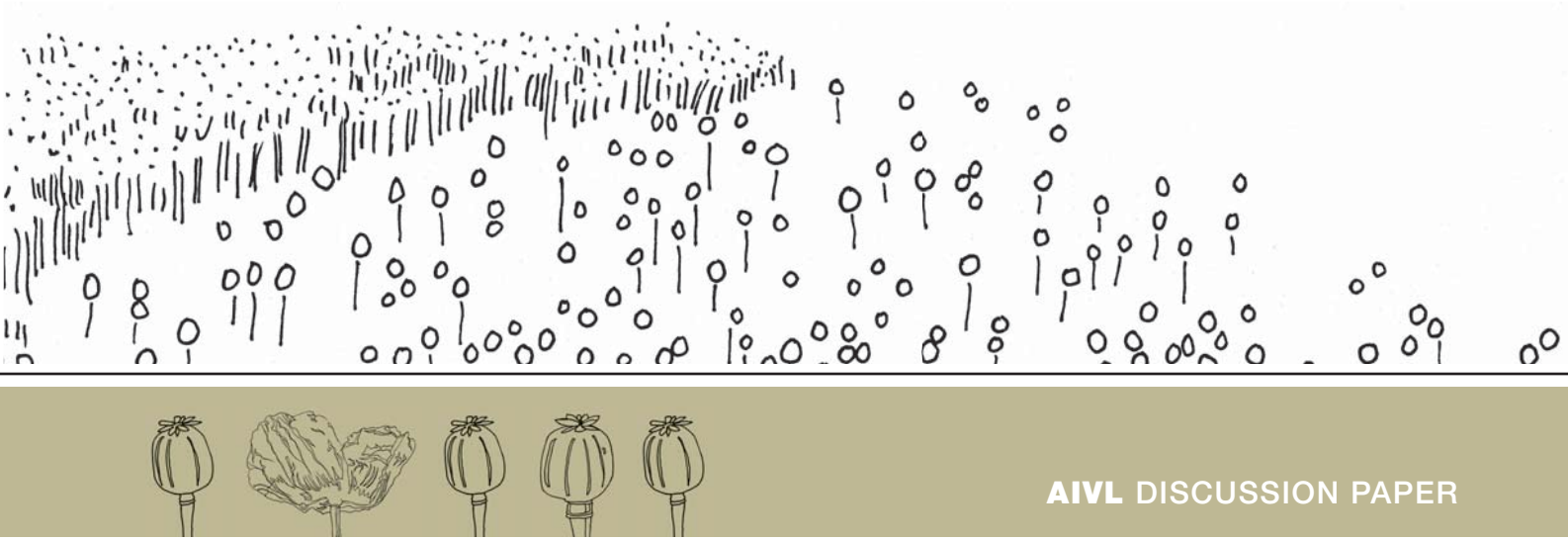
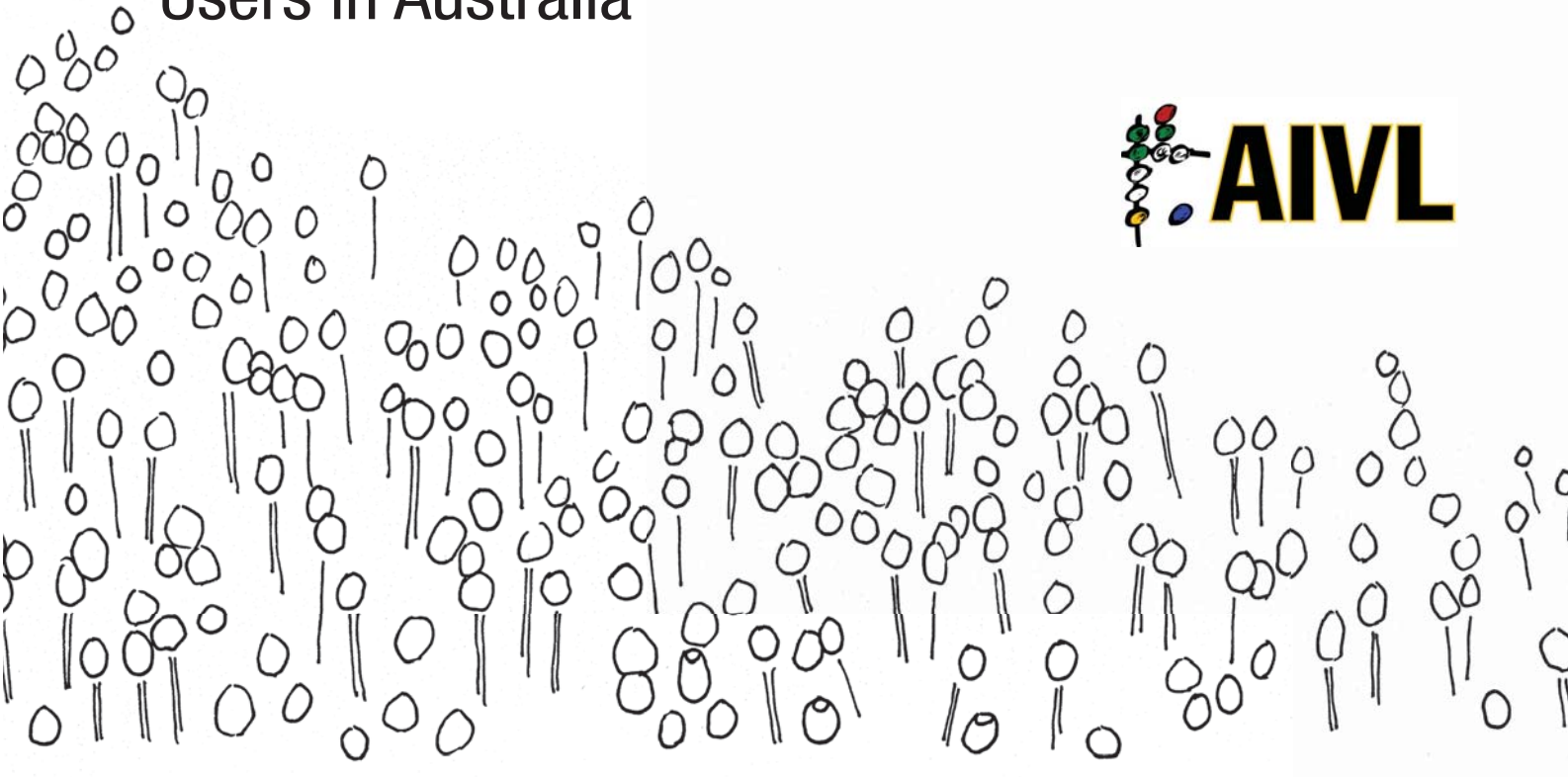


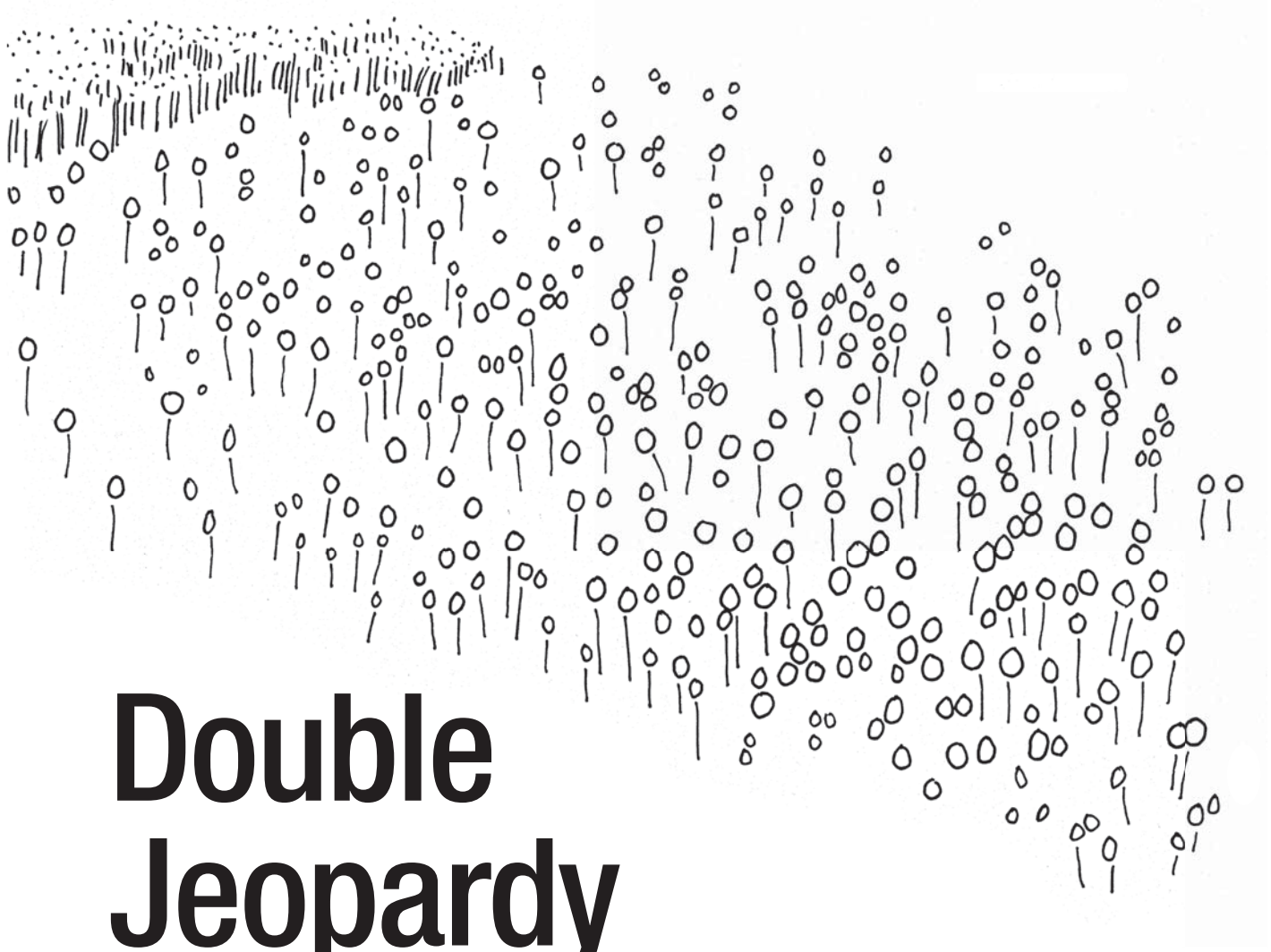
AIVL DISCUSSION PAPER

Double Jeopardy

Older Injecting Opioid Users in Australia



Australian Injecting and Illicit Drug Users League (AIVL)



Double Jeopardy

Older Injecting Opioid Users in Australia

AIVL DISCUSSION PAPER

Australian Injecting and Illicit Drug Users League (AIVL)

The Australian Injecting and Illicit Drug Users League (AIVL) is the national peak organisation for state and territory peer-based drug user organisations and represents issues of national significance for people who use or have used illicit drugs and those on opioid pharmacotherapies. Its mission is 'to promote and protect the health and human rights of people who use or have used illicit drugs'.

Further information on AIVL including a listing and contact details for our state/territory member organisations can be found at: www.aivl.org.au

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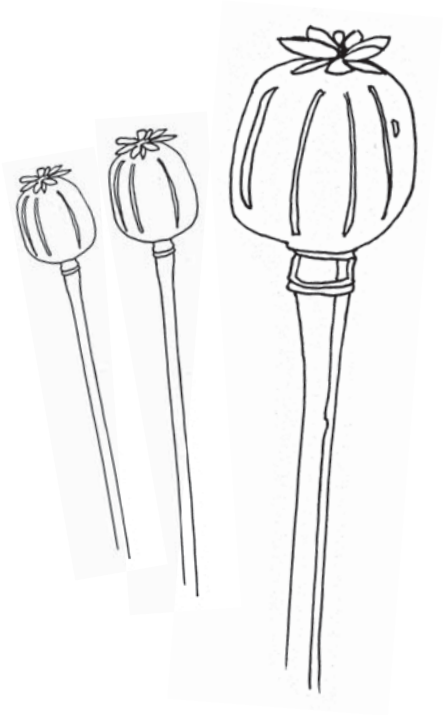

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Older Injecting Opioid Users in Australia

Note: As an 'unfunded' project, this discussion paper is in print due to the tireless efforts and dedication of a number of key individuals within AIVL and its member organisations. The 'drive' to ensure this paper was published comes from the ongoing passion and commitment of the Australian national network of drug user organisations. We have written this paper because we wish to speak for ourselves on the issues that affect us and work in genuine partnership with others to find effective, ethical and humane responses to the issues we identify.

Contents

Glossary / List of Abbreviations

ANU	Australian National University
HCV	Hepatitis C Virus
HBV	Hepatitis B Virus
IDU	Injecting Drug User
IOU	Injecting Opioid User
IDRS	Illicit Drug Reporting Survey
NCEPH	National Centre for Epidemiology and Population Health
NCHECR	National Centre in HIV Epidemiology and Clinical Research
NDARC	National Drug & Alcohol Research Centre
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSP	Needle Syringe Program
NUAA	NSW Users and AIDS Association
OIOU	Older injecting opioid user
OST	Opiate Substitution Therapy
ORT	Opiate Replacement Therapy
PWID	People who inject drugs
PWUD	People who use drugs
AIVL	Australian Injecting and Illicit Drug Users League
CAHMA	Canberra Alliance for Harm Minimisation and Advocacy

Executive Summary

We live in an ageing society. Australians are now living longer than ever before and this marked increase in life expectancy is expected to continue throughout the 21st century. The Australian government has adopted a proactive approach to ageing and promotes the concept of 'positive ageing'. As part of its approach, the government has funded a number of population based studies to track cohorts of ageing Australians into older age with a broad focus on health and well being. None of these studies, however, examines licit or illicit drug use or the experience of ageing through the lens of people who inject opioids.

In keeping with general population trends, the ageing nature of opioid injectors has become apparent in recent years. This stands in stark contrast to the youth focus of our National Drug Strategy 2010-15 and its emphasis on early intervention and drug prevention. Similarly, a strong youth focus is reflected in the body of literature about illicit drug use. The association between drug use and death and destruction is so pronounced in popular culture that it may well come as a surprise to many that illicit drug users have a future and an old age to look forward to. Equally, many drug users, who did not anticipate or prepare for old age and retirement, are also surprised to find themselves still here and advancing in years. In all, this tendency to associate illicit drug use with young people has diverted attention away from older cohorts of drug users and as a result, little is known about ageing in relation to illicit drug use.

The idea for the following paper was first suggested by members of AIVL's constituency, many of whom are reaching older age themselves. As soon as we were alerted to this emerging demographic and the changing composition of the drug using community, AIVL was keen to draw attention to the issue and to explore the needs and concerns of older drug users. As the first stage of the process, a wide-ranging peer-driven paper was developed by AIVL to use as a starting point for discussion. This larger paper was then used to map the key issues and from there inform the development of this much briefer discussion paper for publication. Having drawn on the broader experiences collected, this discussion paper primarily sets out to document the existence of a cohort of injecting drug users aged 40 years or more in Australia and to estimate the possible size of this group. It also aims to explore the experience of advancing age from a drug user perspective and to examine the interrelationship between ageing and illicit drug use.

Definitions

Definitions of 'old' or 'older' are somewhat arbitrary in the literature and a broad range of markers are used to delineate old age. For the purposes of this paper, however, 'older opioid users' are those who are aged 40 years and above. The term 'opioid users' is used to indicate regular users of any opioid, both licit and illicit.[1]

[1] Opioids, as a class of drug, encompass both opium based (non-synthetic) and synthetic substances, including morphine, heroin, pethidine, oxycodone, fentanyl, methadone and buprenorphine as well as a variety of other less commonly prescribed pharmaceuticals.

Methods

The discussion paper was developed in several distinct stages. Initially, in order to establish the existence of the target group and to estimate the possible number of older opioid users in Australia, AIVL drew quantitative information from a range of national surveys including the Annual National Needle and Syringe Survey, the Illicit Drug Reporting System (IDRS) and the National Opioid Pharmacotherapy Statistics Annual Data Collection. The next stage comprised an exploratory review of the literature about older opioid users. In addition, a small qualitative study was conducted with older opioid users who completed face to face interviews or responded to an online questionnaire circulated by AIVL to its member organisations. In total, 24 older opioid injectors were interviewed for the study and a further 17 respondents completed the online questionnaire. The research conducted by AIVL is referred to throughout the discussion paper as 'The AIVL Study of Older Opioid Injectors 2010'. AIVL also encouraged discussion about ageing in relation to injecting drug use via the AIVL e-list (a national peer-based discussion list) and solicited feedback from its members to early drafts of the paper.

Key Findings

Several national studies, including The Australian NSP Survey National Data Report, 2002-2006,[2] and Australian Drug Trends: Findings from the Illicit Drug Reporting System[3] document a growing proportion of older opioid users and a trend towards ageing. In addition, both surveys indicate a decrease in the number of participants in younger age categories. The National Opioid Pharmacotherapy Statistics Annual Data Collection demonstrates a similar trend towards ageing and is another key source, which reports the increasing age of opioid users.[4] The fact that these large sample studies consistently report the increasing average age of participants as well as increasing numbers of older age participants provides strong indication that opioid users are getting older.

Although it is difficult to accurately estimate the number of injecting drug users of any age, there may be as many as 30,000 regular opioid users in Australia aged 40 years and over and up to 80,000 infrequent or non-dependent opioid users. Since patterns of drug use tend to be fluid rather than fixed, the evidence suggests that these categories are not mutually exclusive and many of the latter group will experience periods of regular and/or dependent use, just as dependent drug users may have periods of non use and/or periods on pharmacotherapy.

Although the size of this group is questionable, the existence of a cohort of older opioid users is not. Equally indisputable are the specific needs of older opioid users and their sense of unmet need. Respondents interviewed for the 'AIVL Study of Older Opioid Injectors 2010' raised a wide range of issues and concerns. Health figured high on the list of respondents' priorities as well as financial and employment issues and family matters. Most identified poverty, unstable housing and future hopelessness as key issues.

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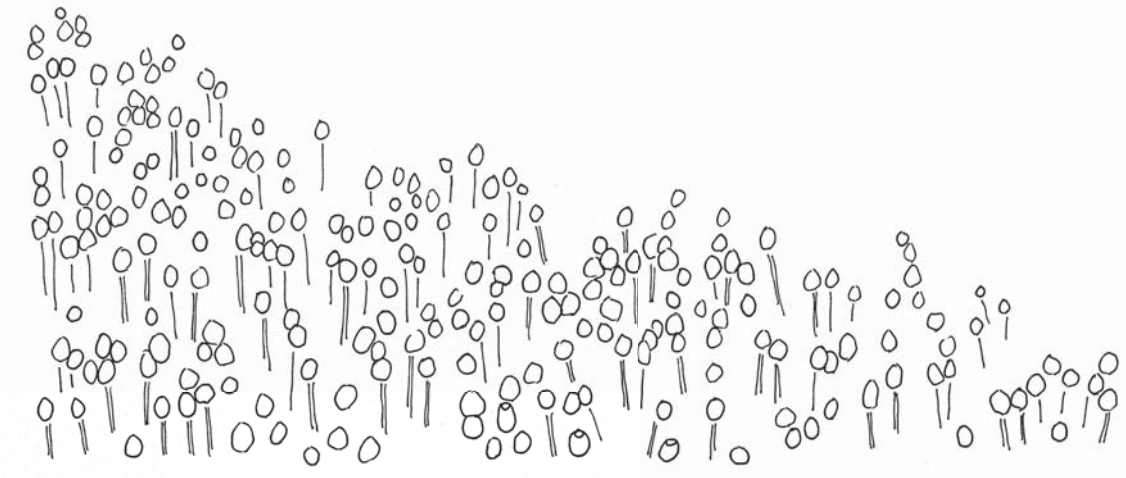
[2] The Australian NSP Survey National Data Report, 2002-2006

[3] Australian Drug Trends: Findings from the Illicit Drug Reporting System

[4] National Opioid Pharmacotherapy Statistics Annual Data Collection: 2008 report

In keeping with drug users in general, older opioid users report considerable difficulty when attempting to access health and welfare services; many present as severely disadvantaged in relation to the social determinants of health and suffer from numerous health conditions which are of no concern to non-users of similar age. Despite the similar experiences of discrimination reported by other groups of drug users including younger people who inject drugs, the older drug users interviewed for this study reported a greater *degree* of discrimination or experienced it more intensely. It would seem that older injecting drug users are considered beyond help and redemption due to their advanced age. As a result they are judged even more harshly than their younger counterparts who, according to popular thinking, may yet 'see the light' and move away from illicit drug use.

AIVL conceived of this discussion paper as an initial investigation into the issue of ageing in relation to illicit opioid injecting, in response to an identified need within drug user networks. The paper is in no way the definitive word on the issue and in many ways it asks as many questions as it answers. However, AIVL trusts that the discussion paper will open the door and encourage further interest and inquiry into this emerging issue in Australia.



Introduction

This discussion paper was initiated by AIVL, following informal discussions with a group of injecting opioid users (IOU) in the ACT in 2009, who identified an increasing number of older opioid users, in their 40's, 50's and 60's, among their peer networks. Further, initial discussions and anecdotal information indicated that older opioid users constituted a sub-group of considerable size, with their own unique needs and concerns which were not acknowledged or addressed by current health and social services. It was apparent that there was little awareness of the existence of this sub-group and consequently a lack of responsiveness on the part of healthcare system in general.

AIVL

The organisational philosophy of AIVL is user-centred and peer-based, with the dual aims of reducing drug-related harm and promoting and protecting the health and human rights of people who use, or have used, illicit drugs. As the national peak body for state and territory drug user organisations throughout Australia, AIVL believes that ***all*** people who use illicit drugs, and those on opioid pharmacotherapies, have the right to be treated with dignity and respect and to live their lives free from discrimination and stigma. In pursuing this end, AIVL works to promote the provision of high quality and accessible services, including drug treatment services, and advocates for policy and legislative reform on key issues which affect the lives of their constituents. Although AIVL represents issues affecting all illicit drug users, AIVL and its member organisations maintain a priority focus on injecting drug users due to the higher levels of harm and marginalisation routinely experienced by this group. Since a substantial number of AIVL's primary constituency are now moving into older age, AIVL is keenly aware of its role in investigating this emerging trend and identifying the needs, and in particular the unmet needs, of older opioid users.

Initially, AIVL sought national input from the various state and territory drug user organisations throughout Australia via the AIVL online discussion list (AIVL e-list) and via a brief online survey. It was immediately apparent that there was sufficient interest within AIVL's member organisations to warrant further investigation. As a result of these early discussions, AIVL decided to develop this discussion paper to document the dimensions of this sub-group in Australia and to publish some of the key issues and available evidence on this important emerging trend. In keeping with AIVL's approach, this discussion paper has been developed in response to an identified need within drug user networks and in order to address the lack of information about this emerging demographic. The growing number of older opioid users in Australia served to underline the sense of urgency with which the paper was developed.

AIVL has embarked upon this paper without funding or financial support of any kind and the scope of the project is inevitably limited by these constraints. However, we trust that the paper will stimulate further debate and highlight the need for funded programs of research in order to fully assess current gaps in knowledge and service delivery for older opioid users. We also hope it will enhance understanding of this emerging issue as well as the implications of failing to address the issue of ageing in relation to injecting opioid use.

Background

We live in an ageing society and Australians are now living longer than ever before. This marked increase in life expectancy is expected to continue and to gather momentum throughout the 21st century. An in-depth report by the Australian Productivity Commission[5] in 2005 which discusses the ageing of the general population states that '*Australia's population, like that of most developed countries, is ageing as a result of sustained low fertility and increasing life expectancy. This is resulting in proportionally fewer children . . . . in the population. The median age of the Australian population has increased by 5.3 years over the last 2 decades, from 31.6 years in 1988 to 36.9 years in 2008. . . . . Over the next several decades, population ageing is expected to have significant implications for Australia including health, labour force participation, housing and demand for skilled labour'*. (2005:5)

Over the last 2 decades, the Australian government has adopted a proactive approach to the issue of ageing and promoted the concept of 'positive' and/or 'healthy' ageing. We now have an Ambassador on Ageing and there are a number of funded population based studies[6] which are following cohorts of Australians into older age. These studies have a broad focus on health and well being and acknowledge that the lifestyle decisions which people make in their 40's will have far reaching implications for their own health and for society as a whole[7]. However, none of these studies examine licit or illicit drug use or the impact of ageing on long term opioid users.

The morbidity and mortality associated with illicit drug use are generally recognised as major public health problems in Australia.[8] It is clear from numerous studies that injecting drug users have a greatly increased risk of premature death by comparison with their non-injecting counterparts. Injecting drug use is associated with a wide range of potential harms and negative health sequelae, including fatal and nonfatal overdose[9] [10], blood-borne viral infections such as hepatitis B and C[11] [12] and soft tissue and

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[5] Economic Implications of an Ageing Australia (2005) *Australian Government Productivity Commission Research Report.*2005. ISBN 174037 173 9

[6] Logie, H., et al., (2004). Longitudinal studies of Ageing: Implications for the future. AIHW, Catalogue. No. AGE 42: http://www.aihw.gov.au/.../age/lsa/lsa.pdf

[7] Department of Health and Ageing (2008). Ageing and Aged Care in Australia. Canberra http://www.health.gov.au/.../Ageing_and_Aged_Care.pdf.

[8] Hulse, G. et al. (1999). The quantification of mortality resulting from the regular use of illicit opiates. Addiction **94**(2): 221-9.

[9] Hulse, G. et al. (1999). The quantification of mortality resulting from the regular use of illicit opiates. Addiction **94**(2): 221-9.

[10] Dietze, P., et al. (2005). Transient changes in behaviour lead to heroin overdose: results from a case-crossover study of non-fatal overdose. Addiction **100**(5): 636-42.

[11] Crofts N, & Aitken CK. (1997) Incidence of blood borne virus infection and risk behaviours in a cohort of injecting drug users in Victoria, 1990-1995. Medical Jnl ofAustralia.167(1):17-20.

[12] Maher, L., et al., (2006). Incidence and risk factors for hepatitis C seroconversion in injecting drug users in Australia. Addiction 101(10): 1499-1508.

vascular problems.[13] Many of these conditions are chronic and associated with lasting ill health for the individual as well as substantial economic costs to the healthcare system. Such problems are likely to be exacerbated by continued illicit opioid use over an extended period of time in conjunction with the tendency for people who inject drugs to not seek health care or to delay accessing it.[14] [15]

There is an extremely high rate of hepatitis C infection among injecting drug users in Australia. HCV infection is strongly associated with duration of injection and prevalence can reach up to 90% among groups of older opiate users.[16] [17] Due to the slow progression of the virus, the more severe consequences of hepatitis C typically manifest 20 to 30 years post infection. As a result, people who began injecting in their 20's are at heightened risk of liver damage and conditions such as cirrhosis and liver cancer by the time they reach their 40's and 50's.[18] In addition, a smaller pre vaccine population of injecting drug users who acquired chronic hepatitis B in their 20's will also be approaching the 20-30 year mark at which progression to serious liver disease becomes more likely. It follows, then, that the longer term implications of hepatitis C and B and living with these BBVs will be most keenly felt by older opioid users.

Although opiate substitution therapy (OST) is widely recognised as the preferred treatment for opiate dependency, the expanded availability of pharmacotherapy programs and the adoption of maintenance regimes did not occur in Australia until the early 1990's.[19] As a result, this is the first generation of opioid users who have lived with maintenance pharmacotherapies and many older clients have been prescribed methadone and/or buprenorphine/naltrexone continually over considerable periods of time, in some cases for up to 20-30 years. The success of OST as a drug treatment option and HIV/AIDS prevention strategy is well documented and pharmacotherapy has clearly played a key role in keeping more injecting drug users alive and well. However, methadone is associated with a number of adverse side effects including diminished bone density[20] and dental decay[21]. It is concerning that there has been little emphasis and a lack of research about the longer term health implications of pharmacotherapy or how the various pharmacotherapy medications might affect opioid users' health and well being in later life.

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[13] Dwyer R. et al., (2009). "Prevalence and correlates of non-viral injecting-related injuries & diseases in a convenience sample of Australian injecting drug users." Drug and Alcohol Dependence 100 (1-2): 9-16

[14] McCoy C. et al. (2001). Drug use and barriers to use of health care services.
Substance Use Misuse **36** (6-7): 789-806.

[15] Morrison, A. et al. (1997). Injecting-related harm & treatment-seeking behaviour among injecting drug users. Addiction **92** (10): 1349-52.

[16] Hagan, H. et al. (2007). HCV synthesis project: preliminary analyses of HCV prevalence in relation to age and duration of injection. Int J Drug Policy **18** (5): 341-51.

[17] Falster, K., et al., (2009). Hepatitis C Virus Acquisition among Injecting Drug Users: A Cohort Analysis of a National Repeated Cross-sectional Survey of Needle & Program Attendees in Australia, 1995–2004.
Journal of Urban Health **86** (1): 106-118.

[18] Shepard C. et al. (2005) Global epidemiology of HCV infection. Lancet Infectious Diseases 5:558-567

[19] Caplehorn, J. & Batey, R. (1992). "Methadone Maintenance in Australia."
Journal of Drug Issues 22(3): 661-678.

[20] Brown R.T. & Zeuldorff M. (2007) Opioid substitution with methadone & buprenorphine: Sexual dysfunction as a side effect of therapy. *Heroin Addiction & Related Problems.* Vol.9, No. 1.

[21] Laslett, A. et al., (2008). "The oral health of street-recruited injecting drug users: prevalence and correlates of problems." Addiction **103** (11): 1821-5.

In general population studies, poorer health outcomes are associated with lower social and economic status.[22] [23] Since people who inject drugs disproportionately report lower economic standing, limited formal education, and inadequate housing, these factors are also likely to contribute to poor physical and mental health for older opiate injectors.[24] Since old age is generally associated with increased risk of poor health for all sections of the community, it stands to reason that older opioid users will face numerous health problems as they age and that their lives are likely to be characterised by considerable levels of morbidity and mortality.[25]

It becomes apparent, then, that concurrent trajectories of ageing and illicit drug use can combine to create a set of unique outcomes for older opioid users. The emergence of an older demographic of opioid users is a recent phenomenon, which poses many questions, many of which are yet to be adequately answered. AIVL maintains that the voices of older opioid users themselves must be heard in the discourse and debate about this emerging issue. However, we have a long way to go before we understand the full impact of ageing on illicit drug users.[26]

[22] Korda, R. et al. (2007). Differential impacts of health care in Australia: trend analysis of socioeconomic inequalities in avoidable mortality. Int. J. Epidem. **36**(1): 157-65.

[23] Adams, R., et al. (2009). Effects of area deprivation on health risks and outcomes: a multilevel, cross-sectional, Australian population study. Int J of Public Health **54** (3): 183-192

[24] Teesson, M. et al. (2008). The impact of treatment on 3 years' outcome for heroin dependence: findings from the Australian Treatment Outcome Study (ATOS). Addiction **103**(1): 80-8.

[25] Beynon, C. (2009). Drug use and ageing: older people do take drugs. Age Ageing **38** (1):8-10.

[26] Beynon, C. et al. (2009). Self reported health status, and health service contact, of illicit drug users aged 50 and over: a qualitative interview study in Merseyside, United Kingdom." BMC Geriatric **9**: 45.

Methodology

In developing this discussion paper, AIVL adopted a range of methods and approaches. Due to the newness of the topic and the absence of discussion in the literature about ageing in relation to injecting drug use, AIVL was compelled to start from scratch in order to establish the very existence of a cohort of older drug users in Australia. Data was drawn from a number of national surveys to quantify the size of the population under examination. In addition, a further review of available literature was undertaken in order to explore potential issues of concern for this sub-group. Finally, AIVL conducted a qualitative study to document the perceptions and experiences of a small sample of older opioid users in the ACT. The original research conducted by AIVL for this paper will be referred to throughout the discussion paper as the 'AIVL Study of Older Opioid Injectors 2010'.

Defining the cohort

The few studies in the literature, which focus on 'older drug users' differ markedly in their definition of 'older age' and the term 'older' can signify any age from 35 to 65 years and above. However, several studies identify 40 years as the marker of older age in the context of injecting drug use and after much discussion, AIVL also decided to subscribe to this definition. AIVL suggests that 40 years is often a pivotal point in life when many of us acknowledge that our youth is behind us. Again, 40 years is the age at which physical capabilities start to decline and the visible signs of ageing become increasingly apparent. Research indicates that approximately 10% of people will develop severe hep C related conditions including cirrhosis, liver failure and cancer at 20 plus years post infection.[27] Since the average age at initiation of injecting drug use is 18.8 years[28] and HCV infection frequently occurs within the first few years of injecting[29] it follows that many will be around 40 years of age after 20 years of living with the virus. In addition, 40 years is considered a critical age in relation to the progression of the virus as well as treatment responsiveness.[30]

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[27] Hepatitis C Virus Projections Working Group (2006) Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2006 National Centre in HIV Epidemiology and Clinical Research. University of New South Wales.

[28] National Drug Strategy (2007)

[29] Aitken C, Lewis J, Hocking J, Bowden S & Hellard M. (2009) Does information about IDUs' injecting networks predict exposure to the hepatitis C virus? Hepatitis Monthly 9, 17-23 (2009)

[30] Hellard, M., Sacks-Davis, R. & Gold, J. (2009) Hepatitis C treatment for injection drug users: a review of the available evidence. Clin. Infect. Dis. 49, 561-573, (2009).

Steering Committee

In the initial stages, AIVL convened a steering committee to oversee the development of the discussion paper. The committee encompassed a diverse range of expertise and included a qualitative researcher, an addiction specialist, several key AIVL staff members and 2 peer consultants, who are older opioid injectors themselves. The members of the steering committee were:

Annie Madden, Executive Officer, AIVL.

Dr. Jo Mazengarb, Addiction Medicine Specialist, Canberra.

Dr. Phyll Dance, Research Fellow, National Centre for Epidemiology and Population Health (NCEPH), Australian National University (ANU).

Jude Byrne, Education Program, AIVL.

Marion Watson, Peer Consultant.

Peter Parkes, Peer Consultant.

Nicole Wiggins, Manager, CAHMA.

One of the committee members (Dr. Phyll Dance) was responsible for conducting a preliminary literature review and providing the committee with initial reference or starting points. Another member of the committee (Dr. Jo Mazengarb) drew from her experience of working with older opioid users to assist in defining potential clinical and psychological domains. The 2 peer consultants were responsible for developing the survey questions and conducting face to face interviews with respondents in Canberra.

Literature Review

In the process of selecting key areas of investigation, the committee quickly identified that the first priority was to establish the existence of an ageing cohort of injecting drug users and to estimate the size of the cohort and the possible number of older opioid users in Australia. As a result, AIVL drew from a number of national data bases which collect demographic information about different sections of the IDU population, including those who attend Needle Syringe Programs (NSP) and those who are currently on pharmacotherapy programs e.g. methadone and/or buprenorphine.

AIVL embarked on a further exploratory review of the literature in relation to 'health problems, physical/mental/social, of older opioid users'. Unfortunately, the review revealed few published studies on the topic, either in Australia or internationally and established little more than the *existence* of older opioid users. Clearly, the limited results highlight the recent emergence of this demographic as well as the urgent need for further research. As a result, AIVL decided to conduct a small sample of interviews with older opioid users in the ACT to address some of the immediate questions raised by the committee and the initial literature review.

AIVL Study of Older Opioid Injectors 2010

Based on domains defined by steering committee members, a questionnaire was developed by the peer consultants, who also agreed to conduct face to face interviews. Essentially, the purpose of the questionnaire was to assess whether older opioid users had specific needs and if so, what those needs were and whether they were currently addressed by available health and social services.

Participants were recruited from the social networks of the 2 peer consultants and in total, 24 older opioid users who fulfilled the eligibility criteria (i.e. aged 40 years or more) were interviewed for the study. AIVL also put out a call for participants via the AIVL e-list and a further 17 respondents completed the questionnaire online. In addition, 4 of AIVL's member organisations also responded to questions online.

Limitations

The discussion paper is limited by a number of factors. From the onset, the lack of funding dictated the size and scope of the project. The paper, then, has been largely driven by volunteers, with support from AIVL and our collective commitment to the task at hand. We trust that the peer flavour of the paper will make up for any limitations with regards to breadth of sampling and lack of detailed analysis and that the authors' own experience of ageing in conjunction with ongoing opioid use, which underscores the writing of this paper, will humanise and enhance the topic.

The small sample size of the AIVL Study of Older Opioid Injectors 2010 is also a limiting factor. In the absence of known population parameters, it is not possible to recruit a random or representative sample of older opioid injectors. We also suspect that older opioid users constitute a particularly hidden and hard to reach group which adds to the difficulty of finding and interviewing eligible research respondents. The study is based on a convenience sample of participants who were recruited predominantly from the peer consultants' social networks in 1 city and as such, it cannot be considered representative of all opioid users of advancing age. As a result, AIVL stresses that generalisations should be made with extreme caution. Our early findings, however, were instrumental in guiding the direction of the discussion paper and identifying key questions which demand further investigation. They also provided initial insight into the concerns of this emerging cohort and confirmed our suspicions that older opioid users constitute a discreet sub-group with their own unique perceptions and experiences of illicit opioid use.

Results

This section reports AIVL's findings from a wide range of sources and a variety of methods. Initially we present the evidence identified in our review of a number of national surveys for the existence of a cohort of ageing injecting opioid users. The paper also draws from these sources to estimate the size of the cohort. The paper then moves from the quantitative to the qualitative and presents the findings of the 'AIVL Study of Older Opioid Injectors 2010'. We discuss the issues and concerns raised by respondents in the AIVL sample in conjunction with the few studies of older opioid users identified by the literature review.

Establishing the existence of a cohort of older drug users

There is a paucity of information in the literature about older injecting opioid users. The review of the literature for this discussion paper found ***no*** Australian studies with a focus on ageing injecting opioid users, although a number of such studies in USA and Europe were identified. These studies establish little beyond the existence of a fast growing cohort of older drug users and the expectation that this cohort will continue to grow over the coming decades. As a result it is also expected that this sub-group will place considerable strain on the health system in addition to the burden of an ageing society.

Why is this cohort growing?

A number of theories are put forward to explain the expansion of this emerging sub-group of opioid users. The most persuasive is that the increased number of older opioid users is simply an aspect of the increased life expectancy of the population as a whole. AIVL also suggests that the advent of harm reduction, in the late '80's and early '90's in response to the threat of HIV/AIDS, including peer education, Needle and Syringe Programs (NSP) and expanded pharmacotherapy treatment programs, has inevitably contributed to the improved health and longevity of injecting drug users. However, little robust data on the morbidity and mortality of injecting drug users was collected in Australia prior to the advent of HIV/AIDS. As a result, all we can say with confidence is that harm reduction initiatives and the accompanying research and surveillance data about injecting drug users in the post HIV/AIDS era have captured a large cohort of injecting drug users, many of whom have survived to date and into older age.[31]

Research[32] [33] indicates that large numbers of the 'baby boom' generation, which saw a dramatic increase in illicit drug use, commenced injecting in their youth during the 1970's and 80's. Many are now aged

[31] Stoové, M., et al., (2008). "Mortality among injecting drug users in Melbourne: A 16-year follow-up of the Victorian Injecting Cohort Study." Drug & Alcohol Dependence **96** (3): 281-285.

[32] Degenhardt, L., et al., (2000). Cohort trends in the age of initiation of drug use in Australia. Australian and New Zealand Journal of Public Health **24**(4): 421 - 426.

[33] Dietze, P. & J. Fitzgerald (2002). "Interpreting changes in heroin supply in Melbourne: droughts, gluts or cycles?" Drug Alcohol Rev **21**(3): 295-303.

over 40 years and are surviving into older age.[34] Historically, it was assumed that, with age, drug users including opioid injectors would mature *out of* drug use and *into* sobriety or die.[35] However, more recent evidence[36] indicates that while some pursue and achieve abstinence with advancing age, many do not. Similarly, although drug users are at increased risk of premature death, many do not die young. Drug treatment programs in Australia and elsewhere are today accommodating an increasing number of older opioid users as long term clients of maintenance pharmacotherapy programs and other forms of drug treatment over a span of many years.[37]

Australian Surveys

Australian research studies about injecting drug users indicate that the median age of respondents is on the increase. Surveillance data from the National Needle and Syringe Program Survey (ANSPS)[38], an annual survey of NSP clients in Australia, indicate a large cohort of ageing opioid injectors. The median age of respondents has increased from 32 years of age in 2004 to 36 years in 2008. The proportion of respondents aged 40 years and over has significantly increased from 14% in 1999 to 35% in 2009[39] and those aged over 50 years increased from less than 1% in 1999 to almost 9% in 2009. Conversely, the percentage of respondents aged 40 years and younger has decreased from 86% in 1999 to 65% in 2009.[40]

Similarly, the Illicit Drug Reporting System (IDRS) (2008)[41] reports a gradual increase in the average age of participants. The IDRS is also conducted annually in Australia to investigate current trends, including the price, purity and availability of illicit drugs. As such, it is well placed to identify and monitor emerging trends and changing patterns of drug use. The mean age at interview for IDRS respondents has increased from 29 to 37 years between 2000 and 2009. Neither the ANSPS nor the IDRS analyze their data with a specific focus on older respondents and as a result, they establish little more than the emergence of this older demographic.

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[34] Patterson T L, Ph.D. and Jeste D V, M.D. (1999) The Potential Impact of the Baby-Boom Generation on Substance Abuse Among Elderly Persons. *Psychiatric Services* 50:1184-1188, September 1999

[35] Winick C (1962) Maturing out of narcotic addiction. *Bulletin of Narcotics* 14:1-7.

[36] Anderson TL, Levy JA (2003) Marginality among older injectors in today's illicit drug culture: assessing the impact of ageing. *International Journal of Addiction* 98: 761-770.

[37] Rosenberg H (1995) The elderly and the use of illicit drugs: sociological and epidemiological considerations. *International Journal of Addiction* 30: 1925-1951.

[38] Iversen J, Deacon R, Shying K, Maher L. (2008) Australian NSP Survey. Prevalence of HIV, HCV & injecting & sexual behaviour among IDUs at Needle and Syringe Programs. NATIONAL DATA REPORT 2004 – 2008. NCHECR University of New South Wales.

[39] Iversen J. et al (2010) NCHECR Unpublished data

[40] National Centre in HIV Epidemiology & Clinical Research. (2009) Unpublished data

[41] Australian Drug Trends, (2008) Findings from the Illicit Drug Reporting System. *IDRS Drug Trends Bulletin, July 2009*. National Drug and Alcohol Research Centre (NDARC)

However, a recent Drug Trends Bulletin based on 2009 IDRS data examined some of the key differences between older and younger participants.[42] Although the Bulletin used 37 years as the dividing line between older and younger participants, based on the median age of 37 years of the national sample, it is probably close enough to our marker of 40 years to be of some relevance. The older IDRS group ranged in age from 37 to 63 years and constituted approximately 50% of the sample. The older participants were more likely to be male and more likely to have a prison history than younger participants. However, patterns of drug use were similar across both groups and frequency of use for most drugs was also remarkably similar. Older users were more likely to cite heroin as their drug of choice, although both groups reported heroin as the drug most injected in the month prior to interview. Again, there were no differences between the older and younger groups as far as involvement in drug treatment at the time of interview. However, younger participants were more likely to report lending and borrowing needles and syringes as well as drug related criminal activity and arrest in the previous 12 months. Similarly, the younger group reported higher rates of drug related harm including experiencing a dirty hit. Sadly but perhaps predictably, it would appear that younger drug users are less aware of harm reduction messages about safer drug use than their older counterparts particularly with regards to sharing injecting equipment.

Further evidence of an ageing cohort of opioid users can be found in the National Opiate Substitution Therapy (OST) data. A report (2008)[43] prepared by the Australian Institute of Health and Welfare (AIHW) indicates that more than a third (38%) of the 41,347 clients currently enrolled in opioid substitution therapy (OST) in Australia are aged 40 years or more and clients aged 50 years and over constitute more than 10%. Clearly, the proportion of older pharmacotherapy clients is on the increase. In addition, the median age of clients has increased from 32 years in 2004 to 36 years in 2008. The AIHW Report, then, demonstrates not only the increasing pool of older opioid users but also the increasing age of opioid users in general. Further, the fact that all of these large sample studies report the increasing average age of participants in conjunction with increasing numbers of older age participants and fewer younger participants provides strong indication that opioid injectors are getting older.

International Research

The trend towards ageing documented in Australian surveys is supported by research conducted in America and Europe. In Europe, the proportion of patients aged 40 years and over receiving treatment for opioid related problems more than doubled between 2002 and 2005.[44] Further, European estimates suggest that the number of people aged 65 years and over in need of drug treatment will more than double

[42] Cassar , J., Stafford, J., & Burns, L. (2009). Examining differences between younger and older injecting drug users in the 2009 National Illicit Drug Reporting System sample. Drug Trends Bulletin, December 2009. Sydney: NDARC, University of New South Wales.

[43] National Opioid Pharmacotherapy Statistics Annual Data collection: 2008 Report. *Australian Institute of Health and Welfare (AIHW) Bulletin* 72 May 2009

[44] EMCDDA (2008) Substance Use Among Older Adults: a neglected problem *drugs in Focus*. 18. ISSN 1681-5157

between 2001 and 2020.[45] Again, projections in an American study indicate an increase in the number of people aged 50 years or more in need of substance use treatment from 1.7 million in 2000 to 4.4 million in 2020.[46] In the same study, modelling projections for those aged 50-69 years indicate increased lifetime prevalence of drug use from 26% in 2000 to 56% in 2020. These trends demonstrate that large numbers of opioid users are surviving into older age. It is suggested that the advent of more effective drug treatment and harm reduction initiatives over the past 30 years, in conjunction with general advances in medicine, have increased the life expectancy of drug users and enabled their survival into older age.[47] As a result of these changing client demographics, drug treatment programs which were accustomed to working with younger drug users have had to adapt to meet the needs of older clients.

Estimating the number of opioid users in Australia

Estimating the number of illicit drug users and in particular dependent heroin users in Australia or elsewhere is fraught with difficulties. Due to the social stigma and illicit nature of drug use, drug users are considered a hidden or hard to reach group by researchers. Although a variety of methods and formulas are used to calculate the size of this invisible population, many studies[48] [49] [50]point to the limitations and anomalies inherent in these estimates as well as the under-reporting of regular illicit drug users in household and population-based surveys.[51] Many claim that the implausibility and poor 'fit' of these numbers and methods underline the need to develop new ways of more accurately calculating how many illicit drug users there are in Australia.[52]

Deitze et al (2005)[53] used a combination of different methods to estimate the prevalence of heroin use and the number of frequent heroin users in Australia, including the capture-recapture method and information about the number of opioid induced deaths, the number of ambulance attendances at suspected overdoses, the number of pharmacotherapy clients and the number of drug related arrests. Rather than

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[45] European Monitoring Centre for Drugs and Drug Addiction (2008) Substance use among Older Adults: A Neglected Problem. *Drug Addiction*. Lisbon.2008; 4.

[46] Gfroener J, Penne M, Pemberton M, Folsom R. (2003) Substance Abuse Treatment Need Among Older Adults in 2020: The impact of the aging baby boom cohort. *Drug Alcohol Dependence* 2003; 69:127-35

[47] Benyon CM. (2009) Drug Use and Ageing: older people do take drugs! *Age and Ageing.* 2009; 38: p.8-10.

[48] Hartnoll R, Lewis R, Mitcheson M, Bryer S. (1985) Estimating the prevalence of opioid dependence. *Lancet*, January 1985, 203-205.

[49] Hall W, Lynskey M & Degenhardt L. (1999) Heroin use in Australia: Its impact on public health & public order. NDARC *Monograph No. 42*.

[50] Hall W. (1995) The Demand for Methadone Maintenance Treatment in Australia National Drug and Alcohol Research Centre, *Technical Report* No 28.

[51] Hartnoll R, Lewis R, Mitcheson M, Bryer S. (1985) Estimating the prevalence of opioid dependence. *Lancet*, January 1985, 203-205.

[52] Dietze, P., Hickman, M. & Kimber, J. (2005) Monograph No. 03: Estimating the prevalence of problematic heroin use in Melbourne. *DPMP Monograph Series*. Fitzroy: Turning Point Alcohol & Drug Centre.

[53] Dietze, P., Hickman, M. & Kimber, J. (2005) Monograph No. 03: Estimating the prevalence of problematic heroin use in Melbourne. *DPMP Monograph Series*. Fitzroy: Turning Point Alcohol and Drug Centre.

extrapolating figures from one jurisdiction only, as is usually the case, Deitze et al (2005) combined their estimate of the number of regular opioid users in Melbourne in 2003/4 with an estimate by researchers in NSW [54] of the number of regular opioid users in that state in 2002. These respective estimates were averaged and extrapolated to other jurisdictions to arrive at the number of frequent opioid users in Australia. Their calculations resulted in an estimate of 41,401 regular heroin users in Australia in 2003, with a range between 33,827 and 80,847. Moore et al (2005) subsequently used these figures to estimate the number of regular opioid users in a recent publication by the Drug Policy Modelling Project (DPMP) about 'Heroin markets in Australia'[55]. These numbers will also be used by AIVL as a basis on which to calculate the number of older opioid users in Australia.

However, the lower end of this range is less than the number of clients currently enrolled in pharmacotherapy programs across Australia, which makes it hard to put too much store by these calculations. It is important to remember that the numbers cited by Dietze et al (2005) are an *estimate* of dependent opioid users, based on 2003 figures and the numbers may well have changed considerably since these calculations were made almost a decade ago. Professor Alison Ritter, who is also a member of the DPMP Research Program, the group which produced the monograph series, including the publications by Deitze et al (2005) and Moore et al (2005) cited above, commented on ABC Radio recently that there were 100,000 dependent heroin users in Australia.[56]

Also, in trying to estimate the number of regular opioid injectors, a comprehensive snapshot of this cohort must also acknowledge the many less frequent opioid users. Patterns of drug use tend to be fluid rather than fixed and while we assign users into artificial categories of 'dependent' or 'non dependent' use, most opioid users experience different levels of use at different times and move between dependent and non dependent periods of drug use. Hall et al. (2000)[57] estimated that there were between 148,000 and 222,000 non-regular heroin users in Australia. Similarly, the Hepatitis C Virus Projections Working Group (2002)[58] calculated between 120,000 and 210,000 occasional injecting drug users. As a result, there may be up to 4 times the number of opioid users in Australia if non-dependent users are taken into account. However, again, figures are dated and it is hard to gauge the accuracy of these estimates.

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[54] Degenhardt, L., Rendle, V., Hall, W., Gilmour, S., & Law, M. (2004a) *Estimating the number of current regular heroin users in NSW & Australia 1997-2002*, NDARC Technical Report No. 198. Sydney: NDARC.

[55] Moore et al. (2005) Monograph No. 09: Heroin Markets in Australia: Current understandings and future possibilities. *DPDP Monograph Series*. Fitzroy, Turning Point Drug & Alcohol Centre.

[56] Alison Ritter, DPMP. (2010) 'World Today' Program. ABC Radio National. Nov 1 2010

[57] Hall, W., Ross, J., Lynskey, M., Law, M. & Degenhardt, L. (2000). *How many dependent opioid users are there in Australia? NDARC Monograph No. 44*. Sydney: NDARC

[58] Hepatitis C Virus Projections Working Group (2002). *Hepatitis C Virus Projections Working Group: Estimates and Projections of the Hepatitis C Virus Epidemic in Australia 2002*. Sydney: National Centre in HIV Epidemiology & Clinical Research. April 2002

Estimating the number of older opioid users in Australia

If we use the same percentage, i.e. 38%, of clients aged 40 years and over as reported in the AIHW OST Report,[59] which is very close to the proportion of clients over 40 years in ANSPS 2004-8,[60] (i.e. 35%), to calculate the number of *older* opioid users in Australia, we arrive at a figure of 15,732, with a range from 12,854 to 30,721. If we apply the same proportion, i.e. 38%, to calculate the number of non dependent opioid users aged 40 years or more, we estimate a further 45,600 to 79,800 older opioid users. Admittedly, these are crude estimates. However, they are indicative of the large and growing number of older opioid users in Australia and the changing demographic of illicit drug users. Although the accuracy of calculations may be questionable, the existence of this sub-group is not and it can be said with confidence that older opioid users constitute a sub-group of substantial proportions.

Findings of AIVL Study of Older Opioid Injectors 2010

In total, 24 respondents were interviewed for the AIVL Study and a further 17 people responded to the online questionnaire. Demographic information was not initially collected from respondents; however, brief demographic information was later included for online participants. The majority, i.e. 10 of the online sample, were aged between 40 to 45 years, 3 were 46 to 50 years, and 4 were in the 51 to 59 age group. Interestingly, 13 respondents were female. However, the sample is in no way representative of all older opioid users and should not be regarded as such. The vast majority identified heroin as their opiate of choice and many were currently enrolled in pharmacotherapy programs.

There was a high degree of consensus in the sample of respondents who responded to the AIVL Survey and broad based agreement about the key issues of concern for older opioid users. Participants raised a wide range of health issues as well as housing, financial and family matters, legal problem and employment concerns. Although almost all respondents were employed at the time of interview, most identified poverty, unstable housing and future hopelessness as key concerns. Here we report briefly on the most pertinent issues raised by respondents who were interviewed for the AIVL Study of Older Opioid Injectors 2010.

Health Issues for older opioid users

Health issues in general were considered extremely important by all respondents, including the availability of a good and sympathetic GP. The issue of disclosure was threaded throughout respondents' comments and the decision about whether to disclose to one's health care providers was a source of major concern. One participant explained her strategy of '*Selective disclosure, i.e. having 2 GPs - one that knows I inject drugs and one who doesn't know. To make sure that I can get IDU related health issues seen to but also*

[59] AIHW (2009) National Opioid Pharmacotherapy Statistics Annual Data Collection: 2008 Report. Australian Institute of Health & Welfare. Aust Govt., Canberra, Australia.

[60] Iversen J, Deacon R, Shying K, Maher L. (2008) Australian NSP Survey. Prevalence of HIV, HCV & injecting & sexual behaviour among IDUs at Needle and Syringe Programs. NATIONAL DATA REPORT 2004 – 2008. NCHECR University of New South Wales.

to have a doctor who will not discriminate or automatically attribute health problems to my drug use'. (AIVL Survey respondent)

Although the use of heroin and other opioids is not considered necessarily harmful in itself [61] [62] injecting drug use over time may have a deleterious effect on the vascular system[63]. Similarly, the scarring caused by repeated injection may eventually lead to circulation problems, even when the user has access to sterile injecting equipment. In addition, non-sterile injecting equipment and/or environments are associated with the risk of endocarditis and blood borne viruses such as hepatitis B or C or, less often in Australia, HIV/AIDS. However, it is important to remember that it is not drug use per se but unsafe injecting practices which put drug users at risk of BBV's like hepatitis C and B and HIV/AIDS.

Another health related concern identified by a number of respondents was to do with the pain killing properties of opioid drugs, which masked the symptoms and prevented timely diagnosis of various illnesses. Several respondents described an illness which was not identified until it became chronic, which in turn exacerbated the condition and complicated their treatment and ultimate recovery. However, this is by no means the main reason that many opioid injectors delay seeking help for medical problems.

Discrimination

Regardless of age, drug users report a wide range of discriminatory behaviour at the hands of the medical profession and the healthcare sector in general. Accusations of 'drug seeking' are routinely levelled at drug users in genuine need of medical assistance and requests for pain relief are frequently dismissed as attempts to manipulate doctors into prescribing opioids. Drug users who made submissions to the NSW Anti-Discrimination Board on Drugs and Discrimination described doctors talking down to them, treating them differently and disbelieving their symptoms.[64] These sorts of experiences were echoed by respondents in the AIVL Study (2010). Many claimed that all their health issues were viewed in relation to their drug use, which often affected the quality of health care they received. The older drug users in the sample complained about their lack of access to appropriate medical care and that both their access to care and the quality of care they received had become increasingly problematic with age. It was in this context that the term 'double jeopardy' was first coined to refer to the compounding health issues experienced by many older opioid users in conjunction with a health care system disinclined to treat them. Some no longer sought medical assistance, believing that it would not be provided even if they did!

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[61] Byrne A. (1996) Addict in the Family: How to Cope with the Long Haul. Redfern, NSW, Australia: Tosca Press, 1996, pp. 33-34. http://www.addictinthefamily.org/

[62] Lintzeris N., Strang J., Metrebian N., Byford S., Hallam C., Lee S., Zador D. & RIOTT Group. (2006) Methodology for the Randomised Injecting Opioid Treatment Trial (RIOTT): Evaluating injectable methadone & injectable heroin treatment versus optimised oral methadone treatment in the UK. *Harm Reduction Journal.* 2006; 3: 28.

[63] Hardacre P, Preston A & Derricott J. (2003) Preventing unnecessary vein damage: a briefing paper for those working with injecting drug users. Exchange Campaigns for Queensland Health, the South Australian Drug and Alcohol Services Council (DASC), and the Victorian Department of Human Services (DHS). Exchange Campaigns 2003 http://www.saferinjecting.info/vcbrieftext.html

[64] Submission to the NSW Anti-Discrimination Board on Drugs and Discrimination. (30. NUAA 1995). p.6

Stigma and discrimination are commonly reported by drug users, regardless of age. However, the older drug users interviewed for the AIVL Study 2010 reported a greater *degree* of discrimination or experienced it more intensely. It would seem that older injecting drug users are often vilified and considered beyond help due to their advanced years. As a result they are judged even more harshly than their younger counterparts who, according to popular thinking, may yet see the light and move away from illicit drug use.

Pain management

Pain is a common aspect of older age and many opioid users fear that as they age and come to need pain relief and/or pain management, such assistance will be denied to them, on the basis of their drug use. For those on suboxone pharmacotherapy (buprenorphine and naltrexone) there is the added worry that opiate based pain medication cannot be used in conjunction with this form of pharmacotherapy. As much as this is an issue of concern for all buprenorphine recipients, the older opioid users in the sample appeared particularly fearful in the face of this knowledge and its possible repercussions.

The issue of access to pain relief and pain management was identified by the majority of respondents in the sample as a major concern. Several respondents reported horror stories about unfortunate friends and associates who had been denied pain relief when in genuine distress. They commented on the seemingly arbitrary withholding of pain medication by hospital staff and the need for clear policies to guide the fair and humane provision of analgesic drugs in hospital environments. A number of respondents reported that medical staff appeared to have little empathy or appreciation that opioid users are subject to the same range of diseases and accidents as anyone else and should be afforded the same access to pain relief. Further, several respondents commented that they would need more rather than less pain medication due to their long term use and tolerance to opiates, which also appeared to be poorly understood by some medical staff.

In fact, studies indicate that those who are opioid dependent and/or on OST are more rather than less susceptible to pain and likely to feel pain more severely than opioid naïve patients.[65] In a study of older adults, those with established patterns of drug and alcohol use reported both more severe pain and the use of alcohol and other drugs to manage pain than those with 'non-problematic' drug use at baseline interview and 3 year follow-up.[66] Respondents in the AIVL Study (2010) voiced the need for some sort of educational campaign aimed at medical and nursing professions, as well as changes in policy and implementation of policy in order to address the issue.

An excerpt from a story recently printed in User's News (NUAA's magazine) captures the almost sadistic treatment which many drug users are subjected to. *'The morning he died (from hep C related liver failure) we were pleading with the nurses to give him some morphine. They wanted to wait another 30 minutes.*

[65] Herndon C.M.et al (2008) Chronic Non-malignant Pain Management and Nonsteroidal Anti inflammatory Drugs: Physiology of Nociception. Pharmacotherapy. 2008; 28(6):788-805

[66] Brennan, P. et al. (2005). "Pain and use of alcohol to manage pain: prevalence and 3-year outcomes among older problem and non-problem drinkers." Addiction **100** (6): 777-

When I asked why, they answered 'because it's not good for his liver . . . . ! Ten minutes later . . . . . he slipped off into the ether.' [67]

Pharmacotherapy

A number of respondents in the AIVL Study (2010) had been on methadone or buprenorphine for 20 years or more and were keen to raise their concerns about long term maintenance pharmacotherapies. Primary amongst their concerns was the issue of cost and the 'user pays' model of pharmacotherapy provision in Australia. The fortnightly cost of $60-120 places those dependent on CentreLink benefits under enormous financial pressure, regardless of age. When this cost was added to the cost of other vital medications, which many older respondents in the AIVL Study of Older Opioid Injectors 2010 required, it became virtually prohibitive. Many respondents advocated for a major overhaul of the pharmacotherapy system so that methadone and/or buprenorphine could be dispensed in a more equitable and affordable manner.

The issue of 'stability' was raised by many respondents of the AIVL Study (2010) in the context of pharmacotherapy provision. Pharmacotherapy prescribers place great emphasis on the stability of the client when assessing eligibility for take away doses and community based dosing (as opposed to clinic based dosing). However, a number of respondents complained that there was insufficient recognition of 'good behaviour' and years of demonstrated 'stability' in other regards. In particular, respondents argued that they deserved to be treated with more trust and afforded more autonomy, and ultimately prescribed their drug of choice since they had more than demonstrated their 'good character' over time and despite, for some, continued use of illicit opioids at some level. Instead, many claimed that they were still viewed in terms of the dominant 'junkie' stereotype and assumptions about dishonesty and criminality prevailed although these characteristics had little to do with who they were or how they lived their lives. As restrictive as pharmacotherapy regimes are for many pharmacotherapy clients, a number of respondents reported that the older they got, the more intense their frustration and humiliation became.

'Getting off' methadone or the termination of pharmacotherapy treatment was also identified as a concern by several respondents in the AIVL Survey. In particular, respondents highlighted the lack of 'exit plans' and targeted support for those wanting to end their dependence on methadone and/or buprenorphine. Several respondents, who had succeeded in terminating their pharmacotherapy programs after many years, lamented the lack of specialised support or assistance of any kind and reported that they did it entirely on their own. The converse was equally problematic for a number of other respondents who wanted to continue on their methadone and/or buprenorphine maintenance programs indefinitely. They reported being 'forced off treatment' or 'strongly encouraged to end treatment' by their prescribing doctors who argued that '*at their advanced age*' they should be '*mature enough*' to stop using. One respondent claimed that her doctor told her that '*she should have grown out of it (opioid use) by now*' and that it was '*undignified*' to be on OST or still using at her age.

Transport to and from daily dosing was also identified as problematic by several respondents, who observed that this sort of issue had special significance for many older clients, whose mobility was compromised

[67] G. McGuckin (2010) So long Soldier. User's News No. 60: 15

by advancing age or illness. A number of respondents highlighted concerns associated with the lack of flexibility within opioid pharmacotherapy programs particularly when older clients experienced serious illness and/or following periods of hospitalisation. Despite documented evidence of serious illness or incapacity, people referred to being forced to continue travelling to their pharmacy or dosing point as usual. This was seen as particularly problematic for those on limited or no take away doses and/or without access to private transport. The need for greater flexibility and more compassion for those recovering from or managing serious illness were identified by a number respondents.

The side effects of methadone and/or buprenorphine constituted another major issue of concern for many long term pharmacotherapy clients in the AIVL Study (2010). While the long term effects of buprenorphine remain unclear, there is sufficient evidence to implicate methadone in a number of adverse medical conditions[68] including reduced bone density and increased dental problems.[69] In keeping with the literature, the most commonly reported side effects by respondents were weight gain, heavy sweating and constipation.

Respondents in the AIVL Study of older opioid injectors 2010 lamented the absence of morphine and/or heroin maintenance programs as well as injectable pharmacotherapies in Australia. Some suggested that these sorts of additional options, which have produced good outcomes in other countries, including reduced crime as well as improved health and social functioning[70], should at least be made available to older, long term clients, who do not respond well to standard treatments if not to the entire drug treatment population.

Several respondents commented on the divergence between their treatment goals and those articulated by their treatment providers. While clients report many benefits from OST including increased control over illicit drug use, their ultimate goal is seldom abstinence or cessation of illicit drug use. Although some do achieve abstinence, others simply want to find a way to live with their drug use and avoid the onset of drug withdrawals. A number of respondents in the sample reported their discomfort at having to lie to their treatment doctors (in some cases also their GPs) about their desire for abstinence, in order to be seen as stable or compliant. As much as the issue of incompatible goals is potentially problematic for pharmacotherapy clients of all ages, the strain of pretence appears to be particularly frustrating for older opioid users, who claim that their treatment needs and priorities will never be met until their reality is acknowledged.

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[68] Brown R.T. & Zeuldorff M. (2007) Opioid substitution with methadone & buprenorphine: Sexual dysfunction as a side effect of therapy. *Heroin Addiction & Related Problems*. Vol.9, No. 1.

[69] European Monitoring Centre for Drugs and Drug Addiction, (EMCDDA) (2008) Substance use amongst older adults: A neglected problem. Lisbon. 2008: 4.

[70] Lintzeris N., Strang J., Metrebian N., Byford S., Hallam C., Lee S., Zador D. & RIOTT Group. (2006) Methodology for the Randomised Injecting Opioid Treatment Trial (RIOTT): Evaluating injectable methadone & injectable heroin treatment versus optimised oral methadone treatment in the UK. *Harm Reduction Journal*. 2006; 3: 28

Pharmaceutical Opioids

Recent surveys of injecting drug users in Australia record a marked increase in the use of legal pharmaceuticals in lieu of heroin. The IDRS (2009) noted that morphine and other prescription opioids increased from 8% in 2004 to 15% in 2008 as the last drug injected and represented the 3rd most commonly injected drug in 2008.[71] There is some speculation that older opioid users are more likely to turn to pharmaceuticals due to their cheaper price and easy availability, although there is no hard evidence to support this suggestion. Opioid pharmaceuticals are regularly prescribed to the elderly and to the severely and/or terminally ill and it stands to reason that older opioid users are more likely to come into contact with other older patients receiving these sorts of medications. It is also suggested that the use of prescribed pharmaceuticals can be seen to legitimise or normalise opioid use, which may be particularly appealing for older opioid users. Although it can be argued that pharmaceuticals are safer than black market opiates, there are still a number of potential dangers when these substances are used contrary to prescription. In particular, they can pose major health risks if injected rather than swallowed including severe circulation problems and in acute cases, gangrene and amputation, when filtering and clean injecting practices are not adopted.

A number of respondents in the AIVL Study were prescribed morphine and/or oxycodone for legitimate ailments common to older patients. Other respondents complained about the exorbitant price of illicit opiates and that the large amounts of money required became increasingly difficult to find, the older they got. Economics, then, appeared to be a key factor in the purchasing patterns of older opioid users and their preference for pharmaceuticals as a cheaper alternative to black market powders. It is unfortunate that this trend, if it is in fact a trend, is unlawful under current legislation, which vetoes the prescription of opiates to maintain dependence as it could perhaps provides an entry point and an opportunity for medical practitioners to engage with older opioid users and to provide them with legitimate pharmaceutical alternatives. It is difficult to determine whether older opioid users who inject pharmaceuticals do so primarily for the instantaneous effect of injecting or whether the method of administration is also driven by economics and the desire to achieve the maximum effect of the drug. Again, research is required to determine the extent to which the use of pharmaceuticals is a pertinent issue for older opioid users.

Hepatitis C and other BBVs

Hepatitis C is often described as the single biggest health issue for injecting drug users in Australia today. Rates of hepatitis C infection are significantly higher among injecting drug users than any other group with more than 90% of new infections associated with injecting drug use.[72] HCV infection is strongly

[71] NDARC (2008) Australian Drug Trends: Findings from the Illicit Drug Reporting System (IDRS). National Drug & Alcohol Research Centre.

[72] Razali K. et al (2007) 'Modelling the hepatitis C virus epidemic in Australia'. *Drug and Alcohol Dependence*, Vol. 91, No. 2-3, 228-35.

associated with heroin use (as opposed to amphetamine use) [73] and with duration or length of use. The Australian NSP Survey 2004-8 found that prevalence was highest among those over 30 years and those with a longer history of injecting drug use.[74]

The health implications of hepatitis C infection for older injecting drug users are manifold. The slow progression of the disease accelerates over time and for approx 10% of those infected, hepatitis C will lead to cirrhosis, liver failure or hepatocellular carcinoma (liver cancer). Morbidity is also a major issue with an estimated 37,800 quality adjusted life years [75] lost in 2005 due to hepatitis C infection and liver disease mostly among older, longer term patients.[76] In addition, a study conducted for Queensland Health, which looked at quality of life (QOL) for people with chronic hepatitis C infection, found that *'participants over the age of 40 years were significantly more likely to have at least one other chronic medical condition compared with those aged less than 40 years . . . . . (and that) the presence of these co-morbidities could impact on health related QOL, symptom profiles, sleep and mental adjustment to illness'*. [77]

Despite the large number of injecting drug users infected with hepatitis C, antiviral treatment uptake remains extremely low, at less than 1%.[78] AIVL recently developed a comprehensive paper which discusses the barriers to HCV treatment and ongoing monitoring and care for many injecting drug users and the need to develop a range of innovative treatment models and methods of service provision. Although the newly implemented National Hepatitis C Strategy 2010-13 identifies the need to increase the number of people who access antiviral therapy every year in Australia, AIVL maintains that the initial emphasis should be on quality and improving models of treatment and care as a precursor to increasing the number people on treatment for hepatitis C.

In addition to hepatitis C, hepatitis B is also a serious issue for this cohort. Although injecting drug users constitute only 5% of cases of chronic HBV infection, almost half (40%) of acute HBV cases are acquired through unsafe injecting practices.[79] Speigal et al (2007) claim that *'people with hepatitis B have a 40-90% increased risk of mortality compared to age and gender matched populations. The risk of liver disease-related and liver cancer-related mortality are 12 and 33 times higher, respectively, than for the background population..... Most people who inject drugs who have chronic hepatitis B will be co-infected with hepatitis C. Co-infection with HCV and HBV increases the risk of liver disease progression, including progression*

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[73] Iversen J, Deacon R, Shying K, Maher L. (2008) Australian NSP Survey. Prevalence of HIV, HCV & Injecting & sexual behaviour among IDUs at Needle Syringe Programs. NATIONAL DATA REPORT 2004–2008. NCHECR. University of New South Wales.

[74] Ibid

[75] QALYS or **quality-adjusted life years** is a measure of disease burden, including both the quality and quantity of life lived.

[76] Canelli F. (2008) Hepatitis C virus infection in the elderly: epidemiology, natural history and management. *Drugs & Aging*, 2008; 25(1):9-18.

[77] Lang C., Dunne M. & Macdonald G. (2003) Quality of Life Among People Living with Chronic Hepatitis C Infection. *Queensland Health File* Ref No: 0055-4757-034 April, 2003: 18

[78] Treloar et al. (2004) Barriers and incentives to Treatment for illicit drug users" 2004, *Monograph No.53* C'wealth Dept of Health and Ageing, Canberra, Australia. 2004: 17.

[79] National Hepatitis B Needs Assessment (2007)

to cirrhosis and liver cancer, and makes clinical management of both viruses more difficult'. [80] Clearly, these health issues are exacerbated over time for older opioid users, particularly for those who are co-infected. Even for those who do not develop serious liver disease, research indicates that 'patients with non-cirrhotic hepatitis B have substantial psycho-social decrements in quality of life'.[81]

Happily, HIV prevalence remains low (1.5% or less) among injecting drug users in Australia. However, in recent years, ageing has emerged as a major issue in relation to HIV/AIDS, which poses its own set of discreet problems and implications. Again, co-infection of HIV and HCV is a matter of particular concern, given the accelerating effect of HIV on hepatitis C infection.

Financial Issues

The exorbitant price of illicit drugs, which is driven by prohibition and the black market, is a major issue for all drug users regardless of age. Again, these issues appear to be exacerbated with age. At a time in life when many people begin to reap the rewards of a lifetime of gainful employment, many older opioid users find themselves without savings or financial security of any sort despite having worked throughout their lives. Financial insecurities and their impact on all other aspects of life were identified as a key issue by the majority of the AIVL sample including those who had held down good jobs. Poverty and in particular chronic poverty is linked to limited access to basic resources such as food, adequate housing, education and employment and strongly associated with psychological stress and poor health outcomes in the literature.[82] In addition, the sense of diminished 'control over destiny' which goes hand in hand with poverty is identified as a mediating influence which helps to explain why the poor are less healthy in almost every way regardless of their particular habits and behaviours.

Respondents in the AIVL Study 2010 attributed their precarious financial status to the high price of illicit opioids as well as to their surprise at reaching 40 or more years of age. Most did not expect to turn 30 and certainly never imagined they would have to prepare for retirement or old age. It is not surprising then that few had put anything aside or made plans for the longer term. As much as the high cost of illicit drugs affects drug user of all ages, drug related poverty in conjunction with old age appeared to present a particularly frightening scenario for many respondents.

Housing

The theme of 'no assets, no security' was voiced by respondents continually as a major source of concern. Many of the respondents in the AIVL Study (2010) recognised that they would never own their own home. Similarly, private rental accommodation has become increasingly difficult to access and/or afford,

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[80] Speigal B., Bolus R., Han S., Tong M., Esrailian E., Talley J., Tran, T., Smith J., Karsan H., Durazo F., Bacon B., Martin P., Younossi Z., Hwa-Ong S., & Kanwal F. (2007) Development and validation of a disease targeted quality of life instrument in chronic hepatitis B: The hepatitis B Quality of Life Instrument: Version 1.0. *Hepatology.* 2007.

[81] ibid

[82] Minkler M. (2010) Poverty Kills. For Want of Resources, Millions Face Early Death and Ill Health. http://www.parkridgecenter.org/Page78.html

especially for those who are economically disadvantaged. However, public housing and in particular public housing estates were identified as increasingly violent and unsafe environments and consequently, places to be avoided. Clearly, fears about security become more pronounced with age and many were alarmed at the prospect of being alone and vulnerable at the end of their lives without any sort of safety net.

Criminality

A number of respondents expressed their fears about the police and the criminal justice system. Several spoke eloquently about their anxiety in the face of an uncertain future, which may or may not involve imprisonment. Many claimed that it became increasingly more difficult to generate the amounts of money needed to score heroin and other illicit drugs and that the older they got, the less inclined they were to resort to crime. Respondents were acutely aware of the numerous consequences and spin-off effects of crime and its potential impact on other areas of life including housing, employment, financial security, and for female respondents, care and custody of children. Several respondents identified crime as one of the key drivers of the stigma and discrimination associated with injecting drug use. Although it is difficult to determine on the basis of the AIVL Study (2010) alone, these issues appear to be more keenly felt by older opioid users than other groups within the IDU population.

'The Juggling Act'

Regardless of age, most Illicit drug users are familiar with the juggling act involved in keeping the various aspects of life separate from one another in an effort to contain and/or conceal their drug use. A male respondent, who held down a highly responsible position as a senior public servant, described his attempts to split his life into different and mutually exclusive compartments. He referred to 'the duality' in his personality, which he assumed was psychologically damaging. Although he claimed that this divergence between who he was and who he presented himself to be was a major stress factor in his life, he saw no way of escaping it. He remained committed to his use of opioids despite the fact that he could never be open about his drug use or drug of choice. This notion of 'self concept differentiation' or the lack of interrelated roles is identified in the literature as an important precursor to mental health problems and related to depression, loneliness and dissociation as well as lack of self esteem.[83] Again, it would appear that the cumulative effect over time of living with these sorts of unresolved tensions may be more keenly felt with age.

Employment Issues

Some respondents in the AIVL Study 2010 found it hard to secure employment and felt increasingly hopeless about their employment prospects since their increasing age made them less attractive in the job market. Those who were employed were adamant that their working lives would benefit from improved access to treatment and greater flexibility within the provision of pharmacotherapy programs. Many complained about the difficulty of combining work with their pharmacotherapy programs, due to restricted take away doses and dosing times which invariably coincide with work hours. As Rosembaum

[83] Lutz C.J. & Ross S.R. (2000) Elaboration Versus Fragmentation: Distinguishing Between Self-Complexity and Self-Concept Differentiation

(1981) commented in a study of female heroin users *'In many ways, meeting the demands of methadone treatment can become its own career that often conflicts with other more compelling and desirable career options'.*[84]

Again, the difficulty of juggling double lives was raised in the context of employment by a number of respondents, who described the lengths they went to in order to conceal their drug use and/or OST in a work environment. Some in the sample were reluctant to access NSPs or other drug related services, including pharmacotherapy in an effort to remain unseen. Others were loath to identify their drug use even to their GPs and therefore risked the possibility of various health conditions not being identified. The need for anonymity, then, can have serious health related repercussions for older opioids users at a time in their lives when their health warrants vigilance.

Fear of disclosure as a drug user was reported by a number of respondents in the context of employment, who claimed that the risk of discovery became more significant as they advanced their careers. However, few respondents in the AIVL Study (2010) occupied highly paid or responsible positions and many identified their drug use as a serious impediment to seniority at work and the pursuit of a brilliant career.

Social Isolation

Levy and Anderson[85] (2005) comment that *'the socio-emotional content of the career of the older user is often marked by loneliness, stress, and fear of victimisation'*. The authors go on to say that *'chronic drug use as a career tends to be characterised by a gradual eroding of ties to the non-using world and lessening interaction over time with family, friends and others who are non-users . . . . such a separation from the straight world is further reinforced when interactions with non-users are unsympathetic or critical'.*[86] As well as hiding their drug use from family and friends, a number of respondents reported that hiding their drug use from the world at large fostered a sense of distrust. Although maintaining a low profile and flying under the radar was a key survival strategy for many respondents, it was also identified as a source of much anxiety and alienation.

A number of respondents alluded to their loss of close friends and/or partners due to drug related overdose and other drug related harms and their increasing sense of isolation. As well as their separation from non-using friends and family, some also spoke of their rejection and estrangement from younger drug users and the cultural differences between younger and older cohorts of opioid injectors. Clearly, social isolation is strongly associated with stigma and discrimination, which sadly are familiar to most injecting drug users. However, it may well be that the cumulative effects of stigma and discrimination are most keenly felt by older opioid users, who, after years of such treatment, despair of any real change in their lifetimes.

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[84] Rosenbaum, M. (1981) Women on Heroin. Rutgers University Press. New Brunswick, NJ.

[85] Levy J, & Anderson T. (2005) The Drug Career of the Older Injector". *Addiction Research and Theory.* Vol. 13, Issue 3. Pg.245-258.

[86] Ibid

Family

A broad range of concerns about family and parenting were identified by respondents of the AIVL Study (2010). For some, tensions increased as their children matured and became adults and better understood the nature of their parents' drug use. As the parent's drug use became more difficult to hide or explain away, some children reacted violently against their parents, while other children followed in their parents' footsteps. Respondents also reported that their parents and siblings expected them to *'grow out of their drug use'* and that their continued use of opiates created ongoing and increasing tensions in their family relationships. As one respondent reported *'...I have learned to be discreet, to avoid situations which may lead to disclosure and to hide my opiate use from anyone who doesn't need to know; I have learned that it is generally a big mistake to disclose to family members, who will never understand and will worry themselves sick about me.'* (AIVL Survey respondent)

Given the number of female respondents in the AIVL Study (2010), the emphasis on family issues is perhaps not surprising. Several female respondents expressed their fears that their mistakes would in turn influence the behaviour of their children, who may go on to become drug users like their parents. As one respondent commented: *'A lot of opiate using parents now have children who are young adults. And its hard not to feel some remorse about using when the kids were younger and about some of the choices you made especially if the children are living the same lifestyle (i.e. as drug users) and seeing it from the perspective of a concerned parent'.*

The older opioid users interviewed for the AIVL Study (2010) were by definition a group of survivors. Despite their profound fears on a wide range of fronts and their stories of poor treatment at the hands of the healthcare system and the community at large, they also displayed remarkable strength and resilience in the face of a largely hostile world. Most were experienced in managing their own drug use and there was general agreement about key survival skills. The ability to be 'discreet' and to 'keep your head down' was repeatedly cited as essential to longevity and survival as a drug user; many described the challenges of remaining invisible and concealing their drug use to the outside world, which also makes this group difficult to identify or quantify. While many reported participation in pharmacotherapy treatment, others were determined to fly under the radar and avoided any form of drug treatment in an effort to elude registration as a 'known addict'. These sorts of fears, whether real or perceived, prevented some in the sample from accessing a range of potentially beneficial services as well as vital services such as needle/syringe programs.

Conclusion

Older people do take drugs'![87] This is the title of a paper about drug use and ageing developed by John Moores University, Liverpool, one of the few papers on this emerging topic identified in the literature review. Despite limited evidence, it appears that older people figure significantly in the use of opioids and as a result the demographic profile of injecting drug users is dramatically changing. However, the few studies on the subject and the lack of awareness of this emerging cohort are cause for concern. Dowling et al (2008) claim that *'concurrent ageing and drug use create a discreet set of unique and, as of yet, not fully understood problems for older people'*.[88] Similarly, Benyon (2009) states that *'ageing users of illicit drugs present unique problems. The brain changes in a variety of ways across the lifespan . . . . . How these changes alter drug brain interactions and what implications these changes have for older drug users is not yet clear'.*[89] We have a long way to go before older opioid injectors can expect to be acknowledged and supported by the healthcare system and the community in general.

This discussion paper was developed by AIVL in response to an identified need and a gap in knowledge within drug user networks. AIVL set out to establish the existence of an older cohort of opioid injectors and to estimate the number of drug users in Australia aged 40 years or more. A further aim was to identify the needs and concerns of older opioid users and in particular unmet needs. Despite the limited scope of the paper, we trust we have achieved our objectives. The respondents of the AIVL Study of Older Opioid Injectors 2010 raised a wide range of concerns, which are described in the 'Results' section of the discussion paper. Unfortunately, we were unable to explore their concerns in greater depth or to conduct more detailed analysis of the key themes. In many ways, the paper merely skims the surface and asks as many questions as it answers. For instance, it would be interesting to examine what enables some to survive the rigours of illicit drug use while many others fall by the wayside. Are there protective factors involved or is it simply the arbitrary twists and turns of fate? Again, are those who continue to inject opioids in the longer term the true 'survivors' or the 'casualties' of illicit drug use? It would also be interesting to explore in more depth the costs and benefits of continued opioid use. Do aspects of illicit drug get harder or easier with time? Similarly, does it become harder or easier with age to integrate drug use with other aspects of life? These are complex and compelling questions which clearly warrant further investigation and interpretation.

At best, it would seem that opioid users in Australia will suffer the same sort of age-related disabilities as the general population as they grow older. In addition, the health concerns of older opioid users are likely to be exacerbated by a history of injecting drug use and/or the side effects of long term pharmacotherapy

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[87] Drug use and ageing: Older people do take drugs! (2005) C.M Benyon, Centre for Public Health, Liverpool John Moores University, Castle house, North Street, Liverpool

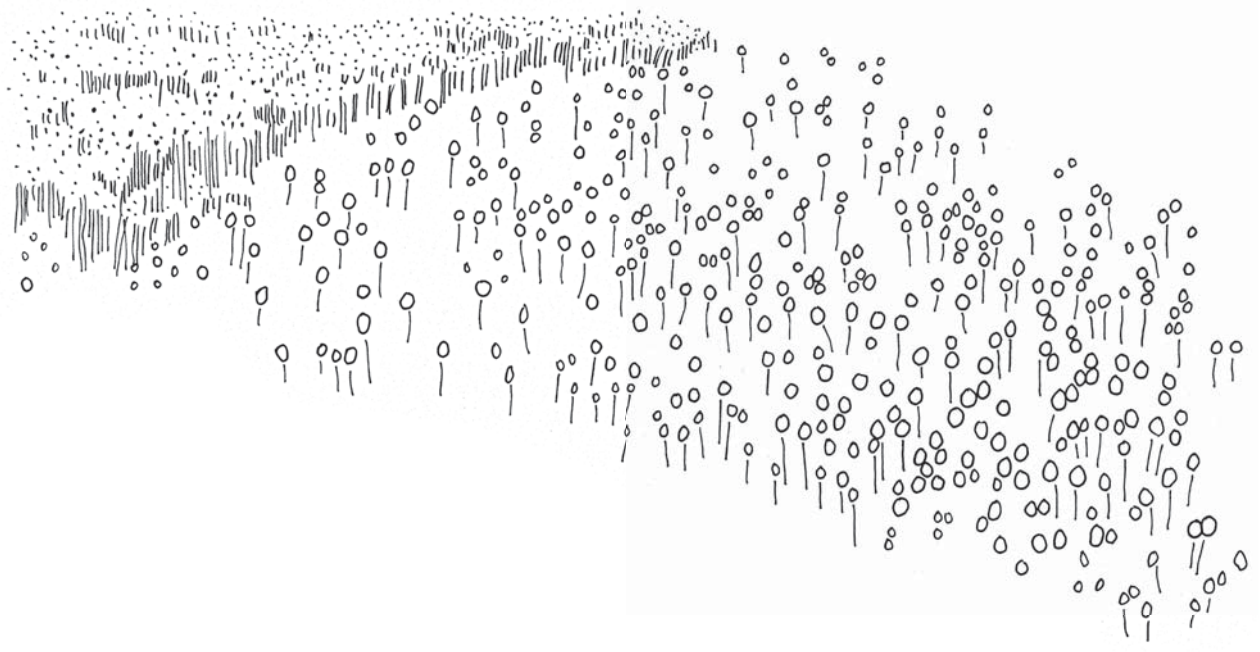
[88] Dowling GJ., Weiss S. & Condon TP. (2008) Drugs of abuse and the ageing brain. *Neuropsychopharmacology* 2008; 33: 209-18

[89] Benyon C.M. (2009) Drug use and ageing: Older people do take drugs! Center for Public Health, John Moores University, Castle house, North Street, Liverpool

treatment. As we have previously noted, drug and alcohol services have traditionally targeted young and less experienced drug users and are largely unused to working with older clients. However, if the aim of health policy is to reduce harm and keep people healthy, it comes with the responsibility to keep pace with and address the changing needs of clients, as they progress through life's stages. Identifying and understanding the needs of this group, then, will be essential if services are to be responsive to their specific needs and concerns.

In keeping with the fears of many of the respondents in the AIVL Study (2010), it seems unlikely that older injecting drug users will experience the dignity and respect traditionally afforded to people in our society as they age, although some may achieve elder status in the drug using community. Once identified as a drug user, it seems that one is often pushed to the margins and denied full membership to civil society and that this sort of alienation is increased rather than diminished with age. Many respondents in the AIVL Study (2010) reported that their drug use cast a long shadow over the way they were viewed by the healthcare system and by society in general. By extension, respondents greatly feared that their entitlement to appropriate care and adequate pain relief in old age would also be diminished.

AIVL trusts that this discussion paper will stimulate further debate and help to draw attention to the issue of ageing in conjunction with opioid injecting. The survival of larger numbers of opioid injectors into older age has already changed the composition of the drug using community and will continue to do so well into the future. However, it remains to be seen what the full implication of these changes will be and how they will impact on the drug using community and society as a whole.



Recommendations

Priority Action Area 1: Research

R1: Significantly increase investment in targeted national research projects to ensure better quality surveillance and monitoring, epidemiology and social research data on the numbers of older injecting opioid users in Australia and the range and scope of health and social issues for this group within the population.

R2: Conduct longitudinal research into the impact of long term opioid pharmacotherapies on the physical health and wellbeing of people with a history of injecting drug use, who have been maintained on methadone and/or Subutex/Suboxone for 10 years or more, (focusing on markers such as bone density, dental health, body mass index, etc.). The findings of this research should be communicated effectively to long term opioid users.

R3: Support investment in peer-driven social research initiatives to document and improve understanding of the impact of ageing on people with a history of injecting drug use in particular on issues such as the impact of long-term stigma and discrimination, illegality and criminalisation and living with complex and chronic diseases.

Priority Action Area 2: Policy Development

R1: Conduct a national policy review process into current opioid pharmacotherapy programs in each jurisdiction to ensure these programs are better tailored to meet the changing needs of the growing numbers of older opioid pharmacotherapy consumers.

R2: Provide resourcing for peer-based drug user organisations to support older injecting opioid users to effectively represent their needs and issues in national and state/territory policy processes and key advisory structures.

R3: Resource the development of a series of in-depth policy discussions papers to both increase the depth of understanding on the key themes and issues briefly explored in this report and to act as a point of advocacy for improving policy responses.

R4: Support a national review of legislative and policy barriers to improving the health and human rights of older opioid injectors including but not limited to the impact of current drug laws and policies.

Priority Action Area 3: Education and Empowerment

R1: Prioritise the issue of hepatitis C and ageing within national and jurisdictional BBV strategies and action plans with the aim of improving access to education, information, services and self-management strategies for older opioid injectors.

R2: Investigate, and if feasible, resource the development of locally/community based and/or online peer support strategies run by and for older opioid injectors to ensure access to relevant and timely information and self-empowerment approaches for individuals and networks of older opioid injectors.

R3: Seek funding for a social history project to document the experiences and wisdom of older injecting opioid users in Australia as part of encouraging drug using communities to value their older members and learn from their life experiences.

Appendix 1

Older Injecting Opioid Users' Survey

1) How old are you?

   (40-45) (46-50) (51-60) (60-65) (65+)

2) Are you Male or Female?

   .....

3) What is you cultural background? (Please circle one)

   Anglo-Australian Indigenous Australian Asian European

   Other, clarify .....

4) How long have you been using opiates?

   .....

5) What is your preferred opiate/opioid? (e.g. Heroin, morphine, oxycontin, methadone, etc)

   .....

6) When your drug of choice is unavailable, what do you mostly use instead?

   .....

7) As an opiate user over 40, do you (or your close friends) have any unmet needs? (i.e. health, social or legal problems now or fears for the future)

   .....

8) Is there anyone that you discuss these issues with?

   .....

9) Are there any problems in your life which you attribute to ongoing opiate use? (i.e. general health, illness, employment, housing, family problems, etc)

   .....

10) Are there any services which you utilize, as a drug user, which you feel work particularly well? What are they?

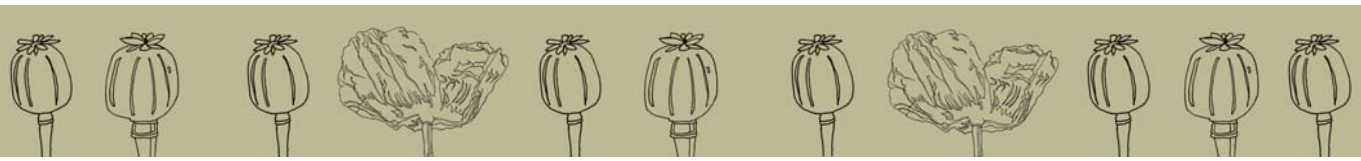
   .....

11) Can you comment on any changes you have made, or things you have done, over your life, which make your life as a drug user easier and might be helpful information for other users?

   .....

12) Can you talk about of some good or positive aspects of your life as a whole?

   .....



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