Re-visioning from *risk & safety* to *survival & wellness*; Behaviors among people who use methamphetamine with opioids

Lisbon Addictions 2022

BC Centre for Disease Control

PEEP Professionals for Ethical Engagement of Peers

CIHR IRSC Canadian Institutes of Health Research / Instituts de recherche en santé du Canada

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CONFLICT OF INTEREST

- The authors declare no conflict of interest
- The '*Concurrent Use and Transition to Methamphetamine among persons at risk for Overdose*' (CUT Meth OD) study was funded by Canadian Institute of Health Research (CIHR)
- CIHR had no input into the data collection, analysis or interpretation used in this presentation

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ACKNOWLEDGEMENTS

- The study team respectfully acknowledges that this work was conducted across the unceded, ancestral and stolen territories of 198 First Nations and that BCCDC is situated and many of the research team members work, live, learn and play on the territories of the xʷməθkʷəy̓əm (Musqueam), skwxwú7mesh (Squamish), and sel̓íl̓witulh (Tsleil-waututh) nations
- We acknowledge the thousands of devastating and preventable deaths that have occurred due to the toxic unregulated drug supply. We would like to recognize the ongoing commitment of people with lived and living experience of substance use who have been and continue to be the lead advocates and actors working to reduce preventable deaths and harms for people who use drugs
- We would like to thank the study participants, peer research assistants and advisory board members for their insights and patience

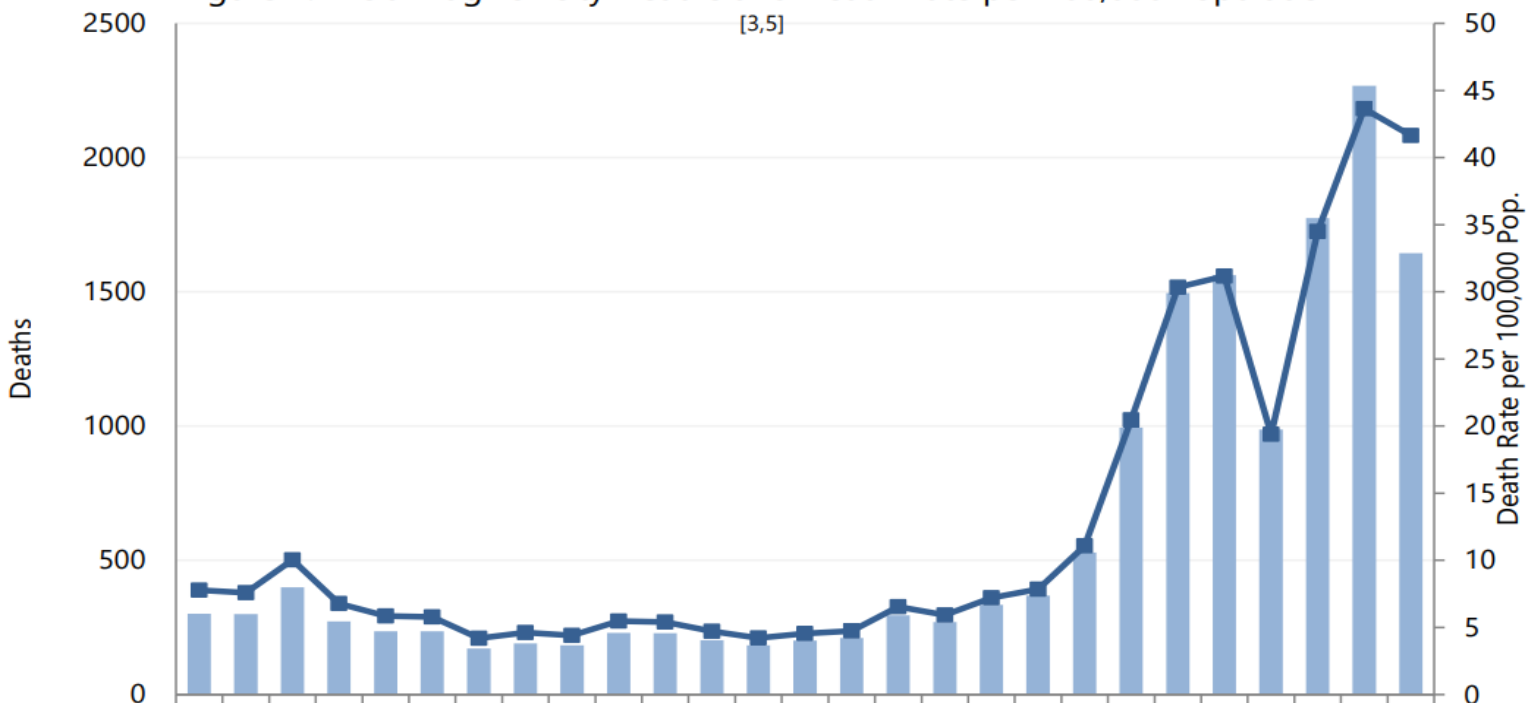
BACKGROUND: DRUG POISONING EMERGENCY (OVERDOSE CRISIS)

- North America is experiencing an increasingly toxic drug supply. In BC extreme fentanyl concentrations are increasing and benzodiazepine contamination is common[1]
- In 2021 the annual unregulated drug toxicity deaths in British Columbia were the highest ever reported n = 2267[1]

BC Coroners Service

Illicit Drug Toxicity Deaths in BC
January 1, 2012 to September 30, 2022

Figure 1: Illicit Drug Toxicity Deaths and Death Rate per 100,000 Population [3,5]



	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06	'07	'08	'09	'10	'11	'12	'13	'14	'15	'16	'17	'18	'19	'20	'21	'22
Deaths	301	300	400	272	236	236	172	190	183	230	229	202	183	201	211	295	270	334	369	529	994	1495	1562	987	1775	2267	1644
Rate	7.8	7.6	10.0	6.8	5.8	5.8	4.2	4.6	4.4	5.5	5.4	4.7	4.2	4.6	4.7	6.6	5.9	7.2	7.8	11.1	20.5	30.3	31.2	19.4	34.5	43.6	41.6

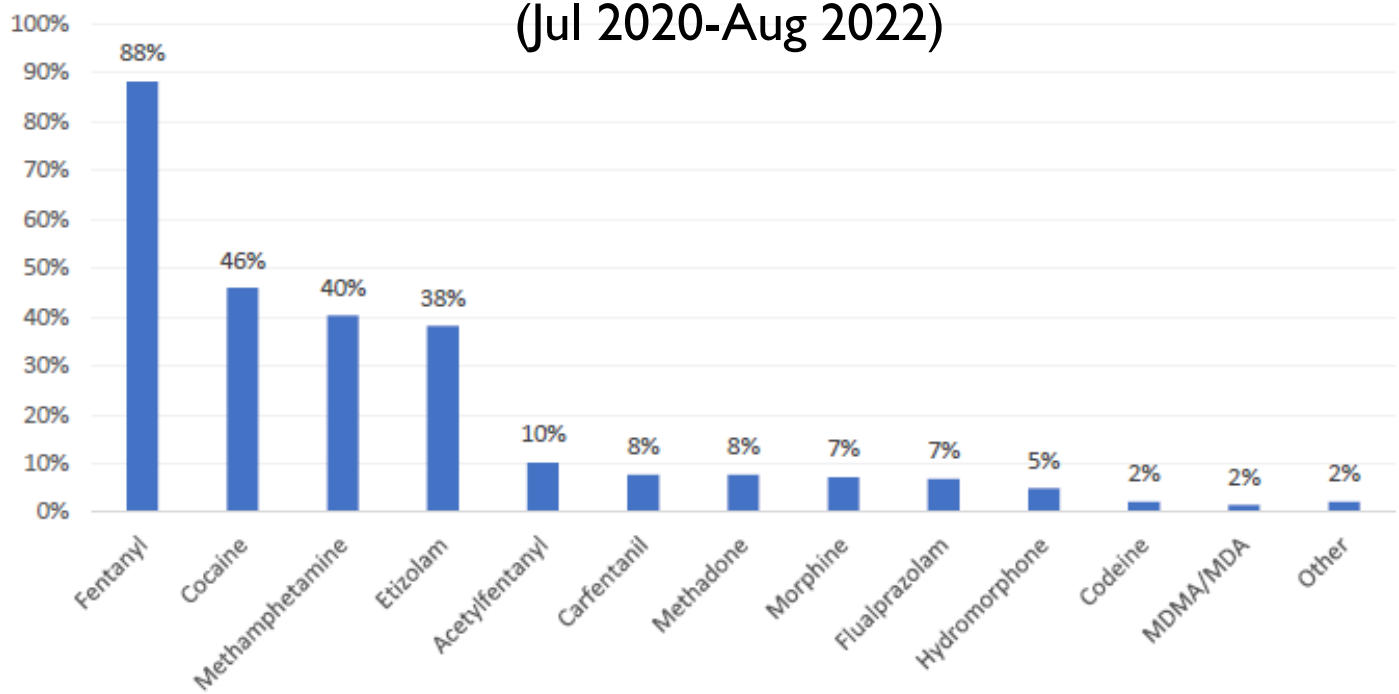
BACKGROUND: STIMULANT USE AND DRUG POISONING CRISIS

- Methamphetamine (MA) and opioids are often detected in illicit drug toxicity deaths:

  Jul 2020-Aug 2022:

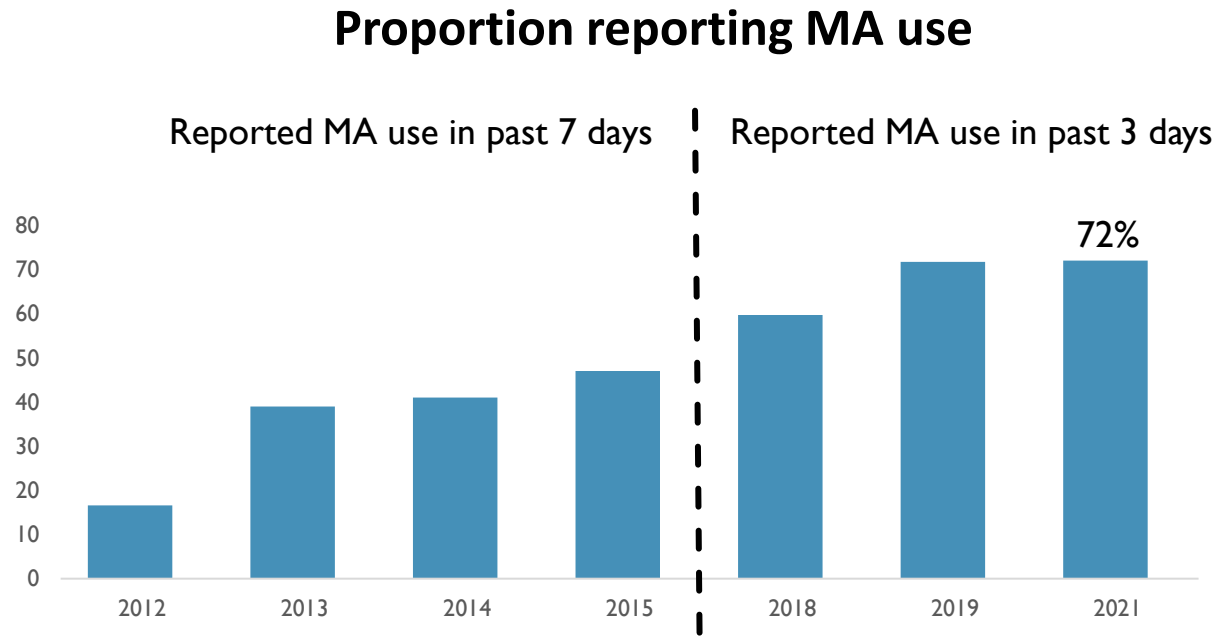
  Fentanyl 88%; MA 40% [1]

Substances detected in expedited toxicology among illicit drug toxicity deaths (Jul 2020-Aug 2022)



BACKGROUND: STIMULANT USE AND DRUG POISONING CRISIS

- MA use is increasing as demonstrated by survey responses among persons attending harm reduction supply distribution sites [2,3]
- Polysubstance use is increasing, with various motivations for use of uppers and downers [4]



STUDY RATIONALE, AIM & OVERVIEW

We received **CIHR** funding to explore *social and systemic factors influencing concurrent use of* ***methamphetamine*** with ***other substances***.

During qualitative interviews we noticed many participants referenced perceived safety from overdose as a reason for using methamphetamine in combination with other substances (despite this perception not being accurate or evidence based)

The aim of this study[5] was:

To identify safety beliefs and behaviours of people who use methamphetamine with opioids

Presentation Overview:

- Background
- Methods
- Findings
- Reflections
- References

METHODS: DATA COLLECTION & ANALYSIS

Peer Research assistants with lived/living experience of substance use (PRAs) were recruited and provided input at all stages of the study

PRAs gave input to interview guide, completed ethics training (TCPS-2) & performed semi-structured, audio-recorded interviews with people who used MA & opioids (n=22)

Quotes related to safety behaviors were extracted. Academic researchers performed a thematic analysis[6]. Input was sought from Professionals for Ethical Engagement of Peers (PEEP) which informed re-analysis using a strengths-based focus.

Themes were taken back to PEEP for further input and validation

FINDINGS: PARTICIPANT DEMOGRAPHIC AND SUBSTANCE USE CHARACTERISTICS (N=22)

Demographics:

- Gender: Men (n=14); Women (n=8)
- Median age: 40 S.D. ±11
- Housing: Housed (n=18); No regular place to stay (n=4)
- Employed: Yes (n=8); No (n=14)

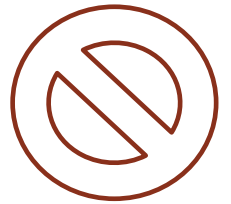
Substance use characteristics:

- Frequency MA use: Daily (n=16); < Daily (n=6)
- Opioid OD in last 3 months: Yes (n=6); No (n=16)
- Preferred route of substance use: Smoking (n=10); Injecting (n=9); Smoking & injecting (n=1); Snorting (n=2)
- Use alone: Always/often (n=15); Rarely/occasionally (n=6) Never (n=1)

FINDINGS: INITIAL THEMES AND INPUT

Academic researchers initially identified three themes to describe participants' risk assessments.

1. **Risks of using illicit drugs** (overdose, stigma)
2. **Risks of not using illicit drugs** (withdrawal, removal of benefits of using)
3. **Risks of engaging with services** (stigma, minimal benefits for some)



These initial themes were reviewed by members of PEEP and co-researchers and there were suggestions to:

- **Avoid focusing on 'risk'** as this can further stigmatize drug use
- **Avoid focusing on using vs. not using** but instead using safely vs. risky use
- **Better capture the perspectives of PWUD** and reasons behind particular discrepancies between PWUD and Public Health messaging around safer use

FINDINGS: FINAL THEMES BASED ON INPUT

This **feedback was used to refocus the study and reanalyse the data with a strength-based lens** to:

- Highlight *how* people are using in order to be safer
- Highlight adaptations to balance perceived benefits and risk of substance use

Re-analysis identified two overarching themes which described how participants adopted substance use practices for survival and wellness

1. **Personal safety behaviours for survival & wellness**
2. **Interpersonal safety behaviours for survival & wellness**

FINDINGS: FINAL THEMES AND SUB-THEMES

Themes	Sub-themes
1. Personal behaviours for survival & wellness	a) Substance use practices
	b) Meeting and balancing substance use and other needs
2. Inter-personal behaviours for survival & wellness	a) Using with others
	b) Engaging with peer-led and public health-led harm reduction services*

*In BC there is a considerable amount of overlap between public health services and peer-led services. However, these are differentiated to recognize unique experiences and strengths associated with peer-led services.

1. PERSONAL BEHAVIOURS FOR SURVIVAL & WELLNESS

a) Substance use practices

- **Using MA due to an inaccurate perception that MA use can reduce the risk of an opioid overdose**

"If you're doing some speed with your heroin, there's less chance you'll OD on heroin."

- **Engaging in polysubstance use to achieve a sense of balance and improved functioning (balancing effect of 'downers' and 'uppers')**

"You'll feel the meth first, and then just as that is dipping you'll feel your down high with fentanyl. Sometimes you kind of use them to get one [combined effect]– 'cause if you do too much meth, you get really…anxious. Sometimes you got to use a little more down just to - it's like you're trying to fight to be normal."

"With the methadone the biggest thing is I get lazy and sleepy and that['s]– when I was using the most meth. Because I used it 'cause I was, like, wow, I can stay awake and I can do shit instead of being lazy and sleepy"

1. PERSONAL BEHAVIOURS FOR SURVIVAL & WELLNESS

a) Substance use practices

- **Using MA to self-medicate for health conditions e.g. ADHD or gain defined benefits e.g. alertness**

"My daughter said, mum, i got my ADHD…from you, why don't you take those drugs [prescribed stimulants for ADHD]? So i did – i got back taxes done, my house was clean, I was on the level."

- **Choosing or managing modes of use for opioids and MA to improve wellness**

"..I used to do them separate [opioids and MA]. I kind of actually like that [using them together] better. Because it's getting hard for me to poke holes in it [inject]. It's really hard for me to find a vein. So why I would to do that to myself twice, right?"

1. PERSONAL BEHAVIOURS FOR SURVIVAL & WELLNESS

b) Meeting and balancing substance use and other needs

- **If peoples' basic needs are not met (nutrition, hydration, sleep, safety) – they are vulnerable to overdose and other harms e.g. physical aliments, mental health issues**
- **People leveraged substances and their unique effects to meet these needs or be resourceful when they could not meet these needs**

"I do make sure I eat. Even if I have to force myself [speaking to reduced appetite from MA], I still eat because I can't just go around, whatever, without any energy…. I can't just fucking live solely of meth"

- **Some faced barriers to meeting all one's needs e.g. due to inadequate income and had to balance competing needs**

"If I had money I'd spend it on dope and –– it was getting too much and then I just upped my Kadian dose so I wouldn't have to -- wouldn't get sick if my money would run out which unfortunately is real easy to do."

"I just think back, think back - what happened when you did this last time. You had no food in your system and you just did a shot of meth and-- yeah, no drug-- you had no fentanyl and no means to get any fentanyl or food or a place to sleep..."

2. INTER-PERSONAL BEHAVIOURS FOR SURVIVAL & WELLNESS

a) Using with others:

- **Using around others provided safety as there was a better chance of a timely response in the event of an overdose:**

"And I have a thing, that if you hide it, you die. Because - if you're in the bathroom hiding it and you don't tell your family you're using it, nobody's going to check on you. Nobody's going to make sure you're okay. If they hear a bump in your bedroom they're not going to come look."

- **Other benefits included, comradery and an opportunity to socialize – particularly when using around people who increased ones' sense of safety and belonging and presented few disadvantages:**

"My group of friends I use with are pretty small, right, so it's not like I'm sharing with everybody who walks up or anything…"

- **Using alone could also be described as a safety behavior if the setting or people one would have to use around translated into considerable safety concerns (e.g. discrimination and stigma, physical safety…):**

"You don't want anyone to find out you're using because they look down on you so much because of lack of knowledge and lack of education. So because of the stigma, people hide it."

2. INTER-PERSONAL BEHAVIOURS FOR SURVIVAL & WELLNESS

b) Engaging with peer-led and public health-led substance use services

- **Engaging with services to encourage safety from overdose, reduce exposure to contaminants, obtain new supplies, get support from peers, etc.**

"Yeah they have drug testing at all these injection sites at different times. It really does help … they actually have the test where it will tell you specifically what is exactly in the damn things [drug checking]."

- **Adaptive behaviors aimed at circumventing service design and delivery limitations and using available resources to meet ones' needs**

"People who do meth would have a safe supply of meth….There's no point giving them Dilaudid or Dexedrine or whatever. They'll just take the pills and fucking sell it and turn it into whatever drug they want to do, right."

"I know people who started injecting just because of that [wanting to access OPS]"

2. INTER-PERSONAL BEHAVIOURS FOR SURVIVAL & WELLNESS

b) Engaging with peer-led and public health-led substance use services

- **Not engaging with services or discontinuing engagement with services that don't meet ones' needs and/or are associated with particular harms e.g. safer supply not meeting one's needs, stigma from healthcare providers for non-peer led services**

"it was a big decision to …. put yourself into the hands of the healthcare professionals…"

> *"I tried doing, dexxies [Dexedrine] and it didn't help at all – I don't think any certain prescription could help it at all, really… it just didn't do anything for me… it was just like I was just taking pills every day, and that's stupid"*

SUMMARY OF FINDINGS

- Risk of harm from illicit substance use is produced through interactions between individuals and the physical, social, economic, and policy environments in which they live.
- People who use drugs have agency in what substances they use and how they use them and often use substances to manage risks and balance their needs and the resources they have available. However, this agency is limited by factors such as having to rely on an unpredictable, toxic supply, barriers to accessing services, stigma, etc.
- Despite best efforts, there exists misperceptions about safety enhancing substance use practices e.g. perception that using meth with opioids reduces risk of overdose
- There is a lack of supports for people who use stimulants

REFLECTIONS

- Researchers and public health practitioners may misinterpret PWUD perspectives and behaviors, emphasizing the importance of collaborating with PWUD at every stage of research and service design to ensure findings are relevant and presented in a non-stigmatizing, strengths-based way
- We identified the need to dispel common myths and address gaps in available services. Harm reduction and treatment responses must be robust and adaptable to meet the diverse and changing needs of people who use substances e.g. increase in methamphetamine use and smoking underlines the importance of improving services for these groups

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