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Executive Summary

Do Toronto and Ottawa need supervised consumption facilities?
Is the implementation of supervised consumption facilities in Toronto or Ottawa feasible? To answer these questions, we conducted the Toronto and Ottawa Supervised Consumption Assessment (TOSCA) a scientific study involving the collection and analysis of data from a variety of sources.

What is a supervised consumption facility?

A supervised consumption facility is a legally sanctioned public health facility that offers a hygienic environment where people can inject illicit drugs under the supervision of trained staff. Some facilities also allow people to smoke illicit drugs. The primary goals of supervised consumption facilities include: reducing drug-related risks including the transmission of Human Immunodeficiency Virus (HIV), Hepatitis B and C and other blood-borne infections; decreasing the number of overdoses; minimizing public order problems (including public drug use); and improving access to health and social services.

To address drug-related problems, communities across the world have responded with policies and programs designed to reduce demand for illicit drugs, reduce the supply of illicit drugs, and reduce drug-related harm. Communities across Canada use a comprehensive approach, which includes prevention, harm reduction, treatment, and enforcement. Supervised consumption facilities are an example of a harm reduction program and are a component of some drug strategies. These facilities were designed to address the health and social problems not addressed by existing drug policies and programs. Across the world, including Canada, other harm reduction programs such as needle and syringe programs and opioid substitution programs have been implemented.

In Canada, there is one supervised injection facility and another organization that offers a supervised injecting service, but no supervised smoking facilities. In September 2003, Canada’s first supervised consumption facility opened in the Downtown Eastside of Vancouver, an area with a high rate of poverty, open drug use, HIV infection rate and overdose deaths. Dr. Peter AIDS Foundation in Vancouver offers a supervised injecting service that is open only to clients of the agency. Several other Canadian cities have considered the establishment of supervised consumption facilities, including Victoria and Montreal. A 2008 report explored the feasibility of a supervised injection facility for Ottawa. In 2005, Toronto City Council adopted the Toronto Drug Strategy, which included a recommendation for a needs assessment and feasibility study for supervised consumption site(s) taking into account the decentralized nature of drug use in Toronto.

The TOSCA Study

TOSCA focuses on the cities of Toronto and
Ottawa since they account for approximately half of all people who inject drugs in Ontario. Toronto has the province’s largest number of people who use drugs but, unlike Vancouver, drug use is not as heavily concentrated in one area. Toronto also has relatively low HIV prevalence rates among people who inject drugs. In contrast, Ottawa has the highest new rate of HIV infections amongst people who inject drugs in Ontario.

We identified key factors to help decision makers when considering the establishment of a supervised consumption facility. We address each of these in the chapters that follow:

- What is the distribution of drug use, risk behaviours and drug-related health problems?
- Are supervised consumption facilities likely to be used by people who use drugs?
- What is the epidemiology of blood-borne infections and associated risk factors?
- Where are people who use drugs located in Toronto and Ottawa?
- What is the social and political environment relating to supervised consumption facilities?
- Are supervised consumption facilities a good use of money?

To address these questions, we used multiple research methods and data sources as follows:

- **Qualitative research methods** were used to explore attitudes towards supervised consumption facilities from residents, business owners, police, social service employees, public health officials, healthcare providers, emergency medical services, and people who use drugs.
- **Survey data** were used to characterize the epidemiology of drug use and the health of people who use drugs, the likelihood that people who use drugs would visit a supervised consumption facility, and Ontarians’ public opinions about supervised consumption facilities.
- We used **geographic analysis** to map the distribution of drug use in Toronto and Ottawa.
- To understand the potential effectiveness and cost-effectiveness of supervised consumption facilities in Toronto and Ottawa, we used **mathematical modeling**. We used **cost-effectiveness analysis** to compare the costs of an intervention with its potential benefits.

The TOSCA team includes researchers with diverse expertise ranging from public health science, epidemiology, health services research, operations research, and health economics. TOSCA also has four advisory groups, with representatives from diverse health and social service providers, as well as people with past/current experience of drug use. TOSCA was funded by the Ontario HIV Treatment Network and the Canadian Institutes of Health Research. The views of this report are not necessarily the views of the funding agencies.

**Detailed information about the research methods used in TOSCA and other materials are available on our study website**, www.toscastudy.ca
Drug Use in Toronto and Ottawa

In Toronto, the large majority of people who inject drugs injected both cocaine (including crack cocaine) and opiates in the 6 months prior to being interviewed. In Ottawa, 79% of people who inject drugs reported injecting cocaine and 64% reported injecting opiates, in the 6 months prior to being interviewed. The proportion of people injecting cocaine most frequently was similar to the proportion injecting opiates most frequently. The frequency with which people inject drugs varied widely in both cities. In Toronto, 27% of adults and 41% of street-involved youths injected at least once a day. In Ottawa, 30% of adults reported injecting at least once a day. In both cities, about 65% of respondents who injected with other people reported that they most commonly injected with a close friend and about 30% reported that they most commonly injected with a regular sex partner. In Toronto, 21 to 27% of people reported that they injected with somebody they did not know at all or did not know well. In Ottawa, 9% of respondents reported that they had injected with somebody they did not know well.

About 18% of people who inject drugs in Toronto and 14% in Ottawa reported that they had used needles that had already been used by someone else. About 10% of adults and 20% of street-involved youth who inject drugs reported that they injected with used needles sometimes, always, or usually. In Toronto, 20% of people who inject drugs reported that someone else used their needles occasionally or sometimes. In Ottawa, 9% of people reported that someone else used their needles sometimes.

Sharing used smoking equipment was common: 73% of people who use drugs in Toronto, 71% of people who use drugs in Ottawa, 76% of street-involved youth who smoke crack cocaine in Toronto, and 81% of street-involved youth who smoke crystal methamphetamine in Toronto reported smoking with used pipes at least once in the 6 months prior to being interviewed. In Toronto, 78% of people who smoke crack cocaine had lent or sold a pipe they already used in the 6 months prior to being interviewed; 74% of people who smoke crack cocaine in Ottawa had done so.

In Toronto, 54% of people who inject drugs injected in a public place such as a washroom or stairwell and 46% injected on the street or in an alley in the 6 months prior to being interviewed. The respective percentages for Ottawa were 25% and 29%. Between 40 to 80% of people who use drugs by non-injection methods in Toronto and in Ottawa had done so in a park, in a parking lot, on the street or in an alley, a washroom, and in a stairwell or doorway in the 6 months prior to being interviewed.

Do Ontario Residents Agree or Disagree with Making Supervised Consumption Facilities Available?

Considerably more Ontarians have read, seen, or heard about supervised injection facilities compared with supervised smoking facilities. More Ontario residents strongly agreed with making supervised injection facilities available than supervised smoking facilities. Ontarians who strongly agreed with making supervised injection facilities available tended to also agree with making supervised smoking facilities available.
More Ontarians were likely to agree with implementing supervised injection facilities if the goals are to reduce negative health consequences, increase contact with health or social workers, or to reduce neighbourhood problems related to drug use. Most Ontarians agreed with implementing supervised smoking facilities if the purpose is to reduce neighbourhood problems related to drug use or improve the health of people who use drugs. However, fewer Ontario agreed with implementing supervised injection facilities and supervised smoking facilities if the goal is to encourage safer drug use among people who inject or smoke drugs.

Overall, Toronto residents were more likely to strongly agree with making supervised injection facilities available than were residents of Ottawa. Between 2003 and 2009, there was a shift in public opinion about supervised injection facilities. The percentage of Ontarians who strongly agreed with the goals of supervised consumption facilities increased over this time period. Stakeholders with mixed opinions about supervised consumption facilities indicated that they would take a more definitive position if concerns about one or more of five key issues were resolved: a better understanding of supervised consumption facility evidence in general; demonstration of need for a supervised consumption facility; understanding the relationship between supervised consumption facilities and a broader health and social response to drug use; evidence about potential impact on homes, businesses, and the community; and proposed supervised consumption facility implementation design. Among those in favour of implementing supervised consumption facilities, a pilot project that includes a comprehensive evaluation plan was recommended as the first step towards implementation. Stakeholders also recommended the evaluation of health and other outcomes (such as drug trafficking, assaults, and other drug-related crime in the local area) and public dissemination of evaluation results.

Supervised Consumption Facility Services, Models, and Rules

Among supervised consumption facilities worldwide, the most frequently offered services address the health of people who use drugs (including education, distribution and disposal of equipment, and medical, nursing, and social work services) and their hygiene (including laundry, showers, and washrooms). Referrals to drug substitution treatment (such as methadone maintenance therapy), detoxification, rehabilitation, and health care were commonly available. Services considered important by people who use drugs included: nursing care; hygiene; counselling; detoxification beds; social workers; drug use information and education; overdose prevention and education; equipment distribution and disposal; referrals for drug treatment, other health concerns, and social services; peer support; mental health services; basic medical care; first aid; wound care; testing for blood-borne infections and pregnancy; and vaccinations. Internationally, supervised consumption facilities are commonly open 6 or 7 days a week for 7 or 8 hours a day. The average number of injecting spaces within a supervised consumption facility was about 7; the number of smoking spaces varied widely.
Stakeholders in Toronto and Ottawa focus groups often said that a supervised consumption facility should be partnered with other agencies that serve people who use drugs. Existing harm reduction programs were often identified as appropriate partners. In focus groups with people who use drugs, most people preferred supervised consumption facilities that permit both supervised injection and supervised smoking within the same facility. However, most people added that within that facility there should be some sort of physical separation between the spaces in which people use different types of drugs being used or administer drugs through different routes. In surveys of people who use drugs in Toronto, the most popular supervised consumption facility models were a separate facility for people who inject or a single facility with separate rooms for injecting and for smoking. Most stakeholders noted that both peer and non-peer workers are essential within a supervised consumption facility.

Commonly reported rules among supervised consumption facilities worldwide included registration, time limits, residency requirements, minimum age rules, rules regarding first time injecting, restricted body sites, rules about sharing drugs and assisted injection, and prohibitions on drug dealing on-site. Among stakeholders in focus groups, a friendly and welcoming facility that is safe from violence and sets clear limits on the length of stay was commonly recommended. Stakeholders in focus groups preferred service models that include policies to protect the anonymity of clients and privacy of the program. Opinions were mixed regarding a minimum age requirement to access a supervised consumption facility. Assisted injection was also debated.

Potential Use of Supervised Consumption Facilities

Up to 75% of people who use drugs said they would use a supervised injection facility and up to 65% of people who use drugs said they would use a supervised smoking facility. Projected use of a facility was similar in both Toronto and Ottawa; it was also similar between men and women. The people most likely to report that they would use a supervised consumption facility included people who are unstably housed or live on the street, people who are unaware of how to access sterile equipment, people who inject in public, and people who lent or sold a crack cocaine pipe after using it. Together, these findings suggest that supervised consumption facilities would attract people who use drugs who are especially vulnerable. These findings are important since these groups might be at particularly high risk for blood-borne infections and other adverse health consequences associated with drug use and social marginalization.

Among people who reported that they would use a supervised injection facility, over half said that they would use the facility always (30 to 36%) or usually (22 to 23%). These rates were similar in Toronto and Ottawa. Relatively few people – 14 to 20% – reported that they would only use a facility occasionally. Data about how often people would use supervised smoking facilities were not available. Projected rates were generally similar among men and women, although women in Ottawa were somewhat more likely than men to say that they would use a facility always or usually. Overall, the demand for supervised injection facilities is high among people who inject drugs in Toronto and Ottawa.
The main reasons for using a supervised consumption facility were related to concerns about safety (from arrest, from street crime, and from overdose), privacy and shelter (compared to using drugs on the street), and cleanliness (to get sterile equipment). Accessing services or referrals were of lesser importance. The main reasons for not using a supervised consumption facility were similar: safety (fear of arrest and surveillance, paranoia, and concern about other people who use drugs), privacy (compared to using drugs at home), and confidentiality. Proximity is an important consideration; people who use drugs indicated that they would like facilities to be located close to where they actually use drugs.

Deciding Where to Establish Supervised Consumption Facilities

We found broad support for locating supervised consumption facilities close to where people use drugs, particularly where drug use is visible or where people who use drugs are homeless or unstably housed. Drug use in Toronto is widely distributed throughout the city with a few foci but no single area of concentration. In Ottawa, drug use is concentrated in a few distinct neighbourhoods. The patterns of cocaine and opioid use appear similar across neighbourhoods in both cities.

In Toronto, about half of all people who inject or smoke drugs said that they would travel up 10 blocks or less to use a supervised injection facility and 28% of respondents said that they would travel more than a kilometre to a supervised injection facility. In Ottawa, about 40% of people who inject drugs said that they would walk 10 minutes or less to use a supervised injection facility and 36% of respondents said that they would walk more 20 minutes to a supervised injection facility. People who use drugs and other stakeholders expressed preferences for implementing multiple smaller supervised consumption facilities rather than one large, centralized supervised consumption facility. People who use drugs felt that one supervised consumption facility, even if “centrally located”, would be inconvenient for potential clients who live in areas far from the facility. Multiple supervised consumption facilities, especially if integrated into existing programs for people who use drugs, may also reduce community concerns. In an analysis of possible facilities in Toronto based on the geographic dispersion of people who use drugs and their willingness to travel, we estimated the first facility would be used by about 11% of people who use drugs. Each additional facility would be used by 10%, 9%, 6%, and 4% of people who use drugs. In Ottawa, the first facility would be used by about 36% of people who use drugs. Each additional facility would be used by 22%, 10%, 1%, and 1% of people who use drugs.

Community opposition was a major theme in discussions about locating a supervised consumption facility. Even residents and business owners who were supportive of supervised consumption facility implementation did not necessarily want to see a facility in their own residential neighbourhoods or near their businesses. Many residents and business owners supported locating a supervised consumption facility in a hospital or other places away from residential or business locations. Community members, especially residents and business owners, would like to be consulted in advance and be given the opportunity to
express their concerns regarding decisions about supervised consumption facility location. Community consultation needs to be extensive and part of the decision-making process but recommendations for how that consultation should proceed were often vague. Multiple, small community meetings across the cities may be preferable to large public forums to give community members ample opportunities to participate.

**Potential Health Benefits and Costs of Supervised Consumption Facilities in Toronto and Ottawa**

A majority of people who use drugs were sexually active in the month prior to being interviewed. More women were sexually active than men. About 40 to 50% of people who reported being sexually active reported that their last sexual activity included using a condom. About 30 to 40% of men and 30 to 50% of women reported having multiple sex partners in the 6 months prior to being interviewed. HIV prevalence was 4% among people who use drugs in Toronto and 11% in Ottawa. In Toronto, HIV prevalence was higher among people who smoke drugs (6%) than among people who inject drugs (3%). Hepatitis C prevalence was 52% among people who use drugs in Toronto and 60% in Ottawa. In Toronto, hepatitis C virus prevalence was considerably higher among people who inject drugs (70%) than among people who smoke drugs (29%). About 1 in 5 people who use drugs in Toronto and in Ottawa reported that they had overdosed in the last 6 months. The percentage overdosing was higher among people who inject drugs (29%) than among people who smoke drugs (12%). Almost half the people who reported smoking crack cocaine in Ottawa reported symptoms related to tooth and gum sores and about 1 in 4 reported skin problems.

We used mathematical modeling to project potential health benefits related to establishment of supervised injection facilities in Toronto and Ottawa. We modeled only the effects of supervised injection facilities since the effectiveness of supervised smoking facilities are unknown. We projected that the number of HIV infections averted by the first three facilities in Toronto was about 2 to 3 per facility per year and that the number of hepatitis C virus infections averted was about 15 to 20 per facility over 20 years. The number of additional HIV and hepatitis C virus infections averted by the 4th and 5th facilities was considerably less. We projected that the number of HIV infections averted by the first two facilities in Ottawa was 6 to 10 per facility per year and the number of hepatitis C virus infections averted was 20 to 35 per facility per year. In Ottawa, the number of additional HIV and hepatitis C virus infections averted by the 3rd, 4th and 5th facilities was considerably less.

The cost per HIV infection averted with the first supervised injection facility in Toronto is $323,496 and with the first supervised injection facility in Ottawa is $66,358. The cost per hepatitis C infection averted with the first supervised injection facility in Toronto is $47,489 and with the first supervised injection facility in Ottawa is $18,591. The greatest cost savings in the Toronto and Ottawa models come from averting hepatitis C virus infections.

Economists often measure health outcomes in quality adjusted life years (QALYs), a measure that incorporates both quality of life and
survival. The incremental cost-effectiveness of an intervention is expressed as the extra cost of the intervention divided by the extra health gain, yielding a ratio expressed in dollars per QALY. An intervention with a low incremental cost effectiveness ratio represents good value for money while an intervention with a high incremental cost effectiveness ratio is economically unattractive. Although debate exists about the threshold at which an intervention stops being considered “good value for money”, commonly used thresholds include $50,000 / QALY and $100,000 / QALY.

At a cost-effectiveness threshold of $50,000 / QALY, the optimal number of facilities in Toronto is three. At a cost-effectiveness threshold of $100,000 / QALY, the optimal number of facilities is four. At a cost-effectiveness threshold of $50,000 / QALY, the optimal number of facilities in Ottawa is two. At a cost-effectiveness threshold of $100,000 / QALY, the optimal number of facilities is three. These estimates are sensitive to estimates of the number of people who use drugs in each city, the projected reduction in needle sharing among users of supervised injection facilities, and the fixed costs associated with running a supervised injection facility.

The differences between Ottawa and Toronto in potential infections averted and cost effectiveness estimates reflect the differences in HIV and hepatitis C prevalence rates as well as differences in the number and geographic distribution of people who use drugs in each city.

Potential Implementation and Liability Issues Involved in Establishing Supervised Consumption Facilities

In cities that have supervised consumption facilities, implementation was preceded by extensive planning and community consultation. From the stakeholders, we learned what they thought would be necessary steps and activities to complete to make supervised consumption facility implementation happen. Some stakeholders who were strongly opposed to supervised consumption facilities were harder to engage than others in discussion about an implementation plan. Stakeholders stressed that an implementation plan should include an assessment of the existing scientific evidence for supervised consumption facilities, consideration of the generalizability of this evidence to local circumstances, a clear explanation of the facility’s goals, community consultations, and a service model design that addresses the unique social and political environments of each city.

Even though more stakeholders were in favour of implementing multiple facilities than a single facility, stakeholders strongly recommended starting with a single pilot facility. This recommendation may give rise to some tensions because stakeholders were also generally concerned that one facility would be highly visible in a given neighbourhood and potentially create some undesirable outcomes (for example, congregation of people who use drugs or people selling drugs). It is possible that starting with a single pilot might produce these unwanted results. This point was not raised by stakeholders who were in favour of the pilot model. Stakeholders were clear that any pilot
site that is implemented needs to include a clear and well articulated evaluation plan and also assurances to the community that the pilot supervised consumption facility would be closed if an evaluation showed that the facility was not working or was having adverse impacts on the community. It is unlikely that supervised consumption facility implementation would be achieved anywhere lacking solid support from communities and local politicians.

While reducing consumption related risks and offering other health benefits, consumption of drugs within a supervised consumption facility may lead to negative health consequences and stakeholders across Ottawa and Toronto raised concerns about these issues. Stakeholders stressed the need to consider liability and responsibility issues related to toxicity and other negative consequences from consumption of contaminated drugs and fatal overdoses on site at a supervised consumption facility. As well, stakeholders wanted an implementation plan to address the issue of assisted injection and related liability issues.
Recommendations

1. **Both Toronto and Ottawa would Benefit from Implementation of Supervised Injection Facilities.**

   Toronto and Ottawa each have a significant number of people who use drugs. We found indicators that suggest supervised consumption facilities would be beneficial in both cities, including frequent sharing of drug equipment and public drug use. People who use drugs in both cities indicated that they are likely to use supervised consumption facilities regularly.

   We project that Toronto would benefit from implementation of three supervised injection facilities and that Ottawa would benefit from implementation of two supervised injection facilities. These projections are based on considerations of the number of people who use drugs in each city, their geographic location, the projected use of supervised injection facilities, the demonstrated decrease in risky behaviours among clients of other supervised injection facilities, and the associated projected long-term costs and health benefits, including the prevention of HIV and hepatitis C infections.

   Multiple supervised injection facilities are optimal to address the dispersed patterns of drug use in both cities. A similar approach has been used to establish needle and syringe programs and methadone maintenance programs. Implementation of multiple facilities that are located close to where people inject drugs will likely optimize access and utilization. Our research indicates that people who use drugs generally did not want a single facility that could serve as the focus of opposition. Community members also preferred multiple facilities spread out across each city to minimize possible impacts on local neighbourhoods.

2. **The Optimal Model for a Supervised Injection Facility is a Fixed Facility that is Integrated within an Existing Organization.**

   Integration and close linkages with existing organizations offering a broad range of services will ensure that supervised injection facilities provide access to needed health and social services and referrals but do not duplicate what is already available. Integration within an existing organization that already works with people who use drugs will also address concerns about establishing a relationship with people who use drugs as clients, the visibility of a facility within a community, privacy for clients, and community impact. We do not recommend mandating attendance at ancillary services within a supervised injection facility. Mandatory attendance may discourage utilization of the primary service of supervised injection.

   While mobile facilities might extend access to supervised injection facilities for to hard-
to reach populations, we did not find a strong desire for such sites among people who use drugs in either city and the evidence base for such a decision is limited.

3. **A Strong Evaluation Plan is an Essential Component of any Implementation Plan.**

A supervised injection facility must have a well-defined evaluation plan that includes clear objectives and specifies the actions to be taken if the objectives are not achieved. Evaluation indicators should assess the impact of a supervised injection facility, including: the number of people who visit the facility and how often they visit; the proportion of people who use drugs who are clients of the facility; the patterns of drug- and sex-related risk behaviours over time; the incidence of HIV, hepatitis C, and hepatitis B infection rates over time; and the incidence of fatal and non-fatal overdoses over time. The evaluation plan should also consider impacts at a community level, including changes in: public litter; visible public drug use; the congregation of clients around a facility; drug-related crime and arrests; property values; and local business viability.

4. **A Supervised Injection Facility should have Clearly Established Rules.**

These rules should balance the needs of clients and the surrounding community but not impede the potential of the facility to meet its objectives to improve the health of clients. Decisions about rules (such as operating hours and eligibility to use the facility) are best made considering the local context in which each facility operates.

5. **There is Insufficient Evidence to Support a Recommendation to Implement a Supervised Smoking Facility.**

There is insufficient evidence regarding the impact of supervised smoking on risk behaviours among people who smoke drugs. Although our analyses indicate that people who smoke drugs such as crack cocaine say they would use such a facility, the frequency with which they would smoke in the facility and the potential change in short-term behaviours and long-term health benefits have not been quantified. The service model that would meet the needs of people who smoke drugs such as crack cocaine also requires further investigation. Such questions are important, but are best addressed within the structure of a formal research study into this specific question. Research is also needed into models of facilities that allow smoking and injecting within a single facility. Many people who inject drugs also smoked drugs such as crack cocaine. Allowing supervised smoking alongside injecting might increase the use of a facility by this group, but more data is needed to evaluate mixed smoking and injecting models. If supervised smoking of illicit drugs such as crack cocaine or crystal
methamphetamine is allowed within a single facility, our research indicates that separate rooms for smokers and injectors are likely to be most acceptable to clients of the facility and maximize use.

6. **The Process to Establish a Supervised Injection Facility Should be Part of a Comprehensive Drug Strategy.**

This strategy should be designed to address the health and wellbeing of the individual and the broader community. The four pillars of a comprehensive drug strategy include: prevention, treatment, enforcement and harm reduction. A well-designed strategy ensures that resources are not diverted from other effective programs to implement new initiatives. While some people will always be opposed to implementation of supervised consumption facilities, our research shows that most people in Ontario will support implementation of a supervised injection facility that maximizes positive outcomes for clients and the surrounding community. Implementation plans must be transparent and include effective mechanisms for community stakeholder input. Such consultations are also relevant to considerations of where sites should be established.