Injecting Space: a cultural history and spatial analysis of the Drug Consumption Space

Hannah Leyland
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Research Advisor: Dr. Sara Stevens
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by
Hannah Leyland
Bachelor of Science (hons.) in Health Science - Simon Fraser University - Vancouver, Canada
Associate of Science - Langara College - Vancouver, Canada

Research Mentor: Dr. Sara Stevens

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After describing my thesis topic I am often asked, “You could have chosen to research anything for your architecture thesis, where did this idea stem from?”

Previous to pursuing a Master of Architecture degree, I completed a Bachelor of Science in Health Science. This statement is usually followed by questions about why the 180-degree switch, as the two fields are seemingly unrelated. Going back nearly four years ago to the Statement of Intent I wrote to receive admission to Architecture School, I stated:

“It may appear as though the paths of architecture and health sciences rarely intersect, or only do so in the construction of health care facilities. However, my academic pursuit of health sciences interwoven with my experiences working at my father’s architecture firm have made it apparent that they are linked at many integral levels. The social determinants of health and the built environment are tightly intertwined within architecture and should be considered in every design whether institutional or domestic. An effective design has the power to promote safety, encourage social interaction, avoid injury, foster support networks, and influence health decisions.”

I ended my statement by saying:

“I hope to one day practice architecture in Vancouver and enhance my designs with my knowledge of health sciences in areas such as epidemiology, mental health, and the social determinants of health as together, they can better our lives.”

I will now admit that at the time I really had no idea whether this was even true, just how I was going to achieve the statement, or if I was even interested in doing that at all. I was merely trying to ‘prove’ to myself and others that I hadn’t abandoned the Medical School direction for something completely unrelated or irrelevant to health.

My second inspiration comes from my brother’s struggle with drug addiction. Throughout his recovery process I visited a number of detox facilities, rehabs, sober-living houses, and saw first hand the way these facilities are structured and designed. I know the lengths an addict will go to get his drug of choice and the destruction this causes to families. I understand the societal perceptions of how these individuals are seen as undeserving of attention or care, and that efforts are often seen as ‘enabling’ drug use.

My third reason stems from my love of Vancouver. I was born and raised in Vancouver, a place that is consistently number one or at least among the top five cities for livability and quality of life. [1, 2] However, “No society can understand itself without looking at its shadow side”. [3] In Vancouver’s ‘shadow side’ lies some of Canada’s most marginalized citizens located in the Downtown Eastside neighbourhood. As a Vancouverite, this is not a new phenomenon, I have known about this reality my entire life. The issues are largely concentrated within a 4-block radius along East Hastings Street and Main Street. It is a huge, complicated problem that attracts worldwide attention and wonder. The Vancouverite in me was curious to understand this phenomenon further.

I truly believe that everyone has a role to play in dealing with societal issues. I felt as though that it would be appropriate to apply the discipline and resources of architecture to what is a broad and disastrous community problem.

My thesis as it stands combines my interests in health, my experiences with my sibling, my familiarity with Vancouver, and my newly acquired training in architecture to investigate ‘Drug Consumption Spaces’.

― Those whom we dismiss as ‘junkies’ are not creatures from a different world, only men and women mired at the extreme end of a continuum on which, here or there, all of us might well locate ourselves.‖
- Dr. Gabor Maté
In the Realm of Hungry Ghosts: Close Encounters with Addiction

―No society can understand itself without looking at its shadow side.‖
- Dr. Gabor Maté
In the Realm of Hungry Ghosts: Close Encounters with Addiction
The Downtown Eastside drug-using population of Vancouver is as deserving of healthcare as any population on the planet. The extensive healthcare system that we have currently devised and the facilities that we have beautifully designed to be efficient, work well for the average person. However, this system is failing the marginalized Downtown Eastside individuals, people who could greatly benefit from it. Healthcare settings are filled with barriers for this population. The Downtown Eastside population has unique cultural requirements that must be acknowledged in designing for their community. For this population, the architecture should have as little resemblance to the failed and feared systems as possible.

As it exists today, the Downtown Eastside is a place of chaos and disorder with extreme poverty, extensive drug use, and homelessness. The safe injection site in this area, Insite, brings order to what is essentially a chaotic experience, injection drugs. Drug Consumption Spaces have pragmatic programmatic spatial requirements. The program can be divided into three categories: Pre-Consumption, Consumption, and Post-Consumption, with each area having different considerations.

Unlike other building typologies such as hospitals or prisons, Drug Consumption Spaces have yet to be defined as a building type. Investigating different building typologies and precedents, creates an understanding of how Drug Consumption Spaces can be placed in the architectural discourse.

There is a valuable knowledge and experience on this issue that is not published. The work that is published on the issue does not investigate architectural concerns. I sought and received valuable and thoughtful information and advice from experts in the field: users of the space, drug users, health professionals, policy makers, law professionals, advocates, and community members, as well as attending related lectures.

There are very clear reasons why Drug Consumption Spaces matter from a public health perspective and this has been extensively researched. However, there remains a knowledge gap as to the architectural requirements of these spaces. In addition, there are no design principles for implementing and creating culturally safe spaces for the intended population. Following the creation of principles, these proposed guidelines will then be applied at different scales: alley way, tent, mobile unit, embedded service, renovated existing structure, purpose-built facility, an opioid assisted treatment clinics, and finally, consider how these spaces could be designed if drug prohibition didn’t exist.

Key words: Cultural Safety, Design Impact, Evidence Based Design, Drug Consumption Spaces, Vancouver, Downtown Eastside, Drug Addiction, Mental Health

By exploring the primary research in this paper, I will set out to create design principles and apply these guidelines to a continuum of design interventions, that aim to understand:

How can architecture make Drug Consumption Spaces more Culturally Safe for the Downtown Eastside community?

Sub questions include:

What is the design initiative of Drug Consumption Spaces?
What are design considerations when working with the Downtown Eastside culture?
How does working within the framework of Cultural Safety help develop the design guidelines?
What do these guidelines look like? Who is the intended audience? How are they intended to be applied?

“The architecture of these spaces are incredibly important. It is essential and vital to their success and existence.”
- Darwin Fisher
Coordinator of Insite

thesis statement

By exploring the primary research in this paper, I will set out to create design principles and apply these guidelines to a continuum of design interventions, that aim to understand:

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individuals who specifically impacted my research

Darwin Fisher: (Met March 13, 2017) Coordinator of Insite, employed by Portland Hotel Society. Fisher gave me a thorough tour of Insite. In addition he spoke at a workshop, *Insite and Harm Reduction*, that I attended at UBC on April 7, 2017. He has worked at Insite for nearly fifteen years. Fisher was able to paint a vivid picture of what life is like for the population of the Downtown Eastside and the barriers they face in healthcare settings. In addition, he discussed in specific detail the different components of Insite and what occurs in each space.

Sean McEwen: (Contacted April 3, 2017) Architect of Insite. McEwen discussed the design considerations and process that went into the design of Insite in 2003. The design was a result of collaboration with Portland Hotel Society who had already interviewed the intended user group and had visited injection sites around the world. The design, permit, and construction processes were fast-tracked and completed in only 6 months. McEwen explained unlike other building types, there was no manual or guidelines to follow for these spaces. Not only did the experience of the user dictate the architecture, but the desire to create a positive work environment for staff and concerns from authorities also determined the design.

Cedric Charvet: (Contacted April 4, 2017) Coordinator of Amsterdam DeRegenboog Groep AMOC, and representative of the International Network of Drug Consumption Rooms. Charvet was the responsible for the design of AMOC. Prior to designing AMOC, Charvet visited a number of drug consumption facilities in Spain, Switzerland, Germany, and researched other sites worldwide. Charvet provided me with a clear and highly specific rational for designing the space and the associated architectural elements. He emphasized the importance of understanding the study, *Rat Park*, in the design of these spaces. In addition, he sent and numerous images of the AMOC facility me a number of photos of the space and other spaces around the world and highlighted certain aspects in each image.

Alicia Breck: (Met April 14, 2017) Breck is currently working with the City of Vancouver to create housing guidelines for First Nations Communities. Breck discussed how there is a growing amount of research surrounding Cultural Safety when working with First Nations, Inuit, and Métis. Breck described how Cultural Safety can also be applied when understanding the intended population of a Drug Consumption Space. More specifically the intended group that resides within Vancouver’s Downtown Eastside may be considered their own culture. In addition, these communities are similar in that all face health and social inequalities, as well as marginalization. This idea of designing to achieve Culturally Safe spaces was critical in furthering my thesis and in informing my intention of the set of design principles I am intending to create.
"Research to prove that injecting inside drug consumption rooms is safer than injecting elsewhere, is like needing to prove that jumping from a plane with a parachute is safer than jumping without one."

-Joan Colom I Faran
Researcher and Policy Maker

Chapter 1: Introduction
Chapter 2: Related Terms
Chapter 3: Goals

What are the issues around Drug Consumption Spaces?

What are the key terms?

What is my goal?
Chapter I: introduction

Our society is not keen on "junkies". Drug addicts are frequently regarded as dangerous, exploitative, and unpredictable, having only themselves to blame for their predicament. This question of the victims being responsible for their own condition is key to the stigma associated with drug addiction. However, statistically sooner or later or even presently, whether we know it or not, everyone has some connection to addiction yet many people have little sympathy for drug users, as they 'chose' to take an illegal substance in the first place. It is commonly believed that if the addict truly wanted to, they could stop using their addicted substance. This attitude however, ignores the nature of addiction.

If you asked anyone what they wanted to be when they grow up, no one would say "drug addict". Yet, according to the United Nations 2016 World Drug Report, 247 million people used drugs in the past year; 28 million people suffer from drug use disorders. [2] Drug addiction should not be considered a result of a 'free' choice. It is an enormous all-consuming misfortune to be a drug addict. Addiction robs people of free will and human agency, as the addict must succumb to the constant, persistent, and unrelenting nature that their addiction demands time and time again. The plight of these individuals cannot be adequately addressed with criminalization and certainly not with stigmatization.

Drug addiction is an extremely expensive life situation to maintain. Addicts are willing to do anything just to get their fix - steal, cheat, exploit themselves and those around them. This comes at the consequence of public safety in the forms of theft and enormous costs, usually causing addicts to risk their own safety or health (ex. prostitution, dirty needles etc.). It is also destructive of the self-respect of addicts, adding yet another acceleration of their addiction(s).

Injecting a drug is a medical procedure that requires the same level of precision as drawing blood, and requires specific tools to achieve the objective, yet people in the Downtown Eastside are performing this medical procedure in unhygienic, unsupervised, and unsafe, environments. Just like any medical procedure, injection drug use deserves to be conducted in a hygienic facility.

The alternative to this highly problematic environment is Drug Consumption Spaces. Drug Consumption Spaces are considered an evidence-based approach of harm reduction. In general it is a controlled care setting where people can more safely inject pre-obtained drugs under clinical supervision and if desired, receive health care, counseling and referrals to health and social services including drug treatment. Drug Consumption Spaces are not intended to 'cure' addiction, but rather they are placed on a continuum from being ill to becoming well. These spaces have been rigorously studied and found to reduce the spread of infectious diseases, overdose deaths, and improperly discarded injection equipment, and to increase public order, access to drug treatment and other health services, and save taxpayer money.

According to the International Network of Drug Consumption Rooms, there are currently 98 facilities operating in 66 cities around the world in 11 countries: Australia, Canada, Denmark, France, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland. Sixteen other countries have proposed facilities under debate: Austria, Belgium, Bulgaria, Czech Republic, Colombia, Greece, Hungary, Italy, Iran, Poland, Portugal, Romania, Serbia, Slovakia, United Kingdom, United States. [4]

In 2003, Insite, the first legal Safe Injection Site in North America opened in Vancouver's Downtown Eastside. Insite does not provide drugs. They provide a clean and safe space with hygienic equipment and supervision for the injection drug user. About half of the people who use their facility are marginalized, meaning they are homeless, living in a shelter, or have severe mental health issues. [5] Overdoses still occur int the facility; however, to date, zero fatalities have occurred due to immediate intervention by medical staff. Investigating Insite provides a clear example of how a Drug Consumption Space operates and raises issues about the needs and Cultural Safety considerations of the intended usergroup.

In 2016 alone, within British Columbia, 914 individuals died from drug
overdoses. This was up nearly 80% from the year before where the toll was 510. This was largest number in nearly three decades of record keeping. Almost 90% of these deaths occurred indoors (61.3% in private homes; 28.7% inside of various other locations), 9.2% occurred inside of vehicles, parks, sidewalks, streets or wooded areas, and 0.9% in unknown locations. [6] In response, to mitigate this epidemic, Overdose Prevention Sites were implemented. [7] However, there remains a clear need for a permanent solution, something which likely could have prevented many of these deaths.

Although, zero fatalities have occurred within Insite, Insite is still not a sufficient solution. People continue to use drugs, usually alone, in their living space just blocks from Insite, possibly because Insite is at overcapacity or individuals may feel as though the space doesn’t serve their needs. [8] In addition, a critical shortcoming of Insite remains: supervision does not extend to the purity, toxicity, type, and amount of the injectant supplied by visitors. And their visitors, given the criminalization of their drugs, are in no position to ensure the safety of what they acquire in the criminalized space of their addiction. The projected or desired next step of these facilities is where drugs are actually provided on site. [9] This concept is exampled at Crosstown Clinic, where 91 individuals receive regulated, pharmaceutical-grade heroin. This space has a highly clinical environment, which through investigating Insite, presents clear barriers to use when delivering services to this population [10].

Vancouver is frequently ranked one of the world’s most livable cities [1, 2] However, among its livability, it has a long history of issues surrounding poverty, drug use and homelessness. In Vancouver we are fortunate enough to have access to a robust health care infrastructure. Canada’s universal health care system, means that the Downtown Eastside is surrounded by clinics offering ‘universal’ access: Pender Community Health Centre, Downtown Community Health Clinic, Native Health Clinic, Women’s Health Collective Clinic, Raven Song Community Health Clinic, St. Paul’s Hospital’s emergency, Mount Saint Joseph’s emergency, Vancouver General Hospital’s emergency, are all within 5-15 minutes away from some of Canada’s most marginalized citizens. Yet, this population is not accessing this extensive health care system “specifically designed” for them. “The question becomes: why is this system failing this population?” [8]

May it be for personal reasons or escorting someone else, we all have experiences accessing this healthcare system comprised of facilities such as emergency rooms, doctor’s offices, walk-in clinics, or pharmacies. However, for the population of the Downtown Eastside, this experience is often radically different than the average person’s. Although this population is likely a primary user of emergency rooms [11], if you enter the emergency room and you look like someone who is a drug user, is homeless, or are a person with mental health issues this experience is likely prejudice. The situation becomes even more inaccessible, “if you display the attributes of pain such as unpredictable movements, loudness, or distress, and you already don’t fit the norm, you appear even more of a threat” the individual will be escorted by security personnel during their visit. “It is not that the health authority doesn’t want to provide care, they just operate with bureaucracy, rules and regulations; it is the nature of that system and this does not work for the needs of this population”. [8]

The culture of this population is based on human interactions. Barriers to use are the unfamiliar Plexiglas window between the receptionist and patient, being required to fill-out forms if you cannot read or write, being asked questions if you can’t speak clearly, or being required produce documents such as ID or having a fixed address. [8] Negotiating these power-dynamic situations is extremely uncomfortable if not impossible, for a population that lacks agency, and who has had countless similar negative experiences with authority and institutions.

The Downtown Eastside drug-using population is as deserving of healthcare as any population on the planet. The extensive health care system that we have devised and the facilities that we have beautifully designed to be efficient, work well for the average person, yet “serves the population of the Downtown Eastside, like garbage”. [12] In designing facilities to effectively deliver services to this population, it is clear that the architecture should have as little resemblance to the failed and feared system as possible.

“As sad as it is, the reality is, what drives social change is death.”
- Darwin Fisher
Coordinator of Insite
Chapter 2: related terms

The list of terms was compiled during research on the topic. It demonstrates the wide range of vocabulary used to define these spaces. From casual to institutional, these terms demonstrate preconceived notions associated with addiction related spaces. This ‘typology’ is defined in many different ways; for example, words like “room”, “den”, “house”, “site”, “facility”, or “center” indicate levels of scale, legality, and morality. The labels show how these places are viewed in society. Words like “safe”, “supervised”, and “medical” have various connotations like healing and empathy as well as alleviating public fears. The use of multiple terms to describe a similar condition shows that the space where people use drugs in a more hygienic and therefore safer environment has yet to be defined in a unified way.

The simplest definition of these spaces are professionally supervised healthcare facilities where drug users can use drugs in a safe and hygienic environment.

For the sake of this paper I will refer to these places as ‘Drug Consumption Spaces’ or ‘DCS’ as to not specify what drugs are being consumed, and within what scale the space operates. In addition, I chose not to include the words “safe” or “supervised” in the term, as I felt that they contributed to the stigma of drug use among the population and the personal stigma drug users experience.

This is a list of binaries I compiled as I explored the design considerations surrounding the urban scale of the Downtown Eastside population and the individual scale of the Drug Consumption Spaces.

<table>
<thead>
<tr>
<th>PRIVATE</th>
<th>PUBLIC</th>
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<tbody>
<tr>
<td>INDIVIDUAL</td>
<td>GROUP</td>
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<tr>
<td>INSTITUTIONAL</td>
<td>RESIDENTIAL</td>
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<tr>
<td>ILLEGAL</td>
<td>LEGAL</td>
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<tr>
<td>SCHEDULED</td>
<td>UNSCHEDULED</td>
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<tr>
<td>REGULATED</td>
<td>SPONTANEOUS</td>
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<tr>
<td>OUTSIDE</td>
<td>INSIDE</td>
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<td>HARD</td>
<td>SOFT</td>
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<tr>
<td>DANGEROUS</td>
<td>SAFE</td>
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<tr>
<td>IDENTIFIED</td>
<td>ANONYMOUS</td>
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<tr>
<td>NIGHT</td>
<td>DAY</td>
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</tbody>
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SHOOTING GALLERY
CRACK HOUSE
DRUG HOUSE
ROCK HOUSE
OPiUM DEN
SIS: SUPERVISED INJECTION SITES
SIS: SAFE INJECTION SITES
SCF: SUPERVISED CONSUMPTION FACILITY
DCF: DRUG CONSUMPTION FACILITY
DCR: DRUG CONSUMPTION ROOM
SIF: SUPERVISED INJECTION FACILITY
SSF: SUPERVISED SMOKE FACILITY
MSIC: MEDICALLY SUPERVISED INJECTION CENTERS
NSP: NEEDLE AND SYRINGE PROGRAM
OPS: OVERDOSE PREVENTION SITES
Drug Consumption Spaces are professionally supervised healthcare facilities where drug users can use drugs in a safe and hygienic environment. The facility aims to reach neglected and marginalized populations, address health inequities, and resolve public health and safety tensions related to public drug use. [4]

Drug Consumption Spaces are considered an evidence-based approach of harm reduction. They are not intended to ‘cure’ addiction, but rather they are placed on a continuum from being ill to becoming well. Drug Consumption Spaces have been rigorously studied and found to reduce the spread of infectious diseases, overdose deaths, and improperly discarded injection equipment. They have been found to improve public order, increase access to drug treatment and other health services, and to save taxpayer money. [13] These spaces face additional issues as they operate with inter-jurisdictional immunity [14], and aim to assist a population viewed by many as undeserving. Although the success of Drug Consumption Spaces is founded in numerous peer-reviewed evidence based studies, these spaces are not without controversy and criticism and people still question whether these spaces are using tax dollars to enable drug use.

“A supervised consumption site is a place specifically designed for people to come in, have their injection under medical supervision, to receive training on safe injection and sterile techniques, to be assessed for any health problems that they have, to be linked with health care and addiction services if they are needed”

-Dr. Perry Kendall
Provincial Health Officer

Figure 2: Goals of a Drug Consumption Space
Creating design principles for a Drug Consumption Space is rooted in creating a ‘Culturally Safe’ design. To attempt to achieve this I have and will continue to try to understand the unique cultural climate of the drug using population of the Downtown Eastside.

Culture is defined as “the customs, arts, social institutions, and achievements of a particular nation, people, or other social group” and also “the attitudes and behaviour characteristics of a particular social group”. [15]

Cultural Safety refers to applying cultural awareness, cultural competency, and cultural sensitivity into practice without judgment. [16, 17]

There is a growing amount of research surrounding cultural safety when working with First Nations, Inuit, and Métis communities. Likewise, this way of thinking can be applied to understand the intended population of a Drug Consumption Space, and more specifically the intended individuals that resides within Vancouver’s Downtown Eastside. These communities are similar in that all face health and social inequalities, as well as marginalization. [16] To deliver services effectively, specific needs and preferences must be met. The overall goal is to treat people with dignity and respect, to ensure they will feel accepted and safe from discrimination in health care environments.

In a document written by the National Collaborating Centre for Aboriginal Health, intended for health care providers with Métis patients, they place cultural safety at the end of a continuum beginning with cultural awareness, progressing through cultural sensitivity, cultural competency and finally cultural safety. [17] Providing a culturally safe environment is critical when considering the design of Drug Consumption Spaces.

Applying these principles to the usergroup of Insite is valuable when considering their specific requirements. Aboriginal communities and the Insite usergroup have separate, multi-layered issues. There are limitations to applying this model, however it is a starting point to uncover ways of understanding the unique needs of the Downtown Eastside culture.

Cultural Awareness:
The first step in achieving cultural safety is by understanding differences and observing these differences. [18] Cultural Awareness is defined by the Aboriginal Nurses Association of Canada (ANAC) as the acknowledgment of difference. [19] The users of Insite come from a variety of backgrounds that have lead them to this community. Many have negative experiences with institutions such as hospitals and prisons that have changed the way they perceive healthcare settings.

Cultural Sensitivity:
ANAC refers to cultural sensitivity as recognizing the importance and need to respect cultural differences. “Cultural sensitivity is expressed through behaviours that are considered polite and respectful by the other” [19]. An example of this in Insite is understanding that these individuals are more than just their addiction so this should not be the only topic of interest, if discussed at all. They have hobbies, interests, and valuable knowledge to transfer. The design of Insite takes into account that the usergroup expects to operate on a person-to-person basis, meaning there are no forms to fill out or the requirement of identification cards, as few individuals in this community have ID.

Cultural Competence:
ANAC uses a number of definitions to describe cultural competence. In general it can be defined as “the focus on skills, knowledge, and attitudes of practitioners”. [19] To achieve cultural competence requires learning about that culture, being able to assess that culture, sharing in that culture, an ability to communicate between and within cultures, and an ability to demonstrate skill outside of ones culture of origin. [19] This aspect deals with the attitudes professionals operate with. As an architectural practitioner, this would mean understanding and acknowledging the experience this group has with architecture, and what they expect from architecture.

Cultural Safety:
Cultural Safety moves beyond awareness, sensitivity, and competence. It considers the social, political, and historical contexts of healthcare, challenges inequalities, acknowledges that everyone bears culture that impacts the way we operate and understand each other. [19] This means understanding issues such as the history of the Downtown Eastside, how society views drug addicts, the complicated nature of addiction, what policies are currently being applied to drug use and Drug Consumption Spaces, and how these were created. Overall, remembering that even though I am not a member of this culture, it is essential to operate with dignity, respect and compassion for this culture, as it is no less important than my own or others.
Chapter 3: goals

Visualizing a space provides the logic and understanding as to how it will operate. Currently there is no design manual for Drug Consumption Spaces. When a new site is proposed, local authorities scour ‘Google Images’ looking at different sites around the world, call other existing sites, travel abroad to visit sites, trying to collect tips for their design. [8, 20, 21] This is inefficient. Knowledge transfer is not happening. How else can we hope to improve, if we do not have a source that examines what has already taken place? These spaces already face political, social, and economic issues. An architectural manual can assist in bridging this gap and ease the process. In addition authorities that are on the fence about the implementation of such sites do not have a resource that provides knowledge of what the space will look like, which shows the hygienic and supervised nature of Drug Consumption Spaces, something that is required before they commit.

The intention of this graduation project is to compile a design manual through cataloging existing sites, discussions with involved parties, and applying existing research. The focus will be primarily on Insite as it operates within the Canadian Government’s rules and regulations and already applies many design principles regarding Cultural Safety in an effort to reduce barriers. Through engaging with authorities who run these spaces, with the staff that maintain the space, and with users who have specific requirements, it is possible to translate this knowledge into an architectural resource tool for the design of Drug Consumption Spaces.

These guidelines may then be applied at many scales on a continuum. At one end is an intervention such as furniture in an alley way that provides the basic requirements for this unique user group. Next on the spectrum is tent or mobile unit for delivering services. Further along is a consumption space embedded in an existing service or residential complex. The manual could be applied to a separate consumption facility, similar to Insite, or a purpose built facility. Finally, it could be applied to the next harm reduction paradigm, providing prescription opioids in a designated facility.

There seem to be few people fighting for destitute individuals, like those of the Downtown Eastside drug consuming community. There are even fewer professionals from the world of architecture and design working within this community. These are our society’s most marginalized citizens and therefore they should be considered of utmost need and attention.

Architecture and design thinking processes are unique in that they can provide immediate and long-term planning to address issues at different scales from standalone buildings to an entire system to deliver services.

I am optimistic that as interest in addiction, mental health and harm reduction grows, as new ways of thinking and communicating shed light on these issues, as more research and engagement brings awareness to the necessity of action, more and more expert attention from all fields, including architecture, will be turned the long-neglected social problems and challenges faced by the Downtown Eastside drug consuming population, including Drug Consumption Spaces.
PART II: INSITE

Immersing in Vancouver’s Safe Injection Site

Chapter 4: Overview
Chapter 5: Programmatic Elements
Chapter 6: In Vancouver

“It has a roof, it is temperature controlled, there is a sink with running water and soap, compared to the situation that the drug users in this area have to endure in the alleys. This is like a journey from the third world to the first world.”

- Darwin Fisher
Coordinator of Insite

What is Insite?

Why is Insite located where it is?

Who are the individuals who use Insite? What do they do there? When do they go there and for how long?

What are the programmatic elements of the space? How do these spaces operate and how well?

What is the status of Drug Consumption Spaces in Vancouver today?

Figure 4: Street art in the Downtown Eastside inspired by the overdose crisis. Created by local artist, Smokey D
Chapter 4: overview

“\textit{I dislike strongly that anything about this site is a secret. It is immoral not to share everything}”
- Darwin Fisher
Coordinator of Insite

Receiving a tour of Insite greatly clarified my thesis, my outlook on the population, and my actions and research moving forward. My first experience of visiting Insite was not the same as touring the facility.

\textbf{Inquiry: Thursday, February 16th, 2017}
I requested to visit Insite but due to the overdose crisis they were understandably too busy to accommodate me.

\textbf{Dropping by: Monday, March 13th, 2017 at 1:43pm}
I had seen Insite from the street and had read about it, but I had never actually entered the facility. My first perception and observations is that Insite is not a place any ‘well’ person would ever want to feel required to visit. Upon entering the dark-teal wooden door, on the right is an open area with hardwood floors - almost appearing like a small dance studio off duty. No dancers are found, only eight addicts strewn about in various positions including sitting, crouching, lying down, fully spread out, or in a fetal position. One woman stood balancing her leg against the wall while another man appearing in agony on the floor was propped up on one elbow. At first glance, it seems apparent that this is not a social place. People are sitting apart from one another, sunk in thought, many are visibly anxious and impatient. I inquired at the front desk about the possibility of a tour, and left.

\textbf{Tour: Tuesday, March 28th, 2017 at 8:18am}
I later came to understand that my initial assumption of Insite appearing anti-social is not the case. The patients of Insite, which the facility terms ‘participants’ deeply care about each other, the staff, and have a great respect for the space itself. The tour took place before opening hours and was lead by Darwin Fischer, the Coordinator of Insite, employed by Portland Hotel Society. He has worked at Insite for nearly fifteen years. Fischer is enthusiastic, candid, articulate, and highly knowledgeable. Fisher states, “I’m just a middle-class boy from Saskatchewan”. He intends this to mean that he is not a doctor or a nurse, nor is he a ‘trained’ mental health or addictions professional, he is a person that is able to engage with anyone and everyone using accessible language with relatable stories. It is evident during my tour that staff and visitors alike share in their fondness for Fisher. Fisher paints a compelling and vivid picture of what life is like for the population of the Downtown Eastside and their experiences accessing health care. I got the impression that he could talk about this subject, with the same passion and dynamism, for days.

The space is in huge demand. Even before it opened at 9:00am, people were lined up along Hastings Street eagerly waiting to enter the building like it was the best new restaurant. It was raining in large, overwhelming quantities. There is no awning or seating outside, the ground is littered with garbage, and it’s loud from the rush-hour traffic. No restaurant in the world would stand to keep this kind of crowd under these conditions. Yet people remain there steadfastly, likely more affected by their discomfort of waiting to get their fix, than the unpleasant environmental conditions that I immediately notice.
Insite overview

Insite has a ‘horseshoe’ layout with three main areas: Pre-injection, Injection, and Post Injection. Individuals enter in one door, complete the U-shape and exit through a different door. As it exists today, only injection drug use is permitted in Insite and exclusively inside of the Injection Room. Insite was originally intended to house a smoking facility in addition to injection, and although this it much needed, it has yet to be fulfilled.

Insite, which opened in 2003, was the first legal Supervised Injection Site in North America. It is located in Vancouver’s Downtown Eastside, arguably the epicenter of drug use in Canada. This area has a high concentration of socio-economic issues, including homelessness, income inequality, unemployment, and public drug use. Insite provides an indoor space, and sterile injecting equipment for people to more safely inject previously obtained drugs under the supervision of staff. Along with counseling and links to housing and drug treatment programs, there is a comprehensive overdose response system, oxygen tanks, access to support services and an on site detox facility, Onsite.

Insite along with Dr. Peter Centre, which has a much smaller injection room for individuals with HIV embedded within their facility, and most recently some Overdose Prevention Sites implemented since December 2016, remain North America’s only Drug Consumption Space. Insite is co-managed by Vancouver Coastal Health and the Portland Hotel Society. Portland Hotel Society has had a deep connection with this group for many years. In 2002, the Portland Hotel Society found the location. The space had previously operated as a sandwich shop for twenty years prior, with an apartment on the second floor and eighteen single rooms on the third floor. Originally, Portland Hotel Society spent $30,000 to renovate the space to create a mock-up of what the space could actual look like. They installed six booths with mirrors, some sinks and low-level lighting. The space did not yet have approval so it was code named ‘the hair salon’. Once the mock up of the site was finished, they then went to seek approval.

Establishing Insite was a result of the efforts of many individuals from numerous backgrounds. Larry Campbell, the Chief Coroner at the time, Phillip Owen, the Mayor of Vancouver at the time, the previous founders and leadership of Portland Hotel Society: Liz Evens, Mark Townsend, and Kirsten Stuerzbecher, Ken Frail from the Vancouver Police Department, Dean Wilson and Shelly Tomic, the drug users who took the case to the Supreme Court and “just decent human beings”.[12]

In 2006, after the three year testing stage was over, there was a change in the Federal Government to Conservative leadership so “the game became not expansion, but survival at that point”.[8]

From 2006 - 2011 there was a series of legal battles ending in the Supreme Court of Canada. The main argument for keeping Insite open was that the alternative of denying drug users access to health services at Insite would violate their rights to life, liberty and security of the person under section 7 of the Canadian Charter of Rights and Freedoms. In summary, the federal government immediately appealed the Court’s decision, and the Portland Hotel Society and two Insite users cross-appealed the judge’s dismissal of the claim to exclusive provincial jurisdiction. Then in 2011, “all nine judges of Canada’s highest court ruled unanimously that attempts by the federal health minister to close Insite went against the country’s charter of rights by threatening the safety and lives of the people who need to use it”.[22]

To date, Insite has housed 3,476,722 injections by 18,093 registrants. There have been 4,922 overdose interventions. On average there are 700 visits/day. No deaths.
The overall objective of Insite is to create a community space that happens to have clinical supports. Insite aims to be a safe harbour from the street. “We have to let people do anything they would normally do outside, or they are not going to come inside.” [8] What this means for the mostly homeless user group is that anything from umbrellas, suitcases, shopping carts, bikes, or even dogs are welcome and accommodated without hesitation.

This is based on an average. There are likely spikes in usage during ‘cheque week’ when welfare cheques are distributed.

*Note: This information is provided by Google. As stated by Google, “to determine popular times and visit duration, Google uses aggregated and anonymized data from users who have opted in to Google Location History.” It should be considered that many users of Insite do not have devices with location history capabilities. Therefore it is possible that this data is incorrect and possibly data is confounded with staffing numbers.
On average a person visiting Insite spends 1 hour in the facility.

There is no time limit at the injection booths which is problematic in a homeless population who have no where else to go. This may be the only clean, dry, warm, and nonjudgmental place they will be in all day.

Insite is operating over full capacity with wait times getting longer. There are 13 injection booths and the space sees on average 700 people per day; sometimes upwards of 1300.

Many individuals visit the site multiple times per day to inject or access other services. There is no limit to the number of times per day an individual can use the space. On average regular visitors use the facility twice per day. Some individuals may choose to use drugs exclusively at Insite, while others may use drugs both inside and outside of the facility for various reasons. [8]

At Insite, people are not consuming the “fun party drugs” like LSD or MDMA. They are using survival drugs for “pragmatic reasons”. Opioids: Heroin, morphine, dilaudid, and fentanyl are all pain relievers. 60-65% of individuals at Insite use these drugs. Drug users describe how these drugs help them negotiate their existence that may otherwise be intolerable. Heroin takes away physical pain and takes away mental anguish. The other category of drugs is stimulants, making up 30-35% of the drugs consumed at Insite. Individuals in the Downtown Eastside community may choose these drugs because they are malnourished. On stimulants, “you’re going to eat less, you’re going to sleep less, and you’re going to be able to move. It may give you feelings of confidence and they have anesthetic qualities, for example cocaine was previously used by dentists”. [8] However, the more used stimulant in this area is Crystal Meth (methamphetamine). This is “the boogieman drug” as it leads to many gruesome ailments that affect a users physical appearance. Most famously is ‘meth mouth’. Fisher stated, “it’s the pornography of addiction”. [8] Crystal Meth is not chemically much different than the “study drug”, Adderall. [8] This demonstrates a bias in the way society views drugs depending on the population: students at the University of British Columbia or drug addicts of the Downtown Eastside. Although both are technically using ‘Speed’ for utilitarian purposes, one group is able to occupy the architecture on campus and applauded for their hard work, while the other is confined by complete poverty and ostracized.

**Figure 8: The Average Visit**

- Post-injection: 21%
- Injection: 54%
- Pre-injection: 25%

**Figure 9: Substances Reported**

- Heroin: 54%
- Methamphetamine: 23%
- Cocaine: 10%
- Other: 13%

*Note: This information was provided by the Insite Coordinator but is assumed to be approximate. [8]*

Insite is solely an injection facility, drugs cannot be smoked, inhaled or consumed in any other way. It should be noted that Insite does not ask to see or test an individual’s drugs. It is completely based on self-disclosure.
location

Drug Consumption Spaces are very place specific, effective only when they are located within the population of drug users. [8, 12, 20, 23]

In Vancouver, the Downtown Eastside has a unique history in Canada. Although it seems hard to imagine today, about one hundred years ago, the Downtown Eastside was the heart of Vancouver. [21] This is apparent by the ornate buildings, many now in disrepair, that line the streets of the area. Interestingly the area has completely reversed itself on the economic and social scale today.

The drug consuming population in Vancouver is a relatively localized community. The largest open-air drug market in North America occurs just down the street from Insite at the intersection of Main Street and Hastings Street. [24] The population of drug users in Vancouver is largely located in this area along the 100 and 200 blocks of Hastings, making the location of Insite ideal to serve this community.

The Downtown Eastside is where the poorest people in urban situations live and residents rarely leave the four-block radius. “For many of Vancouver’s chronic, hard-core addicts, it’s as if an invisible barbed-wire barrier surrounds the area extending a few blocks from Main and Hastings in all directions. There is a world beyond, but to them it’s largely inaccessible. It fears and rejects them and they, in turn, do not understand its rules and cannot survive in it.” [3] Public health authorities working within the Downtown Eastside must wage many battles at once: among them, poverty, homelessness, addiction, mental and physical illness.

In 2016 an unprecedented 914 individuals died in British Columbia from overdose related deaths. [6] In response to this, in December 2016, the BC Health Minister, Terry Lake, decided to open up other injection sites in Vancouver. [25] The population of drug users in Vancouver is largely located in this area along the 100 and 200 blocks of Hastings, making the location of Insite ideal to serve this community.

Although unmapped, Fisher believes that a great deal of the overdoses occur between Gore and Abbot, and between Pender and Water Street. Interestingly Fisher discussed that the year’s total of overdose interventions at Insite equals the total that occurred within the nineteen housing projects that the Portland Hotel Society manages. He described that this isn’t because Insite is poorly located, it is because there are at minimum 2000-6000 intravenous drug users in the area but Insite only can only accommodate 13 booths. [8] This logically means that Insite is too small and is faced with overcapacity, reducing the ability for Insite to more efficiently serve the highly localized population.

Vancouver has some of the most expensive real estate in the world. The ideal location for the space is likely very costly. According to Fisher, the health authority has applied to open two Supervised Injection Sites further east near Oppenheimer Park. Fisher stated, “This is part of a larger strategy to shift this population eastward as gentrification and real estate prices go up. I do not even believe this is cynical, this is just the way the world works. If we are going to sink millions into infrastructure costs we do not want to be doing that in a place that in ten years may not have this population here anymore. It is a complicated question but the fact is that now, in the middle of an unprecedented crisis here and elsewhere, they are investing in services that aren’t even going to reach the population, which is just sad.” [8]

Drug Consumption Spaces can experience major push-back from neighbors and the community at large. A main concern by neighbors of future Drug Consumption Spaces is that it will draw people into their neighborhood with drug addiction. The public fears that by creating a safe area to consume drugs, people will come to their area to use drugs, therefore increasing related crimes. Another concern is that providing a legal space to consume drugs will encourage people who would otherwise not use drugs to decide to. This has been researched and is found to be an unsubstantiated concern. As Fisher describes, “At Insite, this “honey-pot effect” meaning people gravitating towards the area because the space exists, has not and is not occurring”. [8] He went on to describe how this concern largely ignores the realities of addiction, particularly in this area. Drug withdrawal is described as a crisis of despair. When humans are in a state of despair “it is not in our nature to take two bus rides to get that taken care of”. [8] People tend to use in proximity to where they obtain the drugs.

“Every city has to adapt to their unique drug scene”
- Cedric Charvet
Co-ordinator of Amsterdam DeRegenboog Groep AMOC

“For many of Vancouver’s chronic, hard-core addicts, it’s as if an invisible barbed-wire barrier surrounds the area extending a few blocks from Main and Hastings in all directions. There is a world beyond, but to them it’s largely inaccessible. It fears and rejects them and they, in turn, do not understand its rules and cannot survive in it.”
- Gabor Maté
In the Realm of Hungry Ghosts: Close Encounters with Addiction
People’s needs and wants frequently determine their choice of daily occupations. For individuals with drug addiction, time often revolves around a series of occupations supporting a need to obtain drugs.

The addict and addiction issues are redolent of crime, punishment, disgust, fear, and stigma. Unsurprisingly, addicts will never be a magnet for general social concern, or the funds needed to meaningfully address their plight and they are usually too ill and too poor to self-advocate [25]. Society often views this usergroup as undeserving of help. Their sufferings are made worse everyday by social ostracism. Further, marginalization means that this population is often ‘invisble’ to society in any city; however, the creation of Insite meant an acknowledgment that this population exists.

The Downtown Eastside has been painted by the media and many locals as “the pit of hell”, where its issues are clear among its “four blocks of hell”. [26] The user group of Insite is highly localized: 90% of the usergroup of Insite are from the population that resides within the four-block radius of the site. [8] Although everyone is welcome, only a small percentage of individuals visit from outlying areas and only a very small portion of higher socioeconomic individuals may choose to use at Insite for safety reasons. The majority of people in this group however, will use in their own living spaces, which is incredibly risky. Addiction looks different at every point on the socioeconomic scale. At the higher end addicts can appear high functioning, they can afford clean tools, can inject in the privacy of their home or clean environments, and have access to services. At the other end are addicts who lack access to basic resources like shelter or food. [8]

The Downtown Eastside or “Canada’s poorest postal code” as it’s commonly referred to [12], is filled with a community of individuals who are Canada’s castoffs. [9] Previous to ‘choosing’ to live in the Downtown Eastside, many of these individuals faced, and continue to experience a great deal of trauma: physical and sexual abuse, intergenerational poverty, stigmatized for issues of gender or sexuality, family trauma, mental health issues, “there are an abundance of reasons individuals end up living among this community”. [8] Addiction makes seeking and maintaining medical treatment a challenge. Severe drug addicts, like the individuals Insite serves, frequently place their health and wellbeing as less important, than their drug driven needs of the moment. Individuals are in such poor health and yet they are often averse to taking care of themselves. They may be so focused on their next ‘hit’, that caring for themselves is not the priority. Gabor Maté, a former doctor in the Downtown Eastside for twelve years, and author states, “In a real sense, addiction medicine with this population is palliative work. We do not expect to cure anyone. Only to ameliorate the effects of drug addiction and its attendant ailments and to soften the impact of the legal and social torments our culture uses to punish the drug addict”. [3]

Drug use is not the only problem, many drug users suffer from drug related injuries and illnesses, both physical and mental. In addition, frequently individuals are addicted to more than one drug. However, at Insite users can only use intravenous drugs, there is no inhalation or alcohol consuming, complicating the problem further.

This situation is made even more difficult as these individuals have real and perceived barriers and mistrust in the system as it stands. They often mistrust authority figures and fear institutions. The intended user group of Drug Consumption Spaces have specific needs based on their previous experiences with institutions, their expectations of the space, and their perceived barriers to use, must be understood in order for individuals to want to use the services at Insite. Designing for this usergroup means acknowledging their needs, expectations, and experiences and ensuring that he or she feels secure rather than alienated.

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This population is “among the sickest, the neediest and the most neglected of any population anywhere. All their lives they’ve been ignored, abandoned and, in turn, self-abandoned time and again”

- Dr. Gabor Maté

In the Realm of Hungry Ghosts: Close Encounters with Addiction
Chapter 4: programmatic elements

Overall Insite maintains a 'horseshoe' layout consisting of three main areas: Pre-injection, Injection, Post-Injection. Individuals enter in one door on Hastings Street, complete the U shape and exit through a different door on Hastings Street.

There are specific design requirements of Drug Consumption Spaces. For example: from the end of the hand rail on the ramp, the edges of the chairs, the wooden front desk and nurses station, the stainless steel injection booths, to the table in the chill-out room area, all of the edges in the entire space are rounded. This prevents additional injury in the incident of someone falling or in an overdose emergency.
diagrams: program

- coffee
- chill-out room
- wc
- exit
- office
- clinic
- storage
- office
- staff wc
- staff room
- office
- staff patio
- office
- waiting area
- reception
- nursing station
- injection room
- clinic
- staff wc
- staff room
- staff wc
- staff patio

main programs

- pre-injection
- injection
- post-injection
- offices, staff areas, services

sequence / time

- pre-injection
- injection
- post-injection

0 15mins 30mins 45mins 60mins

Figure 13: Program diagrams of Insite

diagrams: elements

threshold

- doorways
- desks separating staff/visitors
- partitions between booths

security apparatus

- video camera
- video camera monitors
- panic button
- blue light activated w/ panic button

surveillance

- staff
- visitors
- windows
- mirrors

Figure 14: Elements diagrams of Insite
1. Entry: Enter from Hastings Street. The reception area is clean and orderly. The space is flooded with an abundance of natural light. There is no treatment or covering on the windows such as frosting or blinds, making the space completely visible from the outside and inside out. The ceilings are high and the space feels open. Allowing the space to maintain an open concept is beneficial for the staff in terms of safety or to see if anything requires attention, and also for the users who may be suspicious or wary to use the services inside. Unlike other clinics or hospitals, there are no security personnel outside or inside the facility. This type of security can be an exclusionary force for this population. As Fisher stated, "that’s going to cut down on about fifty percent of your visits from the most marginalized people". [8] A large majority of the users of the space are unhoused meaning they come with large amounts of personal items including shopping carts, dogs, suitcases etc. that they unpack into the large area between the reception and the door. There is a ramp from the front door to the reception area, making the space universally accessible, which is important for people with mobility issues, shopping carts or bikes.

2. Reception Desk: The reception desk is 25 feet away from the front door making it difficult to manage and greet the people coming in. Space is important for safety, possibly more so for the addict who may be feeling uneasy or nervous or in crisis while waiting to inject. The front desk has harm reduction supplies freely available on the counter, so if individuals are unable to wait, they can still have hygiene equipment. From the reception desk staff can see the waiting area, the door, as well as into the post-injection area as their adjoining wall has a large window.

3. Intake Process: The intake of any hospital or clinic is usually very busy and highly demanding. In a typical clinic, the receptionist or nurse is trying to take people in as quickly as possible. Patients are usually presented forms on a clipboard and asked information that is entered into their database. "If you have literacy issues, if you have been awake for days, if you don’t speak well, if you’re nervous around bureaucracy.... I promise you, you’re not going to ask for help, you are going to take the clipboard outside and I’m going to leave". [8]

In contrast, at Insite the users of the space are referred to as "participants". The word ‘participant’ is defined as a person who takes part in something. Synonyms include contributor and member meaning that the usergroup is seen as an integral contributor to the success and function of Insite. The term also implies the agency and equality of individuals within the space. In addition, intake does not take place at a busy desk. Instead new visitors meet one-on-one with staff. They discuss whether Insite can serve them specifically, what services are offered, the Health Canada guidelines for the space, and staff explain how the space operates.

The guidelines explain that the injection room is the only place in the building where it is legally acceptable to inject. There is no exchange or sale of drugs permitted anywhere. Users are then invited "to participate" with Insite. It is emphasized to participants that "the most important thing that you need to bring to the site is tolerance. Tolerance for your fellow users, for the staff. Tolerance is what makes that place roll". [8]

Participants are then asked to choose a code name. They are not asked for ID as few people in this area have ID. "People get to almost pick their own identity when they choose these names". [8] Once a code name has been chosen, this is the only name an individual is referred to for the duration of their visits going forward, unless they decide to change their name. Sometimes people are asked for an additional identifier such as a name or birth date in case individuals forget their code name. If the participant is unwilling to give other information, they are not pressured to do so because this is about "getting people into a lifesaving service". [8]

It is important to understand that people visit Insite for a variety of reasons: injecting, see a nurse, talk to a peer worker, inquire about detox or other services, and sometimes simply as a place to meet friends. It is a multidimensional resource. All of these visits get recorded.

4. Waiting Area: After checking in at the desk, participants then wait about 10 minutes. The waiting room experience in a typical health care facility can be intimidating. Often it is crowded, people are sitting in close quarters, there is a mixed population with a wide diversity of needs. At Insite, loose chairs are located around the periphery of the space, or participants can sit as they choose on the floor.

A staff member then opens the door to the Injection Room and invites the ‘participant’ in by code name.
pre-injection:

in an emergency staff have a place to go

there is no glass between staff and visitor (photo of Crosstown Clinic)

no security guard is outside (photo of Mobile Medical Unit)

what's your code name?

koolhaus

counter depth is larger than an arm span to prevent harm to staff

harm reduction tools are available in case a visitor can’t wait

front facade has full visibility inside

Figure 16: Section diagram of the pre-injection space
The space itself is set up with injection booths, like voting booths, along one wall, with a nurses station on the other side. The design of the injection room is referred to by Fisher as “the hair salon”. [8] It intentionally does not look like a blood testing clinic or an operating room. It does not resemble an experience in a healthcare setting. The ceilings are high (at least 10 feet high), exposed, and painted black. The lighting is low and the fixtures are not from a hospital catalogue; some are pendant style while track lighting is used above the booths. There is always music playing, “they are usually playing classic rock”. [8] All of these design considerations set the mood and create an environment that people actually want to go to, and spend time in.

1. Before Injecting
From the waiting room you cannot see inside the Injecting room, only the black door that encloses it. This door is left closed, and only opened when a spot becomes available. A staff member then calls the participant in by their code name inviting the participant into the injection room, from the waiting room.

For a first time visitor, they are then introduced to the space in a welcoming way. It is recommended that the participant wash their hands and the importance of hand washing is explained, but they are not forced to as they want people to feel comfortable before suggesting best practices.

Then the participant is asked what they are using. “You might say: “down and side” and that means heroin and crystal meth”. [8] This process is based on self-discloser. Staff do not ask participants to see or test their drugs. This is an important aspect of developing trust with participants. “We take you’re word for it”. [8] This information is then entered into the database and a booth is assigned.

Participants are then shown the various injection equipment available. Tools such as “Rigs (syringes), filters, tourniquet, cookers, alcohol swabs, etc.” are located on the desk of the nurse’s station. The participant is introduced to the nurses and then staff will say “if you need me, let me know” and sits down. [8] This demonstrates again how the staff are operating with dialogue rather than dictating. Everything is done to humanize the experience and reduce the institution environment as much as possible. “The point is not to get in your face, if we do that on someone’s first visit, people will never want to come back”. Overtime trust is developed, peer-workers and staff will develop relationships with participants and offer support.

2. Injecting booths:
After obtaining the required tools, the participant then walks over to the booth and sits down on a sturdy, black plastic chair. The chair has smooth corners, armrests on both sides, without cushions. The injection booth itself is about 4 feet wide. Each booth is separated by partitions.

The injecting area is subtly warmer than the other areas of the building, allowing bodies to be relaxed and veins to be more easily located.

Nurses are not permitted to physically assist in the injection itself, only provide instruction. Throughout the injection process, users can learn best and safer practices. This is especially important for women, as women usually do not inject themselves. This can also be empowering for women as they can now control the angle, pressure, and hygiene of the injection themselves.

3. Clinic (optional)
The clinic is located in a separate room adjacent to the Injection Room. If a participant has a health concern, there is no appointment required - something that is essential when dealing with a population whose schedule and life are unpredictable and transient.

4. In the Event of an Overdose Incident
In the event of an overdose incident, there is an adjacent storage room that houses emergency equipment such as oxygen tanks and Narcan. In addition, there is a substantial space between the booths and the nurses station to allow enough room for an individual to lie down and be treated.

There is no time limit (within reason). Participants can head to the ‘chill-out’ room at anytime.
Figure 17: Injection Booths showing lightings, ventilation, materiality of floors, booths, partitions, walls, and ceiling.

Figure 18: View from the Nurses Station looking at the injection booths. From this location nurses can observe the participants in the injection booths. Necessary injection tools are located on the desk.

Figure 19: Nurses Station from the participant’s location. Participants collect the required equipment such as syringes, cookers, alcohol wipes, and filters before going to their assigned booth.

Figure 20: View from the Nurses Station looking towards the entrance door.
Individuals can choose to have a visit with nurses, staff, or peer workers. In the event of an overdose, emergency equipment such as oxygen and Narcan are stored inside. Mirrors are used by staff to see participants and by participants to see people behind them. Surfaces must be sterile and easy to clean.

Dark ceilings, music, and low lighting make the environment less clinical. Harm reduction tools: rigs, cookers, filters, alcohol swabs etc. Figure 21: Section diagram of the injection space.
**the design: post-injection**

The ‘chill-out’ room is the last stop. The space is lit by the same, non-clinical, pendant lights as the injection room. On one side of the space is an interior window with direct views to the reception desk. The art on the walls is created by local artists and users of the space. There’s a message board with current events. None of the art or posters speak to abstaining from drug use. There is a single occupancy bathroom located in this area.

The chill-out space is the location where social relationship can occur. In this space participants have already got their ‘fix’, so they are less anxious, creating an opportunity for conversations with staff, peer-workers, and other participants if they desire.

The chill-out room is often manned by Brian Allenye, a peer worker at Insite and activist and former drug addict. Allenye is outgoing, personable, direct, and speaks from the heart about the lasting impact Insite has had and continues to creates in this community and to him personally. [28]

1. **Coffee and Juice**
   
   In the corner, against the exterior window is a bar area where Allenye serves coffee and juice.

2. **Seating**
   
   There is a stainless steel picnic-style table with adjoining chairs that are fixed to the ground. There are a few chairs that line the periphery of the space.

   Similar to the entry, there is a ramp towards the exit, providing universal accessibility.

   Participants exit to Hastings Street.

---

**TIME SPENT:**

15 MINS

**Architectural elements achieved and desired:**

- openness
- surveillance
- removing barriers
- safety
- privacy

“I feel very, very, very, fortunate to have this job. Although I’m not an addict anymore, when I got hired here I was a full blown addict. Who else is going to hire me? - Brian Allenye

Insite peer worker and activist

“Collect them before you direct them”

- Dr. Gabor Maté
Peer workers run the coffee/juice area, creating personal connections.

For surveillance, there is visual access from the reception area to the chill-out room.

Like the injection room, the dark ceiling and lighting make the space feel less clinical.

Ramps throughout Insite allow universal access.

Surfaces must be sterile and easy to clean.

There is a bulletin board for local events. All of the art on the walls is by local artists or Insite participants.

For surveillance, there is visual access from the reception area to the chill-out room.

Figure 24: Section diagram of the post-injection space
Chapter 5: in Vancouver

When first conceived, the intention of Insite was that it would be expanded in the future. This has not happened. In 2016 alone 914 people died from drug overdoses. This was the largest number in the three decades of record keeping. [6] This epidemic has resulted in an effort at all levels of government to mitigate the situation.

End of September, 2016: The Federal Health Minister, Jane Philpott along with Vancouver Kingsway MP, Don Davies asked fellow officials at the House of Commons to amend the former Conservative government’s legislation preventing more Supervised Injection Sites to open. [29]

Early December 2016: At the provincial level, BC’s Health Minister, Terry Lake, passed a ministerial order that allows B.C.’s Emergency Health Services and local health authorities to create Overdose Prevention Sites as they see fit, and staff them on an emergency basis. He stated, “We are seeing an alarming increase in illicit drug overdose deaths and action is required at all levels to saves lives.” He went on to say: “The overdose prevention sites will ensure that people have a place where they can be safely monitored and treated immediately if they overdose”. [7] Despite lack of federal approval, seven Overdose Prevention Sites were opened in BC: One in Surrey, one in Victoria, and five in Vancouver.

Mid December, 2016: At the federal level, the Liberal government announced the Canadian Drugs and Substances Strategy, a “new comprehensive drug strategy”. “The new Strategy will replace the existing National Anti-Drug Strategy with a more balanced approach. It restores harm reduction as a core pillar of Canada’s drug policy, alongside prevention, treatment and enforcement and supports all pillars with a strong evidence base”. [30] In addition they introduced Bill C-37. The bill facilitates the creation of additional supervised injection sites by reducing previously established restrictions. Specifically the bill would support the strategy by amending the Controlled Drugs and Substances Act, the Custom’s Act and the Proceeds of Crime and Terrorist Financing Act. This has resulted in applications for sites from the Alberta, Ontario, and Quebec governments.

Mid December, 2016: The City of Vancouver voted and approved a 0.5% property tax increase to help fund its fight against the drug-overdose crisis in the city. This increase “amounts to an extra $1.1 a year for owners of a single-family home, $4 for condo owners, and $19 for people who own an average commercial property”. Although this sounds like a minor charge, there was significant opposition. The tax will generate an additional $3.5-million to go towards more resources to deal with the fentanyl overdose crisis. [31]

Mid February, 2017: Mayor Gregor Robertson called for all social housing to contain a safe injection site stating “There’s been far too many deaths, and with 90 per cent indoors, they have to enable [single-room-occupancy hotels] and low-income housing to set up rooms to keep people alive.” [32]

Today: In Vancouver today, there are the mentioned Safe Injection Sites: Insite and Dr. Peter Centre. In addition there are six Overdose Prevention Sites - in the form of tents, trailers, or embedded within other services. There was also a mobile medical unit but it closed early April, 2017.

“I’ve made it very clear to my department that there should be no unnecessary barriers for communities who want to open supervised consumption sites.”
- Jane Philpott,
Federal Health Minister

Figure 25: Map of Drug Consumption Spaces in Vancouver

1. Insite (139 E Hastings Street)
2. Dr. Peters Center (1110 Comox Street)
3. Crosstown Clinic (84 W Hastings Street)
4. Overdose Prevention Society (62 E Hastings Street)
5. Maple Hotel (177 E Hastings Street)
6. VANDU (380 E Hastings Street)
7. Drug User Resource Center (DURC) (512 E Cordova Street)
8. Livingroom Drop-In/ Powell Street Getaway (528 Powell Street)
9. Healthy Integrated Health Center (330 Heatley Avenue)
### Table of Clinics in Vancouver

<table>
<thead>
<tr>
<th>Name</th>
<th>Type</th>
<th>Address</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insite</strong></td>
<td>Stand alone - renovated building</td>
<td>139 HASTINGS ST E, Vancouver, BC V6A, Canada</td>
<td>Operated by Portland Hotel Society. 9am-3am, 7 days/week (previously 24 hours/day on Wed/Thurs/Fri of cheque week)</td>
</tr>
<tr>
<td><strong>Dr Peters AIDS Foundation</strong></td>
<td>Embedded</td>
<td>1110 Comox St, Vancouver, BC V6E 1K5, Canada</td>
<td></td>
</tr>
<tr>
<td><strong>Crosstown Clinic</strong></td>
<td>Stand alone clinic for select patients</td>
<td>84 W Hastings St, Vancouver, BC V6B 1G8, Canada</td>
<td>The clinic is currently at capacity and closed to admissions. This is only clinic in North America to offer medical-grade heroin (diacetylmorphine) and the legal analgesic hydromorphone within a supervised clinical setting to chronic substance use patients.</td>
</tr>
<tr>
<td><strong>Mobile Medical Unit</strong></td>
<td>Mobile Unit</td>
<td>58 W Hastings St, Vancouver, BC V6B 1G4, Canada</td>
<td>Mobile Medical Unit - Vancouver - Closed April 2017</td>
</tr>
<tr>
<td><strong>Overdose Prevention Society Trailer</strong></td>
<td>Mobile Unit</td>
<td>62 E Hastings St, Vancouver, BC V6A, Canada</td>
<td>Operating since September 21, 2016. 10am-10pm - 7 days per week</td>
</tr>
<tr>
<td><strong>Maple Hotel (alley)</strong></td>
<td>Tent</td>
<td>177 E Hastings St, Vancouver, BC V6A, Canada</td>
<td>Operated by Portland Hotel Society. 12 noon-10pm - 7 days per week</td>
</tr>
<tr>
<td><strong>VANDU</strong></td>
<td>Embedded</td>
<td>380 E Hastings St, Vancouver, BC V6A 1P4, Canada</td>
<td>10am-10pm - 7 days per week</td>
</tr>
<tr>
<td><strong>Drug Users Resource Centre (DURC)</strong></td>
<td>Embedded</td>
<td>412 E Cordova St, Vancouver, BC V6A 1L6, Canada</td>
<td>10am-4pm - 5 days per week</td>
</tr>
<tr>
<td><strong>Portland Hotel Society</strong></td>
<td>Embedded</td>
<td>528 Powell St, Vancouver, BC V6A 1G9, Canada</td>
<td>12 noon-8pm - 7 days per week</td>
</tr>
<tr>
<td><strong>LivingRoom Drop-In / Powell Street Getaway</strong></td>
<td>Embedded</td>
<td>330 Heatley Ave, Vancouver, BC V6A 3G3, Canada</td>
<td>Proposed sites for public supervised injection services</td>
</tr>
<tr>
<td><strong>Heatley Integrated Health Centre</strong></td>
<td>Embedded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Washington Hotel</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DTES Market</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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"Evidence shows that overdoses and deaths due to opioid use are increasing in Canada. It also shows that policies and interventions that focus on harm reduction work. Canada’s new drug strategy will take a public health focused, evidence-based approach to save lives and improve the health of Canadians."

- Dr. Gregory Taylor  
Canada’s Chief Public Health Officer
Figure 27: Dr. Peters Center - Injection Room

Figure 28: Crosstown Clinic - Pharmacy Counter and Injection Room

Figure 29: VANDU - Injection Room

Figure 30: Overdose Prevention Society - Injection Trailer

Figure 31: Vancouver - Overdose Prevention Tent

Figure 32: Vancouver - Overdose Prevention Tent
What do you call a Safe Injection Site for alcoholics?“

“A bar”

- Dean Wilson
Activist, Insite Participant

What is a Drug Consumption Space?

What precedents and building typologies can be explored to uncover how to effectively design Drug Consumption Spaces?

What are key elements that need to be achieved?
Chapter 7: finding precedents

Virtually all buildings are built to serve some human purpose, even if it’s simply to keep the rain off your head. Very primitive, perhaps uninteresting buildings still have an objective.

The building typologies of structures such as prisons, churches, or coffee shops are well established. We know what they are supposed to look like, feel like, what they are supposed to do for people, including who can occupy each space, and how they can move and conduct themselves within it. Although there are some building typologies such as hospitals, hospices, prisons, first aid stations - that can be seen as contextually associated with Drug Consumption Spaces, the sites are unique in the range and type of architectural challenges and opportunities posed by them.

The main purposes of Drug Consumption Spaces are: providing a supervised space to consume drugs as a harm reduction approach, providing users of the space access to resources and required supports, as well as providing a platform to research addiction and the delivery of services. [35] A Drug Consumption Space must be effective in providing life-saving intervention in the event of a visitor’s overdose or possibly fatal reaction to an unknown substance, and it should be capable of providing or arranging a range of support: housing, work, legal aid, basic financial assistance, as well as counseling, and access to treatment. The structure must address security issues at its entrance and exit and also the physical safety of both staff and participants within it. But the provision of security must not compromise the maintenance of an environment supportive of mutual trust between staff and participants. Finally, Drug Consumption Spaces are an invaluable source of data for epidemiologists, neurologists, geneticists, and psychiatrists in their ongoing efforts to further scientific understanding of addiction and the most effective ways of preventing and treating it. Effectiveness and efficacy in design is essential to facilitate these intended objectives.

An investigation of the history of programs germane to Drug Consumption Spaces through time sheds light on their relevance to architectural discourse today. The history of hospital or insane asylums have demonstrated that architecture has a way of addressing questions of public health through different types of programs and structural design. For example, the fight against tuberculosis in the early 20th century created a new focus on cleanliness, hygiene, fresh air, and sunlight. [33] These requirements resulted in many of the distinctive modernist architectural features. Drug Consumption Spaces still remains a new and undefined building typology providing opportunity to further the understanding of the spatial possibilities in an architectural context. Uncovering the typology provides information into their intended purpose and prescribes a way in which society can comprehend their necessity.

Summary of analysis: For each of the main components (Pre-Consumption, Consumption, and Post-Consumption), I identified the main objective, then considered how these could translate to architectural and spatial elements, then finally what building typology or precedent has associations with these elements.

I decided to focus on prisons, hospitals, and opium dens to highlight spatial and environmental qualities that should be applied or be avoided in Drug Consumption Spaces.

<table>
<thead>
<tr>
<th>Main Component</th>
<th>Main Objective</th>
<th>Architectural Elements</th>
<th>Building Typology</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Consumption</td>
<td>- Determine eligibility &lt;br&gt; - provide info &lt;br&gt; - determine needs</td>
<td>- Waiting Area &lt;br&gt; - Adequate Storage &lt;br&gt; - Privacy</td>
<td>- Needle Exchange &lt;br&gt; - ER Room &lt;br&gt; - Hospital &lt;br&gt; - Cafe &lt;br&gt; - Refugee Center</td>
</tr>
<tr>
<td>Consumption</td>
<td>- More hygienic environment &lt;br&gt; - Supervise consumption &lt;br&gt; - Emergency Intervention &lt;br&gt; - Provide Primary Care</td>
<td>- Mirrors &lt;br&gt; - Lighting &lt;br&gt; - Sterile Materials &lt;br&gt; - Booths &lt;br&gt; - Privacy &lt;br&gt; - Accessibility</td>
<td>- Voting Booth &lt;br&gt; - Blood Lab &lt;br&gt; - Bathroom &lt;br&gt; - Prison &lt;br&gt; - Hair Salon</td>
</tr>
<tr>
<td>Post-Consumption</td>
<td>- Monitor Effect of Drugs &lt;br&gt; - Provide Info</td>
<td>- Seating &lt;br&gt; - Lighting &lt;br&gt; - Accessibility</td>
<td>- Opium Den &lt;br&gt; - Sanatorium &lt;br&gt; - Restaurant &lt;br&gt; - Bar &lt;br&gt; - Chat room</td>
</tr>
</tbody>
</table>

Figure 34: Building Typology Analysis Process
The following is a list of existing places from which we can understand how a Drug Consumption Space is characterized.

<table>
<thead>
<tr>
<th>USER GROUP</th>
<th>SCALE</th>
<th>MEDICAL</th>
<th>CREATING</th>
<th>COMMUNITY</th>
<th>VOLUNTARY</th>
<th>INVOLUNTARY</th>
<th>APPT.</th>
<th>HARPO REDUCTION</th>
<th>SURVEILLANCE</th>
<th>CORRECTING</th>
<th>DRUG RELATED</th>
<th>LIVING</th>
<th>VISITING</th>
<th>EMERGENCY</th>
<th>NECESSITY</th>
<th>LUXURY</th>
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<tbody>
<tr>
<td>HOSPITAL</td>
<td>anyone sick</td>
<td>L</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
<tr>
<td>SANITARIUM</td>
<td>patients</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>PHARMACY</td>
<td>anyone req.med.</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>BLOOD LAB</td>
<td>anyone req. tests</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>BLOOD DONATION CENTER</td>
<td>people deemed healthy</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<tr>
<td>HOSPICE</td>
<td>dying people</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>AMBULANCES / EMERG. SERVICES</td>
<td>people req. emerg. care</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
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</tr>
<tr>
<td>BATHROOM</td>
<td>anyone - usually gendered</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<td>X</td>
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<td>DOCTOR'S OFFICE</td>
<td>anyone w appointment</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<td>X</td>
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</tr>
<tr>
<td>WALK-IN CLINIC</td>
<td>anyone</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<td>X</td>
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</tr>
<tr>
<td>ABORTION CLINIC</td>
<td>pregnant women</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<td>INSANE ASYLUM</td>
<td>mentally ill</td>
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<td>X</td>
<td>X</td>
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<td></td>
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<td>X</td>
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</tr>
<tr>
<td>REHAB</td>
<td>people w additions</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>DETOX CENTER</td>
<td>addicts (before treatment)</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
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<td>people w prescription</td>
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<td>X</td>
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<td>NEEDLE EXCHANGE</td>
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<td>CRACK HOUSE</td>
<td>anyone</td>
<td>S</td>
<td>X</td>
<td>X</td>
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<td>WET SHELTER</td>
<td>addicts</td>
<td>S</td>
<td>X</td>
<td>X</td>
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<td>HOMELESS SHELTER</td>
<td>anyone without a home</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<td>SEX BOXES (Zurich)</td>
<td>sex industry</td>
<td>S</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
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<td>BROTHERS</td>
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<td></td>
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<tr>
<td>ABORTION BOAT</td>
<td>emergency abortions</td>
<td>S</td>
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<td>X</td>
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<td></td>
<td>X</td>
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<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PRISON/ PANOPTICON</td>
<td>people who have broken the law</td>
<td>L</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<td>X</td>
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<tr>
<td>VOTING STATION</td>
<td>legal voters</td>
<td>M</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>PASSPORT OFFICE</td>
<td>anyone</td>
<td>M</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
<td>X</td>
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</tr>
<tr>
<td>COMMUNITY CENTER</td>
<td>anyone</td>
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Figure 35: Table of related precedents and building typologies
Chapter 8: Prisons

Drug use has had a long relationship with prisons. The self-treating addict remains on the outskirts of the law. Addicts are frequently in the criminal justice system.

In Canada, the way of dealing with drug use is primarily a criminal justice approach, not a public health or harm reduction. In 1908, drugs like opium, morphine, cocaine, and heroine became criminalized for non-medical purposes, resulting in criminals being created overnight. [9] The RCMP at the time labeled these individuals “criminal addicts”, meaning they are criminals first and addicts second. It was assumed that if individuals were given any drug treatment or maintenance, they were still criminals and a threat to society so it was seen as pointless. There was no publicly funded drug treatment program set up after drugs were criminalized. The view at the time was that maintenance and drug treatment was wrong, and that abstinence was the only avenue that would work. There was no detox facility, the ‘criminals’ were just put in jail, expected to terminate drug use “cold turkey”. The wealthy were sometimes permitted to go to a private asylum. In 1925, laws were established making it illegal to prescribe drugs to a known addict for maintenance purposes. If convicted, doctors could face up to five years in jail. [9]

In the United States and part of Europe for example, state, and municipal clinics opened up to work with people who were addicted to these newly criminalized drugs. Abstinence was not the goal of these clinics but rather preventing suffering was the mission of the clinics. [9]

Surveillance is tightly linked to security and keeping order. Perhaps the most well known example of a structure that facilitates surveillance is the Panopticon prison designed by Jeremy Bentham in the 1790’s. The word Panopticon literally means ‘all-seeing’. The simple definition of Panopticon is a building that is arranged so that the entire interior is visible from a single point, often without the inhabitants being able to tell if they are being watched or not. [34] The prison supervisor was located at the centre of the Panopticon’s circular plan, in a tower with wide windows that open onto the inside of the building. Surrounding the periphery were the prison cells, which extend the entire width of the ring. Each of these cells had two windows, one on the outside, and the other on the inside, which allowed light through the cell. The central governor’s tower was invisible to the prisoners and to the wardens who patrolled the prison. The prisoners’ cells were backlit so the prisoners were continuously visible. [35] In the Panopticon, the movement of the inmates was forbidden. For efficiency, wardens wanted the prisoners to stay as still as possible to maximize their visibility and minimize the number of wardens needed to oversee the inmates. The Panopticon was organized into cells, and it was thought that the prisoners could be organized by race, crime, or level of security needed. [36] To achieve full visibility by the supervisor, the heavy sidewalks of each cell prevented the inmate from contacting other inmates. [37] Foucault describes the effect of the prison stating, “he is seen, but he does not see; he is the object of information, never the subject of communication”. [38]

For Drug Consumption Spaces, supervision is essential to observe if a patient is experiencing an overdose. In addition, since drugs are criminalized, at Insite, using drugs anywhere outside the Injection Room is considered ‘illegal’. Similar to the guards at the Panopticon, the nurses at Insite, are also able to view all angles of the Injection Room. The nurse’s station is on a platform a step higher than the rest of the area. This step although, creating better visibility, is seen to some users of Insite as creating a sense hierarchy. The nurse is always on a higher level physically, essentially always ‘looking down’ on patients. In addition, many of the intended user group have had negative experiences with authority figures such as police, doctors, and with institutional environments like hospitals and prison. [8]

Insite must fulfill the required supervision, surveillance and safety for health, maintain an environment of trust, and autonomy, but distinguish themselves from any association with incarceration.
On a trip to New York in March 2017, I noticed the painting, *The Subway*, by American figurative painter, George Tooker at the Whitney Museum of Modern Art. Although made in 1950, the painting remains extremely relevant today. I found that this painting really spoke to the marginalization that the Downtown Eastside population experiences when trying to navigate health care settings. Further investigation of Tooker’s other paintings shed light on other social and architectural aspects of Drug Consumption Spaces.

**Figure 40: The Subway (1950)**
This painting was “in response to the social injustices and isolation of postwar urban society”. [39] However, it shares many similarities to the stigma, judgment, and experiences surrounding drug use. It could easily be imagined that had the central figure been a drug addict, she would have the same expression of anxiety, fear, and discomfort when trying to navigate a health care setting.

**Figure 41: The Government Bureau (1956)**
The same people are ‘copied and pasted’ in the painting indicating how anonymous these bureaucratic environments are. They lack person-to-person contact that is essential to successfully deliver services to the population of the Downtown Eastside. “Multiple bureaucrats peer out from frosted windows with only their eyes and noses visible — bringing to mind the concept of the “medical gaze” promulgated by the French philosopher, Michel Foucault”. [39]

**Figure 42: The Waiting Room (1957)**
The narrow, repetitive nature of the numbered booths is similar to that of the Injection Room. In addition, the figure on the left could be interpreted as representing the power imbalance the population of the Downtown Eastside feels when seeking health care. The lighting in the painting is highly clinical. The expressions on people’s faces are of agony, boredom, and anxiety, the same feelings that individuals experience when waiting for an injection booth at Insite.

Chapter 9: hospitals

Architecture has a long relationship with medicine. [40] Hospitals have a clear link to Drug Consumption Spaces. “The medical body has informed the rhetoric of theories about architecture and the rhetoric of architecture itself”. [40] Through designing sanatoriums for treating tuberculosis for example, the requirements of hygiene, sun, and air changed the way modern architecture was considered and designed. The designs that responded to these principals are still relevant today. Just as architecture changed roles and meaning when applied to tuberculosis, the architectural discourse could be impacted when applied to designing a Drug Consumption Space. “Modern architecture was unproblematically understood as a kind of medical equipment, a mechanism for protecting and enhancing the body” [40].

In a general sense, the architectural space should be shaped around the body that occupies it and the objectives trying to be achieved. Le Corbusier created the “Modulator” in the 1940’s to set standards for the human body in architecture and mechanical design. The Modulator sought to define a “range of harmonious measurements to suit the human scale”. [41] The population of the Downtown Eastside who frequent Insite, cannot fit into this ‘typical’ definition of the body. Similar to tuberculosis, for drug addiction, “New bodies will probably have to be designed. A new theory of architecture is likely to follow”. [40] Just as the Downtown Eastside community is a culture unto itself, the user of Insite should be considered a ‘new body’ worth defining. This investigation raises questions such as: What is the scale for the user of a Drug Consumption Space? How much space is required per person? What can the way their body moves to achieve the objective of injecting drugs tell us about the way the space should be designed?

Healthcare is designed to serve the general public, not the specific needs of the population of Insite. Hospitals, and other highly clinical places, present barriers for the user group of Insite. Looking at two less clinic types of hospitals, Paimio Sanatorium and REHAB Basel, provides a way to understand how a hospital can still achieve the objective of healing, while removing some of the negative attributes.
The Paimio Sanatorium in Finland, is seen as a successful and well-known example of sanatorium architecture. It was designed by Alvar Aalto, and completed in 1933. Sanatoriums were designed to mitigate the epidemic of tuberculosis. During the late nineteenth and early twentieth centuries, tuberculosis was the single greatest killer of adults in Europe, the United States and many other countries worldwide. This fight against tuberculosis created a new focus on cleanliness, hygiene, fresh air, and sunlight. These requirements resulted in many of the distinctive modernist architectural features such as white concrete, flat roofs, large balconies, eliminating the barrier between indoor and outdoor spaces, and even the furniture such as reclining chairs designed at the time to respond to managing and controlling the transmission of tuberculosis in a time before drug therapy. [42] The sanatorium created a design that was patient focused, and in addition to typical hospital requirements, emphasized elements that were intended to make the stay of the patient more comfortable.

In Vancouver and other cities in North America, drug overdose is at epidemic rates. In British Columbia over 900 people died in 2016 alone, the highest number in thirty years of record keeping. [6] Many individuals question whether the ‘fight’ against this epidemic is not at the forefront of attention because of the associated group being drug addicts, and the common stigma that the victims only have themselves to blame for their deaths. [12] Had drug addiction been seen as equivalent to that of epidemic caused by an infectious disease, then perhaps architecture would have responded with similar innovative structures and interventions.

Sanatoriums also placed an importance on cleanliness and sanitation, architects of sanatoriums used innovative materials that were easy to sanitize such as porcelain, glass and white surfaces and specific colours were selected. Hospitals today lack ornamentation, they have simple forms where all furniture is lifted off the ground on legs for easy cleaning underneath. [43] Likewise in Drug Consumption Spaces, material surfaces should be easy to clean and colours can create a more positive environment. At Insite, they avoided white surfaces due to their association with clinical environments; however, they still maintain hygienic surfaces with the use of stainless steel and plastic surfaces, and linoleum floors. [27] The use of colour is more evident in Drug Consumption Spaces in Amsterdam and Luxembourg.

The need for sanatoriums created a cultural movement in architecture that focused on awareness about hygiene, how to manage and control infectious diseases, and how design can impact health outcomes. These considerations were all realized while trying to control and manage the spread of tuberculosis. Likewise when designing Drug Consumption Spaces, it is important to consider the cultural movement that we view their intended population may be required. Certain design elements are required to create environments for this specific usergroup. For example: eliminating the glass barrier between the receptionist and patient, the need for a less clinical environment, and more person-to-person interactions and connections.

Figure 43: Paimio Sanatorium (1933)
The green and orange awnings make the space look less clinical. In addition, the remote location of the sanatorium was very important to achieving the maximum sunlight and fresh air.

Figure 44: ‘Cure Chair’ at Paimio Sanatorium (1933)
Aalto designed a specific chair for the body of a tuberculosis patient.
REHAB, Centre for Spinal Cord and Brain Injuries was designed by Herzog and de Meuron in 1998 in Basel, Switzerland. It is a rehabilitation centre for patients with injuries resulting in quadriplegic, paraplegic and brain injuries.

The design process of REHAB lead to its success. There was extensive collaboration and communication between the architect and the patients, doctors, nurses and other hospital staff. [44] The clients were seeking a design that would not feel like a typical hospital. The architects researched what defined a hospital and decided they would aim to avoid negative designs associated with hospitals such as long windowless hallways, uninviting waiting areas tucked at the end of corridors or next to elevators. There are many aspects of the building that are directed to the needs of the patients such as the design of the patient rooms, the use of interior courtyards, the use of colour on the walls and glass, the open and flexible spaces, and the views throughout the hospital. Like Paimio Sanatorium, there was an emphasis on providing patients with a connection to the outdoors to foster a low-stress healing environment. This specific design element seems most successful at connecting the interior and exterior environments are the round skylights above patient beds known as ‘light spheres’. These existed in both the patient rooms and the pool creating a peaceful healing environment.

Achieving the non-institutional ambiance was created by the collaboration between all parties involved and a focus on the specific need of the user group. Without these considerations REHAB probably would have ended up as a ‘typical’ hospital and not the innovation that it is. At Insite the founders of Insite looked to find expertise about what people need and expect from the space. They knew that typical ‘experts’ of health or drug use such as the health authority or police, have little or no knowledge of what its like to be a drug addict or belong to a marginalized population. They understood the importance of community engagement. They emphasized that the real experts in this area are the individuals who use the space and live in the area. [8] This process was done before hiring the architect, Sean McEwen. [27] By the time McEwen was involved in designing the space, the founders already had a very clear idea of what they wanted. (See p. 105 for further information)

The designs of Paimio Sanitarium and REHAB can be helpful to inform the design of Drug Consumption Spaces. Sanitariums brought the requirement of easy to clean surfaces and a more patient centered approach to treatment. Both Sanitariums and REHAB investigates how to design for a specific population and realized that the connection to the environment was essential. During the time Paimio Sanatorium was designed, architecture was largely considered the only treatment with views to the outdoors being physically healing. In more recent times, REHAB has access to technology and medical science, however, light, air, and the connection with the outdoors still play a huge role in fostering a low-stress healing environment.

Unlike tuberculosis, a spinal cord injury is obviously not an infectious disease therefore although a sterile environment is needed, it is not as crucial. In the case of Drug Consumption Spaces many of the visitors do have infectious diseases such as HIV of Hepatitis, and drug injection does require a level of hygiene around how to handle blood and proper disposal of drug paraphernalia. However, unlike tuberculosis these illnesses are not transmitted in an airborne nature and when managed properly the risk of transmission is low. Therefore similarly to REHAB Basel, the environment could be less clinical and still achieve its objective. [8, 20]
Chapter 10: opium dens

Historically Opium Dens provided a place for opium users to congregate and smoke opium. At one time opium was considered a “wonder drug”. It was a pain reliever, a stress reducer, and a highly valued therapy for a variety of ailments. Then in the late nineteenth century opium was banned in Canada and the United States, and in 1908 Opium was criminalized for non-medical purposes. [9] The law was reported to have been a response to “moral panic based on the fear that women, young girls, and young men were induced to visit the Chinese opium dens and were ruined morally and otherwise”. These laws affected the use and distribution of opium by Chinese immigrants but not the use of laudanum, a combination of opium and alcohol used by Caucasian Americans. This inconsistency demonstrates that the laws were racist in both origin and intent. [45]

In the Opium Den, customers were taught the methods and best practices to prepare and use the drugs. Once mastering the skill “he might in turn assume the role of instructor and transmit the ritual to others”. [46] At Insite, in addition to nurses, both present and former addicts are employed to assist in teaching about best injection practices. In addition to the environment fostering education, Opium Dens were “a meeting place, a sanctuary, and a vagabonds’ inn… Members of the underworld could gather there in relative safety, to enjoy a smoke with their friends and associates”. [46] Users of the space would chat, sing together, eat together, smoke tobacco, share stories, joke around with each other, similar to my observations of the community of the Downtown Eastside. The expectations of tolerance at Insite are similar to those at Opium Dens. There was a rigid set of rules, a code of ethics of sorts, where smokers would not take advantage of other smokers, or tolerate those who did. In Opium Dens, individuals would “lie down and go to sleep with jewelry exposed and money in their pockets, but no one would ever think of disturbing anything”. [46]

In some ways an Opium Den may be an ideal situation for drug addicts. It is a low-stress environment that provides resting beds, along with providing a safe place to purchase drugs. However, it lacks the treatment component, does not link the users to much needed services, and does not have the extensive nurse supervision or hygiene that Insite maintains. What can be learned from Opium Dens are how they provided a space for drug use that was comfortable and non-judgmental. In addition, there was a level of community and caring for each other that is essential to create a successful space for this usergroup.

Figure 49: Opium Dens from around the world (late 19th century)
Chapter 11: harm reduction precedents

Harm reduction are public health measures that acknowledges that people will partake in behaviours regardless of potential dangers, laws or policies, therefore it is implemented to reduce their associated risks.

In the case of Drug Consumption Spaces they reduce harm in a number of ways. First by using clean injection tools, users cannot transmit HIV, Hepatitis C or other diseases through sharing a syringe. Second, providing a safer, stress-free space to inject means users do not have to rush their injection, which potentially causes damage. In addition, the space provided is usually heated so veins are easier to find, again making the injection process smoother. Third, if a user were to overdose then staff are immediately available and ambulances do not always have to be called which place strain on the emergency response system. Fourth, if users inject in the street or parks, generally there is improper disposal of drug paraphernalia. For the public the harm is reduced through less strain on emergency services and the health care system overall, and through the proper disposal of needles. Overall the harms of disease, personal injury, or death are reduced. [4]

**Sex Boxes Allows** prostitute to use a ‘drive-in’ garage that reduces the personal dangers associated with prostitution. The boxes are equipped with alarms, security guards and safe sex posters. [47]

**Weed Dispensaries** regulate the production and sale of marijuana, sell it in a safe environment, requires a prescription, the marijuana is tested as to not to contain foreign substances. However, in Vancouver; this is not working as it is intended, of the nine samples the Globe and Mail Newspaper tested, “one-third of them would not pass the safety standards set out by Health Canada for the regulated medical marijuana industry”. [48] In July 2018, marijuana is expected to be legalized in Canada so this system will likely change.

**Needle Exchange Programs** provides clean needles and injection equipment in exchange for used needles. The used equipment is then treated as hazardous bio-medical waste and is destroyed safely. [49] Without this program, injection drug users may share needles potentially transmitting diseases.

Figure 50: Sex Boxes, Zürich (2013)
Chapter 12: drug consumption spaces globally

On March 16th, 2017 I contacted the International Network of Drug Consumption Rooms through their website. I received an email from Cedric Charvet, Coordinator of Amsterdam DeRegenboog Groep AMOC, and representative of the International Network of Drug Consumption rooms. Charvet had many similar comments to Darwin Fisher, Coordinator of Insite, and was able to speak to architectural elements more specifically since he was the individual responsible for the design.

Charvet was very knowledgeable about the design requirements of sites and the specific needs of the user group. Charvet provided a clear and very specific rational for designing the space. In addition, he sent me a number of photos of the space and other spaces around the world.

Before designing AMOC, Charvet visited a number of sites in Spain, Switzerland, Germany, and spoke to and researched a number of other sites worldwide. Charvet stated, “I was inspired to take the best ideas from the spaces I saw to create my own style with a team”. [20]

Charvet believes that “Rat Park”, an experiment conducted by Bruce Alexander, demonstrates just how essential architecture is to Drug Consumption Spaces. Rat Park was conducted at Simon Fraser University in British Columbia and published in 1981. This study deeply inspired Charvet’s design choices. In summary, this study hypothesized that it is not drugs that create addiction like previous studies had suggested but rather it is attributable to the rat’s living condition. To test this hypothesis Alexander created a significantly large cage containing rats of both sexes. Positive environmental factors like wheels, mating areas, and a food supply as well as supplying morphine and tap water. The rats did not choose the morphine. The results supported his hypothesis. [3] Likewise, at AMOC, they tried to reproduce an environment with as little stress as possible. It is essential to provide feelings of comfort, non-judgment, with no time limit. “Time limit is stress and stress creates a lower awareness of risk” increasing the chance of risky injection practices”. [20]

Charvet has termed AMOC “a social-oriented drug consumption room”. They are “trying to reproduce a living room for people who do not have a house”. [20] They decided what furniture they wanted and as long as hygiene and safety were guaranteed. “When you look you might think this is a beautiful, colourful living room but it is full of safety features” with each element carefully chosen by Charvet for pragmatic purposes. The space “cannot be a reminder of your last day in prison. We are trying to attract users, not put them off”. [20]

Amsterdam is a different environment than Vancouver. In Amsterdam, drug users are concentrated in 3-4 areas and the population is lower, at just over a million people. In Amsterdam they have 4 drug consumption rooms; each with different services. Charvet’s facility is the only facility that has both injecting and smoking permitted in the same space, the other three facilities have injection and smoking rooms but they are in separate rooms. The usage of AMOC is much different compared to Insite. AMOC sees 18-25 visitors per day, a fraction of that of Insite which sees over 700. The Amsterdam facility is only open 8 hours a day, whereas Insite is open 18 hours a day. At Insite most people stay for 1 hour. In contrast, most people stay at AMOC for 4 hours. However, they are not using drugs for the entire 4 hours. There are other services in the building: on the main floor there is a drop in centre, the basement has showers and a changing room and an emergency night shelter. People can come and go into the drug consumption room many times during a single visit to the building.

AMOC is a single room that’s 8m x 10m (26.2’ x 32.8’). It does not operate in stations (Pre-Injection, Injection, Post-Injection) like Insite’s design. Instead, everything occurs in one room. The nurses and staff area is enclosed and located in the corner, with a giant window looking onto the space, “like an aquarium, we have an enormous transparent window”. [20]
Check in / Eligibility: Like Insite, the drugs consumed at AMOC are previously obtained and there is no dealing of drugs on premises. However, unlike Insite, in Amsterdam, the visitor must be registered in the city where the drug consumption room is located and the must sign a ‘terms of use’ contract. [20]

Fire safety: An evacuation plan is located on the wall. It indicates where to go in the case of a fire and where to locate fire extinguishers and safety fire blankets. There’s an emergency fire button that will close all the doors and isolate every department of the building. Fire safety elements are controlled by the fire department — they worked with Charvet to make sure it is safe for visitors and staff. Their occupancy permit (determined by the square footage of the space) allows 18 occupants at the same time plus one staff member. It will be useful to investigate if there is a specific document in Holland the outlines space required per person for consumption rooms specifically.

Lighting: In addition to the natural light from the windows, fluorescent tube lights on the ceiling; however, these light sources were not enough. Injection drug users prefer indirect light, “this means when you put your vein directly to the light, you cannot see it so well, so the user will put their back to the light” therefore on the wall there are extra lamps. [20]

Smoking: AMOC is a smoking and injecting drug consumption room. To guarantee the quality of the air for staff and visitors, there is an extensive ventilation system within this space. The air handling system is separate from that of the rest of the building as to not contaminate the air elsewhere. The ventilation system installed is approved for the amount of smoke a nightclub would produce. [20] There is an exhaust fan to move the air from inside to outside. The air handling system also provides purified air and circulates it throughout the room. There are additional exhaust fans located above the windows.

Surveillance: The drug users face each other at the tables. This is a security feature “If I am facing a fellow user, the person in front of me will see the first sign immediately and can warn the staff members… with the mirror, like in Vancouver, it take 10-30 seconds longer to observe the problem” [20]. The first sign of an opium overdose is white face and eyes looking down, something that can more easily be recognized if you are sitting directly across from someone, rather than observing him or her through a mirror. Unlike Insite, the staff are not in the same room as the visitors. Staff come in and out of the space, but they cannot stay inside due to the smoke from drugs. Staff observe visitors from an enclosed room within the space.
Floor: The floor is made of Marmoleum, a natural linoleum floor covering is made from 97% natural raw materials. Selecting red was a very intentional choice to provide contrast. If there is blood, the blood is red, and when it falls on a red floor, the floor becomes black. Therefore, staff know if they have clean properly each day. If the black stain remains, they know it is a burn mark, not blood. If the floor is too dark, you will not see the contrast. If the floor is too light will be quickly damaged. Charvet states, “we work with homeless drug users, they come from being in the dirt, and sleeping on the ground”.

Walls: On the walls around the space a white, plastic backsplash that exists on the lower 3 feet of the space. “People move around the room with backpacks, they move their chair... if it is too damaged we can easily remove it and change it”. The wall above the backsplash is painted with washable paint, which can be washed with heavy duty cleaners without damage.

Windows: AMOC is located on the second floor of the building. Charvet described how there are concerns with a visitor potentially wanting to harm themselves by jumping out of the window. Therefore every window is locked with a key only accessible to staff. The visitor is unable to open the window. In addition, the glass is unbreakable, if a chair was thrown at it, it would stay within the glass. The glass is frosted on the bottom half, to allow for privacy while not blocking out light.

Furniture: The tables and chairs were selected for their rounded corners. “You have two possibilities, you buy tables with corners an put tennis balls on the corners, or you invest a little bit more and you have round corners”. People may slip and fall from intoxication or tiredness. In addition, centrally supported tables were selected rather than tables with four legs. This is to improve the ease movement of chairs around the table.

To create a more social space AMOC implemented colorful chairs so it does not resemble a sterile-white hospital, but all surfaces are in fact hygienic. There are 18 seats within the facility, The chairs are a variety of colours. Each chair costs €160, and are guaranteed by the manufacturer for 6 years. They were chosen for their round corners, stackability, strength, and easy to clean surfaces.

Sink: The sink is motion censored for hygiene.

Mirror: The mirror is not a mirror, it is made of aluminum, so it is unbreakable

Art: There are no prevention messages on the wall. There is art, which often includes exhibitions from visitors. “Posters about drug use or prevention are a reminder for visitors of the stigma of drug use, and increase the stress of the visitors”.

There is also a blackboard where people can write inspiring quotes.
Charvet notes that, “every picture you see with tiles, you know it’s Germany. They were built in the 80’s and 90’s”. This should not be in Drug Consumption Spaces as it is difficult to clean between tiles. The floor and walls should be seamless. Corners and cracks allow bacteria to sit and multiply. Ideally floors and wall surfaces should be seamless so dirt cannot harbour within it. In addition, there are no mirrors which is a safety issue.

Figure 64 - 66: Hygiene

Location: Germany

Charvet provided me with a number of photos of various Drug Consumption Spaces he visited or researched prior to designing AMOC. He discussed elements in each of the photos.

Figure 64: ‘Danger Zone’

Location: Spain

This space seems unwelcoming, resembling a prison, the yellow line on the floor translates to “danger zone”. “Danger zone, what does that mean? Who is in danger?” (27). Like Germany, people are facing the wall without a mirror which is a safety risk.

Figure 61: Waiting Area

Location: Spain

In this Drug Consumption Space, visitors take a number, and wait. Everyone is allotted 20mins to use the injection room. “Every user is individual, some need more time and attention”. [20] There is no priority given or different times for different people’s needs. This also gives significant stress to people who are inside the room because they know people are waiting.

Figure 63: Accessibility

Location: Australia

Vancouver and Australia remain the only Drug Consumption Spaces that are universally accessible. The ramp provides accessibility for people with mobility issues. Something which is common in this user group.
Certain colors create different emotions and are associated with different experiences and feelings. Colors create a more social space.

Location: Switzerland

Amsterdam they stayed away from white and green because of their association with hospitals. The impact of colors on behaviour should be investigated further.

This is a staged photo of what a drug consumption space could look like. “The blue might be used because it is clean looking, blue probably triggers something positive” [20].

It shows lighting at each booth and windows and high ceilings create less stress.

This facility uses colorful chairs, doors, and sharps disposal bins to create a more cheerful environment. However, like the Germany space, there is tiles which is problematic for cleaning and hygiene.

This is a new facility. Booth #1 is very large to accommodate multiple people. The other booths are individual. They also have an individual booth for more privacy for people who choose to inject in the groin area.

The floor is seamless, the lighting, both natural and artificial, are carefully considered.
CHAPTER IV: INSIGHT

Listening to experts

Chapter 13: Existing Design Related Research
Chapter 14: Seeking Primary Research
Chapter 15: Narratives

Who are the experts on Drug Consumption Spaces?

What are the various platforms by which knowledge on Drug Consumption Spaces can be transferred and gathered?

Figure 71: Street art in the Downtown Eastside inspired by the overdose crisis. Created by local artist, Smokey D
I was able to find two published studies that partially investigated design elements of Drug Consumption Spaces. However, neither would be significantly helpful or applicable for an authority wishing to set up a Drug Consumption Space. Other studies often provide spatial aspects that could be considered through an architectural lens such comments about lighting, material use, layout or perceived barriers or impressions; however, none were extensive.

**Design considerations for supervised consumption facilities (SCFs): Preferences for facilities where people can inject and smoke drugs.**

This study interviewed 236 stakeholders in two Canadian cities without Supervised Injection Sites (Toronto and Ottawa) and asked participants how they thought the facility should be designed. “We consulted with people who use drugs and other stakeholders including police, fire and ambulance service personnel, other city employees and city officials, healthcare providers, residents, and business owners”. [23] It was noted that “Many participants in the study had little, if any, direct experience with SCFs which renders some of their responses hypothetical”. There was no architect or design professional consulted in this study. There is little information on how to actually design the space.

Overall this study covers the concerns of supervised drug smoking facilities and supervised injection facilities and whether either or both are of interest. In addition where these should occur in the same facility, and if they be separated in that facility.

One architectural consideration that could be learned from this study is that, although there was interest in allowing both smoking and injecting, “we did not hear a lot of support for the option of having both in the same immediate space without separation between them”. [23]

This study doesn’t fully investigate existing Safe Injection Sites, and should not be asking what they would want in a hypothetical design. It should be first be asking why isn’t a site already implemented, where would this facility be best located in these cities, and what are the barriers to use for these populations in each specific city.

**Injection drug users’ perceptions regarding use of a medically supervised safer injecting facility**

This study interviewed 1082 users of Insite, they asked “What would you like to see changed about or added to Insite?” Their responses indicate ways in which Insite could improve. The top three responses were: longer operating hours (53%), additional washroom facilities (51%), reduced wait times (46%). Other responses included access to a shower facility (25%), additional treatment options (24%), a more discrete entrance (22%), and access to laundry facilities (20%). [51] With the exception of longer operating hours and additional treatment options, which are driven by available resources, the other responses can be considered architectural issues worth further investigation. In addition, unlike the Watson et al., study, this study interviewed individuals who had actually used a safe injection facility so their responses are likely more credible.

When conceptualizing the space, the founders of Insite researched what people need and expect from the space. Normally when considering how best to design a space there is a tendency to rely on ‘experts’. In the case of Drug Consumption Spaces, it may be assumed that those experts are the health authority, the Chief Coroner, and the police department. These ‘experts’ have little or no knowledge of what its like to be a drug addict or belong to a marginalized population. This was demonstrated in the way Watson et. al defined their stakeholders as in addition to drug users, as “police, fire and ambulance service personnel, other city employees and city officials, healthcare providers, residents, and business owners”. [23] However, the real experts in this area are the individuals who use the space and live in the area. Insite’s design is largely successful due to the realization early in the design phases, that there needed to be grass-roots engagement.

Again, when setting up a Drug Consumption Space these studies do not provide design information about programing spaces, materiality, room layout, glass treatments, furniture requirements, lighting considerations, accessibility, and other architectural issues. Further, the design information on Insite’s tried and tested design is undocumented.

We already know that drug users will visit the space (just look at Insite!) Yes, Drug Consumption Spaces work. Yes, if you locate them within the population that actually needs them, not just where the real estate is available, then people will come. Yes, they are safe to be located within neighbourhoods, and provide social benefit in some areas.

Now is the time to stop researching the popularity, effectiveness, safety, or other issues and move towards implementation. Architecture is a large piece, not the whole puzzle, to that process.
Since I was unable to locate any sources that speak explicitly about the architectural intentions or design thinking that should be applied to Drug Injection Spaces, it was therefore clear that there was a need to seek this information elsewhere. I sought and received valuable and thoughtful information and advice from experts and experienced people in the field. Their “lived” experience sheds light on the many facets of the topic. These people include users of the space, drug users, health professionals, policy makers, law professionals, advocates, and community members, as well as attending related lectures. I met these individuals though acquaintances, websites, social media, and suggestions from others. There is a substantial amount of valuable knowledge and observations on this issue that are not published. I hope to continue these conversations and continue to collect contacts.

Through these interactions I received access to various facilities and I was able to interact with some usergroups of the spaces. Often individuals would refer me to other valuable people, send me informative photos, or suggest related books, movies, or podcasts. Many times I found myself surprised by what I learned, and how my opinions were changed or clarified through the discussions.
ALICIA BRECK
- Adjunct Professor at SALA, UBC
- Urban Strategist

CEDRIC CHARVET
- Coordinator of Amsterdam DeRegenboog Groep AMOC
- Drug Consumption Room

JOHN DIXON
- former president of BC Civil Liberties
- former advisor to Prime Minister Kim Campbell
- retired Philosophy professor Capilano University

DARWIN FISHER
- Coordinator at Insite
- Employed by the Portland Hotel Society

MARILOU GAGNON
- Nurse / Associate Professor at the School of Nursing,
  Faculty of Health Sciences, University of Ottawa
- Director of the Unit for Critical Research in Health
- founded Coalition of Nurses for SIS

JEREMY KALIKUM
- involved in initiating a pop-up injection site in Nanaimo

SEAN MECEWEN
- architect of Insite

MARTIN SCHETTER
- doctor, founding director of the School of Population and Public Health
  in the Faculty of Medicine, UBC
- NAOMI and SALOME heroin trials

JANINE STEVENSON
- nurse
- NAOMI and SALOME heroin trials

SHELLY TOMIC
- filed a constitutional claim in the B.C. Supreme Court to keep Insite open
- works at the Women’s Health Collective
- former addict and participant of Insite

MARGOT YOUNG
- Professor, Allard School of Law, UBC

MARCH 27: HEROIN ASSISTED TREATMENT:
SAVING LIVES DURING THE OVERDOSE CRISIS

DONALD MACPHERSON
- Executive Director of the Canadian Drug Policy Coalition
- one of Canada’s leading figures in drug policy at the local, national and international levels

SUSAN BOYD
- Professor, Faculty of Human and Social Development, UVic
- author

DOUGLAS KING
- Lawyer at the Pivot Legal Society

SCOTT MACDONALD
- lead doctor at the Crosstown Clinic (the site of NAOMI and SALOME heroin trials)

DAVE MURRAY
- formerly NAOMI trial participant
- founder of SNAP (SALOME/NAOMI Association of Patients)

MARTIN SCHECTER
- doctor / founding director of the School of Population and Public Health
  in the Faculty of Medicine, UBC
- NAOMI and SALOME heroin trials

NICHOLA HALL
- Founder of From Grief To Action

DEAN WILSON
- filed a constitutional claim in the B.C. Supreme Court to keep Insite open
- addict / participant of Insite

APRIL 7: INSITE AND HARM REDUCTION

MAXWELL CAMERON
- Professor, Department of Political Science, UBC

KENNETH E. SHARP
- Professor, Department of Political Science, Swarthmore College, PA

MARGOT YOUNG
- Professor, Allard School of Law, UBC

SPEAKERS:

MAXINE DAVIES
- Executive Director of Dr. Peter AIDS Foundation

LIZ EVANS
- Founder / Executive Director of Portland Hotel Society
- Founder of Insite

NICHOLA HALL
- Founder of From Grief To Action

DEAN WILSON
- filed a constitutional claim in the B.C. Supreme Court to keep Insite open
- addict / participant of Insite
Facebook groups:

To further immerse myself within the topic I joined a number of Facebook groups. These groups provide information from a diverse range of individuals and often share current events and news on Drug Consumption Spaces from around the world.

- Harm Reduction = Nursing Care
  https://www.facebook.com/Nurses4HarmReduction/
- Everywhere But Safe: Public Injecting in New York
  https://www.facebook.com/EverywhereButSafe/
- SIF NYC
  https://www.facebook.com/sifnyc/
- International Harm Reduction Day
  https://www.facebook.com/InternationalHarmReductionDay/
- Global Commission on Drug Policy
  https://www.facebook.com/globalcommissionondrugs/
- Harm Reduction Coalition
  https://www.facebook.com/HarmReductionCoalition/
- Canadian Harm Reduction Network
  https://www.facebook.com/noharmcanada/
- Canadian Drug Policy Coalition
  https://www.facebook.com/CANdrugpolicy/
- Streetworks Edmonton
  https://www.facebook.com/streetworks.edmonton/
- Nanaimo Onsite Safe Consumption Site Support Page
  https://www.facebook.com/groups/627150157471065/

Chapter 15: narratives

Insite was designed by local Vancouver architect, Sean McEwen in 2003. McEwen described when the founders of Insite approached him, they had already thoroughly researched and visited injection sites around the world so they had a clear vision of what they wanted from the design. In addition, the Portland Hotel Society had already made an unapproved mock-site in the space where each booth had its own sink, however, the plumbing wasn’t commercial grade and the space was not to code.

McEwen described how the permit process was fast-tracked since the injection site was on the political agenda of the recently elected mayor, Larry Campbell. The space was to be opened within 6 months of Campbell being elected, meaning the design, permit, and construction had to move quickly. “This shows that political will can actually make things happen, if desired”. [27]

The health authority was most concerned with the design of the injection room. The partitions were required to ensure that people didn’t exchange drugs in the injection room, in addition these partitions had specific height requirements, and the chairs had to be separated a specific distance. There were certain requirements for the nurses station and for the mirrors. When selecting finishes McEwen said there was no manual or regulations to follow like other building typologies have. He had to research materials that were durable, low-cost, washable, and easy to maintain. The health authority was concerned that the air changes were done frequently to protect staff in case visitors had tuberculosis or other airborne illnesses.

McEwen said there were certain humanistic design components he included in his design; respect for the occupant, an interior surrounding that was welcoming and not like a morgue, avoiding clinical colours, and making the space comfortable, not oppressive, for staff.

The budget was low and interestingly authorities wanted it to appear that way. There was a pressure from authorities for the space to “look cheap”. When McEwen selected the pendant lights for the space, the healthcare authority and other officials thought it was “too nice for junkies”. The light fixture he had selected was only slightly more expensive than that highly clinical option authorities wanted, so he insisted on his selection, and paid the difference. Likewise, furniture in the ‘chill-out’ room could not be “too nice” or “too comfortable”. [27]

Going forward McEwen doesn’t think that anyone will replicate a standalone building like Insite, as it is much more expensive than the alternative of embedding the service within housing or health care settings. In addition, he suggested looking at airport lounge design where an effort is made so people do not sleep, but still remain comfortable and visually appealing.
‘Monica’ described her life before and after Insite. “Without this place I would be dead. I have overdosed here twice.”

The CBC Radio program, The Doc Project, featured a story about Crosstown Clinic. In this story, Kevin described his life before and after HAT. Kevin was recruited for the NAOMI trial in 2005, and since has received prescription heroin at Crosstown Clinic. Once he was given prescription heroin, Henry’s life became stabilized. He no longer had to hustle for drugs, or hide from police resulting in extra time. “I started going for walks. Seeing stuff. Realizing that I have been living a block from the ocean and I hadn’t been down there for the 25 years I’ve lived here.” In addition, since receiving his prescription he has housing, he has a job, has a girlfriend, hadn’t had any police interactions. [10]
CHAPTER V: INCEPT

Proposing my GP 2 project

What can be learned and improved on by the thorough analysis of Insite?

How can barriers be considered on a continuum and architectural scale?

How can Drug Consumption Spaces be measured in terms of achieving Cultural Safety?
Insite gave a physical locus to the unprecedented building type of Drug Consumption Spaces that is at the forefront of surge in present time. From an architectural point of view, Insite is not by any standards an architectural wonder. However it is achieving its objectives, and was certainly far better than I expected. I was taken aback by the business-like efficiency and functional routine of what otherwise seems like a chaotic activity, injecting drugs.

It is understood that Insite is a space welcome to everyone. Everyone is and will be treated with dignity and respect. There is a common misconception that this population disrespects public property however, it is clear that the participants of Insite have great respect and pride for ‘their’ space, which is essential for its maintenance. The model of a nonjudgmental environment, with peer-workers as well as naming visitors ‘participants’ means that the population takes ownership and responsibility of Insite. Participants understand that the space and staff deserve respect because if rules are not followed, ‘their space’ is at risk of closing.

There are unique aspects about this usergroup. They could benefit greatly from engaging architecture, that was Culturally Safe for their needs. When dealing with this specific population, the space should have a minimum number of policies and regulations because “every time you have a policy, someone gets excluded”. [8] Designing a facility for this population, and for Harm Reduction in general, is about lateral engagement, not hierarchical engagement. In a traditional doctor-patient relationship, the doctor creates a plan that the patient is expected to be compliant with and has little input on. Harm Reduction however, is a dialogue and wants to engage with personal needs and realities. “Let’s have fun with people, let’s appreciate people who decide to come here, let’s recognize that the people who come in the door are more than drug users or people with mental health issues, let’s talk about baseball or cars. That is harm reduction.” [8]

Drug Consumption Spaces should not be considered the silver bullet for creating complete health among the Downtown Eastside population. This population is also in desperate need of other basic life requirements like housing and food security. In addition, they need access to meaningful work. Drug Consumption Spaces can provide nonjudgmental spaces, creating a doorway for people to access other services.

**Chapter 17: GP 2 proposal: furthering Insite**

Through my investigation of Insite, I identified some challenges and aspects that could be improved or applied to further benefit the usergroup.

**Space:** The largest issue Insite faces is capacity. Insite only has 13 booths and on average 700 visitors per day. I wonder if there were no partitions, and just a long counter, if they could have more people in the space. Through conversations with the architect of the space, Sean McEwen, I came to understand that these partitions were so people didn’t exchange drugs on site [27]. However, it would be worth investigating if this should be considered a valid concern. From my research I do not think it is, but rather a way for the health authority to feel more in control of a population they are trying to understand. In addition, other sites around the world do not have these partitions and in France there are group areas, individual booths, and a private injecting stall.

**Circulation Challenges:** Like any space, efficiently moving people through is important for business. It is even more difficult to move people without proper housing through the space. At the same time, participants should not feel rushed. Creating meaningful relationships within the space allows people to feel more connected, and more willing to trust other services like health clinics, treatment centers, or hospitals for the care that Insite cannot offer on site, only refer people to. Also, rushing can lead to poor injection practices.

**Windows:** In addition, previously the glazing on the front façade was frosted with blinds. However, this was changed to accommodate Occupational Health and Safety standards. When considering the window treatment, the windows are intentionally not blacked out with the concern that the space may appear as a “porno shop, or a triple-X shop, or that something illicit is going on in here, after all it is healthcare that is going on in here”. [8] The new design leaves the glazing transparent, at the consequence of privacy. Perhaps a solution would be frosting the window half way, as to create more privacy but still allow natural light to enter. This was demonstrated in AMOC in Amsterdam. Although AMOC is located on the second story (not at grade like Insite), the glass is frosted on the bottom half, to allow for privacy while not blocking out the light. [20]
Entry Area: The reception area underwent an Occupational Health and Safety redesign in 2013. In reference to this new design Fisher went on to say, “it sucks so badly it’s not even funny”. [8] From an occupational health and safety lens, it achieves its objective. For example, the reception counter is designed deep enough so that a human arm length is unable to reach over and possibly harm or strangle the staff member at the desk. It was also important that the entry area have egress in case of emergency, the “when shit hits the fan, the terrified staff can run into the back room”. [8] However, this extreme situation has rarely, if ever occurred. In any event this was a requirement mandated by the city. This population is viewed as a threat, and the Occupational Health and Safety requirements are a response to this. [8] What has resulted from this redesign is an abundance of open space. In general Fisher views this undifferentiated space as difficult to manage and perhaps best used to serve other purposes. Previously the desk was located upfront. This seemed to be more successful way to welcome people into the space, even though it did not pass the Occupational Health and Safety standards.

Message board: Many members of the population of Insite do not have cellphones or a home address. In the entry area there is a small bulletin board where visitors leave messages for one another. This was really inspiring. The bulletin board was full of notes from friends trying to meet up, to talk, to create connections and relationships. However, there were no pins, paper, or pens available so these notes are written on only receipts, papers, or grocery bags and attached with tape, a couple pins, or even a safety pin. This idea could be expanded throughout the entry space or even onto the exterior of the building. Some ideas may be to use chalkboard paint, this would reduce the need of paper and pins, though would require chalk, or just supplying pins and paper next to the board. It would be a simple intervention, but I believe impactful. After all, beyond their addiction, like any human, we need to feel connected to our communities and to each other.

Nurses Station: In the injection room, a user of the space noted that the nurses station is one step higher than the main area. She felt that nurses were then constantly looking down on her and created hierarchy. Although I am sure this was intended to increase surveillance and thus safety, it is still important to realize that this community, with their negative experiences with health care and authority may experience things differently.

Hanging Space: It is often raining in Vancouver meaning people enter Insite with wet clothes, shoes and umbrellas. At the booth, there are no hooks for people to hang wet jackets or umbrellas. People end up hanging umbrellas on the track for the lighting, which obviously isn’t ideal, this demonstrates a clear need for hooks.

Private Booths: Another user said that when he injects in the groin area, he would like privacy but the current design does not allow this. He suggested individual stalls. The partitions do provide some privacy, but if privacy was really a concern, then booths should be designed differently – but this may compromise surveillance by the nurses. In France, the injection facility has private stalls. It would be beneficial to understand how surveillance is achieved.

Women Only Section: A staff member described how women often feel that sharing the space with men is a barrier for use, so perhaps a women-only section would be beneficial, again space is an issue. [28] Perhaps a compromise would be having a curtained off area during hours when women of most need of the space – for example when female sex workers finish their shift.

Bathrooms: Going to the bathroom is a basic human need we all share. There is a bathroom in Insite, however it is located in the chill-out room and it is a single stall. One user of the space described how some drugs are cut with laxatives so they require the bathroom almost immediately after injection. He said that he has run out to the alleyway to relieve himself, this is a terrible misfortune for everyone.

Chill-out room: Creating connections is an essential aspect of Insite’s success. The chill-out room is a good site of intervention to foster community. It was originally proposed that Insite would serve food and have comfortable chairs. However, the healthcare authority at the time did not approve this, as they feared it would encourage drug users to keep using. Fisher believes that the mentality of authorities is unfortunately “do everything we can to make it uncomfortable so that they realize the errors of their ways”. [8] There is only one table in this space, which looks like it’s out of a prison cafeteria. No one would want to meet a friend, peer-worker or staff there for coffee or a discussion, which is what is needed for this population to feel like they can access services. This should be a space that echoes elements of a living room: colour, comfort, and relaxation.
Art: A founder and former doctor at the nearby Crosstown Clinic, who started the NAOMI and SALOME heroin trials, Dr. Martin Schecter, described how people waiting in the clinic would often be drawing, writing poetry, or participating in other creative releases. This clinic operates with the same population as Insite. I am sure every minute that an addict waits to inject probably feels like a lifetime. I wonder if adult coloring books or just paper and colored pencils in the waiting area could make the wait less unpleasant. The ‘chill-out’ room could also provide art supplies. In addition, I wonder why there isn’t a limited amount of art on the walls.

Awning and Seating outside: It rains in Vancouver a significant amount of the year, yet there is no rain protection for people waiting for Insite to open, waiting for a booth to become available, or for the people who Insite is unfortunately too busy to accommodate. Some people end up injecting outside their doors if they cannot wait. Seating on the sidewalk outside of Insite would further establish Insite as a meeting place for this population and a place people can rest while they are waiting for a booth to become available. Instead this population is sitting on the often wet ground or sitting on the curb text to oncoming traffic. People are already waiting outside, why not make it more accommodating?

Colour: Colour can create a more cheerful and welcoming space. Although white was avoided in an effort to reduce the clinical feel, the space is still primarily black and white with some wood elements. After all, a black chair is in theory the same price as a red or pink chair.

Showers and foot baths: The waiting room experience in a typical healthcare facility can be intimidating to this population. Waiting rooms are crowded with people are sitting in close quarters, and this population often does not have access to a shower, resulting in high levels of anxiety and insecurities. Insite is a non-judgmental space, individuals are around their peers, so they feel more at ease. Providing access to showers would undoubtedly be beneficial to this community for hygienic purposes but also for self-image and confidence. In addition, foot problems associated with hygiene are common among the homeless population. Providing buckets for people to soak their feet would be a positive intervention.

<table>
<thead>
<tr>
<th>Street use (status quo)</th>
<th>Needle Exchange</th>
<th>Place to inject</th>
<th>Providing Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>- alley way</td>
<td>- van</td>
<td>- separate facility</td>
<td></td>
</tr>
<tr>
<td>- parks</td>
<td>- vending machine</td>
<td>- embedded service</td>
<td></td>
</tr>
<tr>
<td>- public washroom</td>
<td>- specific location</td>
<td>- tent</td>
<td></td>
</tr>
<tr>
<td>- car</td>
<td>- at home</td>
<td>- mobile</td>
<td></td>
</tr>
<tr>
<td>- at home</td>
<td></td>
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</tr>
</tbody>
</table>

**Advantages:**
- hygienic tools
- proper disposal
- hygienic, stress-free environment
- safe
- connected with other services
- access to hard to reach population
- hygienic tools
- proper disposal
- hygienic, stress-free environment
- safe
- connected with other services
- access to hard to reach population
- eliminates danger/criminal act of obtaining drugs
- drugs are regulated, tested
- removes the requirement of money for drugs (usually crime)

Figure 77: Continuum of Services

“A drug consumption space cannot be a reminder of your last day in prison. We are trying to attract users, not put them off.”

- Cedric Charvet
  Coordinator of Amsterdam DeRegenboog Groep AMOC
Chapter 18: GP 2 proposal: continuum of Drug Consumption Spaces

Insite has successfully created a low-barrier, low-judgment space. However, there are individuals who may feel like Insite is still too institutional. Insite is achieving their main objective of harm-reduction as well as reaching a hard to reach population and further, treating a hard to treat population. Architecturally there is a substantial amount that could be learned from their approach. Many aspects of Insite were learned on a ‘trial and error’ basis. Knowledge transfer is essential for designing the best possible spaces. Undertaking a thorough examination of the case study of Insite was useful for the architectural discourse, discussions on Culturally Safe spaces for the Downtown Eastside population, and for the public at large to understand how Insite operates. Applying these lessons on a continuum of Drug Consumption Facilities will hopefully create spaces that cater to the needs within this community.

1. Alley way or Park: outside, unsupervised, low cost.

Drug use is occurring. When individuals have to hide it leads to being rushed leading to potential harm, or seeking dark possibly unsafe spaces, and many of these places are unhygienic, even containing human waste. Rather than attempting to cover up the reality of drug use or banning it elsewhere, perhaps there’s a way to use a minimal intervention to make it safer and more comfortable similar to a covered bench or bus stop.

2. Tent: outside, lightly supervised, covered, low cost, temporary, portable.

A tent is a low barrier response that provides shelter from the weather and more privacy. The requirements are basic: a tent, a table, a chair, and some emergency response equipment. There are architectural issues with privacy and surveillance. In addition, a tent appears as a temporary solution so it is possible that the intended users will not see the service as something they can depend on. A tent may appear too temporary or ad-hoc to be considered a dependable source of safety to this group.

3. Mobile Unit: heated, supervised, secure, portable.

A mobile unit could provide a heated environment, which is obviously more comfortable and for injection drugs makes finding a vein easier. The first aid station would be more significant than a tent. It could also have a bathroom and shower facility integrated within. Like the tent, a mobile unit appears as a temporary solution so again, it is possible that the intended users will not see the service as something they can depend on. It would not be the landmark and predictability that a permanent building would provide.

4. Embedded Service (ex. Dr. Peters Centre / in social housing projects): heated, connected, dependable.

An embedded service is what seems to be the trend for implementing Drug Consumption Spaces moving forward. A Vancouver Nurse who was involved with the NAOMI and SALOME heroin trials, Janine Stevenson, discussed how there is starting to be a shift towards “wrap around services” meaning creating a one stop shop. [52] Providing a Drug Consumption Spaces in a social housing facilities, as proposed by Mayor Gregor Robertson [32], would be a reasonable start for this type of Drug Consumption Spaces. Another aspect is implementing Drug Consumption Spaces in a hospital setting. A doctor in New Hampshire proposed this idea in the New York Times stating, “Safe drug-use rooms are typically designed to help keep addicts out of the hospital, but they could work for addicts within hospitals. A safe place to inject for addicted patients in the hospital could reduce conflict with staff, protect patients and providers from dirty needles and other drug hazards, and enable patients to receive respectful, high-quality care when back in their hospital beds”. [53]

5. Renovation (ex. Insite): heated, standalone service, less costly than purpose built.

Renovation is the category that Insite falls into. This option might be a less expensive and might be how to reach the desired location. Re-purposing an existing space may be a better option, as the location may already be known,
6. Purpose Built

Renovating an existing building limits some architectural opportunities to meet the needs of patients. A purpose built facility would learn from Insite and other facilities but also be able to be more specific in the design and layout. For example, the entry way from the street in an existing building is usually maintained in a renovation. In the case of Insite, the some users voiced that they would appreciate a more discrete entrance. In addition, as mentioned, the expansive space between the entrance and the reception desk is difficult to manage. A purpose built facility is inherently more expensive and timely to execute.

7. Methadone, Suboxone or HAT Clinic (ex. Crosstown Clinic)

Since the 1990’s successful Heroin Assisted Treatment (HAT) programs were set up in Switzerland, Denmark, the Netherlands, UK and Germany. [9] It is restricted to those where conventional treatments such as methadone maintenance or suboxone have failed them. In Vancouver, Crosstown clinic is the only clinic in North America to offer medical-grade heroin (diacetylmorphine) and the legal analgesic hydromorphone within a supervised clinical setting to chronic substance use patients. It appears to be the desired next phase of development. [12]

This facility, although similar to Insite, would also encompass a new requirement of housing drugs. Since it would still deal with a similar user group to Insite, creating a low-barrier, low-judgment space is still essential, however the one at Crosstown Clinic is extremely clinical, a model that does not work for this user group for reasons stated throughout.

8. W/O Prohibition ... Legalize Drugs

This option would investigate what a space would look like if individuals could essentially inject or use drugs anywhere. There would still be a requirement of surveillance in the event of an overdose, but there would be less restrictions as to how the facility was organized and how visitors could move and operate within the space.

Chapter 19: assessment tools

Assessment tools that investigate wellness, health, and livability of spaces will be further investigated.

Possible Assessment tools:

International WELL Building
WELL is a building standard that focuses exclusively on the health and wellness of the people who occupy buildings. “WELL is a performance-based system for measuring, certifying and monitoring features of the built environment that impact human health and well-being, through air, water, nourishment, light, fitness, comfort and mind. It marries best practices in design and construction with evidence-based medical and scientific research – harnessing the built environment as a vehicle to support human health and wellbeing”. [54]

Healthy Impact Assessment (HIA):
https://www.cdc.gov/healthyplaces/hia.htm
http://www.who.int/hia/en/

Healthy Development Assessment (HDA):

The Economist Intelligence Unit: Livability Ranking
All human spaces are worth designing well and are worthy of design thinking. Drug Consumption Spaces are no different, but merely present a challenging and urgent instance.

As future architects it is important to understand the issues that exist in the city fabric and how these issues impact all physical and socioeconomic scales. I believe that architecture has some obligation of creating socially sustainable spaces that provide a positive social impact.

Researching for this topic required that I visit Vancouver’s Downtown Eastside numerous times, an atmosphere so far removed from the area of Vancouver I live in. This was an area I was raised to avoid. My research has made me be more conscious of my own actions and judgments. I have come to know Vancouver, the city I was born and raised in, and previously thought I knew quite well, in a new way. I will admit that at times it was uncomfortable, scary, and intimidating but these were purely preconceived notions, an unconscious bias of sorts. In reality I was never threatened or in danger.

Crime and violence does absolutely occur in the Downtown Eastside and is by no means a ‘model’ community, but the authenticity of the community can still be appreciated. Everyone is as they appear, they are upfront and straightforward; doing their best with limited resources. People in the Downtown Eastside community care and look out for one another. They truly ‘know’ their neighbors something that is rare in the rest of the city. There, the people around them are often all each other have. In the face of what is obviously terrible, living your life in the alley, it is interesting to realize that there is a kind of community and a range of moral expectations of those who find themselves reduced to this extreme destitution. I had many moments of feeling lost or out of place however, everyone I encountered was friendly and accepting. It became apparent that this community has vital knowledge to transfer and it is essential we engage and listen. Their care for one another, points the way to indicate the importance of the rest of us to try to help, acknowledge, and understand their needs.

This project has presented me with moments of stress. I am dealing with a real life problem with very real constraints. We are never going to design in a vacuum like architecture school often presents. Personally I did not want my thesis to be comprised of my own imagined constraints and rules, rather I wanted to address a real problem. The design of Drug Consumption Spaces is a real and critical pressing issue.

“We may not be responsible for the world that creates our minds, but we can take responsibility for the mind with which we create our world.”
- Dr. Gabor Maté
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