

Supervised Consumption Site Opposition Response Research Paper

Stigmatization of individuals experiencing substance use disorder (SUD) is pervasive and ever-present in news media, medicine, and society. Assigning labels of deviance to those experiencing a medical condition worsens the overdose crisis by creating barriers to important efforts including syringe service options, overdose death prevention, expanding access to basic medical care, and connecting individuals with SUD to treatment services. Harm reduction, on the other hand, is the public health [concept](#) of accepting some health risk-taking behavior and developing public health responses to lessen the negative impacts of that behavior instead of a zero-tolerance approach. Harm reduction helps people *survive* their addiction until they are ready to receive treatment, and in some cases contact with harm reduction services is the impetus for some to initiate a range of health care services, including addiction treatment, in the first place.

Supervised Consumption Sites (SCSs) are based on a harm reduction philosophy. SCSs are facilities where people can use drugs under the supervision of trained professionals, preventing overdoses from turning fatal, increasing safe injection hygiene, and improving access to SUD treatment and other vital services. There are [currently](#) more than 100 sites in 11 countries worldwide. Many US [cities](#) are considering implementing these facilities to address the overdose crisis. However, no sanctioned SCSs operate in the U.S. due largely to community opposition and political and federal roadblocks that are often rooted in stigma. This review aims to address those concerns through a discussion of evidence-based support of SCSs.

In order to better understand public opposition to SCSs specifically in the Boston community we first conducted a review of comments and social media responses to news media from Boston news outlets about SCSs. During this review process, we searched for comments and statements of public concern to compile an overview of the negative public perceptions about SCSs in Boston.

Media Review of Bostonian Public Perceptions of Supervised Consumption Sites

Despite earlier reluctance, in a 2019 WBUR radio [interview](#), Boston Mayor Walsh referred to safe consumption sites as “a harm reduction model worth exploring.” But the Mayor highlighted two major concerns: funding and the legal barriers posed by U.S. attorney Andrew Lelling’s [opposition](#) to safe consumption sites. In June 2017, Boston City Councilor Michael Flaherty [referred](#) to supervised consumption sites in Boston as “asinine.”

In November 2020, a search for the key terms “supervised consumption sites Boston” “supervised consumption Boston” and “supervised injection facilities Boston” was completed on the websites of the following major Boston news outlets: *The Boston Globe*, *The Boston Herald*, *Boston.com*, CBS’ Boston affiliate, and the WBUR radio station.

Articles included in this review met two criteria: 1) the article was published in 2017 or after, and that the article specifically covered news about SCS. The public comment section and quotes from Boston citizens within the stories were reviewed to identify the key concerns of public

citizens who oppose supervised consumption sites in Boston. Additionally, the replies to Tweets sharing these news stories on the social media site Twitter were reviewed. In total, 63 articles met the criteria and were reviewed. This method is limited because social media comments are often anonymous so users may not represent their opinions truthfully. Also, the method does not highlight the overall negative public perceptions of Bostonians and represents a small sample of public comment users. Despite these drawbacks, media comments are one of few publicly available discourse communities that display public opinions and in this case, to SCSs. Importantly, analyzing these reactions highlights what public beliefs will need to be overcome by Boston’s public health community in order to successfully enact SCSs.

The following is a compilation of anonymized comments, likely from the Boston area, responding to Boston news media outlet postings about supervised consumption sites:

Concern Type	Public Comment
Financial Barriers	<ul style="list-style-type: none"> ● “And who exactly is funding this?” ● “This idea is sick as hell instead use the money to help them get help have a place they can go to detox, and ask for help, make phone calls for help for them, feed them a meal give them a blanket idk many things besides help them do more drugs we have enough G*D damn trap house!”
Ethical opposition to condoning drug use	<ul style="list-style-type: none"> ● “Underground. How bout calling it what it really is. ILLEGAL.”
Against public health support for people with SUD	<ul style="list-style-type: none"> ● “Are the needles going to be replaced with bleached filled needles? If so, I vote yes. If no, then why the fuck not?” ● “Mistake it SHOULD have a stigma. We're supposed to let people feel it's ok to wait until "they're ready to go in to recovery"?! No. You want someplace safe, away from the "stigma"? Make the effort to get into a rehab. Every possible tool that can be used to convince people to get help should be used. This is not a problem that responds well to coddling. Want to see what that results in? Look up East Hastings St. in Vancouver. They've been doing it for well over a decade and last year had 6.25% more OD deaths per 100,000 than we did. That's where we could be headed with this approach.”

SCSs furthering drug use not decreasing it	<ul style="list-style-type: none"> • “Next they’ll be giving them the drugs.” • “There should at least be a requirement of a treatment plan attendance. You really going to give people drugs for "10 years" straight?”
Area safety and cleanliness	<ul style="list-style-type: none"> • “What in the exquisite crackhouses... this era hella different with it.”
Legal barriers and city liability	<ul style="list-style-type: none"> • Serious Questions. Who supplies the drugs? Will the city be responsible for an OD that does not survive that may cause families to sue? • “Plus you can collect people’s DNA”
Concerns about whether this is an effective public health approach	<ul style="list-style-type: none"> • “Limit production of fentanyl, stop heroin from entering country Educate young people & fix DARE PROGRAM. Stop lies that pot leads to heroin.” • “This seems like a bad idea. I understand why it’s happening but there has to be better answers.”

Articles Containing Negative Comments:

- <https://www.boston.com/news/local-news/2019/11/10/somerville-2020-safe-injections-site-plans>
- <https://www.bostonglobe.com/2020/05/15/metro/legislative-committee-approves-bill-allowing-safe-injection-sites-mass/>
- <https://www.bostonherald.com/2020/07/09/zero-deaths-at-underground-supervised-injection-site-helps-massachusetts-effort-to-open-facilities-advocates/>
- <https://abcnews.go.com/US/boston-hospitals-mock-safe-injection-site-medical-procedure/story?id=66369748>
- <https://twitter.com/BostonDotCom/status/1088818816333856768>
- <https://www.newbedfordguide.com/u-s-attorney-lelling-says-massachusetts-injection-sites-would-be-prosecuted/2018/07/21>
- <https://boston.cbslocal.com/2017/06/16/boston-public-meeting-supervised-injection-sites/>

Boston Community Fears About SCSs

After reviewing the negative media comments in opposition to SCSs the following themes were identified as the concerns for online media users who are likely Boston residents. We also reviewed the work of public health experts in Boston working on SCS and spoke with some field experts to highlight some of the issues they identified.

- Area safety and cleanliness
- Against public support for people with SUD
- Legal barriers and city liability
- Financial barriers
- Ethical opposition to condoning drug use
- SCSs furthering/enabling drug use not decreasing it
- Concerns about whether this is an effective public health approach

It is important to note that many of these comments are rooted in stigma and misinformation about the overdose crisis. This review does not aim to validate these public opinions, but instead to understand the full scope and context of that stigma in order to outline evidence-based responses to these opinions for policymakers and advocates to successfully implement programs. Ahead, we will break down these concerns using recent, evidence-based research and public health expert opinion to highlight the feasibility of supervised consumption site implementation in Boston.

First, it is valuable to provide a distinction between syringe services and supervised consumption sites. Both are harm reduction resources aimed at lessening the health risks associated with drug use without using a zero-tolerance approach. Syringe service programs are community-based [interventions](#) which provide access to sterile injection equipment and disposal sites and can provide access to vaccinations and testing. Their main focus is largely to ensure safe syringe practices to prevent the spread of disease. Massachusetts currently [has](#) 10 syringe service programs. While many states of comparable populations have [fewer](#) syringe service programs, notably, Kentucky and New Mexico each have over 20 such programs despite a smaller population. Supervised consumption sites, on the other hand, differ from syringe service programs in that they provide healthcare workers who can supervise drug use to help prevent overdose, offer access to substance use disorder treatment, while *also* implementing sterile syringe usage.

“Honey pot effect”

The honey pot effect is the idea that SCSs will lead to increased drug use and drug-related crime by attracting more people who use drugs to the area. But, the scientific evidence from international SCSs denies this effect’s existence. One [study](#) considered the effect on crime from SCSs in Sydney, Australia and found “there was no evidence that the [SCS] trial led to either an increase or decrease in theft or robbery incidents.” They also noted that: “there was no increase in the proportion of drug use or drug supply offences committed in Kings Cross that could be attributed to the opening of the [SCS].” Additionally, one case study [review](#) noted that police in Vancouver, British Columbia tolerated the SCSs in their community because they found in practice it increased public safety by reducing public drug use in unsafe locations. A series of

[studies](#) on a SCS that a harm reduction group operated in secret in the US also found a reduction in crime in the area.

The Ontario HIV Treatment Network reviewed the effectiveness of Canadian SCSs in 2014 and compiled a series of international studies in Canada, Australia, and Germany assessing public safety in response to SCS. Every study they examined noted either no increase in crime near the SCS or an increase in public safety, which was attributed to the reduction of public injections. They concluded that, “supervised injection sites do not lead to any significant disruptions in public order or safety in the neighbourhoods where they are located.” Importantly, people who use drugs also reported feeling safer doing so in supervised injection sites than in public.

“Supervised Consumption Sites Work Abroad But Would Not Work in the US”

The concern that supervised consumption sites work abroad but will not work in the US was addressed in this series of [studies](#) on the SCS which operated in secret in the US. One of these studies found that “participants reported that having a safe space to inject drugs had led to less injections in public spaces, greater ability to practice hygienic injecting practices, and greater protection from fatal overdose.”

“This will be expensive and will increase my taxes”

SCSs represent an economic benefit to the communities that implement them according to recent financial reviews. The New England Comparative Effectiveness Public Advisory Council conducted an economic [analysis](#) to determine whether supervised injection sites would reduce municipal costs for a handful of major cities, including Boston. If the SCS is approved to be operated outside of the local government system, such as through a non-profit organization, then this would also not pose a financial burden on the city. By taking into account healthcare costs like emergency services, hospitalization, and ambulance rides related to overdose and the city’s overall overdose rate, they estimated that Boston would see savings upwards of \$4 million a year if an SCS was implemented, this is including the operation costs of the facility. Much of this calculation is based on the ability to avoid the on average excess 773 ambulance rides, 551 emergency room visits, and 264 hospitalizations related to overdose each year. Not addressing the overdose crisis ultimately hurts the local economy in lost workforce productivity and in paying for the hospitalizations of the uninsured.

“Public injection and disposal of needles”

Supervised Consumption Sites will reduce this public issue by moving drug use from public spaces to supervised facilities. The nonprofit amFAR, the Foundation for AIDS Research, compiled a literature [review](#) on the effectiveness of SCSs and determined that “the absence of private, secure, and hygienic spaces often drives people who inject drugs to do so in public, with discarded syringes posing a health hazard.”

Alternatively, the European Monitoring Centre for Drugs and Drug Addiction compiled a research [review](#) on SCS outcomes and found that they directly lead to these public health benefits:

- Reduction in needling sharing, which can reduce risk of HIV and Hep C
- Reduction of drug-related overdose deaths
- Greater use of substance use disorder treatment

“Jail time is more effective at curbing drug use”

The overdose crisis is worsening in the United States, despite high levels of incarceration for drug-related offenses. Research over the last few decades has [shown](#) that criminal punishment alone is not effective in curbing drug use: Addiction is shown to be a chronic health condition that requires medical intervention. The National Institute on Drug Abuse [examined](#) SUD treatment in the criminal justice system in a 2010 study and concluded that: “Punishment alone is a futile and ineffective response to drug abuse, failing as a public safety intervention for offenders whose criminal behavior is directly related to drug use.”

Not only is jail time not an effective deterrent to drug use, but studies show that the days and weeks after release from a short stint of incarceration are the most deadly for people with OUD. Some [studies](#) find the risk of fatal overdose after incarceration is 79 to 129 times higher than those with no incarceration history. Another systemic issue with the carceral system’s response to the overdose crisis is involuntary commitment. This is the legal practice of people who use drugs being forced into treatment programs that often fail to meet clinical international standards for SUD treatment. Involuntary commitment is not the result of an arrest related to committing a crime, but rather its legal [basis](#) is rooted in civil commitment under the broad police powers to protect citizens from harm. According to the Health in Justice Action Lab’s own 2019 [research](#), zero states require evidence-based treatment, such as medication for opioid use disorder, be used in involuntary commitment settings. Worse still, HIJAL found that 16 states allow people with SUD in the justice system to be subjected to this “treatment” without their consent. In 2018, Massachusetts conducted 10,770 involuntary commitments. Of which, in 2018, MA civilly committed 6,048 individuals for substance use under Section 35.

“Why is this issue important?”

According to the Centers for Disease Control and Prevention (CDC), overdose deaths [quintupled](#) from 2000 to 2016. Massachusetts remains one of the hardest hit states in the country by the overdose crisis and saw an increase in overdose deaths from 2017 to 2018. Accidents are the third leading cause of [death](#) in Massachusetts, driven largely by accidental drug overdose also according to the CDC. Massachusetts also [saw](#) 2,241 drug overdose deaths in 2018, which is about six overdose deaths a day. During the first three months of 2020, Massachusetts saw an [estimated](#) 505 overdose deaths. As a result of the COVID-19 pandemic, experts [predict](#) that overdose deaths will increase over the remainder of 2020 data.

Harm reduction efforts like syringe service programs and supervised consumption sites have proven to effectively reduce these overdose deaths, but are not being implemented. While

public health interventions like improving access to naloxone and overdose awareness campaigns are present in Massachusetts, the overdose crisis could be mitigated further by preventative harm reduction efforts such as supervised consumption sites.

“Legal barriers exist making this illegal, so why condone it?”

Massachusetts Governor Charlie Baker has objected to the implementation of supervised consumption sites in Massachusetts under the concern that there are substantial legal barriers. Legislators often cite the Controlled Substances Act’s “crack house” statute as including SCS, making them illegal to operate since they would fall under the broad definition of a “crack house.” There is growing legal support for overcoming this definition. Philadelphia’s proposed supervised consumption site, called Safehouse, was [supported](#) under Judge Gerald McHugh’s 2019 decision that no argument would place supervised consumption sites under the “crack house” statute definition.

However, in January 2021, the federal Third Circuit [overturned](#) this decision. Judge Roth of the Third Circuit, [dissented](#) this decision because of its overly strict interpretation of the law and its potential to broadly prevent other harm reduction efforts. In addition, it is possible that the Biden administration will allow supervised consumption sites to proceed by choosing not to federally prosecute these sites. Despite this, Pennsylvania along with Massachusetts legislatures have not authorized supervised consumption sites under state law largely because of this opposition. Nonetheless, state legislature approval is not necessary for a supervised consumption site to open, although it would be ideal in preventing future federal legal action. They can also be approved through state administrative action or they can be implemented by local governments under their discretion to protect and promote public health. Additionally, historical legal precedence shows that it is possible for harm reduction efforts to be approved despite legal barriers as researchers noted in 2008’s [The Law \(and Politics\) of Safe Injection Facilities in the United States](#):

“State legislation authorizing politically controversial harm reduction interventions is not unprecedented; since the beginning of the HIV epidemic, 19 states have passed laws authorizing syringe exchange programs, pharmacy syringe sales, or both, and syringe exchange programs have been authorized by city or county governments in two additional states.”

This is not to say that SCSs wouldn’t face other legal difficulties after approval. The RAND corporation, a non-profit, non-partisan research organization, conducted an in-depth [review](#) into the feasibility of SCSs as a method to combat the overdose crisis in the United States. They noted it could be challenging to obtain informed consent for treatment during drug use as there would be concern about the client’s ability to make a clear decision while under the influence. There is also a concern that supervised consumption sites would be exposed to tort liability: Legal precedent holds social hosts accountable for their clients’ actions after leaving an event. In theory, SCSs could be held to the same accountability. However, the researchers also note that waivers could mitigate some of the risk of client suits against the SCS. On the other hand,

liability insurance purchased by the SCS may ameliorate some of the risk of suits brought against the SCS under social host liability.

Ultimately, supervised consumption sites are rooted not in condoning “illicit drug use” but in valuable, harm-reducing health care that can help mitigate the overwhelming epidemic of preventable overdose deaths in the US. To that end, as a medical research team from Brown Medical School [noted](#) in the Journal of Healthcare for the Poor and Underserved, “it is unethical to allow a narrow focus on the harms of drug use to overshadow an opportunity to save human lives.”

“Why help people who use drugs?”

Drug addiction is often the result of predisposed environmental and genetic factors, including socioeconomic biases in policy and policing. The pathways to adolescent substance use disorders are also clear according to a [study](#) from Baylor College of Medicine: prenatal exposure to drugs, genetic vulnerability, lack of parental support, and peer drug use push adolescents to drug use. All of these factors are out of the control of young people and escalate their vulnerability to developing substance use disorders. About [20%](#) of Americans who have depression or an anxiety disorder also have a substance use disorder. Harm reduction interventions spark controversy and grab attention, while the abundant structural cracks in society that drive addiction—that necessitate harm reduction in the first—place go unaddressed. Thus, advocates of supervised consumption sites can apply a “both/and” strategy, demanding policies address the root causes of addiction (poverty, trauma, mental distress) while also building harm reduction infrastructure that prevents addiction from turning fatal. po

Stigma related to SCSs also dissipated over time in other countries like Switzerland and British Columbia after SCS implementation, so this opposition is likely to become less of a barrier after implementation. “However, according to interviewees, objections to SCSs from local stakeholders tended to disappear following their implementation, something that was also observed in numerous places that opened SEPs.” (Tempalski, 2007) Unlike other less stigmatized chronic medical illnesses like arthritis or diabetes which are also often the result of structural factors and individual vulnerabilities, people who use drugs are punished and kept from accessing medical resources because of unnecessary societal biases about which illnesses are treated and which illnesses are punished.

Importantly, quality, evidence-based substance use disorder treatment is difficult to access due to a host of legislative and socioeconomic barriers. Of the estimated 21 million Americans in need of substance use treatment in 2016, only 3.1 million received it [according](#) to the US Department of Justice. Issues like [lack](#) of access to health insurance, poor geographic distribution of treatment centers, and financial barriers like cost all prevent people from receiving care. There is also a lack of quality substance use disorder treatment in the US.. Less than [half](#) of the licensed 12,000 addiction treatment facilities tracked by the federal government offer evidence-based medications for opioid use disorder, namely methadone and buprenorphine, which are considered the “gold standard of care.” Despite decades of research supporting their efficacy and billions of dollars made available to states through block grants, which went [largely](#)

[unspent](#), people with substance use disorders still face significant hurdles accessing life-saving treatment.

“Will this even work? Is this the right public health response?”

In Canada, overdose mortality [declined](#) because of the introduction of supervised consumption sites and drug users became more likely to receive on-site nursing services that improved their overall health. A [2019 study](#) analyzing overdose mortality in Canada found that without harm reduction interventions, overdose deaths would be more than twice as high. According to the study, there were 2,177 overdose deaths in British Columbia from 2016 to 2017, and more than additional 3,000 deaths were prevented thanks to harm reduction interventions. SCSs also have the ability to [reduce](#) the spread of infectious disease by preventing needle sharing. The need for immediate action to address the public health threat of infectious disease spread from drug use is already clear in Boston. The greater Boston area is currently experiencing an HIV outbreak, which the Boston Public Health Commission [states](#) is occurring among people who use drugs and are experiencing homelessness.

Notably, SCSs are also supported by major organizations of medical professionals proving that they have garnered not only epidemiological success in international research, but support from practicing American physicians. The American Medical Association, the largest professional organization of U.S. physicians, voted to endorse SCSs in 2017. The Massachusetts Medical Society also voted in 2017 to promote the use of a supervised consumption site in Massachusetts. The Harm Reduction Coalition is also in support of supervised consumption sites in Massachusetts as an effective public health tool.

There is a common misconception that SCSs would discourage visitors from seeking substance use disorder treatment. However, [research](#) studying an SCS in Vancouver called Insite, showed that after the site opened, the area saw a 33% increase in detoxification service use and Insite visitors were 3.7 times more likely to participate in addiction treatment. Of 1,000 Insite visitors over the period from 2003-2005, 18% enrolled in detoxification services. The study ultimately concluded that, “contrary to fears that Insite might be deterring drug users from seeking treatment, these findings strongly suggest that Insite is facilitating entry into detoxification services among its clients.”

Conclusion

Supervised consumption sites are an effective harm reduction-based public health intervention for the overdose crisis, but the concept is plagued with stigmatizations and misconceptions. In the Boston community, it is clear that citizens are concerned about increased crime, cost to taxpayers, and condoning “illegal” activity. These concerns are refuted by a body of evidence, notably from numerous successful supervised consumption sites abroad. In order for a supervised consumption site to be successfully enacted in the Boston area, continued advocacy and educational efforts to address these community misconceptions are necessary.

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