DRUG & ALCOHOL FINDINGS *Analysis*

This entry is our analysis of a document considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original document was not published by Findings; click Title to order a copy. The summary conveys the findings and views expressed in the document. Below is a commentary from Drug and Alcohol Findings.

Canadian guidelines on opioid use disorder among older adults.

Canadian Coalition for Seniors' Mental Health
Canadian Coalition for Seniors' Mental Health, 2019

What Canadian experts judged to be the best clinical practice around the prevention, assessment, and treatment of opioid use disorders in older people.

SUMMARY The Canadian Coalition for Seniors' Mental Health received a grant from Health Canada to create a set of four guidelines on the prevention, assessment, and management of substance use disorders among older people. This analysis outlines recommendations for opioids. The guidelines for alcohol, cannabis, and benzodiazepines have also been added to the Effectiveness Bank.

Most clinicians are aware that chronic opioid use can lead to tolerance, dependence, and withdrawal when opioids are discontinued (or when the doses are lowered too quickly). However, many health care providers and patients are unaware that opioid use can paradoxically cause a generalised increase in sensitivity to pain. During withdrawal, further pain sensitivity can arise and pain can return to old healed injury sites. It may take weeks to months for pain sensitivity to normalise after opioids are discontinued. These issues are particularly important for older people as a large proportion suffer from chronic pain, and they become increasingly prevalent until the age of 85.

The 'opioid crisis' in North America has frequently made headline news, however, the impact on older adults has often been missed. In Canada, from 2007 to 2015, hospitalisations for opioid overdose (opioid poisoning) have been consistently higher in older adults than in any other age cohort. At over 20 per 100,000, admissions were almost double that of 15–24-year olds, and represented 30% of all admissions to hospital for opioid poisoning.

Older people who develop opioid use disorders typically fall into one of two categories:
• The first group is made up of people who have been exposed to opioids for many years through drug experimentation, often beginning in adolescence or early adult life. Some have been identified with and treated for an opioid use disorder, and many have had adverse health consequences related to their drug use.
• The second group of people are those prescribed opioids by a health care provider for a pain condition, who may have continued taking prescription opioids for an extended period. Some may have turned to the illicit market in order to maintain an ongoing supply of opioids after their prescription was discontinued by a health care professional.

A guide to the guidelines

The goal of the featured document was to provide useful guidance for clinicians on either preventing the development of opioid use disorders or optimally assessing and treating older people who have developed opioid use disorders. The term 'opioid use disorder' refers to a problematic pattern of opioid use leading to clinically significant impairment or distress. According to DSM-5 criteria, opioid use disorder is indicated by the presence of at least two pre-defined symptoms or adverse effects within a 12-month period (unfold the supplementary text). Mild opioid use disorder is evidenced by the presence of 2–3 symptoms, moderate opioid use disorder by 4–5, and severe opioid use disorder by six or more. DSM-5 criteria may under-identify substance use problems among older people due to some screening questions potentially becoming less relevant to this cohort (eg, impact of substance use on occupation and social obligations).

Close supplementary text

1. Opioids are often taken in larger amounts over a longer period than was intended.
2. There is a persistent desire or insignificant effort to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain opioids, use opioids, or recover from their effects.
4. Craving or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in failure to fulfil major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations which are physically hazardous.
9. Opioid use is continued despite knowledge of having persistent or recurrent physical or psychological problems that are likely to have been caused or exacerbated by opioids.
10. The person builds a tolerance for opioids, by either a need for markedly increased amounts of opioids to achieve intoxication and desired effect or a markedly diminished effect with continued use of the same amount of opioids.
11. Symptoms of withdrawal are relevant or opioids (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Close supplementary text

The quality of evidence for each recommendation in the guideline was graded high, moderate, or low, where:
• **high** meant further research was unlikely to change confidence in the effect of the proposed course of action;
• **moderate** meant further research was likely to have an important impact on confidence and may change the estimated effect of the proposed course of action;
• **low** meant further research was very likely to have an important impact on confidence and is likely to change the estimated effect of the proposed course of action.

The strength of each recommendation was also graded:
• **strong** recommendations indicated high confidence that desirable consequences outweigh undesirable consequences;
• **weak** recommendations indicated that there is either a close balance between benefits and downsides (including

adverse effects and burden of treatment), uncertainty regarding the magnitude of benefits and downsides, uncertainty or great variability in patients' values and preferences, or that the cost or burden of the proposed intervention may not be justified.

A separate category was created for recommendations which were not primarily based on evidence, but were agreed to represent **best clinical practice**.

Prevention

Older people have a greater risk of developing opioid use disorders if they are male, have been exposed to illicit opioids earlier in life, are socially isolated or lonely, have a psychiatric disorder, and experience chronic, severe, or persistent pain. To curb opioid overdoses and opioid use disorders, primary and secondary prevention measures need to be implemented – ie, before opioids are used for the first time, and after opioids have been used for the first time but prior to the person experiencing problems.

Recommendation 1. In order to avoid the risk of developing an opioid use disorder, older people with acute pain for whom opioids are being considered as pain relief should receive the lowest effective dose of the least potent, immediate-release opioid for a duration of three days or less; in rare situations, the duration may exceed seven days.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 2. In most circumstances, avoid prescribing opioids for older adults with chronic non-cancer pain. An opioid treatment could be trialled if the person has severe pain, has not responded as desired to non-opioid therapy, does not have a history of substance use disorder, and does not have a current mental health problem. Consider obtaining a second opinion before prescribing opioids long-term. After explaining the risks and benefits to the patient: prescribe only in accordance with published guidelines for adults; initiate and maintain opioids at lower doses than for younger adults; and discontinue if function does not improve or if adverse effects arise.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 3. Patients and their families should be advised to store opioids safely, never to share their medication, and to return unused medication to the pharmacist for disposal.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 4. Pharmacists and nursing staff are advised to inform the prescriber if there are concerns with medications prescribed in conjunction with each other, adherence to treatment, or intoxication.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 5. In older people prescribed multiple medications or with multiple medical problems that increase the risk of opioid overdose, the lowest effective opioid dose should be used and the clinician should consider gradually reducing the dosage of the opioid and/or other medications (known as 'tapering').
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 6. Once a decision is made to reduce opioid doses, a slow tapering schedule (eg, a 5% reduction every 2–8 weeks with rest periods), on an outpatient (rather than inpatient/residential) basis, is preferable to more rapid tapering. Under special circumstances where there is medical need, a faster tapering schedule may be attempted, provided the patient is in a treatment setting with medical supervision.
Quality of evidence: low
Strength of recommendation: weak

Recommendation 7. Dispense the 'overdose antidote' naloxone to anyone using opioids regularly, including people dealing with chronic non-cancer pain and opioid use disorders. Train household members and support staff on how to use naloxone.
Quality of evidence: low
Strength of recommendation: weak

Recommendation 8. Invite skilled pharmacists and nurses to collaborate on educating patients about the appropriate use of opioids and other medications.
Quality of evidence: low
Strength of recommendation: weak

Recommendation 9. Older people with or at risk for an opioid use disorder should be given advice on strategies to reduce the risk of an opioid overdose and information on supervised consumption sites (also known as drug consumption rooms), if available in the community.
Quality of evidence: moderate
Strength of recommendation: strong

Screening and assessment

Screening and assessment are the starting points for care if someone has an opioid use disorder. However, clinicians working with older people should be aware of the different ways opioid use disorders can manifest in older people. For example, with regard to DSM-5 criteria for diagnosing opioid use disorders, older people with entrenched habits may not recognise cravings in the same way as the general adult population, and because of increased sensitivity to substances as they age, older people may seem to have decreased rather than increased tolerance. It may therefore be necessary to alter approaches to screening and assessment to accommodate the unique needs of older people, and conduct further assessments if an older adult has just one positive feature for an opioid use disorder.

Other signs to keep in mind that might help distinguish the older person with an opioid use disorder from the older person with pain but no opioid use disorder are:
• the patients with pain *and* an opioid use disorder tend to be on higher doses than is usual for their underlying condition;
• they sometimes run out of opioid medication early or have other atypical behaviours;
• they usually have underlying risk factors (eg, anxiety, insomnia, depression, past history of a substance use disorder);
• they can have poor or deteriorating function and mood;
• they have reported significant withdrawal symptoms;
• they can show extreme resistance to tapering or cessation, even though they do not appear to get much pain relief from the opioid;
• family members have expressed concern about their opioid use.

Recommendation 10. Older people should be screened for an opioid use disorder using validated tools.

Medication reviews and urine drug screens should be used if the patient is taking opioids for chronic non-cancer pain or an opioid use disorder.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 11. Diagnose an opioid use disorder by conducting a comprehensive assessment, taking into account the cultural context, and conducting a brief assessment of challenging behaviour. In addition, a detailed physical examination should be conducted, with an emphasis on signs of intoxication or withdrawal and the consequences of substance use. Reassessment is essential and should be conducted episodically throughout long-term care.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 12. A full explanation of findings and diagnosis must be shared with patients (and caregivers where appropriate). The clinician should provide therapeutic optimism, giving hope that dependence is treatable and that older people (and even more so older women) typically have better treatment outcomes than younger people.
Consensus that this represents best clinical practice

Treatment

Long-term medications for an opioid use disorder include opioid agonists and opioid antagonists:
• An **opioid agonist** is a medication which has similar psychoactive effects to the misused substance which is the target of treatment (eg, methadone for heroin dependence). This is also known as opioid substitution therapy.
• An **opioid antagonist** is a medication which blocks the effects of the misused substance which is the target of treatment (eg, naltrexone for heroin dependence).

Robust evidence on the effectiveness of behavioural interventions in older people with opioid use disorders is lacking, however, there is a need for incorporating psychosocial support. Older people may have an accumulation of losses (job, spouse, family, friends, role, home), and may struggle with a lack of social support.

Recommendation 13. Opioid withdrawal management should only be offered in the context of a plan for longer-term treatment for dependence.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 14. Opioid substitution therapy is recommended over withdrawal from opioids using non-opioid drugs in older people with an opioid use disorder. If a trial of tapering is attempted, there should be the option to initiate longer-term opioid substitution therapy or opioid antagonist therapy to block the effects of the misused opioid.
Quality of evidence: moderate
Strength of recommendation: weak

Recommendation 15. Buprenorphine–naloxone should be considered a first-line treatment for managing withdrawal from opioids in older people. Alternatively, methadone may be used, but clinicians should consider the added risk of adverse events including overdose.
Quality of evidence: moderate
Strength of recommendation: weak

Recommendation 16. Withdrawal from opioids is not as effective as opioid substitution therapy and should only be undertaken if the patient explicitly rejects opioid substitution or is in a controlled environment where access to opioids is restricted. For managing the symptoms of opioid withdrawal, medications that can increase the efficacy or potency of other medications can be used in a time-limited fashion but with caution about co-existing medical problems, risk of side effects, and other concerns related to older age.
Quality of evidence: moderate
Strength of recommendation: weak

Recommendation 17. Maintenance with buprenorphine should be considered a first-line treatment for an opioid use disorder in older people.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 18. Methadone maintenance treatment may be considered for older people who cannot tolerate buprenorphine maintenance or for whom it has been ineffective.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 19. If their kidney function is adequate, daily supervised consumption of slow-release oral morphine may be considered for older adults in whom buprenorphine and methadone maintenance have been ineffective or could not be tolerated. Careful supervision of initiation onto short-acting morphine is recommended, prior to transition to maintenance with the long-acting 24-hour formulation.
Quality of evidence: low
Strength of recommendation: weak

Recommendation 20. Naltrexone can be offered when opioid agonist treatments are unsuitable – for example, because they may be harmful, are unacceptable, are unavailable, or have been discontinued – and the older person has been abstinent for a sufficient period of time.
Quality of evidence: moderate
Strength of recommendation: weak

Recommendation 21. Medical treatments should be offered in the context of a plan for longer-term connection to long-term substance use, mental health, and primary care treatment, and where careful monitoring and adjustments of dose can take place.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 22. Patients should be advised about the risks of consuming alcohol, benzodiazepines, and other psychoactive substances with a sedative effect combined with opioid substitution therapy. If the older person is living in the community and is already physiologically dependent on one of these substances, slow tapering of the substances (until use is eliminated if possible) rather than abrupt cessation is recommended. If the patient is in hospital, residential treatment, or a long-term care setting and medically managed by an experienced provider, withdrawal can be facilitated more rapidly, with the appropriate use of medication to support this.

Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 23. Early take-home buprenorphine maintenance treatment can be considered in patients who are low risk, if they find it difficult to attend the office and if the patient has social supports at home. This approach should not be considered for methadone initiation unless supervised (eg, reliable caregiver or medical personnel).
Quality of evidence: low
Strength of recommendation: weak

Recommendation 24. The balance between benefits and adverse effects of medication often differs in older people. Too high an initial dose of medication or too rapid an increase in dose can risk sedation, delirium, and falls. For these reasons, clinicians should adopt a cautious approach to prescribing medications for an opioid use disorder in older people: reducing initial doses of medications for treatment of an opioid use disorder (eg, by 25–50%); slowing the frequency of increasing the dose (eg, by 25–50%); using the lowest effective dose to suppress craving, withdrawal symptoms, and drug use; and monitoring the patient closely, especially for sleep apnoea, sedation, cognitive impairment, and falls.
Quality of evidence: low
Strength of recommendation: strong

Recommendation 25. There should be a lower threshold for admitting an older adult with social, psychological, or physical comorbidities to residential or hospital care for opioid withdrawal management or induction onto medications for an opioid use disorder than for a younger person.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 26. Alternatives to medication (and specifically opioid medication) are recommended for older people with mild-to-moderate pain or chronic non-cancer pain who are also taking medication for an opioid use disorder. For those on an opioid agonist for an opioid use disorder who have severe pain that has been unresponsive to non-opioid strategies, a short-acting opioid may be considered for a short duration (1–7 days) accompanied by a period of tapering if necessary (1–7 days).
Quality of evidence: moderate
Strength of recommendation: weak

Recommendation 27. Psychosocial interventions should be offered at the same time as medical treatment, at a pace appropriate for age and patient needs. However, they should not be viewed as a mandatory requirement for accessing pharmacotherapy.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 28. Contingency management can be offered as part of opioid treatment programmes and used if acceptable to the patient.
Quality of evidence: moderate
Strength of recommendation: weak

Recommendation 29. Traditional healing practices used by indigenous communities can be integrated with buprenorphine treatment to improve outcomes for an opioid use disorder.
Quality of evidence: low
Strength of recommendation: weak

Recommendation 30. Experienced clinicians may manage older people with a mild-to-moderate opioid use disorder. However, for patients with more severe or complex disorders, they should be supported by personnel or teams with advanced substance use disorder management skills. The threshold for an admission to hospital or drug and alcohol treatment facility under the care of an addiction medicine specialist is lower than for younger adults, and closer follow-up is needed on discharge to ensure appropriate community-based support.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 31. Older people with an opioid use disorder who are admitted to a hospital, drug and alcohol treatment facility, or non-medical facility with access to medical care (eg, prisons and shelters) should be offered opioid agonist treatment at the onset of withdrawal (advisable within 1–3 days), with bridging pharmacological treatment on discharge with confirmed transfer of care.
Quality of evidence: moderate
Strength of recommendation: strong

Recommendation 32. In Canada, substance use disorders are one of few chronic medical conditions that can require the patient to pay for some or all of their own treatment. The recommendation is that medically-advised pharmacological and non-pharmacological treatments for opioid use disorders in older people should be covered by Canadian public health care.
Quality of evidence: moderate
Strength of recommendation: strong

The authors' conclusions

The featured guidelines were designed to provide evidence-informed, clinically-relevant direction and advice on how to manage opioid use disorders in older patient populations. It is hoped that practitioners will find it a practical clinical aide, and that the community at large will find it a helpful educational resource.

FINDINGS **COMMENTARY** The annual accounting of the treatment caseload in England has registered a continuing fall in total numbers and decreasing success with people who use opioids, thought to be due at least in part to the 'ageing population' of opiate users. With older opiate-dependent people staying in or returning to treatment, and fewer young adults using the drugs at all or in a way which results in treatment, in England and the UK in general the opiate-using treatment population is on average getting older. According to Public Health England (1 2), this ageing cohort is often in poor health, with a range of vulnerabilities associated with long-term drug use including social isolation, and more

entrenched, hard-to-treat dependence.

The featured guidelines make a strong case for an age-sensitive approach to determining what constitutes best clinical practice for treating and managing opioid use disorders. For older people, this includes taking age into account when screening for opioid use disorders (older people may 'slip through the cracks' if clinicians base their assessment solely on standard diagnostic criteria), choosing which treatments to use and on what dose / over how long to prescribe medication (older people can be more vulnerable to sedation, delirium, and falls), and deciding whether to manage treatment and withdrawal on an outpatient or residential basis (there should be a lower threshold for admitting older people for inpatient care).

In respect of opioid substitution therapy, one of the key recommendations was for clinicians to prescribe buprenorphine over methadone:

> *"Buprenorphine–naloxone should be considered a first-line treatment for managing withdrawal from opioids in older people. Alternatively, methadone may be used, but clinicians should consider the added risk of adverse events including overdose."*
>
> *"Maintenance with buprenorphine should be considered a first-line treatment for an opioid use disorder in older people."*
>
> *"Methadone maintenance treatment may be considered for older people who cannot tolerate buprenorphine maintenance or for whom it has been ineffective."*
>
> *"Early take-home buprenorphine maintenance treatment can be considered in patients who are low risk, if they find it difficult to attend the office and if the patient has social supports at home. This approach should not be considered for methadone initiation unless supervised (eg, reliable caregiver or medical personnel)."*

While methadone is a 'full opiate agonist', meaning it produces greater opiate-type effects the higher the dose, buprenorphine is only a 'partial opiate agonist', creating a 'ceiling' of opiate-type effects, limiting the respiratory depression typically responsible for overdose deaths, and attenuating the effect of 'on top' heroin use.

In 2007, experts and advisers convened by the UK's National Institute for Health and Care Excellence (NICE) published evidence-based guidance on the use of oral methadone and buprenorphine for managing opioid dependence in adults. Reviewed again in 2016, NICE found no new evidence to change their recommendations. The overarching conclusions were that both methadone and buprenorphine are legitimate options for maintenance therapy, and "the decision about which drug to use should be made on a case by case basis, taking into account a number of factors, including the person's history of opioid dependence, their commitment to a particular long-term management strategy, and an estimate of the risks and benefits of each treatment". However, with everything being equal, the recommendation was that "methadone should be prescribed as the first choice" (unfold the supplementary text for extended opinion from the NICE guidance).

Close supplementary text

> *"The Committee heard from the experts that it was not always clear which drug (methadone or buprenorphine) should be prescribed in individual cases. In some circumstances there can be clinical reasons for prescribing either methadone or buprenorphine, taking into account the person's history of opioid dependence. For people who are less opioid dependent and are planning on becoming abstinent, buprenorphine may provide greater flexibility and enable earlier detoxification. The Committee also heard that some people may have a preference for one drug over the other, which will affect their compliance with and retention in treatment. The Committee considered carefully the issue of mortality from overdose, particularly when methadone treatment is started. The Committee was also aware of the risks of diversion of these drugs to non-drug-users, especially children, in particular the high mortality risk associated with methadone in opioid-naïve people. However, the Committee considered that the current guidance, while taking account of the adverse effects of therapy in people prescribed the drugs, could not deal individually with all the issues associated with diversion. The Committee was persuaded of the importance of having both drug treatment options available, and that the decision on which was the most appropriate treatment for an individual should be made on a case by case basis. The Committee concluded that the responsible clinician, in consultation with the person, should estimate the risks and benefits of prescribing methadone or buprenorphine, taking account of the person's lifestyle and family situation (for example, whether they are considered chaotic and might put children and other opioid-naïve individuals living with them at risk)."*
>
> *"For the comparison of methadone with buprenorphine, the Committee noted that the trials showed that people on methadone were retained longer in treatment compared with those on buprenorphine. For illicit opioid use while in treatment, there were no statistically significant differences between the two drugs. The Committee noted that there was uncertainty around the risk of mortality in the published research, and heard from the experts about the potential increased risk of death for people using methadone compared with buprenorphine, and the potential increased risk of death for other people when diversion (where the*

> *medication is forwarded on to others for non-prescription uses) of methadone occurs. The Committee considered the importance of supervision of both methadone and buprenorphine and noted that the Assessment Group's model assumed supervised administration of the drugs for 6 days a week for the first 3 months, which is in line with the Department of Health guidelines."*
>
> Close supplementary text

This appraisal of the evidence was supplemented in 2014 by a review conducted according to rigorous Cochrane Collaboration procedures. The analysts' verdict was that, given adequate doses, methadone was the more effective treatment, but not by such a margin that buprenorphine could positively be advised against. Methadone's key advantage was greater retention – important, because over the periods represented in the studies, when patients left, relapse to dependent illicit opiate use was the norm.

Both methadone and buprenorphine are effective treatments, and designated by the World Health Organization as essential medicines in the management of opioid dependence. Uncertainty about overall advantage, allied with differences in the safety and effects of the drugs and feasible dispensing arrangements, suggest that some patients will be best suited to methadone, others to buprenorphine. Unfortunately, there is little in the research to indicate who will be in which camp.

The featured guidelines suggested that buprenorphine may be favourable due to it having a "better safety profile" than methadone. From the UK, there may be evidence that buprenorphine is associated with lower rates of overall mortality and specifically of drug-related poisoning deaths, including the first four weeks when patients are presumed to be at greatest risk. An analysis of patient care records found that during treatment at primary care practices, buprenorphine was consistently associated with lower rates of overall mortality and drug-related poisoning deaths than methadone. However, across the population buprenorphine is unlikely to give greater overall protection because of the relatively short duration of treatment (an average of 173 days vs. 363 days).

In UK primary care, most patients receive relatively short durations of opioid substitution treatment, and this is particularly the case among patients prescribed buprenorphine. Therefore, the authors concluded that the combination of short average treatment durations and high mortality risk in the period after treatment cessation suggests that in the UK neither buprenorphine nor methadone can impact the number of drug-related poisoning deaths in the population. Rather than comparing different opioid substitution treatments against each other, further trials are needed that can test how best to optimise opioid substitution treatment alongside other interventions, both to reduce the heightened risk of mortality at the start of treatment and to retain people in treatment long enough to have an effect on the number of drug-related deaths in the population. For a more in-depth analysis of these findings, see the Drug and Alcohol Findings commentary.

Last published in 2017, there is no more important document for UK clinicians involved in treating problem substance use than the so-called 'Orange guidelines', which includes a section on how to treat older people. Turn to page 251 of the original document to read the recommendations on long-term opioid substitution therapy for older people.

Finally, recommendation 9 (▸ skip) in the Canadian guidelines advocated for harm reduction advice for older people who may be at risk of an opioid overdose, as well as the provision of information on drug consumption rooms, which provide hygienic and supervised spaces for people to inject or otherwise consume illicit drugs. Growing acceptance of safer injecting facilities and increasing concern about overdoses in Canada has prompted a rapid escalation in efforts to establish consumption rooms in various cities. However, to date only one facility exists, and even this has been in "perpetual pilot status for over a decade". For Canada, political opposition to drug consumption rooms remains the most significant barrier to expansion. Through successive political parties, the UK Government too has remained opposed to drug consumption rooms. An Effectiveness Bank hot topic, "Time for safer injecting spaces in Britain?", examines the arguments for and against drug consumption rooms.

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