Older intravenous drug users in methadone treatment: Numbers, stories and lessons learned for harm reduction

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Background

Methadone is used world-wide as a first choice treatment for opioid dependency. However, heroin use in treatment is common, especially for dual users of heroin and crack/cocaine or other stimulants. In addition, intravenous (IV) use increases the risk of health complications, and in an ageing population further chronic conditions such as diabetes, COPD, chronic pain, kidney and liver disease contribute to a deteriorating quality of life.

Ageing drug users in treatment experience low quality of life

Aim

To explore physical health and drug use in methadone treatment in older people with a history of IV heroin use.

Methods

Participants: Dual users of heroin and crack cocaine who have ever injected heroin and are currently in methadone treatment at two services in London, UK (age over 40, n=148 for clinical records; n=27 for interviews)
Data collection: Secondary analysis based on clinical records and and interviews covering the history of drug use, treatment, and physical health.
Groups compared: Group 1: currently using heroin, good health
Group 2: currently using heroin, poor health
Group 3: heroin abstinent, poor health
Outcome: IV-related physical health ('poor health' = IV-related adverse events such as varicose veins, septic arthritis, septicaemia, DVT, pulmonary embolism, endocarditis, stroke)
Statistical analyses: Chi^2 , t and Fisher's exact tests, bivariate associations.

ABBREVIATIONS:

H – heroin | **C – crack cocaine** | **SM – smoking** | **MTD – methadone** | **IV – intravenous** | **CVR – cardiovascular risk(s)** | **OST – opiate substitution therapy** | **PSI – psychosocial interventions**

NUMBERS

	Group 1 H use good health	Group 2 H use poor health	Group 3 No H poor health	
Clinical records	N=55	N=62	N=13	
Current H IV	29%	**52%**	**(0%)**	P=0.02
Current C IV	18%	**34%**	**0%**	P=0.04
Current C use	98%	97%	77%	
Interviews	N=10	N=10	N=7	
Current H IV	40%	60%	0%	
Current C IV	20%	30%	0%	
Current C use	80%	80%	29%	
Years on MTD	10	15	18	
Years IV on MTD	6	**11**	**13**	P=0.01
High Risk IV sites	20%	**70%**	**71%**	P=0.04
Switch from IV to SM	**90%**	50%	29%	P=0.03

Switch from IV to SM ↔ good health (OR=0.08, 95% CI: 0.01 – 0.76)

High risk IV sites ↔ poor health (OR=9.6, 95% CI: 1.5 – 62.2)

Why are some people injecting crack and/or heroin in good health (group 1) and some people not using heroin at all and only smoking crack in poor health (Group 3)?

Why did those in group 3 stop injecting and using heroin but not those in group 2?

Is it as simple as switch to SM → good health | HR sites → poor health?

STORIES

	Group 1 H use good health	Group 2 H use poor health	Group 3 No H poor health
Case studies	**SAM**	**PAT**	**CHRIS**
High Risk IV sites	**YES**	**YES**	**YES**
Switch from IV to SM	**YES**	**YES**	**YES**
Age	46y	46y	54y
Years of drug use	**25**	31	**37**
Years of IV drug use	19	**31**	20
Years on MTD	**12**	**29**	18
Years IV on MTD	**11**	**27**	15
MTD dose	55	100	100
IV-rel health problem	NO	DVT	stroke
Reason to stop IV	to improve health	Kidney Disease	No veins anywhere
Reason to stop SM	NO	NO	COPD

QUESTIONS & COMMENTS?

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LESSONS – all interviews

- **motivation for treatment:** reducing/controlling drug use more often than abstinence

Need for new treatment discourse away from abstinence (-only)?

- **Switch to neck/groin and DVT/stroke** after first MTD treatment or on MTD

MTD does not always prevent transition to high risk IV and deterioration of health

- **Group 1 (H use, good health)**: reasons for IV stop: social/improve health; little groin/neck IV; MTD mainly <60 mg/day; less frequent IV use than groups 2 & 3

IV stop before health compromised

- **Group 2 and 3 (poor health)**: IV stop after health scare (DVT, OD), or no veins at a high risk site regardless of MTD dose

IV stop only after health compromised

- **reverse transition** from IV to smoking before compromised health more often on MTD <60 mg/day

could lower MTD dose + PSI help achieve a reverse transition?

How else does MTD help people use safer (use only one instead of both H and C)?

Some people want to continue enjoying H

On high MTD dose there's no point in using H without the C.

Would a lower MTD dose help to use H only?

Some people enjoy the C but not the 'come down'

If I have MTD I feel more comfortable using only the C, before I had to have H to come down

If you smoke C on MTD you only feel the C and not the MTD, I always need H to come down

√

Would a higher MTD dose and/or PSI help to use only C?

LESSONS – Chris

Harm Reduction aims for BALANCE. What went wrong with Chris?

Chris' view

PAST PRESENT

My heroin use was the only thing my abusive partner could not control.

Heroin helped me perform better at work.

poor circulation
stroke
pre-metabolic syndrome
COPD

Drug service's view

PAST AND PRESENT

Stop using! MTD and PSI aiming at abstinence

Risks and problems increase with ageing!

Early signs that MTD didn't work for abstinence and future severe cardiovascular problems could have been recognized earlier by services :

- 15 years of IV use on MTD; start of IV in the neck while on MTD

- early signs of poor CV health/CV risks: tobacco smoker from very young age, poor injecting technique, veins collapsing quickly, pre-metabolic syndrome

What else could have the treatment service?

- earlier switch IV → SM? (but poor CV health from young age, so was SM ever lower risk than IV for Chris?)
- Lower or higher MTD dose and PSI aimed at lower frequency of drug use on top?
- safer injecting advice along with MTD prescription?
- education on ALL CVR factors e.g. diet, tobacco/heroin/crack smoking, exercise, injecting technique...?
- broader behaviour change support to reduce any possible CV risk (diet, exercise...) ?
- emotional support/counselling despite drug use?
- Could such interventions have prevented or at least delayed the COPD (and the stroke?)
- **Further COPD exacerbations and diabetes could possibly still be prevented!**

Discussion

MTD is a harm reduction intervention but IS THIS ENOUGH?

Some people access methadone treatment to reduce rather than stop drug use.
Routinely collected clinical data give only a partial view on long-term outcomes of IV users in treatment.
The history of injecting behaviour, health, social life and users' own narratives are necessary to understand poor outcomes in older age, and find ways to reduce health deterioration.

MTD could be as well a safer drug use intervention and could further improve drug users' health if (prescribing) services would:

- **consider equally benefits and risks of drug use**
- **create space to talk openly about the true motivation and listen to people's choices**
- **talk about long-term health deterioration due to drug use but offer OST and PSI aimed at safer use on top if this is person's choice**
- **not limit counselling for broader life challenges to only those who are 'stable' on OST but offer it in Drug Consumption Rooms, Needle Exchanges and to those using on top of OST if they want it**
- **review risks of drug use, general health and safer use advice when people age**

Moving forward?

Limitations of this study: retrospective, recollection bias, regional sample, low numbers

- **more research**
- **Larger-scale data (e.g. routinely collecting data on IV-related health, changes in injecting sites and other relevant parameters during MTD/OST treatment at national and European level)**
- **design and trial of PSI aimed at safer and controlled drug use, and optimization of MTD dose for safer on top use**
- **change of political, social and health care discourse!**

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