



Research paper

Assessing support for supervised injection services among community stakeholders in London, Canada

Geoff Bardwell^{a,b}, Ayden Scheim^c, Sanjana Mitra^d, Thomas Kerr^{a,b,e,*}^a British Columbia Centre on Substance Use, St. Paul's Hospital, 608-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada^b British Columbia Centre for Excellence in HIV/AIDS, St. Paul's Hospital, 608-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada^c Department of Epidemiology and Biostatistics, The University of Western Ontario, K201 Kresge Building, London, ON N6A 5C1, Canada^d Ontario HIV Treatment Network, 1300 Yonge Street, Suite 600, Toronto, ON M4T 1X3, Canada^e Department of Medicine, University of British Columbia, St. Paul's Hospital, 608-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada

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ABSTRACT

Objectives: Few qualitative studies have examined support for supervised injection services (SIS), and these have been restricted to large cities. This study aimed to assess support for SIS among a diverse representation of community stakeholders in London, a mid-sized city in southwestern Ontario, Canada. **Methods:** This qualitative study was undertaken as part of the Ontario Integrated Supervised Injection Services Feasibility Study. We used purposive sampling methods to recruit a diversity of key informants (n = 20) from five sectors: healthcare; social services; government and municipal services; police and emergency services; and the business and community sector. Interview data, collected via one-to-one semi structured interviews, were coded and analyzed using thematic analyses through NVivo 10 software.

Results: Interview participants unanimously supported the implementation of SIS in London. However, participant support for SIS was met with some implementation-related preferences and/or conditions. These included centralization or decentralization of SIS; accessibility of SIS for people who inject drugs; proximity of SIS to interview participants; and other services and strategies offered alongside SIS.

Discussion: The results of this study challenge the assumptions that smaller cities like London may be unlikely to support SIS. Community stakeholders were supportive of the implementation of SIS with some preferences or conditions. Interview participants had differing perspectives, but ultimately supported similar end goals of accessibility and reducing community harms associated with injection drug use. Future research and SIS programming should consider these factors when determining optimal service delivery in ways that increase support from a diversity of community stakeholders.

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Introduction

Injection drug use continues to be associated with health-related harms, including human immunodeficiency virus (HIV), hepatitis C virus (HCV), endocarditis, and overdose (Milloy, Kerr, Tyndall, Montaner, & Wood, 2008; Tung et al., 2015; Tyndall et al., 2006; Wood et al., 2005). Additionally, adverse social and community impacts often include public injecting and associated discarded injection debris such as needles and syringes. This is true of London, a mid-sized city in south-western Ontario, Canada, with

a population of close to 370,000 (Statistics Canada, 2011). It has a higher burden of injection drug use compared to most other cities in Canada. For example, in 2014, 2.5 million needles and syringes were distributed, making the local harm reduction distribution program the second busiest per capita next to Vancouver (Campanella, 2015). In 2011, a multi-city study of people who inject drugs (PWID) in Canada found higher levels of injection equipment sharing and lifetime HCV infection among London PWID than the national average (Middlesex-London Health Unit, 2012). Further, according to a more recent report, opioid-related death is more than two times higher than the provincial average (Middlesex-London Health Unit, 2014). Multiple community stakeholders – ranging from business associations to public health officials – have identified injection drug use as an issue that is negatively affecting the city (De Bono, 2016; Ghonaim, 2016), with the Medical Officer of Health and one city politician calling for

* Corresponding author at: British Columbia Centre on Substance Use, St. Paul's Hospital, 608-1081 Burrard Street, Vancouver, BC V6Z 1Y6, Canada.
Fax: +1 604 806 9044.

E-mail address: uhri-tk@cfenet.ubc.ca (T. Kerr).

supervised injection services (SIS) as a necessary response to the individual and community harms associated with injection drug use (Sher, 2016).

SIS are interventions that have been implemented elsewhere in Canada and rigorous evaluations demonstrate their effectiveness and positive impacts on communities (Milloy, Kerr, Mathias et al., 2008; Rhodes et al., 2006; Wood, 2004). Despite the proven benefits of SIS, they remain controversial and face continued opposition from some segments of the public (Small, Palepu, & Tyndall, 2006). SIS feasibility studies have been undertaken in larger urban settings to inform the design of such facilities and to gauge community support and concerns (Bayoumi, Strike, Brandeau, & Degani, 2012). In the Canadian context, federal laws that govern the establishment of SIS require community consultation (Woo, 2016).

Public and stakeholder opinions substantively impact policy decisions (Burstein, 2003) and should be considered for the development of harm reduction strategies such as SIS. SIS programming, similar to other harm reduction strategies such as needle and syringe distribution programs (Vernick, Burris, & Strathdee, 2003), has been met with mixed opinions from the general public (Cruz, Patra, Fischer, Rehm, & Kalousek, 2007). While there has been an increase in public support for SIS in Ontario, public opinion remains divided (Strike et al., 2014). Few studies on public opinion and perception of SIS exist and these are primarily quantitative (Cruz et al., 2007; Kimber, Dolan, & Wodak, 2005; Salmon, Thein, Kimber, Kaldor, & Maher, 2007; Strike et al., 2014). Minimal qualitative studies on public and stakeholder support of SIS have been conducted in Canada, and like past feasibility studies, these are limited to large cities (Strike, Watson, Kolla, Penn, & Bayoumi, 2015; Watson et al., 2012). Therefore, we undertook this study to assess support for SIS among a diverse representation of community stakeholders in London, Canada. This study challenges the assumption that smaller cities are resistant to harm reduction drug policies, which runs counter to the argument of Draus and Carlson, who suggest that in contrast to smaller cities and towns, larger cities are “often characterized by a higher degree of anonymity and more liberal attitudes toward individual behaviour” (Draus & Carlson, 2009).

Methods

This qualitative study was undertaken as part of the Ontario Integrated Supervised Injection Services Feasibility Study in London, Canada. Key informant interviews were conducted with community stakeholders ($n=20$) to identify concerns related to injection drug use; describe perceived perspectives on SIS; and identify opinions and support for SIS, including levels of acceptability, design, and location preferences. We used purposive sampling methods to recruit a diversity of key informants from five sectors: healthcare ($n=5$); social services ($n=5$); government and municipal services ($n=3$); police and emergency services ($n=2$); and the business and community sector ($n=5$). The study was overseen by a community advisory committee composed of members from various stakeholders (e.g., business associations, health services) and they were selected based on their expertise and interest in community responses to injection drug use. This committee finalized the list of stakeholder groups (e.g., neighbourhood associations, police, health centres) to invite to participate in the study. Each group was contacted via email to participate and individually chose who would represent them in the confidential interview process. The interview participants ranged from frontline workers to middle management and executive directors.

Between May and June 2016, the lead author conducted one-to-one semi-structured interviews. An interview guide was used to facilitate a range of topics, including: impacts of injection drug use

on the community, knowledge of SIS, perceived positive and negative effects of SIS, and support for SIS. Participants provided written informed consent and the interviews were audio recorded and transcribed verbatim. Interview data were coded and thematic analyses were completed using NVivo 10 software. Inductive and deductive methods were utilized, which involved the use of a priori categories (deductive) and emergent categories (inductive) from the dataset via line-by-line coding and constant comparative analysis (Bradley, Curry, & Devers, 2007). During thematic analyses, multiple themes and subthemes emerged relating to support for SIS, including: location, accessibility, and integration with other services. Each stakeholder interview was assigned an individual number to ensure anonymity. Ethical approval for this study was obtained from the University of British Columbia and the University of Toronto.

Results

Key informants unanimously supported the implementation of SIS in London. However, support for SIS was met with some implementation-related preferences and/or conditions. These included the decentralization or centralization of SIS; accessibility of SIS; proximity of SIS to key informants; and other services and strategies offered alongside SIS.

Decentralization of SIS

Some key informants said they preferred the location of SIS to be away from a centralized location (e.g., downtown). Most of these decentralization perspectives came from participants in the business and community sector. There were concerns about having SIS located where there is a pre-existing concentration of other health and social services. Participant accounts illustrated concerns about having a concentration of services in one specific area. For example, one participant described the potential for SIS to have positive impacts on PWID, but at the perceived expense of other segments of the community:

They need to be making sure that whatever location it is, [it] is not furthering to create a concentration that will, to be frank, will damage another whole component of the community for the sake of another population . . . I think there needs to be balance and I think concentrating the services doesn't create balance. (Business and community participant 020)

This participant drew comparison to social housing projects and how ghettoization can create negative impacts on community. Decentralization of SIS, according to this participant, was necessary to avoid the stigmatization of a neighbourhood:

[SIS] need to be decentralized because as I understand it you know . . . people realize they made big mistakes when they put . . . all of affordable housing into one area because it stigmatized the area and it created this lack of diversity and lack of mixed neighborhoods that really led to some negative results. (Business and community participant 020)

Other participants also had concerns about the concentration of services in one area. The decentralization of SIS, not only would avoid further stigmatization for a particular neighbourhood, but it would spread services out so PWID in other areas of London would be able to access SIS. One participant suggested that decentralization would work as long as the service was accessible by public transit:

I would think it needs to be a location that's very accessible by public transit, for sure, but it doesn't have to be you know downtown or east end or like a typical spot that we've already had services. It could be another well-bussed spot and maybe

have things spread out a little bit would be a good choice. Like it's not like there are not drug users on the west end. We're painting a story that it's on the east end by putting all the supports for it in the east end. (Business and community participant 012)

Some participants were not opposed to SIS being centrally located. However, they saw the need for services across the city, as demonstrated in the following excerpts:

I think we need them all over town. I think people assume that everything will be concentrated downtown. Yes, we need them downtown but we also need them east end of London, north end of London. We need them all over. (Social services participant 006)

One model that I looked at one time and this was about methadone and getting your carries, was looking at having 35 pharmacies in the city, well trained with outreach attached to them, to run the methadone programs. Without putting buildings in place, you train pharmacists who actually have extraordinary skills. And if we look at all the Shopper's Drug Marts in the city and they do their flu shots there, what about a scattered site model where we're training up those with talent, our pharmacists, to look at what they can offer through a centralized system that's got the right outreach, right training, right prevention, right all the way around. (Government and municipal services participant 017)

Centralization of SIS

Many key informants specified that SIS should be located in a centralized area. These perspectives came from interview participants from all five sectors (as identified in the methods section). Having SIS centrally located was seen as beneficial not just to PWID, but also for the London community as a whole. While there were concerns from other participants about the concentration of services in London's core, this was not seen as a negative aspect of SIS to some participants. For example:

So if you're going to have one, it would be centralized. And then preferably close to other services, like again, I told you about my dream about sort of one block like where it would be a centralized collection, amalgam of services. There are places in Canada like that and there ain't fucking one here and it's terrible. You've got to go to 15 different spots and ride 6 different buses to make it. (Healthcare participant 008)

Other participants suggested that having SIS close to other services would increase the likelihood of PWID in using those services. For example, one participant suggested that by not having SIS centrally located, there would be a risk of people not using its services:

[SIS] should be not quite downtown but Dundas east . . . probably near the methadone clinics and stuff that are around that area would be useful just because of the fact that it's easier for people to come get their drink and you know I think having it in that area, I think it's going to make it more available to them and they're more likely to use it . . . I mean I think ultimately I think some of the community would probably want an area like, something that's probably quite isolated because they probably wouldn't necessarily want that kind of resource right in their neighborhood. However, I think the more isolated you make it, the less likely it is to be used. (Police and emergency services participant 018)

Despite perceived potential negative impacts of SIS on central neighbourhoods, some participants felt that SIS need to be proximate to locations where injection drug use more frequently

occurs. For example: "As far as the site, it would have to be in the downtown core because we know that's where people are injecting drugs more frequently than other places" (Healthcare participant 019). Having SIS centrally located would not only respond to the need for these services for PWID in the area, but participants also saw SIS as a public health response to a high volume of publicly discarded needles and syringes in certain neighbourhoods. In the words of one participant: "If we're doing three [SIS] I think they would be downtown, SoHo, and Old East. I live and work in basically all those neighborhoods. They're already there, right? I'd rather see those needles deposited in a bin as you exit the site" (Healthcare participant 007). The centralization of SIS in the downtown area was seen by many key informants as important not only for addressing public injection and associated waste, but also because of close proximity to other health and social services accessible to PWID.

Accessibility of SIS

Most key informants discussed accessibility of services by PWID as a key condition for SIS in London. Similar to the preferences for decentralization or centralization of SIS, participants discussed accessibility in terms of the location of SIS in London: "The most important thing is it's going to be readily accessible, accessible to the most number of people and really where people are either accessing care or where they're using already" (Healthcare participant 002). Another participant suggested: "Well it needs to be located somewhere that's easily accessible right. I think for street users it needs to be someplace that's easily accessible and unfortunately it always seems to be the east side there" (Police and emergency services participant 014).

While some participants in favour of the decentralization of SIS suggested that services need only be accessible by public transportation, the following excerpts illustrate how public transportation could be a barrier to PWID accessing services: "For sure one [SIS] central because again, people that tend to be of the IV drug using ilk quite often don't have access to transportation. So for it to be in a place where they could access it necessarily without having to travel would be good" (Healthcare participant 008). According to another participant: "If there was more of a centralized site where they could have anonymity with like maybe a back door, then it would probably work okay somewhere that's accessible. But I'm also finding that a lot of individuals are having a hard time with getting bus tickets and/or getting about" (Social services participant 016).

Some participants suggested a mobile SIS as a way to make the services accessible to PWID throughout the city. The following excerpts illustrate this perspective:

This is going to sound crazy . . . you need three sprinter vans . . . You need a mobile injection site. I think that's the answer because it's not located anywhere. If you're going to have to locate it somewhere, I think it needs to be located downtown. The problem with London is it's so . . . there's so much urban sprawl that you're not going to hit all your population with one location right. I think you just have a nurse and a worker. They get a phone call. They just drive up to where it is and done. I think that's the way to go. (Social services participant 010)

I think in Denmark they have vans that are staffed and equipped with harm reduction supplies and they can be sent to various locations upon request in order for someone to access their services. I think it would make sense to offer some kind of a supervised injection service; the Dundas corridor, perhaps right downtown. But I think ideally what I'd like to see is that whole idea of a mobile service. (Healthcare participant 013)

Aside from the accessibility of the location of SIS, almost all key informants discussed accessibility in terms of days and hours of operation, suggesting that these services be readily available when needed. The following excerpts demonstrate the need for SIS at all times: “Well individuals need help 24/7, so help should be available for them whenever they need it” (Government and municipal services participant 005) and, “You need to have some options that were 24/7 and you’d need to have some other ones that were certain hours of the day like 8 to 8 . . . If you’re going to really try and provide a safe place for people, it needs to be available when they want to inject drugs” (Government and municipal services participant 001) Accessibility to SIS was a condition that all of the participants agreed upon. While their perspectives differed in terms of the location they all provided ideas for ensuring the services responded to the needs of PWID.

Proximity of SIS to key informants

Key informants from the business and community sector exclusively discussed their preferences regarding the proximity of SIS in relation to their businesses or neighbourhood locations. Almost all of these perspectives suggested that this sector in particular saw issues with having SIS located in close proximity to them. Concerns pertaining to the concentration of services were perceived as having a negative impact on this sector. Some participants suggested that SIS should be located with other health and social services, but not in a central location by neighbourhoods and businesses. In the words of one participant: “I think ideally they should be located where other services are located. But I support anything that’s going to try and tackle the problem. But I think they should be located where other services are located and not centrally located” (Business and community participant 009). This participant suggested that the development of SIS was not part of the City’s official plan for downtown and, as seen in the following excerpt, there was the perception that it would tarnish the neighbourhood’s image:

I think the [research] team also has to look at what’s being planned for the entire city, I mean the London Plan, which is their official plan. I think the planning principles have to be applied to this as well. I mean the city is about to drop \$60 million on Dundas Street. We don’t want it to be an injection site. We’re not under any impression that downtown is ever going to be you know sparkling clean and you know . . . it’s busy. It’s going to get tarnished. But we want it to be as clean and safe as it can possibly be because it affects the entire city. (Business and community participant 009)

While key informants from this sector were largely opposed to SIS being in close proximity to their businesses and neighbourhoods, this view was not unanimous. For example, one business and community participant saw a positive potential impact of SIS as addressing harms in her neighbourhood such as publicly discarded syringes in parks and playgrounds. While it is clear from the previous section that key informants wanted SIS to be accessible to PWID, its location away from their business and neighbourhoods was conditional for most in this sector.

Other services and strategies for SIS

Many key informants across all sectors discussed their support for SIS in terms of what other health and social services are being offered alongside the injection services as part of a continuum of care. Key informants not only saw these additional services as conditional to their support for SIS, but also as necessary to ensure the effectiveness of SIS. Some participants did not see a

stand-alone site as effective in addressing the complex needs of PWID. For example, one participant said:

I think it’s a good idea for London. I think the key is the services and making sure that the services provide it . . . I’m not totally convinced at this point that something like a big injection site is the right kind of model for London. I don’t know if that’s really the right thing but certainly providing supervised injection services I think would deal with many of the major issues we’ve got around injection drug use. It’s not going to solve everything but it’s going to be a big step. (Government and municipal services participant 001)

Integrated services were discussed as providing a continuum of care for PWID where there are multiple strategies to support clients and prevent harms associated with injection drug use:

I think definitely in integrated services, so where there is that continuum of care already that exists and where people are ready. But in terms of again that model of the hubs, normalizing being able to go someplace and use a service without it automatically everybody knows that’s what I’m going in there for. You know, places where there are multi-services that already exist. (Social services participant 011)

When probed about specific services or strategies that should be offered alongside SIS, many participants provided specific suggestions, including community partnerships; education and awareness campaigns for the general public; supportive housing programs; substance use treatment options; and counseling supports. Participants saw these as important strategies and services for effective SIS programming.

Discussion

In summary, our findings suggest that community stakeholders in London support the implementation of SIS. These findings were met with five preferences or conditions. First, some participants suggested that the decentralization of SIS was a positive alternative to the concentration of services in a particular area that they perceived as having negative impacts on a neighbourhood. Decentralization was also seen as a way to reach PWID who live in other neighbourhoods in the city. Second, other participants saw the centralization of SIS as beneficial to PWID because it would be close to other services thus increasing the likelihood and ease of use, and it would decrease the high frequency of public injection and associated debris. Third, most participants discussed how SIS need to be easily accessible by PWID, which sometimes meant accessibility within walking distance. Some suggested a mobile unit to increase accessibility of SIS for PWID throughout the city and almost all participants indicated that SIS should be open 24 h a day. Fourth, some participants discussed their support for SIS in terms of its close proximity to them. This was perceived as having a negative impact on business while others saw it as having positive community impacts such as less public injection. Fifth, many participants saw integration with other services and strategies as critical to the effectiveness of SIS in London.

Accessibility of SIS was a theme that emerged across stakeholder interviews from both the centralization and decentralization perspectives. However, it is important to further explore what exactly accessibility meant for participants from each of these perspectives. Participants from the centralization camp saw accessibility in terms of having SIS in a location where most PWID live, access services, and inject drugs publicly. Public transportation was described as a barrier for many PWID. Ultimately, those who endorsed centralization perceived a concentration of PWID in central neighbourhoods and thus saw these neighbourhoods as offering the greatest SIS accessibility.

Participants from the decentralization camp described accessibility in terms of being accessible outside the city centre where some local PWID also live and inject drugs. Rather than having a fixed SIS located in one neighbourhood, mobile vans were seen as an option to reach PWID. In contrast to the centralization position, public transportation was seen as a means for PWID to access SIS in these other areas of the city. Furthermore, some participants from the decentralization camp, in contrast to the centralization perspective, described the centralization of services and supports in one area as suggesting that the issue is not a city-wide problem. These participants suggested this was “painting a story” that the problem is geographically-specific to the central core of the city (business and community participant 012) and that “there needs to be balance” in terms of providing services across the city (business and community participant 020).

While SIS is a harm reduction strategy that could benefit multiple levels of the community (e.g., individual, organizational, and neighbourhood levels), the experiences and preferences of PWID should be central in determining where a SIS is located, as it would be a direct service to them. In terms of accessibility of SIS, the centralization perspective most benefits PWID given their high concentration and public use in central neighbourhoods (Kerr et al., 2017), as well as evidence indicating that many PWID will not travel great distances to use SIS (Petrar et al., 2007). Further, quantitative data also suggests that PWID have an overwhelming preference for centrally-located SIS (Kerr et al., 2017). Therefore, it appears that the decentralization perspective aligns less with effectively responding to issues related to injection drug use. Public transportation, for example, is not accessible for many marginalized PWID, and while mobile SIS vans are an option worth exploring, they likely would have less PWID accessing them in comparison to services in the central neighbourhoods where PWID overwhelmingly congregate (Kerr et al., 2017).

What is perhaps most notable of much of the decentralization perspectives is that many who hold this position also do not want SIS in close proximity to them. Among some, NIMBYism (not-in-my-backyard) appears to be hidden under the guise of decentralization, which makes it less of a consideration related to accessibility for PWID and more about its geographical location in proximity to some stakeholders. Responses of NIMBYism to harm reduction services have been well-researched (Bosque-Prous & Brugal, 2016; Davidson & Howe, 2014; Smith, 2010; Strike, Myers, & Millson, 2004; Tempalski, Friedman, Keem, Cooper, & Friedman, 2007). For example, Smith (2010) examines the opposition from residents and business owners to the relocation of a methadone clinic into a gentrifying neighbourhood in Toronto. Smith demonstrates how residents and business owners perceive the clinic and its clients as stigmatizing the neighbourhood. Tempalski et al. (2007), suggest that NIMBYism is more aptly an “inequitable exclusion alliance” that works to institutionalize the stigmatization of PWID and other marginalized communities. Similarly, our study highlights an emphasis on the themes of decentralization and proximity to key informants mostly from participants from the business and community sector. There were expectations that negative impacts of SIS on businesses and neighbourhoods would emerge, despite evidence from settings with SIS suggesting that these programs can actually improve public order (Wood, 2004). One participant, in particular, opposed establishing SIS downtown, citing a need for the downtown core to be “as clean and safe as possible” (business and community participant 009). NIMBY perspectives on harm reduction interventions are characterized as being in opposition to new strategies, but rarely question their usefulness to the very problems they face such as public injection (Bosque-Prous & Brugal, 2016; Strike et al., 2004). Other participants in our study suggested that SIS be centralized. They saw SIS as responding to issues related to public

injection, which can be seen as a strategy to increasing cleanliness and safety for the downtown community (Wood, 2004). Studies have shown that over time, businesses and residents in close proximity to SIS undergo a significant decline in witnessing public injection and publicly discarded syringes as a result of declines in public injecting (Salmon et al., 2007; Wood, 2004; Wood, Tyndall, Lai, Montaner, & Kerr, 2006), making the centralization of SIS a public health and public order strategy worthy of consideration. Further, most participants agreed that SIS should be accessible to PWID and include a variety of wrap-around services to support clients. Rather than perceiving the centralization of SIS as increasing the concentration of services in a particular area (and therefore increasingly stigmatizing), having SIS located in close proximity to other services would increase the likelihood of PWID accessing other community supports that are needed. This type of integrated service model has been considered as the optimal model for SIS in other Canadian cities (Bayoumi et al., 2012), and past evidence has shown that SIS can serve as effective vehicles for connecting PWID to other services, such as substance use treatment (Wood, Tyndall, Zhang, Montaner, & Kerr, 2007).

Previous qualitative research in Toronto and Ottawa, two larger Canadian urban centres, has illustrated that community stakeholders tend to be either ambivalent about SIS (Kolla et al., 2017; Strike et al., 2015) or uniformly opposed to SIS (Watson et al., 2012). For example, a qualitative study of community stakeholders (n = 141) in Ottawa and Toronto, Canada, found a variety of reasons why stakeholders were ambivalent to SIS. These include concerns that the goals of SIS are narrow and need to be part of a larger strategy, the uncertainty that drug use problems are big enough to warrant SIS, and worries about the potential damages of SIS on businesses and communities (Strike et al., 2015). Another qualitative study in Ottawa and Toronto found that residents and businesses saw SIS as reducing health risks of PWID but increasing risks at the community level through loitering, drug dealing, and littering (Kolla et al., 2017). Similar perspectives were found among stakeholders in San Francisco (n = 20), who had concerns about an oversaturation of services as negatively impacting the community and skepticism about whether SIS would actually reduce harm or if they would enable drug use. While stakeholders in San Francisco had concerns about SIS, they were open to dialogue about the possibilities of SIS implementation (Wenger, Arreola, & Kral, 2011). Participants in our study shared some of these concerns, but unlike the studies in Toronto and Ottawa, these concerns did not lead to ambivalence about the establishment of SIS in London. Perspectives in London were similar to perspectives from community stakeholders in San Francisco. In another qualitative study with police services in Toronto and Ottawa (n = 18), participants were generally opposed to SIS. Some of their responses suggested that SIS and other harm reduction strategies were ineffective in addressing addiction and that SIS are counter to police efforts in addressing drug problems (Watson et al., 2012). This opposition was not demonstrated by participants in our study, which included representation from police and emergency services. Contrary to the studies in Toronto and Ottawa, our findings demonstrate different results for a smaller Canadian city. The results of this study challenge the assumption that smaller cities are resistant to harm reduction drug policies and responses (Draus & Carlson, 2009; Peters, 2011). However, while having differing viewpoints, community stakeholders from various sectors in London were ultimately supportive of the implementation of SIS with some preferences or conditions.

Why is London different than other larger cities? London has a higher burden of issues related to injection drug use, compared to most other Canadian cities. Given this reality, community stakeholders are very aware of the multiple ways in which these issues impact the community. The concentration of public injection in

central neighbourhoods (e.g., downtown and Old East) make this a very real and everyday issue for community stakeholders who live and work in these areas. It is clear that the status quo is not working. Other harm reduction efforts (e.g., needle and syringe distribution, street outreach teams, needle bins, and publicly-discarded debris retrieval services) have been effective in addressing some of the concerns of community stakeholders. However, it is also clear based on these interviews, that more harm reduction policy and programming is needed. As evident in cities such as Vancouver, for example, changes to stakeholder attitudes regarding harm reduction have occurred where problems associated with injection drug use have persisted despite investment in conventional public order initiatives (Wood & Kerr, 2006). Given the evidence and positive impact of these other harm reduction services, coupled with the day-to-day reality of the diversity of community stakeholders in London, it is not surprising that they support other harm reduction interventions such as SIS.

This research is both timely and has implications for other smaller urban centres that are dealing with the negative consequences associated with injection drug use in their communities. Minimal qualitative studies on stakeholder support of SIS have been conducted in Canada, and these are limited to large cities. Given the lack of research on smaller cities and towns, they are often assumed to be more conservative and have 'small town mentalities,' which are in contrast to larger cities that have more liberal perspectives (Draus & Carlson, 2009). Given the overwhelming support for SIS in London, governments and public health officials should not make assumptions about support for SIS in other smaller urban centres as one means to respond to community problems of injection drug use.

This study has its limitations. While we recruited and interviewed a diversity of community stakeholders, this may not be representative of all community stakeholders in London and our findings may not generalize to all of London. Further, two potential participants declined participation and may hold different perspectives such as opposition or ambivalence to SIS. Study participants may have been responding hypothetically in terms of their support for SIS given that little reflection was made on the reality of costs associated with SIS, and thus the usefulness of their perspectives are limited in informing actual policy and programming. Finally, this study was specific to London, and the results may not reflect the levels of support and conditions or preferences among community stakeholders in other mid-sized cities in Canada.

In conclusion, our study illustrates a high degree of support for SIS among community stakeholders in London, provided this support is met with varying preferences and conditions. While some of these perspectives conflicted with each other, participants' preferences for SIS were ultimately based on the belief that SIS could potentially benefit the whole community. It is clear that accessibility perspectives varied among stakeholders, with the centralization perspective as converging most with the preferences of PWID, while the decentralization perspectives were in many but not all instances nuanced with NIMBY viewpoints. Evidence-based education on the benefits of SIS in central neighbourhoods could lead to changing perspectives among the decentralization camp. Exposure to past successes of other harm reduction interventions and experiences of the very real consequences of injection drug use on a day-to-day level, are instrumental and ultimately inform stakeholders' perspectives on SIS in London. Given that stakeholder support is key to creating an "enabling environment" for harm reduction, future research and SIS programming should consider stakeholder opinion and these factors when determining optimal service delivery.

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Conflict of interest

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

References

- Bayoumi, A. M., Strike, C., Brandeau, M., & Degani, N. (2012). *Report of the Toronto and Ottawa supervised consumption assessment study*. Toronto, ON.
- Bosque-Prous, M., & Brugal, M. T. (2016). Harm reduction interventions in drug users: current situation and recommendations. *Gaceta Sanitaria*, 30, 99–105.
- Bradley, E. H., Curry, L. A., & Devers, K. J. (2007). Qualitative data analysis for health services research: Developing taxonomy, themes, and theory. *Health Services Research*, 42(4), 1758–1772.
- Burstein, P. (2003). The impact of public opinion on public policy: A review and an agenda. *Political Research Quarterly*, 56(1), 29–40.
- Campanella, E. (2015). *More than 2.5 million needles distributed in London last year*. August 14. Retrieved January 17, 2017, from: <http://www.lfpress.com/2015/08/13/more-than-25-million-needles-distributed-in-london-last-year>.
- Cruz, M. F., Patra, J., Fischer, B., Rehm, J., & Kalousek, K. (2007). Public opinion towards supervised injection facilities and heroin-assisted treatment in Ontario, Canada. *International Journal of Drug Policy*, 18(1), 54–61.
- Davidson, P. J., & Howe, M. (2014). Beyond NIMBYism: Understanding community antipathy toward needle distribution services. *International Journal of Drug Policy*, 25(3), 624–632. <http://dx.doi.org/10.1016/j.drugpo.2013.10.012>.
- De Bono, N. (2016). *London city hall: Consultant calling for downtown crackdown*. October 25. Retrieved December 2, 2016, from: <http://www.lfpress.com/2016/10/24/consultant-calling-for-downtown-crackdown>.
- Draus, P., & Carlson, R. G. (2009). Down on main street: Drugs and the small-town vortex? *Health & Place*, 15(1), 247–254.
- Ghonaim, H. (2016). *Strategy planned to reduce spike in HIV and hep C among drug users*. June 16. Retrieved December 2, 2016, from <http://www.lfpress.com/2016/06/16/strategy-planned-to-reduce-spike-in-hiv-and-hep-c-among-drug-users>.
- Kerr, T., Scheim, A., Bardwell, G., Mitra, S., Rachlis, B., Bacon, J., et al. (2017). *Ontario integrated supervised injection services feasibility study report: London, Ontario*. London, Canada. Retrieved from: <http://www.ohtn.on.ca/wp-content/uploads/2017/02/OISIS-London-Report-Online.pdf>.
- Kimber, J., Dolan, K., & Wodak, A. (2005). Survey of drug consumption rooms: Service delivery and perceived public health and amenity impact. *Drug and Alcohol Review*, 24(1), 21–24.
- Kolla, G., Strike, C., Watson, T. M., Jairam, J., Fischer, B., & Bayoumi, A. M. (2017). Risk creating and risk reducing: Community perceptions of supervised consumption facilities for illicit drug use. *Health, Risk & Society* 1–21. <http://dx.doi.org/10.1080/13698575.2017.1291918>.
- Middlesex-London Health Unit (2012). *A profile of people who inject drugs in London, Ontario*. Retrieved December 2, 2016, from <https://www.healthunit.com/uploads/public-health-agency-of-canada-i-track-survey-phase-3.pdf>.
- Middlesex-London Health Unit (2014). *The impact of prescription and non-prescription drug use in Middlesex-London*. Retrieved from <https://www.healthunit.com/uploads/2014-05-15-report-032-14.pdf>.
- Milloy, M. J. S., Kerr, T., Mathias, R., Zhang, R., Montaner, J. S., Tyndall, M., et al. (2008). Non-fatal overdose among a cohort of active injection drug users recruited from a supervised injection facility. *The American Journal of Drug and Alcohol Abuse*, 34(4), 499–509.
- Milloy, M. J. S., Kerr, T., Tyndall, M., Montaner, J., & Wood, E. (2008). Estimated drug overdose deaths averted by North America's first medically-supervised safer injection facility. *PLoS ONE*, 3(10), e3351. <http://dx.doi.org/10.1371/journal.pone.0003351>.
- Peters, D. (2011). *The positive life: Small-town life*. Retrieved December 2, 2016, from <http://www.catie.ca/en/positiveside/summer-2011/small-town-life>.
- Petrar, S., Kerr, T., Tyndall, M. W., Zhang, R., Montaner, J. S. G., & Wood, E. (2007). Injection drug users' perceptions regarding use of a medically supervised safer injection facility. *Addictive Behaviors*, 32(5), 1088–1093. <http://dx.doi.org/10.1016/j.addbeh.2006.07.013>.
- Rhodes, T., Kimber, J., Small, W., Fitzgerald, J., Kerr, T., Hickman, M., et al. (2006). Public injecting and the need for safer environment interventions in the

- reduction of drug-related harm. *Addiction*, 101(10), 1384–1393. <http://dx.doi.org/10.1111/j.1360-0443.2006.01556.x>.
- Salmon, A. M., Thein, H.-H., Kimber, J., Kaldor, J. M., & Maher, L. (2007). Five years on: What are the community perceptions of drug-related public amenity following the establishment of the Sydney medically supervised injecting centre? *International Journal of Drug Policy*, 18(1), 46–53. <http://dx.doi.org/10.1016/j.drugpo.2006.11.010>.
- Sher, J. (2016). *New stats on HIV and hepatitis C among drug users backs calls for safe injection sites in city*. June 14. Retrieved December 2, 2016, from: <http://www.lfpres.com/2016/06/14/local-public-health-emergency-means-london-needs-safe-injection-site-medical-officer-of-health-says>.
- Small, D., Palepu, A., & Tyndall, M. W. (2006). The establishment of North America's first state sanctioned supervised injection facility: A case study in culture change. *International Journal of Drug Policy*, 17(2), 73–82. <http://dx.doi.org/10.1016/j.drugpo.2005.08.004>.
- Smith, C. B. R. (2010). Socio-spatial stigmatization and the contested space of addiction treatment: Remapping strategies of opposition to the disorder of drugs. *Social Science & Medicine*, 70(6), 859–866. <http://dx.doi.org/10.1016/j.socscimed.2009.10.033>.
- Statistics Canada (2011). *Focus on geography series, 2011 census*. Retrieved December 2, 2016, from: <https://www12.statcan.gc.ca/census-recensement/2011/as-sa/fogs-spg/Facts-cma-eng.cfm?LANG=Eng&GK=CMA&GC=555>.
- Strike, C. J., Myers, T., & Millson, M. (2004). Finding a place for needle exchange programs. *Critical Public Health*, 14(3), 261–275. <http://dx.doi.org/10.1080/09581590400004386>.
- Strike, C., Jairam, J. A., Kolla, G., Millson, P., Shepherd, S., Fischer, B., et al. (2014). Increasing public support for supervised injection facilities in Ontario, Canada. *Addiction*, 109(6), 946–953.
- Strike, C., Watson, T. M., Kolla, G., Penn, R., & Bayoumi, A. M. (2015). Ambivalence about supervised injection facilities among community stakeholders. *Harm Reduction Journal*, 12(1).
- Tempalski, B., Friedman, R., Keem, M., Cooper, H., & Friedman, S. R. (2007). NIMBY localism and national inequitable exclusion alliances: The case of syringe exchange programs in the United States. *Geoforum*, 38(6), 1250–1263.
- Tung, M. K. Y., Light, M., Giri, R., Lane, S., Appelbe, A., Harvey, C., et al. (2015). Evolving epidemiology of injecting drug use-associated infective endocarditis: A regional centre experience. *Drug and Alcohol Review*, 34(4), 412–417. <http://dx.doi.org/10.1111/dar.12228>.
- Tyndall, M. W., Wood, E., Zhang, R., Lai, C., Montaner, J. S., & Kerr, T. (2006). HIV seroprevalence among participants at a supervised injection facility in Vancouver, Canada: Implications for prevention, care and treatment. *Harm Reduction Journal*, 3(1), 36. <http://dx.doi.org/10.1186/1477-7517-3-36>.
- Vernick, J. S., Burris, S., & Strathdee, S. A. (2003). Public opinion about syringe exchange programmes in the USA: An analysis of national surveys? *International Journal of Drug Policy*, 14(5–6), 431–435.
- Watson, T. M., Bayoumi, A., Kolla, G., Penn, R., Fischer, B., Luce, J., et al. (2012). Police perceptions of supervised consumption sites (SCSs): A qualitative study. *Substance Use & Misuse*, 47(4), 364–374.
- Wenger, L. D., Arreola, S. G., & Kral, A. H. (2011). The prospect of implementing a safer injection facility in San Francisco: Perspectives of community stakeholders. *International Journal of Drug Policy*, 22(3), 239–241. <http://dx.doi.org/10.1016/j.drugpo.2011.01.001>.
- Woo, A. (2016). *Ottawa to ease rules for injection sites as death toll climbs*. Retrieved from: <http://www.theglobeandmail.com/news/british-columbia/ottawa-moves-to-facilitate-more-injection-sites-as-death-toll-climbs/article33293294/>.
- Wood, E. (2004). Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *Canadian Medical Association Journal*, 171(7), 731–734. <http://dx.doi.org/10.1503/cmaj.1040774>.
- Wood, E., & Kerr, T. (2006). What do you do when you hit rock bottom? Responding to drugs in the city of Vancouver. *International Journal of Drug Policy*, 17(2), 55–60. <http://dx.doi.org/10.1016/j.drugpo.2005.12.007>.
- Wood, E., Kerr, T., Stoltz, J., Qui, Z., Zhang, R., Montaner, J. S. G., et al. (2005). Prevalence and correlates of hepatitis C infection among users of North America's first medically supervised safer injection facility. *Public Health*, 119(12), 1111–1115.
- Wood, E., Tyndall, M. W., Lai, C., Montaner, J. S., & Kerr, T. (2006). Impact of a medically supervised safer injecting facility on drug dealing and other drug-related crime. *Substance Abuse Treatment, Prevention, and Policy*, 1(1), 13. <http://dx.doi.org/10.1186/1747-597X-1-13>.
- Wood, E., Tyndall, M. W., Zhang, R., Montaner, J. S. G., & Kerr, T. (2007). Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. *Addiction*, 102(6), 916–919. <http://dx.doi.org/10.1111/j.1360-0443.2007.01818.x>.