them into the city. We tried to integrate them into society, whether they use drugs or not. Now we try to give them treatment if they want it, medical support, provide them with housing, low threshold jobs, working possibilities, try to make sure they can continue their life as independently as possible.

This emphasizes that the role of local government was not always static, or an obstacle to progressive policies. I view the willingness to evolve, and adapt policies at a municipal level as an inherent sense of social justice built into the governmental approaches. Furthermore, the shift to acknowledging the rights of drug users to safety, shelter, accessible health services, and communicate their choices shows that local government and policymakers recognized their role in influencing drug use and social norms and decided to use this power to empower drug users to make their own choices and develop the necessary tools to do so.

### *5.2.2 Inclusion*

I found the aspect of inclusion to be central to the discussion around consumption sites, and was underlying theme when discussing the importance of the open codes. I did not find literature addressing the inclusionary nature of consumption sites, but personally found it to be a powerful argument for the benefits of these sites. From reading existing literature around NIMBYism, it appears that many municipalities and organizations are working towards building inclusive and welcoming communities. I argue that consumption rooms are resources that provide a sense of belonging and pride for drug users in their own networks and communities. When asked about the relationships between staff, the neighbourhoods and drug users, the participants believed that the sites offered an outlet for inclusion and interaction. It became apparent that consumption sites were a unique place that fostered relationships while providing a service and a sense of safety and security. Especially with medical staff and nurses overseeing the consumption, there is a sense of caring that does not exist with other drug services.

The participants acknowledged how drug users may feel more excluded or unwelcomed in certain communities. One participant in Vancouver (Vancouver 2) mentioned how drug users "feel invisible or useless, like what they do doesn't matter". Others cited a lack of support network combined with poor living conditions can often exacerbate problems with addiction, if drug users feel that no one cares about where they live or what is happening to them. As well, this lack of community or interaction may not be addressed with other drug services or harm reduction initiatives. A participant in Vancouver (Vancouver 2) argues that "needle exchanges undermines the importance of support… there is a lack of social contract or conscience". This is also true of substitution therapy and detox programs; these services may be important to a drug user's health and reduce harms, but still do not address how important a sense of belonging or community is to an individual. It is clear that access to such services work best in conjunction with a consumption site, making the case for supporting an overarching harm reduction network.

It was clear to me that the aspect of communication was an effective way to promote inclusion. Many of the participants believed that the direct interaction is very helpful in reducing harms. They say that regular conversation allows medical and site staff to informally check in with a

client, and staff can intervene directly and quickly if there is a medical emergency or an imminent concern. A participant in Frankfurt (Frankfurt 1) also points out the importance of communication and interaction: although the East Side facility is located at the periphery of the city, there are ample opportunities for connecting and building relationships. As all of the services and employment opportunities are located under one roof, this facility becomes a community and provides an invaluable support network that may not be found elsewhere.

Participants in Berlin believed that establishing supportive, trusting relationships could lead to safer, more hygienic practices at home – thereby reducing the harms associated with drug use. For instance, staff members are not happy about the laws prohibiting sharing needles within the facility. They believe that this is a lost opportunity to encourage safe and supportive behaviour in the site, which could be taken into their homes. A participant in Vancouver (Vancouver 1) also agrees with the benefits of a supportive atmosphere in the site: they believe that if these sites have partnerships with organizations that offer programs such as providing food, community gardening or landscaping activities, it could "foster a social network, which gives meaning to daily activities". This could provide drug users the chance to interact with each other, the staff and members of the community. The activities could also establish a sense of pride in the public realm surrounding the site and in the community as a whole. These statements also reinforced how important it is to consider context, and how the surrounding environments play a role in marginalizing or empowering drug users.

Besides promoting programs that provide opportunities for interaction and inclusion during the planning and development processes, involving drug users from the start could also achieve a sense of belonging. A participant in Vancouver agrees, describing how Insite has become more than just a facility due to the push from the community:

> Vancouver 3: That's where places like the non profits in the Downtown Eastside try to build a sense of community, residents and neighbours. I think that's a really important piece of the puzzle. People feel that sense of, people feel like they belong somewhere. Insite isn't just a place to shoot up. If you had been outside at 6am when the Supreme Court decision came down (in 2011), it was a real community victory. Half of the people that were there use the thing, so it's a sense of being part of something bigger than a

> clinical health facility. Bud Osborne, the poet, would say it's a testimony to a community's endurance, suffering and persistence in achieving something this significant.

In Berlin, drug users are involved more informally. The participants explained that drug users were not involved in official development or planning processes, but it appeared that including drug users and their feedback in running the sites was important to them.

> Berlin 1: [Drug users are] not [involved] in a formal way, but we are, colleagues are always in close contact with the drug users and if they want some changes or don't agree with anything, we discuss it, of course. There is no working group or something like that though.

Drug users were not involved in the processes in Zurich or Frankfurt; this could be attributed to the top-down approach in how the sites were implemented. However, it seems apparent that the drug users' input would be valuable, as these services are targeted towards their needs. Although the effects of the sites have been arguably positive in the European cities, the sites might look differently if the drug users were involved at start.

### *5.2.3 Rethinking 'the community'*

'The community' has been referred to many times throughout this document and the interviews. One theme that kept coming up for me is the need to rethink what 'the community' means. *Who* is the community? When we talk about working with communities, *which* voices are really being represented? Although this concept is central in planning theory and practice – after all, planning is supposed to be for people – I aim to explore how the notion of community was underlain in these discussions.

In the literature, the community was often portrayed as a dichotomy in contentious situations. There were cases of NIMBYism perpetuating an 'us vs. them' mentality, and I noticed this in varying degrees in all of the sites. After speaking with the participants, it was interesting to examine how policymakers and officials reacted to opposition. Despite the underlying social justice tendencies in policies, it seemed that the community was understood as a static entity at first.

> Zurich 1: Yeah you have them all the time. It's like a constant process. If they find too

> many syringes in their neighbourhood near the site, they get annoyed. If you don't go to them and make sure it doesn't happen again or make sure that there are regular cleaning teams… they are not happy. It has to be a compromise.

However, it became clear that in certain cases in Europe, the 'community' referred to opposition groups that presented barriers in establishing and operating the site. When examining this further, I realized that when some participants spoke about the 'community', they were really discussing how to work with contentious situations. Thinking about 'who' the community is reinforced how important communication is, and understanding how to work with various community groups in different situations.

However, it was later recognized that these opposition groups in the communities could not fall under one label. Research discussing NIMBYism suggests that the root cause of opposition cannot always be taken at a superficial level or attributed to ignorance (Lyon-Callo, 2001). This was the case in Berlin, where they found that the neighbourhood was not actually against the site but at the political situation surrounding the development. The consumption room location was actually a site for a political protest, so the neighbourhood felt that the local government was ignoring their concerns and trying to shift the focus to the drug problem in the area. This emphasizes the importance of communication, and how a lack of honest discussions can distort the realities of what is happening in neighbourhoods.

> Berlin 1: In our experience, it was a big movement and there were lots of discussions, press, a lot of trouble two years before the site opened. Really, really angry and then it got quiet, when we were collecting money and preparing for construction. And then we opened, and nothing happened. No neighbourhood coming, no problems, it was just really quiet.

In Frankfurt, they also noticed their concerns around NIMBYism and opposition did not materialize. One interviewee reflects on how they underestimated the public:

> Frankfurt 1: They [politicians and policymakers] started a discussion at the main train station. Everybody can have their say, put forth this idea of how about this place where drug users can come and take their drugs, provide services that include shelters, methadone. But they were so afraid, they thought there would be people saying 'why don't you lock them up', but that wasn't the case. In fact, everybody was saying 'if your ideas are so good to get these people off the street and into better conditions, why

don't you just go ahead and do it?

The fact that policymakers' assumptions did not turn out to be true underlies a need to connect with community members, and to understand the multiple perspectives within the space.

There were also expectations of NIMBYism from the banks in the area, but the police managed to convince Deutsche Bank, one of Germany's largest banks, to hold a public forum in the branch. This exercise in open communication and dialogue proved to be very positive, and the banks and other businesses in the neighbourhood donated two million Deutsche Marks toward harm reduction facilities near the main train stations. However, they also allocated some of this money to build the large-scale East Side facility outside of the city. This could be read as NIMBYism, as a means to move the drug users to the periphery. However, there was infrastructure in place to provide housing and access to a variety of services to prevent complete displacement. This could be read as a means to develop a larger harm reduction network in response to community members' input. The East Side facility can be seen as another way to build a new inclusive community, and to reshape relationships that may have been contentious in previous settings.

The actions and decisions of the policymakers and organizations developing the sites suggest that values of caring and social justice may be more prevalent in Germany than the literature suggests. This could be due to the fact that the research I looked at around NIMBYism is mostly North American. The experiences in uncovering the deeper meanings behind opposition that the participants spoke about signified to me that they were internally re-evaluating and rethinking who and what the community means. The participants appeared to realize the importance of considering context, and learned not to label the community as a singular being, but rather as a dynamic entity comprising of many viewpoints and relationships.

In Vancouver, the participants appeared to refer to the 'community' in two ways (I am referring to the Downtown Eastside in this context). First, the community was recognized as the driving force behind opening Insite. It is argued that the grassroots efforts led to changes and progress in drug policy because of the sheer determination and the will of the community members

and non-profit organizations working together. However, there was opposition within the Downtown Eastside that can be construed as NIMBYism.

> Vancouver 1: There was opposition from the merchants, the BIAs and Chinatown. There were big protests, there was a big anti drug sentiment in Chinatown. They thought there would be free drugs everywhere, people would be shooting up more, a lot of uninformed fear. That was actually the opposition, but it has definitely come around. After a year or two after the site opened, the fear did not materialize. Less shooting up, no random violence, no theft, no littering. It was all proven wrong because there was simultaneous evaluation. The Chinatown Association of Merchants actually wrote a letter supporting the site.

> Vancouver 3: Now we've changed the culture of the discussion, there is a cultural change that happened here… Another part of reframing the discussion is saying that if you don't do an injection site, it just means the injection activity keeps going up. Injection sites don't increase injecting, it encourages safer current practices and makes it safer for everybody. How can you explain this to people? They don't want people injecting in back alleys, so here's a solution and they don't want it either. Okay, so where do you want it? Well the answer is nowhere. It's a fantasy world. The drug users are not going away. They're part of us.

The distinctions between the different groups in the DTES were made clear when the participants reflected on the challenges in gaining consensus and public support. On one hand, the participants identified the DTES as being a 'low-income community' with problems relating to homelessness and drug use. They referred to the 'community' and their activism as the largest motivating factor in Vancouver. However, the participants also acknowledged the opposition groups within the same community – symbolizing the complex relationships that exist within neighbourhoods. I think these statements demonstrate the need to move away from viewing 'the community' as a cohesive identity, and acknowledge the tensions and challenges that exist within a space.

Upon reflection, I agree with what the literature says about rethinking NIMBYism and its functions within a neighbourhood (Lyon-Callo, 2001). The causes and reasons behind opposition must be carefully examined, and not just treated as a general NIMBY level. A former City planner (Vancouver 2) recalls how the opposition in Gastown stemmed from the experiences of people who lived and worked there, and were concerned about the image of the neighbourhood. But the

portrayal of the opposition made the residents feel vilified and unwelcomed in the neighbourhood. Another participant (Vancouver 1) explains that the general community was concerned about the imminent gentrification of the neighbourhood. They were worried that the opposition and rejection of the site in the Downtown Eastside would lead to revitalization, and further displacement of the low-income community. Nevertheless, when the site opened in 2003, there was a formal public process but not much opposition at that point. This example illustrates the importance of considering the differing viewpoints in a community, and not to simplify conflicts into general NIMBY arguments. Rethinking the community means there needs to be a closer look into who and the community means. Multiple motivating factors, relationships and challenges exist within a space; processes and policies should reflect these differences.

### *5.2.4 Transdisciplinary Work*

The notion of working together across disciplines is appealing to me, and is what drew me to planning in the first place. Planners come from a variety of backgrounds, which generates unique opportunities to learn from one another. During this thesis, I was often asked how my chosen topic of analysing the development supervised consumption sites fit into the understanding of mainstream planning practices. Many people did not understand, or grasp, how addiction or harm reduction related to 'traditional' planning. The challenge of coming up with answers to this question is what drives my thesis. This is how the idea of 'transdisciplinary work' was generated from reading the open codes I came up with. I questioned myself on what my objectives were, and what information I was trying to present. As I read through my thesis proposal and the interview transcriptions, it was clear that collaboration or involvement across multiple disciplines was very important. It also appeared to be inherent in all of my participants' explanations. People spoke about working with others and the exciting learning opportunities, as if it were the obvious next step in establishing the sites. This caused me to question why this concept was missing from the existing literature on supervised consumption sites, especially if it seemed to be the underlying approach in the participants' experiences.

I believe that supervised consumption sites, and harm reduction in general, require various

viewpoints and perspectives to fully comprehend what is at stake before trying to address any harms or social issues that are associated with drug use. As I read deeper into multiplicity and transdisciplinary work, it appeared to encapsulate the approach to establishing the consumption sites. I want to stress the difference between interdisciplinary and transdisciplinary work: both approaches emphasize working across disciplines and sharing knowledge to inform projects or research (Transdisciplinary Research on Energetics and Cancer Centers website, n.d.). However, transdisciplinary work focuses "on issues within and beyond discipline boundaries with the possibility of new perspectives" (Holistic Education Network, 2011, not paginated). Transdisciplinary work is centred on generating new knowledge and sharing resources to work on a shared objective or project (Transdisciplinary Research on Energetics and Cancer Centers website, n.d.).

This approach appeared to be the case during the beginning processes of developing the facilities. I gathered that participants were aware of the need to learn from others because collaboration between the disciplines was already established in the European contexts. In Zurich, the health department, social policy and drug policy all had input into the logistics and development of the contact centres. In the German cities, it was almost a given that there would be partnerships between the health sector and social services. One participant from a Berlin NGO stated that their particular organization provided expertise in public health promotion and nursing, so it was absolutely necessary to work with socially oriented groups. The participants were encouraged to work together because they realized each stakeholder had different knowledge about the contexts they were working in. One participant notes that they would not attempt to work on a supervised consumption site project on their own without collaboration with other stakeholders, because they simply do not have enough knowledge to do so (Berlin 3). Although the literature positions supervised consumption sites as part of the public health/medical discipline, the processes leading up to the implementation appear to transcend discipline boundaries. The development processes considered motivation for opening the sites across perspectives: participants point out rising HIV/AIDS and Hepatitis C rates (public health/medicine), public safety and associated crime (police/enforcement), and public order and neighbourhood image (municipal and local government concerns). Furthermore, the participants repeatedly associated the harms from drug use with lack

of stable housing and access to health services or a supportive network, and emphasized the importance of considering context. To me, this signifies that the interviewees were aware of the importance of transcending discipline boundaries and sharing knowledge with each other. The participants were respectful of different perspectives, and were comfortable communicating their concerns when working as part of a team.

In other scenarios, it seemed that participants were aware of the need to collaborate among disciplines but reiterated that they "were not there yet" (Vancouver 4). When looking over what participants said about the processes of establishing Insite, they identified important stakeholders and key players who were from multiple fields and backgrounds. I would make the argument that, although participants expressed a need for further communication among stakeholders, the processes in Vancouver can still be recognized as the beginnings of transdisciplinary work.

> Vancouver 3: I think these things work best when the cities and health authorities work together. Ideally, because you risk having different views and visions, and if both can agree on the problem and begin to agree on a solution, it's much better. I've seen it in the City of Vancouver where health authorities can be seen as "they", like they're something different. I mean Insite was a rare example. They were sort of forced to. Partly because the City was so strong on, the health authority was forced to come to our table. So the mayor had a meeting every few weeks, so the health authority was there. Their CEO had to come to that meeting. But often, the health authority has their own planning and community consultation staff, so they can do their thing. Besides it's not our jurisdiction. We have our planners, we do these two year community plans with no health people here. But what about the health standards? Don't you want to bring a health planner to talk about that? I think it's a real problem, especially as we're all trying to address the same issues. Especially on these types of harm reduction programs, the closer the health authorities and the City can work together, the better… there needs to be a commitment to working that way.

Transdisciplinary work is "open to new experiences and processes, at the same time requiring individual interests of each participant to be taken into account" (Jahn, 2012, not paginated). This was the case for Insite, as they were trying something that had not been done in a North American context. The participants were open to new methods to working with drug use within a neighbourhood, and were willing to share knowledge and learn from others. They criticized the gap in communication with health officials and authorities, but adopted a reflexive stance and

recognized the need for increased transdisciplinary approaches. Through these kinds of comments, it appears that the participants realize that each discipline has their own unique knowledge that should be brought to the table in favour of working towards a common goal.

Overall, there are opportunities to generate new forms of knowledge that reflect the uniqueness of each project and context instead of simply exchanging and forcing knowledge to conform to rigid boundaries (Holistic Education Network, 2011). Besides analysing the interview data, it occurred to me that the interview processes were also exercises in transdisciplinary work. I came to understand our discussions as knowledge exchanges. This is defined as the "dynamic, ongoing, two-way interaction and flow of ideas and people between colleges and universities and business, public and third sector organisations" (Scottish Funding Council, 2009, p3). The participants had as many questions for me as I had for them, and would send me information or documents after the interviews for further learning. As interviews can be opportunities for all participants to learn, I found that the interviews reinforced what I read in research methodology literature (Guba and Lincoln, 1989). I enjoyed reflecting on how sharing our personal experiences shaped the conversations. Instead of just exchanging knowledge, we generated new knowledge together when we brainstormed recommendations that came about from the conversation. Disagreements and exchanging ideas are all part of the process, both in the academic and professional realm. I believe this notion of transdisciplinary work transcended geographical and disciplinary boundaries in this thesis, as going abroad and learning about drug use in an international context was a way to generate knowledge.

### *5.2.5 Summary: Uncovering the Themes Behind Development Processes*

The themes generated in this analysis reflect the relationships and what I perceived to be the underlying meanings behind the open codes discussed in the beginning of this chapter. Social justice, inclusion, rethinking 'the community', and transdisciplinary work all function as a means to understand what was important and what drove the development processes of supervised consumption sites. As I re-listened to the participants recount their experiences, I noticed a profound sense of social justice that permeated their 'pragmatic' approaches to working with drug

use. This was further reflected in uncovering the inclusionary nature of supervised consumption sites, as these facilities provided a space for communication and support that would not have been possible with another harm reduction initiative. Although the participants spoke about providing services and meaningful activities for drug users, promoting a space of inclusion appeared to be the deeper purpose of the sites. In terms of working with communities, the participants often referred to 'the community' as a singular entity but spoke about the different groups within the space. It became apparent that there needed to be a shift towards rethinking who and what the community means, and how to acknowledge these differences when developing sites or going through planning processes. Finally, the participants reiterated the importance of working together and communicating with each other. It seemed there was a sense of moving past discipline boundaries and respecting the different knowledge that each person brings, and an openness to trying new approaches to drug use. This kind of transdisciplinary work is what I hope to continue to promote throughout my thesis and career.

### 5.3 Concluding Thoughts

In these interviews, I aimed to get a sense of the planning and development processes of supervised consumption sites. I looked at the literature for guidance, and learned about the public health benefits and harm reduction. However, there was a gap in discussing the processes around establishing these sites. I wanted to know what the challenges and opportunities were, instead of being inundated with facts and statistics. I also wanted to uncover the important issues that planners and policymakers should consider in the future. During the first coding process, I identified open codes that summarized the trajectories of the development processes. Although each site was different and had their own set of obstacles, I noticed common recurring threads that ran through each participant's stories. There were motivating factors and contexts to consider, then creating strategies for effective communication and achieving political support, and then partnerships in developing a comprehensive harm reduction network. The second stage of coding shows that themes around social justice, inclusion, rethinking 'the community', and transdisciplinary work underpin the relationships and meanings behind the first set of codes. Ideally, these findings and analyses will provide useful information for future processes. Not all development processes or

priorities of the site will be the same, but there are certain aspects and approaches that could be applicable to interested communities.

## 6| Conclusions: Lessons Learned and Recommendations

This is a small contribution in terms of understanding how supervised consumption sites function in a neighbourhood context and in a larger harm reduction framework. The issue is highly complex and warrants further research into recognizing the important roles supervised consumption sites play for drug users, and also within a community. The research shows the medical and public health side of the story, but leaves out experiential knowledge in communities and the social benefits of these sites. There is lack of research looking into how these facilities were planned and developed, and what aspects were considered when implementing the consumption sites. Although statistics showing improvement in terms of health outcomes and public order objectives are beneficial for achieving support within a neighbourhood, I argue sharing other perspectives and generating new knowledge provides a more holistic understanding of how planners and policymakers can work with addiction in an urban context. The following sections aims to share some lessons learned and implications for the planning field, as I have learned from the Swiss, German and Vancouver precedents.

### 6.1 Implications for the Planning Profession and Theory

After reviewing the literature and embarking on research trips to speak with planners and policymakers, there are links between the work in planning and developing supervised consumption sites. Planning theory, such as participatory planning and communicative action, present ways to engage communities in discussions around supervised consumption sites. If the *Respect for Communities Act* is passed in Canada, carefully reviewing these processes and tailoring the approaches to work within different contexts will be helpful. Planners that utilize communicative action (Healey, 2006) can generate new knowledge, and uncover existing structures and relationships within communities. This may assist in rethinking planning processes to empower marginalized groups of people, and promote respect for drug users' rights in conversations around addiction.

I would like to stress the importance of trandisciplinary collaboration in planning and

developing supervised consumption sites. I learned that there were many key stakeholders involved in the development processes in all the precedents, who contributed different ideas that were important in their context. I saw in Zurich, Berlin, Frankfurt and Vancouver how these facilities could not have existed without partnerships and collaboration among diverse stakeholders. The need for further collaboration between planning and health is another implication for the profession: the two disciplines are inevitably intertwined since their inception. Especially when it comes to implementing supervised consumption sites in Canada, it will be crucial for public health authorities to bring their medical knowledge and planners and policymakers to share their communication and facilitation experiences. In the European cities, the collaboration among the various stakeholders appeared to be a given; in Vancouver, there was some expressed concerns about the lack of continued partnerships among the different authorities. Perhaps Vancouver and other Canadian cities could learn from the continuous collaboration and communication after implementation from the European examples.

I learned that local and experiential knowledge is key when looking at establishing supervised consumption sites. Interview participants stressed that understanding the local drug scene and its impacts on the neighbourhoods was crucial in getting the processes started. Learning from experience – the challenges and opportunities others faced – is a useful way to start to generate new knowledge. I also learned that understanding the politics behind opening up a site was crucial in getting support and funding. I would agree that an important lesson would be to collaborate with local government officials, and focus on the issues at a community level to gain support. In terms of community knowledge, I argue that more input from drug users is needed in opening future sites in Canada. Empowering drug users to share their experiences using the consumption sites fosters a sense of inclusion and belonging, and provides unique knowledge from the ground. As the consumption sites are targeted towards drug users, it would be valuable to hear their needs and concerns about using such a facility.

The notion of ‘inclusion’ has significant implications on the planning profession. As the field moves towards a more ‘holistic’ and comprehensive approach, priorities like social justice and

welcoming communities become more present in planning discourse. As I believe consumption rooms are spaces of interaction and build a sense of community and support, the planning field should be involved in advocating for these facilities and shaping how they look in a community. Although interaction was more of a positive outcome of the European consumption sites, involving drug users from the beginning could develop even stronger relationships. Planning and policy research could shift the discussion to how sites improve or create relationships within a neighbourhood, and breaking down barriers that currently exist.

Planners are often placed in the middle of neighbourhood and community opposition and disagreements. There are NIMBY toolkits available (State of California, 2006; Pivot Legal Society, 2011), which provide checklists and strategies for community engagement. However, there are two important points that should be considered before jumping into a NIMBY discussion. First, consider the community as a whole. Who is represented? Be mindful of the complex relationships that exist within a community and the power relations that are present. Second, working in a NIMBY context may be the ideal time to draw on community and experiential knowledge. Along with communicating 'facts' and bombarding people with 'convincing arguments', encouraging community members to share their experiences and allowing them to present their side of the story may be a more effective strategy. For instance, if community members are concerned about the safety around the facility, planners could ask questions about why and what makes them feel that way. In Zurich, some neighbourhood residents had bad experiences with being robbed or getting things stolen and made the links from junkies and drug users to crime. In that scenario, regular community meetings and interactions with drug users using the facility helped ease the initial opposition.

As well as overcoming NIMBYism, planners need to consider where the motivation comes from and whose interests are being served. As part of a highly politicized environment, planners have to find a balanced approach while working with marginalized communities. Although there have been substantial strides made to shift from a rationalist to participatory/communicative-action paradigm, there needs to be a further move to 'legitimize' qualitative evidence and prioritize work

with the community and acknowledging their needs. Social justice in itself should be a convincing case to start harm reduction initiatives. Public order and health are strong arguments, but the discourse needs to expand to include the rights of drug users to supportive health services and access to initiatives that reduce harm.

When we consider the importance of communication and engagement, it should be stated how information will be presented and who is represented. There are many implications for what planners' roles could potentially be in engagement processes in the future. As planners, it becomes increasingly crucial to be aware of how we present ourselves and who is included in processes. The main reason why I believe supervised injection sites and health-related facilities should be viewed as planning issues is because of how communication can shape or stall development processes. Planners play a variety of roles across different sectors, but communication is at the forefront of the job. Because of the connection between planning and working with the community, supervised injection sites present a positive opportunity for planners to advocate, engage and recommend.

The collaboration aspect of the development processes has clear implications for the future role of planners in developing supervised consumption sites. Planners can bring their facilitation and communication skills necessary to organize or lead the discussion groups. Planners can also form networks that include stakeholders and community members. Through these processes, planners can play a variety of roles: advocating and working with communities and marginalized populations, presenting information and recommendations to politicians, and also constantly developing and rethinking engagement and collaborative processes to address the challenges at hand. In terms of working with challenging partners, planners can act as a bridge between opposing groups. This unique opportunity allows for deeper learning and understanding, and for planners to utilize the *communicative action* approach*:* using their skills to work with divergent opinions and generating new knowledge and sharing experiences.

In terms of context, planners need to look at what their current drug scene is like and how it functions as part of the city, then deciding what methods will be most effective to reduce harms. As

well, the type of drug use will continue to change in the future. As part of working with communities, planners will hopefully gain knowledge of how these changes affect neighbourhoods and individuals. Planners need to be aware of current drug use and issues in order to communicate with other stakeholders on updating strategies to fit the needs of drug users. Finally, location is something planners can work with regardless of department. A topic that merits further exploration is how sites can be designed to fit in with the neighbourhood, or stand out to make a statement. Planners need to consider if the location is functional for the site to run, and for people to access it. As well, participants agreed that the site should be accessible by transit or walking.

When discussing application in a Canadian context, planners can utilize their skills as liaisons between politicians and communities. With the current new changes to federal legislation, planners may be needed more than ever. With the government failing to renew the exemption three years ago and the community taking the lawsuit to the Supreme Court of Canada, there is much to be recognized about the power of the public. Although the citizens in Canada may not have the same political sway as those in Switzerland, the rise of the community in defeating the federal government implies that social justice is a very relevant concept. As the government passed a law in the summer of 2013 stating that supervised injection sites must have community approval, scholars and critics have cried "NIMBY" and the heavy-handed role of the government. However, I argue this could be beneficial in giving planners more implicit power in presenting information or working alongside communities. This could be an excellent opportunity for planners to advocate for marginalized populations and come up with creative and innovative community engagement techniques. The lessons learned from the European contexts in terms of developing participatory approaches from a top-down perspective could be very relevant.

### 6.2 Recommendations & Lessons Learned for Future Communities

*Motivation*

Although there is always a breaking point that forces discussion and interventions, motivation needs to be sustained. Whether it is a top-down or bottom-up approach, something will trigger the

conversation. It may be useful for cities to define their priorities and use that as a springboard to learn from others and start processes. The public order and health key themes have spurred a wealth of literature discussing the scientific benefits of consumption rooms and evaluating the effects on public order. However, this does not mean that there will not be other motivating factors. In the future, a shift to acknowledge the rights of drug users to safety and improved health is vital. Hopefully, some planning initiatives have moved past simply serving an arbitrary public interest. In conversations around addiction and consumption rooms, working closely alongside the community and making efforts to humanize drug addiction may spark a change in future discourses.

1. There needs to be a consistent level of determination and persistence to continue processes that lead to development.
2. A comprehensive approach that considers the very diverse and unique needs of the community is needed, where planners can be aware of and balance motivations from different groups.
3. Expand the conversation to include social justice.

*Context*

Context is everything. Planners and policymakers should look at how the city functions, and how to consider the needs of drug users in a relevant way.

> Zurich 3: Have a proper look at the city as a whole. How do people work together in a complementary way? Communicate benefits you get from the site. Drug users are better off inside than outside, in an environment where they can use safely.
>
> Frankfurt 1: Learning from others and see how they did it. Then tailor it to the needs at home.

1. Consider the drug scenes and drug use patterns. One participant suggested a mapping project of where the drug concentrations are, and keeping this as a living entity that can constantly be updated.
2. Tailoring the site models to the drug scene and context is another way for planners to utilize their collaboration and technical mapping skills. Mobile services or following the Dr. Peter model could complement stand-alone sites, or be the set model for dispersed, small drug scenes.

> Vancouver 3: I think most cities in Canada are looking at more of a dispersed, three or four smaller ones than an Insite type model. But it's well worth hearing and looking at the Dr. Peter model because it could be the way of the future. You could have eight injection rooms in Toronto, and you wouldn't even know this existed walking by. Only the people who operate it do because they'd be part of a larger shelter and health clinic network.

*Communication*

Bringing in speakers from abroad was a step in gaining support and trust from the general community in Vancouver. Some of the interviewees mentioned how useful it was to listen to experiences from European policymakers and non-profit organizations. Politicians and community members learned that these sites were still running successfully in major European cities with positive impacts on the neighbourhood over time. An employee from a Vancouver non-profit organization mentioned that empirical evidence helped demonstrate that supervised injection sites were beneficial in conveying the public health benefits. However, they also stressed that visual evidence and community input such as videos, images and speakers were an important way of highlighting the public health benefits and social aspects. They believed that portraying addiction at a personal level was an effective way to share information and engage people across all walks of life.

1. Make information accessible – this can include increased access to viewing materials physically or online, and also accessible in language and visual representation – is another important part of communication, especially when planning with marginalized populations.

*Working with Others*

Facilitating networks and partnerships is one way supervised injection sites can gain public support. Working together also supports provides opportunities for different perspectives to be heard, which ideally translates into relevant and effective strategies. Planners can spearhead discussion groups and act as champions for collaboration across levels of governments, various sectors and

community members. One participant in Frankfurt wished to emphasize how effective the collaboration between the Monday Group roundtable was in gaining support:

> Frankfurt 1: What I learned is that you cannot be doing this all by yourself. Join up with whoever you can because it gives you more power, in speaking to a higher level.

Planners can also promote approaches to generate new knowledge. Due to current federal legislation, there could be various opportunities for planners to play a significant role in future development processes. Planners already work closely with communities; there may be chances to work with local and experiential knowledge to appeal to neighbourhoods on a personal level. Instead of focusing resources and time on gaining political support, planners could make use of their communication and facilitation skills to work meaningfully with communities and enact positive change at a local level.

As addiction is often a grey area in terms of policy and law, collaborating with the police becomes an important starting point. To prevent a lack of trust from drug users and the site from actually being used, the police cannot use the facility as a means to increase arrests or confiscation of drugs. In the cities I visited, the police were more or less in favour of developing sites.

1. Establish a committee or steering group, or an advisory board that involves a variety of stakeholders to identify priorities, strategies and share knowledge.
2. Promote cooperation with the police. This can include education with police schools, information on how social and health services work, what facilities are currently offered for drug users, a tour of the consumption facilities, and open discussions with facility staff to establish guidelines and policies.

*Working With Community Members*

One interviewee in Zurich mentioned that regular meetings and committee or work groups were an effective way to address concerns and complaints in a timely manner. Even twenty years after the sites opened, these meetings still run and foster a sense of open dialogue and communication between City staff and residents. Similarly, in Berlin, the non-profit groups held an open house

where the neighbourhood was invited to tour the facility and ask questions. Several public meetings were held in conjunction during the opening to explain the purpose of the site, and to address any initial comments and concerns.

One of the themes in the analysis suggests shifting how we think about 'the community'. Acknowledging the different individuals and relationships present within a local setting. Working with a community means making an effort to understand how people interact, relate to one another and recognizing that needs within one neighbourhood may be diverse. Be aware of how the community can also be something positive that promotes collaboration and inclusion. Move away from dichotomies within a community, and promote ways to understand each other.

Another way to work with community members could be a means to learn from the community and promote experiential knowledge. Planners could potentially continue to include community members in committees or roundtable meetings. In Vancouver, a former City planner suggests informal community interactions as a way to encourage open communication. The participants from Vancouver all remarked on the strength and determination of the Downtown Eastside community in pushing for the opening of a sanctioned site. Perhaps the biggest lesson of all is that community members can enact progressive change at a grassroots level.

> Vancouver 4: The very basic thing would be to work collaboratively, working together. Listening to the community is very important. The lesson to learn from Vancouver is extreme persistence. They were so strong and determined, the community groups. Can you imagine rallying together and taking the federal government to the Supreme Court? It's such a big victory.

1. A space like a community garden could be an effective engagement atmosphere where people are encouraged to connect differently outside of formal public hearing processes. This could promote more open and less structured conversations, while including those who may not be comfortable in a public forum setting.
2. Consider implementing a 'Good Neighbour' policy: a former City planner (Vancouver 2) states that Insite has this agreement with surrounding businesses, which ensures the site contact info

will be kept up-to-date to address any concerns. The agreement also states the site's façade and the sidewalk must be kept clean.

*Politics*

Planners need to be conscientious of the political climate. That is to say, planners still need to be aware of when and where they are needed. As a Vancouver planner says:

> Vancouver 4: We've been very lucky to have mayors supporting this work… But as planners, we have to be careful as and when we are needed, as the advocacy and support is needed. So, there is an opportunity to get involved if there is a need for it. As planners, one of our roles is to be an intermediary and our role is to facilitate these processes and advocate and help policymakers turn it into policy. It is very different to keep our nose to the ground, and that we can do by working with communities and taking it back to the politicians.

1. Promote a national drug strategy with clear jurisdiction. Switzerland and Germany both have a national drug strategy that delegates responsibility and outlines funding roles. Although supervised injection sites are a relatively new concept, a national drug policy in Canada with streamlined development processes could ensure relevant and timely initiatives.
2. Increase collaboration between the different levels of government so drug policy laws do not undermine the importance and the role of each level.

*Location*

Location needs to be part of the starting conversation. As a general suggestion, one participant from Berlin explains:

> Berlin 1: [You have to] be flexible, adapt to changing conditions. You have to choose sites that are closest to the drug scenes. For every block farther away you are, the more people you will lose.

An interviewee from Zurich goes on to add:

> Zurich 2: One thing is that it shouldn't be too far away from the city. But it shouldn't be in a quarter, where people are living, like all residential. It should probably not be close to a school or where a lot of young children are. Coming back to this urban

compatability strategy, consider if the area has a lot of facilities for drug addicts, like clinics, poly clinics, don't put too much pressure on one area. One site in the centre of the city is actually in the middle, people live there, there's a museum right next to it, and it works.

1. Take into account what is going on in the neighbourhood. As the opinions on having services located under one roof, concentrated in one community or dispersed around the city vary – so do the opinions of the neighbourhoods.
2. Also consider the demographics and the different challenges that should be addressed when deciding on a location. For instance, the services under one roof model would be beneficial for older drug users who may have mobility challenges or severe health problems.

*Inclusion & Establishing an Inclusive Harm Reduction Network*

Consumption sites foster a sense of belonging and community that do not appear to exist in other drug services. There could be opportunities to create projects and programs within the sites or establish partnerships that build on this sense of community. Ultimately, the consumption rooms are there to meet drug users' needs for a safe and sanitary place to inject in addition to other supports. It would make sense to include them from the start to get their input immediately. By acknowledging their right to a safe and welcoming place, this would be an example of a truly inclusionary practice. It also validates the drug users' inputs in a way that can be seen and experienced.

1. Establish other harm reduction and detox initiatives in conjunction with the sites. If there is a sense of trust and support at the site, drug users may feel more comfortable seeking guidance and access to other harm reduction options.
2. One participant mentioned community gardens and landscaping as a way to engage drug users in the public realm. This could also create opportunities for informal interaction with neighbourhood residents. Ideally, this would be located in or near the consumption site to encourage participation.

3. Develop an inventory of housing and services. It may also be beneficial to map where these facilities are located. This can help determine the best place to put a facility, and provide a starting point for connecting to resources. It could potentially inform other development processes, hopefully mitigating the potential negative impacts of gentrification by indicating where important services and housing are.
4. Creating a map with contact information could also be used for distribution to the community, as part of a 'Good Neighbour' Policy and providing drug users with increased access to services.
5. Involve drug users in the whole planning and development processes.

**6.3 Recommendations for Further Studies**

It would be useful to pursue a community impact assessment study with qualitative and quantitative methodology, which would ideally complement the scientific findings put forth by public health researchers. This could include interviews with neighbourhood businesses and residents, surveys and focus groups with site staff. Also, developing a social impact assessment tool for future sites would be an interesting topic – and would also be beneficial in meeting one of the *Respect for Communities Act* criterion. An idea for researching how supervised consumption sites promote inclusion could be done as a community-based research project, where the objectives and research methods are developed in conjunction with drug users and other community members. It may also be worthwhile to look further into the links between supervised consumption sites and services such a housing and primary health care as part of a larger harm reduction network. This could be done as a comprehensive analysis of harm reduction networks within communities. Finally, it would be helpful to produce an updated report on consumption rooms around the world to reflect global changes and contexts.

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## Appendix 1 | Interview Questions (Policymakers, Researchers & Site Staff)

1. What triggered opening the safe injection site?

2. Who was involved in the planning & development processes?
    - Were planners involved?
    - Identify key stakeholders and their roles.
    - Were drug users involved in the processes?

3. What were the processes undertaken to develop the safe injection site?
    - What were some of the challenges? (Political, logistics, policy, legislation)
    - What were some of the opportunities? What worked? What was beneficial to getting the process going?

4. Did you encounter any financial obstacles? What recommendations would you give prospective supervised injection sites in obtaining funding or maintaining financial stability?

5. Were there any community consultations/public hearings?
    - Identify opposition groups/allies
    - Was NIMBYism a concern? If so, what were strategies to counteract NIMBYism?

6. How was the location of the site decided?
    - What aspects were considered?
    - In the future, where should sites be placed?
    - What contextual factors need to be considered?

7. Are there other services attached to the site?
    - What were the processes around developing partnerships with other social services?
    - Could this be an opportunity for planners (government/acting on behalf of non-profit or

public health entity) to get involved?

8. Were safety concerns addressed, in terms of community safety? If so, how?

    - How about safety concerns, in terms of drug users?
    - What are some ways to mitigate safety concerns in the future?

9. What recommendations would you offer to cities interested in implementing safe injection sites in the future?

## Appendix 2 | Interview Questions (Planners)

1. What triggered opening the safe injection site?

2. Who was involved in the planning & development processes?
    - Were planners involved?
    - Identify key stakeholders and their roles.
    - Were drug users involved in the processes?

3. What were the processes undertaken to develop the safe injection site?
    - What were some of the challenges? (Political, logistics, policy, legislation)
    - What were some of the opportunities? What worked? What was beneficial to getting the process going?

4. Did you encounter any financial obstacles? What recommendations would you give prospective supervised injection sites in obtaining funding or maintaining financial stability?

5. Were there any community consultations/public hearings?
    - Identify opposition groups/allies
    - Was NIMBYism a concern? If so, what were strategies to counteract NIMBYism?

6. How was the location of the site decided?
    - What aspects were considered?
    - In the future, where should sites be placed?
    - What contextual factors need to be considered?

7. Are there other services attached to the site?
    - What were the processes around developing partnerships with other social services?
    - Could this be an opportunity for planners (government/acting on behalf of non-profit or

public health entity) to get involved?

8. Were safety concerns addressed, in terms of community safety? If so, how?

    - How about safety concerns, in terms of drug users?
    - What are some ways to mitigate safety concerns in the future?

9. How do planners get involved in health planning?
    - What roles can planners play in public health initiatives?
    - Do schools' planning curricula prepare planners to work with health issues?
    - In terms of urban addiction, can planners mediate between drug users and the public?

10. Do you think planners should play a role in safe injection site development processes? If so, what should be the extent of this role?

11. What recommendations do you have for cities looking to implement safe injection sites in the future? What about recommendations for future planners?

Appendix 3 | Informed Consent Form

Department of City Planning
201 Russell Building
84 Curry Place
Winnipeg, Manitoba
Canada R3T 2N2
Tel: (204) 474-9558
Fax: (204) 474-7533

UNIVERSITY OF MANITOBA **Faculty of Architecture**

Research Project Title: *Addiction in the city: Analyzing safe injection site development processes*

Researcher(s): **Joyce Rautenberg**
Research Supervisor: **Dr. Ian Skelton**

Please contact me if you have any questions:
Joyce Rautenberg
Email:
Phone:
Mail:

**This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.**

**1. Purpose of the Research:**
The purpose of this research is to satisfy the major degree project requirements of the Master of City Planning Degree at the University of Manitoba. The project is titled *Addiction in the city: Analyzing safe injection site development processes*. The purpose of this project is to analyze safe injection site development processes and to determine the implications on the planning profession. I aim to explore how discussions around safe injection sites are relevant to urban planning. I would like to understand what challenges and opportunities occurred during safe injection site development processes. I would like to determine if there is a role for planners (I am referring to planners working for in a government setting or on behalf of a non-profit/public health entity) in future site developments, and the extent of these roles.

**2. Risk:**
There are no particular risks or benefits to you in participating in this study. There are no risks associated with this project beyond normal everyday risk. The study does not address personal or

confidential issues. The study asks only for your professional knowledge about safe injection site development processes and operations, and recommendations for future site development projects.

**3. Procedures:**
You are being asked to participate in an interview involving questions on safe injection site development processes and operations. Interviews are intended to clarify and supplement published public materials on these matters. The interviews are expected to take approximately 45 minutes to one hour in length. The interviews will be recorded and notes taken. The project will include up to five semi-structured interviews from three different cities. Recommendations and information generated from this interview will inform one or two focus group sessions in Toronto, Canada.

**4. Recording Devices:**
This interview will take approximately 45 minutes to one hour of your time. With your permission, the interview will be recorded with a digital recorder and notes of the interview taken. You will not be identified in the thesis document. All audio files and interview notes collected during the research process will be stored in a locked drawer in my home office. One year after the project is complete, interview recordings and notes will be destroyed. If you do not wish for the conversation to be recorded, I will take hand-written notes only. However, recording will ensure a more accurate record of your responses in the final document.

**5. Confidentiality:**
**Your privacy is important.** You will not be personally identified in the thesis document. Information you provide during the interview will be coded for use in the project. Recordings of interviews, and notes taken, will be secured during the project and destroyed one year after project completion, expected in August 2013. You should be aware that the general nature/locale of your place of work, and the broad parameters of your professional role will be indicated to help contextualise your input. It may be possible for those with special knowledge of these contexts to infer your identify. Given the small pool of relevant participants, a participant might be identifiable by their turn of phrase as used in the project. However, no personal information will be gathered and I will only be asking questions relating to your professional expertise on the subjects of this study. If at **any** time you wish to withdraw from the interview please let me know and your responses will not be used in the final document. If after the interview you wish to withdraw from the project, please contact me directly **(prior to April 1, 2013)** and your responses will not be used in the final document.

**6. Feedback:**
A summary of research results will be made available to all participants. For those who are interested, the final completed thesis will also be made available. Feedback will be provided by email in PDF format.

**7. Credit or Remuneration:**
There is no credit, remuneration, or compensation for participant involvement in this study.

**Your signature on this form indicates that you have understood to your satisfaction the information regarding participation in the research project and agree to participate as a subject.** In no way does this waive your legal rights nor release the researchers, sponsors, or involved institutions from their legal and professional responsibilities. **You are free to withdraw from the study at any time, and /or refrain from answering any questions you prefer to omit, without prejudice or consequence.** Your continued participation should be as informed as your initial consent, so you should feel free to ask for clarification or new information throughout your participation.

**The University of Manitoba Research Ethics Board(s) and a representative(s) of the University of Manitoba Research Quality Management / Assurance office may also require access to your research records for safety and quality assurance purposes.**

**This research has been approved by the Joint Faculty Research Ethics Board. If you have any concerns or complaints about this project you may contact any of the above-named persons or the Human Ethics Coordinator (HEC) at 204 474-7122. A copy of this consent form has been given to you to keep for your records and reference.**

Participant's Signature _____ Date _____

Researcher Signature _____ Date _____