Prevalences of illicit drug use in people aged 50 years and over from two surveys

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Abstract

Background: little is known about illicit drug use in older people. Prevalences may rise as populations for whom illicit drug use has been more common and acceptable become older.

Objectives: to quantify illicit drug use in people aged 50 years and over in England and inner London and to compare this between 50 and 64 and 65+ age groups.

Methods: primary analyses used data from the 2007 Adult Psychiatric Morbidity Survey (APMS) and the 2008–10 South East London Community Health (SELCoH) Survey. Secondary analyses included additional data on 50–64 year olds from the 1993, 2000 and 2007 APMS, and on 65–74 year olds from the 2000 and 2007 APMS.

Results: cannabis was the drug most commonly used in all samples. Prevalences of use within the last 12 months in 50–64 and 65+ age groups were 1.8 and 0.4%, respectively, in England and 9.0 and 1.1%, respectively, in inner London. Prevalences of use at any time previously were 11.4, 1.7, 42.8 and 9.4%, respectively. Lifetime cannabis, amphetamine, cocaine and LSD use in 50–64 year olds had increased approximately tenfold in England from 1993. Lifetime and 12-month trends in tranquillisers were relatively stable.

Conclusions: use of some illicit drugs, particularly cannabis, has increased rapidly in mid- and late-life.

Keywords: substance use, aged, survey, cannabis, amphetamine, elderly

Introduction

Demographic ageing presents important challenges, not only because of increases in numbers of older people, but also because of rapidly changing patterns of behaviour across generations. Compared with alcohol use in older people, less data are available on use of other substances [1]. In the UK, the principal resource for estimating illicit drug use (which is underestimated by service contact data or the National Drug Treatment Monitoring System) is the British Crime Survey; however, its upper age cut-off is 59 years [2, 3]. Although illicit drug use is currently likely to be relatively rare in older age groups, a significant increase can be expected as generations for whom this has been more common and accepted become older. Clinical services specialising in the care of older people may have to adapt rapidly to these secular changes, particularly those covering urban populations where use is likely to be higher. We therefore sought to describe prevalences of illicit drug use in older people both nationally and in inner London, comparing the 65+ and 50–64 year age groups, and national trends from three surveys carried out over a 14-year period.

Method

As mentioned, data on illicit drug use were analysed primarily from two household surveys: the 2007 English National Survey of Psychiatric Morbidity (NPMS; with supplementary analyses also carried out on data from near-identical surveys in 1993 and 2000) and the South East London Community Health (SELCoH) survey, carried out in 2008–10 in the boroughs of Lambeth and Southwark.
Table 1. Prevalence of reported lifetime substance use (%) by the age group in the two surveys

<table>
<thead>
<tr>
<th>Substance use</th>
<th>England sample</th>
<th>London sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Age 50–64 (n = 1,827)</td>
<td>Age 65+ (n = 2,009)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>11.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>2.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Cocaine</td>
<td>1.2</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.4</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.3</td>
<td>0.0</td>
</tr>
<tr>
<td>LSD</td>
<td>1.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Tranquilizers</td>
<td>2.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>2.1</td>
<td>0.6</td>
</tr>
<tr>
<td>Amyl nitrate</td>
<td>0.6</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Methadone</td>
<td>0.2</td>
<td>0.0</td>
</tr>
<tr>
<td>Anabolic steroids</td>
<td>0.2</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Solvent inhalation</td>
<td>0.1</td>
<td>&lt;0.1</td>
</tr>
</tbody>
</table>

*Odds ratios comparing substance use in the 50–64 age group with that in the 65+ age group, carried out in cases where prevalence was at least 0.1% in each cell.

For details of sampling methodology and statistical analyses, see Supplementary data available in Age and Ageing online, Appendix 1. In all surveys, drug use was ascertained by direct questioning, covering a range of potential agents. Participants were asked first whether they had ever used the substance in question and then, if so, whether they had used it within the last year. These were termed ‘lifetime’ and ‘recent’ use for the purpose of this investigation. Both surveys enquired about cannabis, amphetamine, cocaine, crack, ecstasy, heroin, LSD and tranquilisers. The NPMS additionally enquired about magic mushrooms, amyl nitrate, methadone, anabolic steroids and solvent inhalation. All substances are termed ‘illicit drugs’ for shorthand, although it should be borne in mind that tranquilisers or methadone potentially included prescriptions. In order to achieve sufficient precision, prevalences in the 50–64 and 65+ year age bands were compared. Where data were sufficient, odds ratios derived from weighted logistic regression models were used to quantify the differences between these age groups.

Discussion

In this analysis we aimed to describe current prevalences in England and inner London of illicit drug use in people aged 65+ from a national and inner London sample and to estimate how these might change in future by considering the same prevalences in the 50–64 age range. In additional analyses we describe national changes in the 50–64 and 65–74 age ranges from 1993 to 2007. Taken together, these findings indicated increased prevalence for some illicit drugs in older age ranges, particularly in inner urban populations. Strengths of the study include the large samples with comparable recruitment and measurement methodology as well as the inclusion of both nationally representative surveys and one which focused on a higher-risk locality. Limitations include the cross-sectional design, the reliance on self-report data and the limited range of substances evaluated (e.g. not including misuse of prescription analgesics).

To our knowledge, these are the first epidemiological data on illicit drug use in people aged 60+ to be reported for British community populations, at least within the last
Table 2. Prevalence of reported substance use within the last year (%) by the age group in the two surveys

<table>
<thead>
<tr>
<th>Substance</th>
<th>England sample</th>
<th>London sample</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
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</tr>
<tr>
<td>Amphetamine</td>
<td>&lt;0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>&lt;0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Crack</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>LSD</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Tranquilisers</td>
<td>0.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Magic mushrooms</td>
<td>0.3</td>
<td>0.4</td>
</tr>
<tr>
<td>Amyl nitrates</td>
<td>0.1</td>
<td>&lt;0.1</td>
</tr>
<tr>
<td>Methadone</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>Anabolic steroids</td>
<td>&lt;0.1</td>
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*Odds ratios comparing substance use in the 50–64 age group with that in the 65+ age group, carried out in cases where prevalence was at least 0.1% in each cell.

10 years. Because of wide international variations in access to and/or use of different substances, generalisability cannot be assumed from other countries. In the oldest, 55–59, age group sampled in the 2006–07 British Crime Survey, prevalences of recent (12 month) illicit drug use were 1.1% for cannabis, 0% for Class A drugs, and 1.7% for any drug; respective prevalences of lifetime use were 12.8, 4.1 and 18.1% [2]. These are broadly comparable to the 2007 APMS data; however, prevalences of recent overall use from 1998 to 2007 from the British Crime Survey in England and Wales have been reported to be relatively stable in 55–59 year olds, whereas English data from the 1993, 2000 and 2007 APMS surveys indicate increasing prevalence for the 50–64 year range for certain drugs. Even around this age range there is substantial variation: for example, the fourfold increase in recent cannabis use for 45–54 year olds [3]. Considering other communities, US ECA surveys reported lifetime illicit drug use in 7% of 45–64 year olds and 1.6% of 65+ year olds [4] while more recent US surveys in 2005–06 found recent use of marijuana, cocaine and inhalants respectively in 0.7%, 0.04% and 0.07% of 65+ year olds, and in 3.9, 0.7 and 0.13% of 50–64 year olds [5]—i.e. higher than our findings from England but lower than those from London.

Recent illicit drug use remained uncommon in older people but there was a marked gradient between the two age groups of interest for certain agents. Cross-sectional findings are limited; however, they were consistent with the longitudinal data: for example, the fourfold increase in recent cannabis use for 65+ year olds over a 10–15-year period suggested by age-group comparisons in the 2007 APMS (Table 2) is broadly consistent with the twofold increase in 65–74 year olds from 2000 to 2007 (Supplementary data are available in Age and Ageing online, Appendix 2). The stability in tranquiliser use is also consistent. Recent use of other agents remained too uncommon for conclusions to be drawn, although in the London sample, all apart from heroin indicated higher prevalences in 50–64 year olds compared with 65+ year olds.

Even relatively low prevalences can represent high absolute numbers of users at a national, regional or service level. Most older recent users are likely to have had prolonged use since initiation of substance use has been found to be rare in mid-/late-life [13]. Therefore, our findings suggest at least that health service staff providing care for older people should be aware of the possibility of illicit drug use as part of the clinical context, particularly as previous research [14] and policy reports [15] have suggested that this is often missed.

Considering lifetime use, increased exposure to most agents was found, particularly in the urban sample and particularly for cannabis. More research is required to clarify whether observed trends in lifetime use have clinical implications: particularly long-term effects on health outcomes in older people (e.g. associations between illicit drug use and risk of neurodegenerative disorders have received little research to date). It is also unclear to what extent past use may predispose a person to resume illicit drug use in later life in response to one or more stressful events or a physical illness combined with increased availability. Our data suggest at the very least that large numbers of people are entering older age groups with lifestyles about which we know little in terms of their effects on health and would benefit from further monitoring—in particular, extending the upper age cut-off for core surveys such as the British Crime Survey, as well as more specific data collection in urban areas where risks appear to be substantially higher than national averages.
Key points

- Little is known within the UK about the prevalence of illicit drug use in late-life.
- The prevalence of illicit drug use in English residents aged 65+ years is currently low (for cannabis, the most commonly used: 0.4% recent use, 1.7% lifetime use) but is higher in inner London (for cannabis: 1.1% recent use, 9.4% lifetime use).
- The prevalence of some illicit drug use in people aged 50–64 years is higher than that in 65+ year olds (recent and lifetime use of cannabis 1.8 and 11.4%, respectively, in England, 9.0 and 42.8%, respectively).
- Increasing use of cannabis in both age groups is confirmed by trends observed in previous mental health surveys in 1993 and 2000.
- The clinical and public health relevance of these potential secular changes in both lifetime and recent prevalence is not clear but should be a research priority. There is a need to develop a treatment infrastructure that is sensitive to problems of older illicit drug users.

Conflicts of interest

None declared.

Funding

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Supplementary data

Supplementary data mentioned in the text is available to subscribers in *Age and Ageing* online.

References


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