



London
South Bank
University

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

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The authors declare no conflicts of interest

Background

- Methadone – first choice of treatment
- Users of heroin and crack/cocaine/other stimulants - more heroin on MTD
- IV use → poor health
- ageing → further chronic health conditions

Ageing drug users in treatment experience low quality of life

MTD is a harm reduction intervention but is this enough?

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In treatment services our discourse is more about abstinence:

MTD optimization: increasing the dose → less heroin use/abstinence

PSI – assumption of motivation to abstinence

Sample and Data

Participants:

- currently in methadone treatment (two centres in London, UK)
- current/previous
 - IV users of heroin AND
 - crack users (IV or SM)
- aged over 40 y

Medical records (n=148) and interviews (n=27)

The study was approved by the Ethics Committee of the London South Bank University and was partially funded by Lifeline Project.

Groups compared

Group 1

currently using H
good health

Group 2

currently using H
poor health

Group 3

H abstinent
poor health

‘poor health’ = IV-related adverse events such as varicose veins, septic arthritis, septicaemia, DVT, pulmonary embolism, endocarditis, stroke

Numbers – clinical records N=148

	Group 1 N=55	Group 2 N=62	Group 3 N=13
	H use good health	H use poor health	No H poor health
Ever Crack IV	31%	53%	31%
Current H IV	29%	52%	(0%)
Current C IV	18%	34%	0%
Current C use	98%	97%	77%

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)?

Numbers – interviews N=27

	Group 1 N=10 H use good health	Group 2 N=10 H use poor health	Group 3 N=7 No H poor health
Ever Crack IV	70%	80%	43%
Current H IV	40%	60%	0%
Current C IV	20%	30%	0%
Current C use	80%	80%	29%
Years on MTD	10	15	18
IV on MTD	6	11	13
High Risk IV sites	20%	70%	71%
Switch from IV to SM	90%	50%	29%

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

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

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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 – interviews

Group 1	Group 2	Group 3
H use good health Sam	H use poor health Pat	No H poor health Chris
High Risk IV sites	YES	YES
		YES

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High Risk IV sites	YES	YES	YES
Switch IV to SM	YES	YES	YES
Age	46y	46y	54y
Drug use	25y	31y	37y
IV drug use	19y	31y	20y
MTD	12y	29y	18y
IV on MTD	11y	27y	15y
MTD dose	low	high	high

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MTD dose	low	high	high
poor health	N/A	DVT, endocarditis	stroke (off MTD and H)
IV stop	to improve health	ESRD	No veins anywhere
SM stop	NO	NO	COPD

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Stories – interviews

- **motivation for treatment:** (more often) reducing/controlling drug use rather than abstinence
- **Switch to neck/groin and DVT/stroke after being a while in MTD treatment**
→ MTD does not always prevent health deterioration
- Switch from IV to SM happened more often on lower doses of MTD
→ could low dose + PSI help some people achieve reverse transition?
- Group 1 (H use, good health): → IV stop before health compromised
- Group 2 and 3 (poor health): → IV stop only after health was compromised

Stories – interviews

- how else does MTD help people use safer?

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Some people prefer the heroin but...

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Would a low MTD dose help them to use heroin only?

Stories – interviews

- **how else does MTD help people use safer?**

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

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- how else does MTD help people use safer?

Some people enjoy the crack 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

I am now able to smoke the C, using the MTD to come down

high MTD

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

Low MTD

Stories – interviews

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Low MTD

Would a higher MTD dose help them to use only crack?



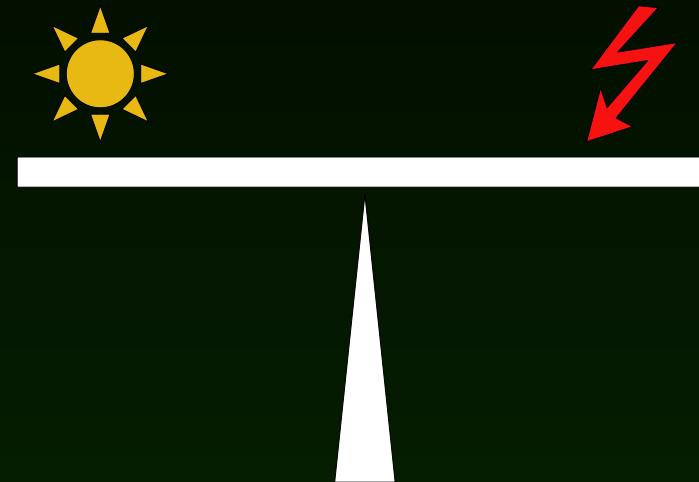
Chris

What went wrong?

Early signs that MTD didn't work for abstinence and severe cardiovascular problems were to come:

- **years of IV use on MTD**
- **starting IV in the neck despite being on 100 mg MTD/day**
- **early signs of poor CV health: tobacco smoker from very young age, poor injecting technique, veins collapsing quickly, pre-metabolic syndrome**

Every Behaviour has positives and risks

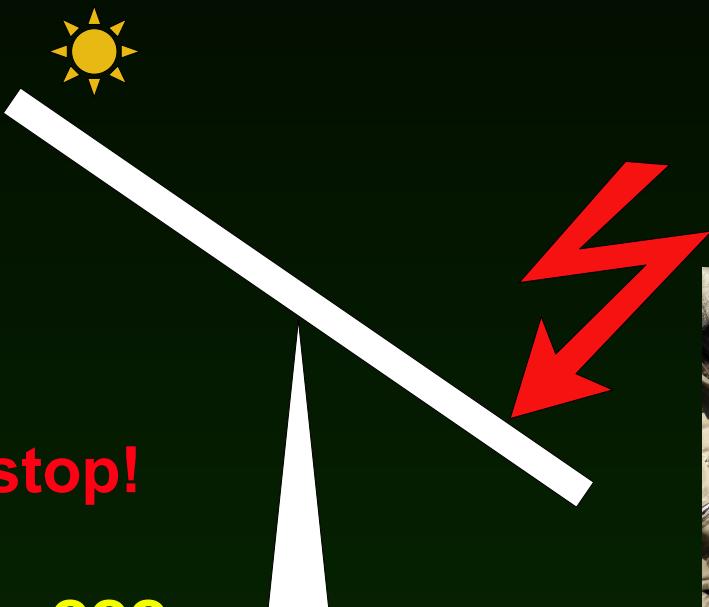


Harm reduction should aim for a balance

Heroin
use

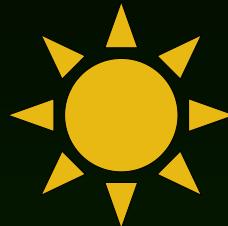
You've got to stop!

Safer behaviour???



Chris

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



Heroin helped me perform better at work.

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Figure
skating

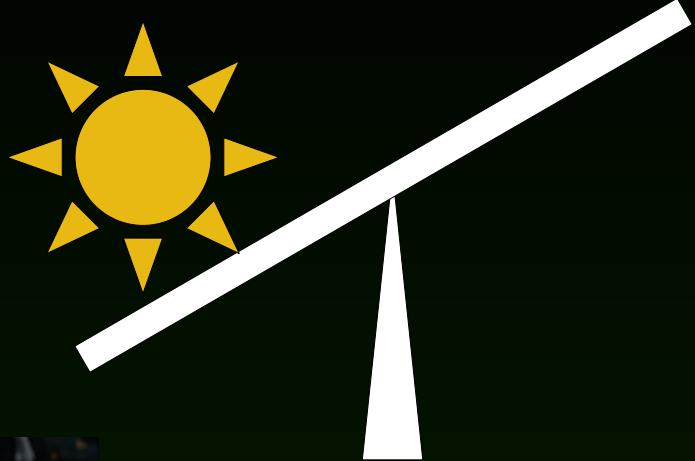


Figure
skating

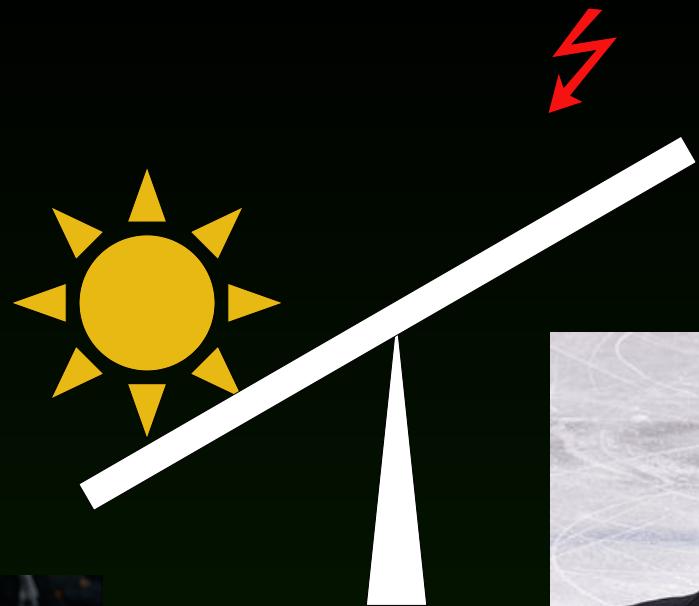
You're amazing!

Safer behaviour???

<https://www.gettyimages.co.uk/detail/news-photo/lilah-fear-and-lewis-gibson-of-great-britain-compete-during-news-photo/1052719236>

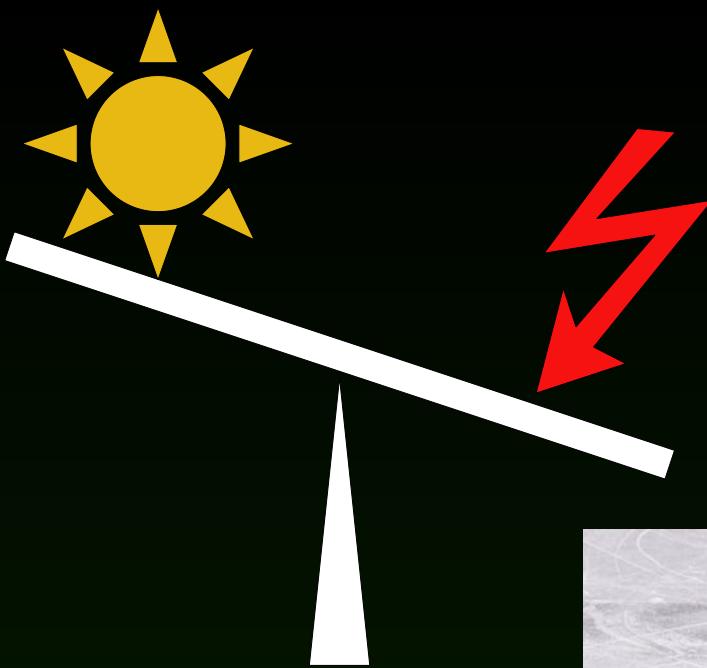
<https://www.scotsman.com/sport/more-in-sport/scottish-figure-skater-lewis-gibson-inspired-by-dancing-on-ice-1-4814743>

<https://eu.azcentral.com/story/sports/winter-olympics-2018/2018/02/19/madison-chock-evan-long-program-fall/353734002/>



You're amazing!

Safer behaviour???



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Safer behaviour???

Risk increases with aging!



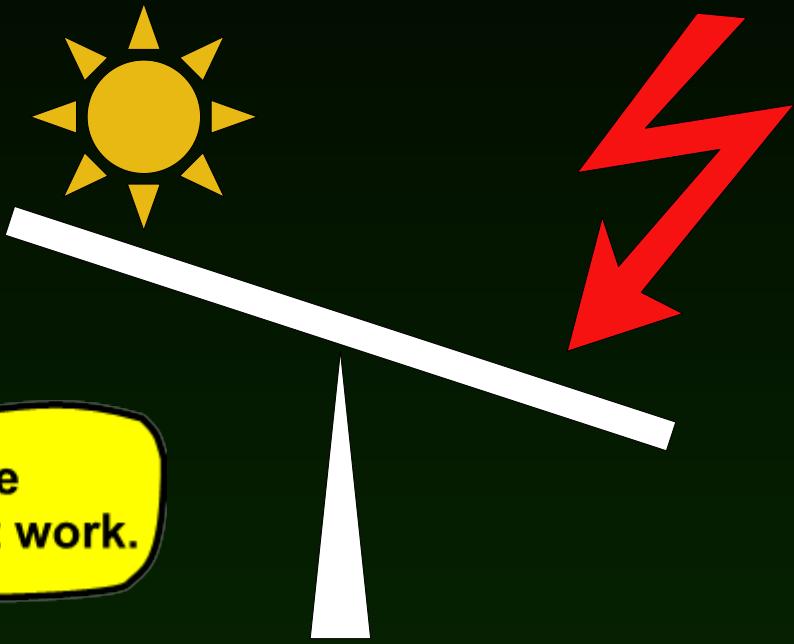
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What else could the treatment service have done ?

- earlier IV → SM? (but poor CV health from young age → was smoking ever lower risk than injecting?)
- PSI → lower frequency of drug use on top
- Lower or higher MTD dose ? → lower frequency of drug use on top
- safer injecting advice along with methadone prescription
- education on ALL CVR factors: tobacco/heroin/crack smoking, diet, lack of physical activity, poor injecting technique...
- broader behaviour change support to lower CVR
- emotional support/counselling despite drug use



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- broader behaviour change support to lower CVR
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- Could such interventions have prevented at least COPD (and the stroke?)
- Further COPD exacerbations and diabetes could possibly still be prevented!

Conclusion

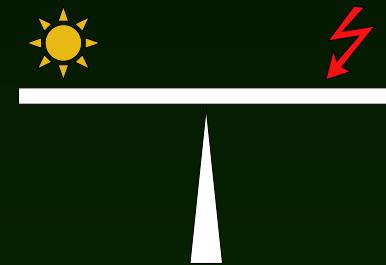
MTD treatment needs to be as well a safer drug use intervention

- **create space to talk openly about motivation and listen to people's choices**
- **talk about long-term health deterioration but offer OST and PSI aimed at safer use on top**
- **don't limit counselling for broader life challenges to only those who are 'stable' on OST, but offer it in DCR, NX 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**

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How do we get there?



- **more research**
- **design and trial PSI aimed at safer and controlled drug use, and optimization of MTD dose for safer on top use**
- **we need a change in political, social and health care discourse!**

Acknowledgements

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- **All interviewed drug users for their time and willingness to share their views and experience**

More on my research and updates:

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