Methadone and Aging

I wrote this essay because as a methadone client and a senior I am interested in the topic and thought you might be too …

by Signe Dewar

Dispensing methadone became a responsibility of the provinces’ Colleges of Physicians and Surgeons in the ‘90s and, as a result, it became much more accessible. However, this decision was not universally loved. Many believed that criminalization of users and abstinence was the right way and, in some cases, the only way. Earlier research had proven the effectiveness of harm reduction. Even so, proper funding of a comprehensive harm reduction strategy never materialized (Cavalieri and Riley, 2012). I would also add that drug addicts are a marginalized group and don’t make for very sexy research.

According to College of Physicians and Surgeons of Ontario data, there are now approximately 38,000 people on Methadone Maintenance Treatment (MMT) in Ontario. Of these 6,240 (approx. 16%) are 50 years of age or older. Poverty within this group is also a huge problem. Because there was almost no MMT available to us, we spent much of our working lives seeking drugs instead. Ontario Disability Support Program (ODSP) benefits are no longer available after age 65. Because many of us never worked, we won’t receive very much (if any) Canada Pension benefit. Harm reduction, such as it is, came too late for us. With earlier access to methadone, we might have returned to the workforce, developed additional skills and survived better financially.

A study at Beth Israel hospital in New York (Rajaratnam R, et al, 2009) looked at the quality of life for older methadone patients (age 50 or over). They found that “older adults were more likely to have had longer periods of treatment on MMT, were less likely to report current heroin use and overall drug use but were more likely to also have a history of alcohol misuse.” They also found “that despite numerous medical and psychiatric complaints, only a small proportion of MMT patients have regular contact with a primary care physician and the rate of contact does not appear to increase with age.” Often, in Ontario, MMT physicians are not prepared to offer family practice services. Therefore you may require a separate physician and, in some parts of the province, this may not be possible. For me this means that at the very time we might need more access to medical care we might not get it.

Living in poverty can make our senior years increasingly difficult (e.g. no dental coverage; perhaps, the need to share accommodation). What if you have to pick up a ‘drink’ daily? Think about icy sidewalks in the winter. Being poor can mean that it is increasingly difficult to eat properly and that may put an added expense on the health care system if we develop heart disease or Type II Diabetes.

And then there is stigma. O’Conner and Rosen note “Older adult methadone clients experience multiple stigmas simultaneously. The stigma about drug addiction, aging, taking psychotropic medications, and depression may be the most pervasive for this population.” This means that I can only look forward to being regarded with perhaps more distrust or downright disdain because I’m now an “old recovering drug addict on methadone”. How that will impact my ability to get the additional medical care I might need, access to social services and assistance with daily living, I don’t know.

So it would seem I have more questions than information. And, given that about 16% of the total MMT population in Ontario is 50 years old or older, and drug users’ lives have been extended because of MMT, it stands to reason the sub-population of seniors on MMT will only continue to grow (Doukas, 2011). So, I hope, will the interest in research on this group.

Other needed areas of research include: the relationship between drug addiction, MMT and Alzheimer’s or any of the ‘diseases of aging’; the impact of MMT on menopause; and the long term impact of hepatitis C?

Given the challenges, perhaps this growing cohort might exercise some political will. We can be successful at getting our needs met. Being able to benefit from a harm reduction approach is proof of that and we are certainly invested in finding ways to make our lives better.

Work Cited


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