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DRUG USE: AN OVERVIEW OF GENERAL
POPULATION SURVEYS IN EUROPE





European Monitoring Centre
for Drugs and Drug Addiction

GENERAL TRENDS IN POPULATION SURVEYS IN EUROPE

DRUG USE: AN OVERVIEW OF GENERAL
POPULATION SURVEYS IN EUROPE

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Preface

Just over a decade ago, Europe's capacity for monitoring its drug problem was extremely limited. National approaches to the topic varied greatly and although some European countries had conducted population surveys on drug use, it was impossible to talk with confidence about patterns and trends in drug use across the EU. When the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) became operational in 1995, it built on the earlier pioneering work at national level and launched several consecutive projects to develop common European guidelines, while allowing flexibility for implementation at national level. A European expert group was created and it continues to meet regularly.

Now the EMCDDA is the hub of drug-related information in the European Union and it is widely acknowledged that some form of general population survey is necessary to develop national drug strategies. At present, almost all Member States have conducted recent surveys on drug use and in most countries they are being repeated on a regular basis, to track changes in levels and patterns of drug use and in the characteristics of users. This has been a remarkable achievement as population surveys are neither cheap

nor easy to organise. We are aware that despite the considerable progress achieved, comparability across Member States is still far from perfect and that major conclusions cannot be drawn from small differences in prevalence. But, increasingly, observed trends and patterns of drug use show consistency within and between countries.

This report is of considerable value to highlight remaining differences in instruments, reporting formats and methodologies. And together with the authors, we hope the updated and extended overview presented here is a great leap forward in the work and progress to facilitate the comparison of survey practices in EU countries.

I would like to take this opportunity to thank all the governmental and non-governmental partners in Belgium that contributed to the funding, collection and preparation of this important work, as well as the experts from different Member States who collaborated with the research team.

Wolfgang Götz
Director, EMCDDA

Contents

Preface	3
Foreword	9
Introduction	11
Chapter 1 Expert survey	13
Chapter 2 Intrinsic focus	15
2.1 Objectives	15
2.2 Prevalence of drug use	17
2.2.1 Illicit drugs	17
2.2.2 Licit drugs	20
2.3 Prevalence measurements	23
2.3.1 Illicit drugs	23
2.3.2 Licit drugs	25
2.4 Frequency of drug use	27
2.4.1 Illicit drug use	27
2.4.2 Licit drug use	29
2.5 Quantity of drug use	32
2.5.1 Illicit drug use	32
2.5.2 Licit drug use	34
2.6 Other items related to illicit drug use	36
2.6.1 Age of onset	36
2.6.2 Availability of drugs	37
2.6.3 Multiple drug use	38
2.6.4 Perceived health effects of use	38
2.6.5 Intravenous use	38
2.6.6 Other item: susceptibility	39
2.7 Respondent attributes	41
2.7.1 Socio-demographic attributes	41
2.7.2 Socio-economic attributes	42
2.8 Environment	46
2.9 Lifestyle attributes	48
2.10 Attitudes and opinions	51

Chapter 3	
Methodological focus	54
3.1	Cross-national comparison of surveys 54
3.2	General characteristics 54
3.2.1	Context 54
3.2.2	Frequency 56
3.2.3	Level of analysis 56
3.3	Commissioners and responsible agents 59
3.4	Target population characteristics 64
3.4.1	Target population 64
3.4.2	Reasons for oversampling 66
3.5	Survey methods 70
3.5.1	Interviewing and completion modes 70
3.5.2	Arguments for the choice of interviewing and completion modes 70
3.5.3	Changes in interviewing and completion modes 72
3.6	Sampling characteristics 75
3.6.1	Sample frame 75
3.6.2	Sampling method 76
3.6.3	Weighting 76
3.7	Sample characteristics 82
3.7.1	Sample size 82
3.7.2	Response rates 82
Chapter 4	
Financial focus and timetable	87
4.1	Financial sources 87
4.2	Timetable 91
Chapter 5	
Utilitarian and valorisation focus	94
5.1	Accessibility of the fieldwork and data documentation 94
5.1.1	Publication form and language 94
5.1.2	Content 94
5.1.3	Time 95
5.2	Accessibility of data set 95
Conclusion	98
References	99

Survey questionnaire

The questionnaire on national population surveys on drug use is available online: <http://www.emcdda.europa.eu/publications/thematic-papers/gps/questionnaire>

List of tables

Table 1: Overview expert survey	14
Table 2: Survey objectives	15
Table 3: Prevalence of illicit drug use	18
Table 4: Prevalence of licit drug use	21
Table 5: Prevalence measurements of illicit drugs	23
Table 6: Prevalence measurements of licit drugs	25
Table 7: Frequency of illicit drug use	28
Table 8: Frequency of licit drug use	30
Table 9: Quantity of illicit drug use	32
Table 10: Quantity of licit drug use	35
Table 11: Other items related to illicit drug use	39
Table 12: Socio-demographic attributes	42
Table 13: Socio-economic attributes	44
Table 14: Environment	47
Table 15: Lifestyle	49
Table 16: Attitudes and opinions	51
Table 17: General characteristics	56
Table 18: Agencies and authors of main survey reports	60
Table 19: Target population characteristics	67
Table 20: Survey methods applied	73
Table 21: Sampling characteristics	77
Table 22: Sample characteristics	85
Table 23: Financial sources	88
Table 24: Average costs per activity in EUR	89
Table 25: Average requirements concerning staff	90
Table 26: Timetable	92
Table 27: Accessible data archives	96

Foreword

In 2001, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) produced an overview of the general features and sampling and interviewing methods of 13 drug use surveys. This report presents an updated and more extensive meta-analysis of recent general population surveys in European Union Member States. The analysis presented here was part of a larger feasibility study of a repetitive drug survey among the general population in Belgium. This study was commissioned and financed by the Belgian Federal Science Policy, within the framework of the 'Research programme in support of the federal drugs policy document' (see <http://www.belspo.be/belspo/fedra/prog.asp?l=en&COD=DR>), a research programme since 2002 in response to drug problems, and closely linked to drug policies of public authorities.

Although Belgium puts in a great effort to gain insight into the epidemiologic situation concerning drug use (e.g. among the school-going youth), Belgium has no extended research tradition. So far, the prevalence of drug use within the Belgian general population has never been studied systematically. The general aim of this research was to study the feasibility of a recurrent alcohol and drug survey among the general population. The research covers a detailed comparison of methods and designs, used in prevalence studies in other European countries, and the evaluation of the strengths, the restrictions, the preconditions and the costs of former studies, and includes a limited cognitive test of the included items with a view to the implementation of such study in Belgium, taking into account the general cultural and social practices and specific implications and limitations. The Belgian study was carried out by two research groups: the Institute for Social Drug Research (ISD), Ghent University, and

the Research Centre for Longitudinal and Life Course Studies (CELLO), the University of Antwerp and performed in cooperation with the EMCDDA and key experts from 30 European Union Member States.

The meta-analysis presented in this report can be seen as a follow-up on the previous overview produced in 2001 by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). However, the present report is wider in scope, now including intrinsic and methodological discussions and a description of financial sources, timetables and accessibility of the fieldwork and data documentation of 25 population surveys on drug use in Europe.

Beyond providing a useful instrument to compare survey practices in EU Member States, this overview is intended to be a reference tool for everyone planning, organising or executing a survey about drug use among the general population. The overview is a compilation of the intrinsic, methodological and financial aspects of population surveys in Europe, and the ways their results are disseminated. We hope this report is a valuable instrument to those making (policy) decisions; the work presented here may help them to clearly understand the costs and the benefits of the options available.

This overview is a collective endeavour and we thank all those who have contributed to it.

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Introduction

Today, the European Union comprises 27 countries: Austria, Belgium, Bulgaria, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom (1). In many of these European countries one or more general population surveys have been carried out to get a notion of the characteristics of illicit drug use at the national level.

In 2001, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) produced an overview of the general features and sampling and interviewing methods of 13 drug use surveys (EMCDDA, 2002; EMCDDA, 1997). It examined the general population surveys that had been conducted in France, Finland, Germany, Greece, the Netherlands, Ireland, Spain, the United Kingdom, the United States, and four Nordic countries (Denmark, Norway, Sweden and Finland). These countries were selected for practical reasons, i.e. availability and language accessibility to the researchers.

The present study provides an overview of the general population surveys on drug use in Europe. It focuses on the most recent surveys, i.e. surveys conducted since 2001. An effort has been made to complete and update the 2001 EMCDDA overview, to make a detailed comparison of methods and designs used in prevalence studies in European countries, and to evaluate their strengths, restrictions and compliance with the European Model Questionnaire (EMQ). We are aware that some national population surveys on drug use have not been included, in particular those that have been published in native languages only and/or that have not been made public. Furthermore, some European countries have not yet developed or planned a general population survey on drug use.

We would like to emphasise that the 2001 EMCDDA overview only included the 1998 and 1999 population surveys in Ireland/Northern Ireland. They are omnibus

surveys (2) and therefore not comparable with the results of the national population surveys on drug use in 2002/3 and 2006/7. So we decided to exclude both surveys from the updated overview. Furthermore, as questions about drug use have been included in the Belgian Health Interview Survey since 2001, the 1997 Health Interview Survey is not incorporated in the overview. In Finland, population surveys focusing on drug use and drug attitudes (1998, 2002, 2006) have alternated with surveys focusing on alcohol use and drinking habits (2000–04). Although the surveys focusing on alcohol use have included some questions on drug use, this overview only incorporates the Finnish population surveys on drug use and drug attitudes.

This document discusses the intrinsic, methodological-technical and financial components as well as valorisation aspects and presents them in table format to provide a convenient overview (EMCDDA, 2002). In these tables 'year' refers to the year in which the survey was conducted and 'country' to the country that is being surveyed. We have not included any local or regional studies. Some surveys lacked the relevant data; this is indicated by 'n.a.' (not available) in the table. We have indicated the data of the 2001 EMCDDA overview in grey.

This overview of general population surveys in Europe is part of a feasibility study of a repetitive survey among the general population in Belgium (3). It includes a detailed comparison of methods and designs used in prevalence studies in European countries as well as evaluating the strengths, restrictions, preconditions and costs of former studies. It also contains a limited cognitive test of the included items with a view to implementing such a study in Belgium, taking into account the general cultural and social practices. The feasibility study was carried out between 1 October 2007 and 30 November 2008.

The feasibility study was commissioned and financed by the Belgian Science Policy Office (4) and carried out by the Institute for Social Drug Research (5) (Prof. Dr

(1) http://europa.eu/abc/european_countries/index_en.htm

(2) A general omnibus survey is a multi-purpose survey. The Northern Ireland Omnibus Survey provides a snapshot of the behaviour, lifestyle and views of a representative sample of the people of Northern Ireland.

(3) For further information about the research project, see the website <http://www.belspo.be/belspo/fedra/proj.asp?l=en&COD=DR/35>

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Tom Decorte, Ghent University) and the Research Centre for Longitudinal and Life Course Studies ⁽⁶⁾ (Prof. Dr Dimitri Mortelmans, University of Antwerp).

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Chapter 1

Expert survey

For a meta-analysis of the existing national prevalence studies in Europe, an e-mail survey was conducted among international experts who were responsible for national surveys on drug use in Europe. An e-mail survey (with an attached questionnaire) was chosen as the interviewing method because it is a fast, easy and inexpensive way to collect data, especially when the respondents are located across Europe (De Winne et al., 2003). The experts' opinions and experiences on the content and the methodology of the respective national prevalence studies were taken into consideration. Special attention was given to the legitimization of the choices made as well as to (reasons for) any deviations from European guidelines. Also, the impact of a country's social, cultural and political practices on the design of the study, and the specific implications and limitations of the national context were inquired into. Finally, the expert survey also dealt with the comparability and the valorisation of the data.

The first contact with all national experts and national focal points (Austria, Bulgaria, Cyprus, Croatia, the Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Turkey and the United Kingdom (Scotland, England and Wales)) was established in November/December 2007. The European Monitoring Centre for Drugs and Drug Addiction provided the contact details of each expert. After explaining the aim of our research project, we kindly asked the experts and focal points to send us, if available, the reports of their national population surveys on drug use. At the same time, we announced that we would conduct an e-mail survey in April 2008.

Following an analysis of the EMCDDA's survey reports and/or national abstracts, we contacted all experts and focal points a second time in April 2008. All experts responsible for national population surveys in

the European Union were invited to complete a detailed country-specific questionnaire on their national general population survey on drug use. Also, the three countries that had not yet conducted a national population survey (Luxembourg, Croatia and Slovenia) were invited to complete a short questionnaire on their (concrete) plans to conduct a survey. The questionnaire was developed in close cooperation with the EMCDDA and was aimed at gaining insight into the experiences and know-how of the national experts, and at updating the overview of general populations surveys produced by the EMCDDA (EMCDDA, 2002).

The questionnaire consisted of four parts. An example of the questionnaire is available on the EMCDDA website (⁽⁷⁾). Some general questions were followed by detailed questions about intrinsic (A.) and methodological aspects (B.) in order to complete the EMCDDA overview (2001). The questionnaire ended with some questions about financial (C.) and valorisation aspects (D.). It could be completed in an electronic or in a printed version. We asked the experts to return the questionnaire by e-mail, postal service or fax before 19 May 2008 at the latest. Shortly before the deadline, we sent a reminder to those who had not yet responded.

Experts from 18 countries among the 30 countries we approached completed the questionnaire. One country (Portugal) mentioned that they had had no time to complete the questionnaire and they sent us some additional information (e.g. original questionnaire, national abstracts). Two countries (Turkey, Luxembourg) that had not yet conducted a population survey on drug use, informed us that they had no concrete plans to do so, and that they were thus unable to complete the questionnaire. Croatia stated that it had concrete plans and completed the short questionnaire. Finally, even though we had approached each expert at the expert meeting in June 2008, eight countries did not reply to our request (EMCDDA, 2008a).

(7) <http://www.emcdda.europa.eu>

After analysing the completed expert questionnaires, some (methodological or intrinsic) issues remained unclear. All 18 experts who were cooperating were

contacted again (July 2008) and asked a few additional questions. Eleven countries responded to this additional request.

Table 1: Overview expert survey		
Response	N (= 30)	Country
Completed	18	Austria, Croatia, Cyprus, the Czech Republic, Denmark, England and Wales, Finland, France, Hungary, Ireland, Italy, Lithuania, the Netherlands, Norway, Romania, Slovakia, Spain, Sweden
Not completed	8	Bulgaria, Estonia, Germany, Greece, Latvia, Malta, Poland, Scotland
No time	1	Portugal
No concrete plans to conduct a population survey	3	Luxembourg (2009), Slovenia (?), Turkey (2009)

NB: Countries in bold also completed the additional expert survey.

Chapter 2

Intrinsic focus

This section provides an overview of the items and questions in the national questionnaires. Not surprisingly, there is wide variation in the number of questions and items among the countries. From surveys where the questions on drug use are part of a survey with a wider scope (e.g. health survey, crime survey), only the questions on drug use are analysed. The items and the questions are grouped around the same themes as in the 2001 EMCDDA overview: prevalence of drug use, prevalence measurements, frequency of drug use, quantity of drug use, other items related to illicit drugs, respondents' attributes, environment, attitudes and opinions and lifestyle. First, the objectives of each general population survey are explained.

2.1 Objectives

Most countries have established national surveys that focus on illicit drug use, mostly in combination with the use of other drugs (e.g. alcohol and tobacco): Austria, Bulgaria, Cyprus, Germany, Hungary, Ireland/Northern Ireland, Italy, Latvia, Lithuania, Malta, the

Netherlands, Norway, Poland, Portugal, Romania and Spain. Others incorporate questions about drug use in a *health survey*: the Czech Republic, Denmark, France, Greece and Sweden. Only Scotland and England and Wales insert questions about drug use in a *crime and victimisation survey*. As a matter of fact, the context influences the specifications of the aims and objectives that the commissioners of the survey want to pursue. In most cases, general population surveys on drug use (and tobacco or alcohol consumption) aim to measure prevalence rates of drug use, to assess beliefs and attitudes towards drugs and drug users, and to evaluate the efficiency of drug policies (Table 2). Drug-related questions are usually included in a health survey in order to monitor perceptions concerning health and health risks, as the consumption of alcohol, tobacco or illicit drugs is regarded as risky behaviour. In addition, both crime surveys consider illicit drug use to be a crime-related topic and consequently ask about the respondents' exposure to illicit drugs as victims of crime in a crime context. The context is discussed in more detail in the section on methodological focus.

Country	Context	Objective(s)
Austria	(il)licit drug use	<ul style="list-style-type: none"> • To measure prevalence rates of (il)licit drug use among the general population • To provide information about the relationship between the consumption of (il)licit drugs and opinions or lifestyles • To gather information about gender-related aspects of alcohol consumption
Belgium	health	<ul style="list-style-type: none"> • To identify health problems, health consumption and its determinants, and possible trends in the health status and health needs of the population • To analyse the prevalence and distribution of health indicators, and the social (in)equality in health and access to health services
Bulgaria	(il)licit drug use	n.a.
Croatia	health	<ul style="list-style-type: none"> • To estimate prevalence and continuation rates of (il)legal drug use • To conduct a cross-country assessment of the general patterns of use • To assess relationships between particular population attributes and illicit drug use

Table 2 continued		
Country	Context	Objective(s)
Cyprus	(il)licit drug use	<ul style="list-style-type: none"> To measure the prevalence of (il)licit drug use among the general population To assess beliefs and attitudes towards drugs and drug users To assess the relationship between particular population attributes and drug use
Czech Republic	drugs/health	<ul style="list-style-type: none"> To assess the extent and patterns of (il)licit drug use among the general population To describe the risk areas related to (il)licit drug use To evaluate the drug policy and to formulate effective strategies
Denmark	health	<ul style="list-style-type: none"> To describe the status and trends in health and the factors that influence health status To improve prevention programmes To investigate attitudes towards specific drug issues
England and Wales	crime and victimisation	<ul style="list-style-type: none"> To gather information about the experiences of property and personal crimes and about a range of other crime-related topics (e.g. exposure to illicit drugs) To provide information to inform crime reduction measures and to gauge their effectiveness.
Estonia	health	n.a.
Finland	(il)licit drug use	<ul style="list-style-type: none"> To monitor prevalence rates of (il)licit drug use To assess trends in (il)licit drug use and in attitudes towards drugs
France	health	<ul style="list-style-type: none"> To monitor behaviour, attitudes and perceptions concerning health and health risks To evaluate policy decisions with an eye to developing an evidence-based prevention policy
Germany	(il)licit drug use	<ul style="list-style-type: none"> To observe trends in prevalence rates of (il)licit drug use, abuse and dependence To analyse changes in consumption patterns over time
Greece	health	n.a.
Hungary	(il)licit drug use	<ul style="list-style-type: none"> To explore the extent of (il)licit drug use among the general population To describe trends in (il)licit drug use To explore the factors that have an impact on problem drug use
Ireland/ Northern Ireland	(il)licit drug use	<ul style="list-style-type: none"> To make cross-regional comparisons on the prevalence of (il)licit drug use in the general population. To clearly identify the extent and nature of (il)licit drug use amongst the general population, specifically identifying trends amongst different segments of the population
Italy	(il)licit drug use	<ul style="list-style-type: none"> To measure prevalence rates of (il)licit drug use To monitor risk perceptions and opinions about (il)licit drug use
Latvia	(il)licit drug use	<ul style="list-style-type: none"> To evaluate the drug policy and to identify a more effective approach and new priorities. To tackle the social problems caused by (il)licit drug use and drug addiction, and to re-examine and redirect Latvian policies to combat illicit drug use
Lithuania	(il)licit drug use	<ul style="list-style-type: none"> To collect and assess standardised data on (il)licit drug use To estimate the relationship between particular population attributes and (il)licit drug use
Malta	(il)licit drug use	<ul style="list-style-type: none"> To monitor the drug problem from a more general perspective To analyse trends over time, by regularly conducting such surveys
Netherlands	(il)licit drug use	<ul style="list-style-type: none"> To measure prevalence, incidence and continuation rates of (il)licit drug use among the national population, differentiated by age, gender and urbanisation To detect trends over time
Norway	(il)licit drug use	n.a.
Poland	alcohol	n.a.

Table 2 continued		
Country	Context	Objective(s)
Portugal	(il)licit drug use	n.a.
Romania	(il)licit drug use	<ul style="list-style-type: none"> • To remedy the lack of programmes/strategies concerning drugs • To monitor prevalence rates of (il)licit drug use among the general population • To detect trends in drug abuse and to evaluate the efficiency of drug policies
Scotland	crime and victimisation	<ul style="list-style-type: none"> • To gather information about public perceptions and experiences as victims of crime • To monitor the knowledge and the use of a range of legal and illegal drugs
Slovakia	alcohol and tobacco	<ul style="list-style-type: none"> • To monitor opinions on drug addiction danger, drug users, and policies • To measure prevalence rates of (il)licit drug use, the availability of drugs and risk perceptions
Spain	(il)licit drug use	<ul style="list-style-type: none"> • To gather information about (trends in) the prevalence rates of (il)licit drug use • To monitor (trends in) risk perceptions • To monitor trends of perceived availability of (il)licit drug use • To identify determining factors of (il)licit drug use
Sweden	health	<ul style="list-style-type: none"> • To monitor (trends in) the health status among the general population

2.2 Prevalence of drug use

2.2.1 Illicit drugs

Most countries want to include all psychoactive drugs that are known to be used, in order to obtain a good estimate of any drug use (Table 3). It is recognised, however, that these estimates actually underestimate the use of some drugs in the population as a whole (UNODC, 2002a).

The number of illicit drugs surveyed varies from 6 to 16, except for the Swedish survey, which includes only cannabis. The Swedish expert admits that the inclusion of only one illicit drug makes cross-national comparability difficult (EMCDDA, 2008b). The other European questionnaires distinguish cannabis from other illicit drugs. The term 'cannabis' mostly refers to hashish and/or marihuana. Other illicit drugs are mainly ecstasy, cocaine, heroin, amphetamines and LSD. While the European Model Questionnaire considers those six drugs as a common minimum set, the WHO guidelines also include volatile inhalants and opium. The ESPAD studies cover crack, GHB, methadone, magic mushrooms, injected drugs and steroids.

Some countries (e.g. Cyprus, Malta, Greece, Croatia) follow the European Model Questionnaire and select only cannabis, ecstasy, cocaine, heroin, amphetamines and LSD. However, many countries include one or more

additional drugs, because other national surveys (e.g. health surveys, school surveys) or other national data (e.g. treatment and mortality statistics) show high prevalence rates of these drugs. Another reason to include additional drugs is to improve the comparability with, for instance, the ESPAD studies or the HBSC studies. These countries aim at comparing drug use among the general population with that among the youth population. In this respect, many countries (e.g. Austria, Scotland, Denmark, Latvia, Lithuania, Romania, Hungary, England and Wales, Ireland, Italy, France, Spain, Germany, the Czech Republic) investigate the use of magic mushrooms, crack, anabolic steroids⁽⁸⁾ or solvents/inhalants. For the same reasons, methadone and/or poppers are included in both crime surveys (British Crime Survey and Scottish Crime and Victimization Survey), the French Health survey and the Irish population survey on drug use. Furthermore, both crime surveys also include ketamine, as the expert survey shows that its use is becoming increasingly common in the club scene. For the same reason, the British expert intends to include methamphetamines in the next survey⁽⁹⁾. Methamphetamines are already included in the Czech survey, because the Czech ESPAD study shows that in the Czech Republic use of this drug is more problematic than that of amphetamines. The most recent Finnish survey also assesses the use of GHB and methadone. The former was included because newspapers had reported on the use of GHB at some festivals, and as other research had

⁽⁸⁾ The Dutch survey includes the 'performance enhancing drugs' category as this illicit drug was included in the assignment by the Ministry. 'Performance enhancing drugs' refer to anabolic steroids, EPO, growth hormones, etc.

⁽⁹⁾ The Scottish Crime Survey includes methamphetamines for the same reason as for ketamine.

reported an increase of the misuse of methadone, policymakers also wanted to measure the prevalence of methadone use.

In some countries (e.g. France, Ireland, Finland, Lithuania, Norway, Portugal) an open-ended question is added to establish whether the respondent has used a drug that is not on the list. Questions such as 'Have you taken any other illegal or illicit drug(s) not mentioned in this study?' and 'What is the name of the drug(s) that you took?' may help to detect new drugs or new wordings for common drugs. However, the Irish expert perceives the inclusion of an open-ended question as less useful, as he states that these data were never used anyway.

The EMQ and the ESPAD questionnaires include a *dummy drug* (Relevin) to control the reliability of the responses. Some surveys include a dummy drug, such as Relevin (e.g. Cyprus, Finland, Malta, Hungary, Austria, Portugal), Semeron (e.g. England and Wales, Scotland), Mop (e.g. France), Nubain (e.g. Ireland), or Cinnamon (e.g. Norway). Most countries use the name 'Relevin', as this bogus drug is included in the EMQ. The 2000 French survey preferred the name Mop because, according to the expert, 'Relevin' sounded too much like a pharmaceutical in French. In both crime surveys, 'Semeron' was preferred as the name had to be realistic but not too closely resembling any actual drug name. Although some experts (e.g. Cyprus, Austria, Finland, Hungary) are of the opinion that the inclusion of a dummy drug may be useful as an indicator of reliability (it may reveal errors and identify respondents who have not answered properly), most highlight the difficulty in analysing the low number of respondents who report the

use of the bogus drug. In this respect, concerns have been expressed that the name of the dummy drug may have become too familiar. It is also put forward that false claims of use are less likely in general population surveys than in school surveys. Some countries (France, Norway, Ireland) have therefore decided to remove the dummy drug altogether. Other countries (e.g. the Netherlands, Romania, Spain, Latvia) did not include a dummy drug at all. According to the Dutch expert, data on the use of a dummy drug do not provide unequivocal cues for interpreting other data.

In most surveys (e.g. Malta, Ireland, Finland, Portugal, England and Wales), each drug is accompanied by *synonyms* to describe the drugs better, because a respondent may only know an illicit drug by one of its street names. As street names may be quite different in the cultural setting of different countries, no names or descriptions of drugs are included in the EMQ, the WHO guidelines, or the ESPAD study. It is appropriate to determine a list of street or slang names for various drugs in each country separately (UNODC, 2002b).

Finally, the 2006/7 Irish population survey on drug use made a distinction between different *forms of cannabis*: grass, weed, skunk, hash oil, herb, hash, resin and other. Also, the British Crime Survey wants to collect more information on the types of cannabis, as there has been considerable concern that the increasing use of UK-grown and higher strength 'skunk' may be linked to increased health risks. Although it is not known how extensive its use has become, nor whether it is being used differently, further knowledge of the phenomenon is of policy importance.

Table 3: Prevalence of illicit drug use

Country	Year	Illicit drugs							
		Cannabis	Ecstasy	Cocaine	Heroin	Amphetamines	LSD	Other	Dummy
Austria	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belgium	2001	Yes	Yes	No	No	Yes	No	No	No
	2004	Yes	No	No	No	No	No	No	No
	2008	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	Yes	Yes	Yes	Yes	Yes	Yes	No	No
Cyprus	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Czech Republic	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Denmark	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No

Table 3 continued									
Country	Year	Illicit drugs							
		Cannabis	Ecstasy	Cocaine	Heroin	Amphetamines	LSD	Other	Dummy
	2008	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
England and Wales	1996	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	1998	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2001/2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2002/3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2003/4	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2004/5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2005/6	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2006/7	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	1992	Yes	No	Yes	No	Yes	Yes	Yes	Yes
	1996	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	1998	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	2002	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
France	1995	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Germany	1995	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n.a.
	1997	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n.a.
	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes	n.a.
	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes	Yes	Yes	Yes	No	n.a.
	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ireland	2002/3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2006/7	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Italy	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Latvia	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Lithuania	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Malta	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Netherlands	1997	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Norway	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Romania	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Scotland	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Table 3 continued		Illicit drugs							
Country	Year	Cannabis	Ecstasy	Cocaine	Heroin	Amphetamines	LSD	Other	Dummy
	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Slovakia	2002	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Spain	1995	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	1997	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Sweden	2004	Yes	No	No	No	No	No	No	No
	2005	Yes	No	No	No	No	No	No	No
	2006	Yes	No	No	No	No	No	No	No

NB:

Adapted from the EMCDDA Handbook, p. 132 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

2.2.2 Licit drugs

Virtually all questionnaires include questions about *alcohol, tobacco and pharmaceuticals* (licit drugs) (Table 4). Most experts (e.g. Croatia, Cyprus, Finland, France, Lithuania, the Netherlands, Slovakia) agree that the inclusion of questions about licit drug use in a survey on (illicit) drug use is necessary because of the interaction between licit and illicit drug use. Questions about licit drug use may also serve as ‘warming up questions’ for questions about illicit drug use. However, whether questions about licit drug use are included depends on the survey’s objectives. Most surveys aim to obtain comparable and reliable information on the extent and patterns of the consumption of (il)licit drugs in the general population. Therefore, most population surveys on drug use and health surveys include tobacco as well as pharmaceuticals and alcohol.

Both crime surveys (England and Wales, and Scotland) do not include questions about licit drugs. Although both measure the prevalence of the use of pharmaceuticals, questions about tobacco consumption are not included. Alcohol use is only inquired about in the British Crime Survey. These surveys do not (or to a lesser extent) include licit drug use because it is covered by several other continuous national surveys (e.g. General Household Survey), and because of lack of space. The same is true for the 2008 Danish drug survey.

Some countries make a distinction between *different forms of tobacco* consumption (pipe, cigarettes, cigars, etc.) and between *different kinds of alcoholic drinks* (beer, wine, cider, etc.). In the French and Danish Health surveys and the surveys in Norway, Portugal, Slovakia, Malta and the Netherlands, different forms of both tobacco and alcohol are considered. It is implied that many policy questions are related to various forms of alcohol or tobacco (e.g. ‘*Has the use of snuff increased after the ban of smoking in bars and restaurants?*’). The Czech and Irish surveys consider only different modalities of tobacco consumption, in the belief that differentiating between forms of tobacco consumption renders the questions more clear to cigar and pipe smokers. The Hungarian, Belgian, Lithuanian and Romanian surveys only ask after different forms of alcohol consumption. The EMCDDA guidelines make it clear that differentiating between alcohol drinks may influence the answers. Answering ‘no’ to a general question about drinking may turn into a ‘yes’ when the different modalities are presented (EMCDDA, 2002). Most experts comply with this guideline and underline that the inclusion of different modalities of alcohol consumption may be helpful both to determine the type of consumption and to stimulate the respondents’ memory.

While all countries include *pharmaceuticals* in the surveys, the interpretation of the term differs enormously, as most only include pharmaceuticals that are known to be misused or abused in their country.

Moreover, health surveys (e.g. France, Denmark, Sweden) usually include the most number of pharmaceuticals (e.g. also anti-depressants, neuroleptics, hypnotics, sleeping pills, anxiolytics), while crime or victimisation surveys include the least. The British Crime Survey includes non-prescribed use of tranquillisers, the Scottish Crime Survey measures the use of temazepam and valium. In line with the EMQ, pharmaceuticals mostly comprise of tranquillisers and sedatives (e.g. Hungary, Malta, the Netherlands, the Czech Republic). The Austrian and Italian surveys are exceptions. The Austrian survey only includes tranquillisers and the Italian survey only sedatives. Some countries also include other pharmaceuticals than tranquillisers and sedatives: anti-depressants (e.g. Romania, Lithuania, Ireland), hypnotics (e.g. Portugal), painkillers (e.g. Finland). The Spanish population

survey only includes sedatives and hypnotics, and the Cypriot survey includes hypnotics and tranquillisers. In the Latvian survey, different categories are implemented: barbiturates, benzodiazepines, antihistamines and other medicines.

While some surveys (e.g. Romania, Malta, the Netherlands, Belgium) make a distinction between *prescription* and *non-prescription pharmaceuticals*, others only focus on non-prescribed use of pharmaceuticals (e.g. the British and Scottish Crime Survey). However, the line between misuse and proper use of medication is difficult to draw, as some prescribed medications may be overused, and occasional use of sleeping pills might be innocuous (Koroleva et al., 2003). The EMQ therefore includes both prescribed and non-prescribed use.

Table 4: Prevalence of licit drug use

Country	Year	Licit drugs		
		Alcohol	Tobacco	Pharmaceuticals
Austria	2004	Yes	Yes	Yes
Belgium	2001	Yes	Yes	Yes
	2004	Yes	Yes	Yes
	2008	Yes	Yes	Yes
Bulgaria	2005	n.a.	n.a.	n.a.
Croatia	2009 (expected)	Yes	Yes	Yes
Cyprus	2006	Yes	Yes	Yes
Czech Republic	2004	Yes	Yes	Yes
Denmark	2000	Yes	Yes	Yes
	2005	Yes	Yes	Yes
	2008	No	No	No
England and Wales	1996	Yes	Yes	Yes
	1998	Yes	Yes	Yes
	2000	Yes	Yes	Yes
	2001/2	Yes	Yes	Yes
	2002/3	Yes	No	Yes
	2003/4	Yes	No	Yes
	2004/5	Yes	No	Yes
	2005/6	Yes	No	Yes
2006/7	Yes	No	Yes	
Estonia	2003	n.a.	n.a.	n.a.
Finland	1992	Yes	Yes	Yes
	1996	Yes	Yes	Yes
	1998	Yes	Yes	Yes
	2002	Yes	Yes	Yes
	2006	Yes	Yes	Yes
France	1995	Yes	Yes	Yes
	2000	Yes	Yes	Yes

Table 4 continued				
Country	Year	Licit drugs		
		Alcohol	Tobacco	Pharmaceuticals
	2005	Yes	Yes	Yes
Germany	1995	Yes	Yes	Yes
	1997	Yes	Yes	Yes
	2000	Yes	Yes	Yes
	2003	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes
	2004	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes
	2003	Yes	Yes	Yes
Ireland	2002/3	Yes	Yes	Yes
	2006/7	Yes	Yes	Yes
Italy	2001	Yes	Yes	Yes
	2003	Yes	Yes	Yes
	2005	Yes	Yes	Yes
Latvia	2003	Yes	Yes	Yes
Lithuania	2004	Yes	Yes	Yes
Malta	2001	Yes	Yes	Yes
Netherlands	1997	Yes	Yes	Yes
	2001	Yes	Yes	Yes
	2005	Yes	Yes	Yes
Norway	2004	Yes	Yes	Yes
Poland	2002	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	Yes
Romania	2004	Yes	Yes	Yes
Scotland	2000	No	No	Yes
	2003	No	No	Yes
	2004	No	No	Yes
	2006	No	No	Yes
Slovakia	2002	Yes	Yes	Yes
	2004	Yes	Yes	Yes
	2006	Yes	Yes	Yes
Spain	1995	Yes	Yes	Yes
	1997	Yes	Yes	Yes
	1999	Yes	Yes	Yes
	2001	Yes	Yes	Yes
	2003	Yes	Yes	Yes
	2005	Yes	Yes	Yes
Sweden	2004	Yes	Yes	Yes
	2005	Yes	Yes	Yes
	2006	Yes	Yes	Yes

NB:

Adapted from the EMCDDA Handbook, p. 132 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

2.3 Prevalence measurements

2.3.1 Illicit drugs

There is consensus about the prevalence measurement of illicit drugs (Table 5). In accordance with the EMQ, the WHO guidelines and the ESPAD study, most countries include three prevalence indicators (lifetime prevalence (LTP), last year prevalence (LYP), last month prevalence (LMP)) for each illicit drug included. Malta and Belgium are exceptions. Malta measures lifetime prevalence of all illicit drugs (cannabis, ecstasy, amphetamines, LSD, heroin and cocaine) and last year and last month prevalence rates of cannabis and the general category

‘other illicit drugs’. The most recent health survey (2008) in Belgium measures last year prevalence of all illicit drugs studied and restricts lifetime prevalence measurement to a limited number of illicit drugs (cocaine, amphetamines, ecstasy and cannabis).

Measuring the prevalence of drug use yields information about the *continuation* or the *discontinuation* of use. However, some countries (e.g. Scotland) believe that prevalence rates of illicit drug use must be interpreted with a great deal of caution because of the low number of users among the general population. Continuation rates are highly sensitive to small changes in prevalence figures.

Table 5: Prevalence measurements of illicit drugs

Country	Year	Illicit drugs		
		LTP	LYP	LMP
Austria	2004	All	All	All
Belgium	2001	All	No	All
	2004	Cannabis	Cannabis	Cannabis
	2008	Yes	All	Cannabis
Bulgaria	2005	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.
Cyprus	2006	All	All	All
Czech Republic	2004	All	All	All
Denmark	2000	All	All	All
	2005	All	All	All
	2008	All	All	All
England and Wales	1996	All	All	All
	1998	All	All	All
	2000	All	All	All
	2001/2	All	All	All
	2002/3	All	All	All
	2003/4	All	All	All
	2004/5	All	All	All
	2005/6	All	All	All
2006/7	All	All	All	
Estonia	2003	n.a.	n.a.	n.a.
Finland	1992	All	All	All
	1996	All	All	All
	1998	All	All	All
	2002	All	All	All
	2006	All	All	All
France	1995	All	All	No
	2000	All	All	All
	2005	All	All	All
Germany	1995	All	All	All
	1997	All	All	All

Table 5 continued				
Country	Year	Illicit drugs		
		LTP	LYP	LMP
	2000	All	All	All
	2003	n.a.	n.a.	n.a.
Greece	1998	All	All	All
	2004	n.a.	n.a.	n.a.
Hungary	2001	All	All	All
	2003	All	All	All
Ireland	2002/3	All	All	All
	2006/7	All	All	All
Italy	2001	All	All	All
	2003	All	All	All
	2005	All	All	All
Latvia	2003	All	All	All
Lithuania	2004	All	All	All
Malta	2001	All	Yes	Yes
Netherlands	1997	All	All	All
	2001	All	All	All
	2005	All	All	All
Norway	2004	All	All	All
Poland	2002	n.a.	n.a.	n.a.
Portugal	2001	All	All	All
Romania	2004	All	All	All
Scotland	2000	All	All	All
	2003	All	All	All
	2004	All	All	All
	2006	All	All	All
Slovakia	2002	All	All	All
	2004	All	All	All
	2006	All	All	All
Spain	1995	All	All	All
	1997	All	All	All
	1999	All	All	All
	2001	All	All	All
	2003	All	All	All
	2005	All	All	All
Sweden	2004	All	All	All
	2005	All	All	All
	2006	All	All	All

NB:

Adapted from the EMCDDA Handbook, p. 133 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

LTP: lifetime prevalence

LYP: last year prevalence

LMP: last month prevalence

n.a.: not known/not available.

2.3.2 Licit drugs

The inclusion of prevalence measurements of alcohol, tobacco and pharmaceuticals varies widely among countries (Table 6). Sometimes, only lifetime prevalence (LTP) is measured, sometimes last year (LYP) and/or last month (LMP). The determinant factor seems to be the survey's context. Most surveys on alcohol and drug use include three prevalence measurements for every licit drug (e.g. Malta, Romania, the Netherlands, Austria, Portugal). In the health and crime surveys, the inclusion of prevalence indicators tends to be limited.

As far as prevalence measurements of *alcohol* use are concerned, only Hungary, Lithuania, the Czech Republic and Latvia are compatible with the EMQ, which includes last year and last month prevalence. These experts do not regard lifetime prevalence of alcohol consumption as a meaningful indicator, because abstinence of alcohol use is quite rare. However, apart from Finland, France, Belgium, Denmark and England and Wales, many surveys include three prevalence measurements for alcohol consumption (e.g. Cyprus, Germany, Greece, Ireland, Malta, the Netherlands, Norway, Romania, Portugal, Spain, Slovakia). The latest Finnish survey only measures lifetime and last year prevalence of alcohol consumption. The French Health survey includes lifetime prevalence, last year prevalence and last week prevalence (prevalence of use during the past 7 days). The 2005 Danish Health survey and the Belgian Health interview surveys only measure last year prevalence rates of alcohol consumption. The British Crime Survey only measures last year and last month prevalence of alcohol consumption.

Cyprus, France, the Czech Republic, Denmark and Finland are compatible with the EMQ regarding *tobacco* use, in that they only inquire after lifetime prevalence. Except for both crime surveys and Greece, Belgium, Norway and Hungary, most other countries (Germany, Ireland, Latvia, Malta, the Netherlands, Romania, Spain, Portugal, Lithuania, Slovakia) include the full set of prevalence measurements for tobacco consumption. Greece, Belgium and Hungary measure lifetime prevalence and last month prevalence to differentiate between occasional (ever) users and regular users. The Norwegian survey only measures last year prevalence rates of tobacco consumption. Neither of the crime surveys (England and Wales, Scotland) implements questions about the prevalence rates of tobacco consumption.

As for *pharmaceuticals* (both prescription and non-prescription), most surveys contain three prevalence measurements, in addition to the EMCDDA guidelines that recommend only last year and last month prevalence. A distinction can be made between countries that implement prevalence measurements of each pharmaceutical separately and those that measure one or more categories. While most countries prefer to measure prevalence rates of each pharmaceutical separately, Malta opts to question lifetime, last year and last month prevalence of a general category of 'medical drugs'. The Romanian survey makes a distinction between (lifetime, last year and last month) prevalence of prescription pharmaceuticals and (lifetime, last year and last month) prevalence of non-prescription pharmaceuticals.

Table 6: Prevalence measurements of licit drugs

Country	Year	Alcohol			Tobacco			Pharmaceuticals		
		LTP	LYP	LMP	LTP	LYP	LMP	LTP	LYP	LMP
Austria	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belgium	2001	No	Yes	No	Yes	No	Yes	No	No	Yes ^(?)
	2004	No	Yes	No	Yes	No	Yes	No	No	Yes ^(?)
	2008	No	Yes	No	Yes	No	Yes	No	No	Yes ^(?)
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Cyprus	2006	Yes	Yes	Yes	Yes	No	No	No	Yes	Yes
Czech Republic	2004	No	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Denmark	2000	No	No	No	Yes	No	No	No	No	No
	2005	No	Yes	No	Yes	No	No	No	No	No
	2008	No	No	No	No	No	No	No	No	No

Table 6 continued										
Country	Year	Alcohol			Tobacco			Pharmaceuticals		
		LTP	LYP	LMP	LTP	LYP	LMP	LTP	LYP	LMP
England and Wales	1996	No (°)	No	No	No	No	No (°)	Yes	Yes	Yes
	1998	No	No	No	No	No	No	Yes	Yes	Yes
	2000	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes
	2001/2	No	Yes	Yes	No	No	Yes	Yes	Yes	Yes
	2002/3	No	Yes	Yes	No	No	No	Yes	Yes	Yes
	2003/4	No	Yes	Yes	No	No	No	Yes	Yes	Yes
	2004/5	No	Yes	Yes	No	No	No	Yes	Yes	Yes
	2005/6	No	Yes	Yes	No	No	No	Yes	Yes	Yes
	2006/7	No	Yes	Yes	No	No	No	Yes	Yes	Yes
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	1992	Yes	No	Yes	Yes	No	No	Yes	No	No
	1996	Yes	No	Yes	Yes	No	No	Yes	No	No
	1998	Yes	No	No	Yes	No	No	Yes	Yes	Yes
	2002	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes
	2006	Yes	Yes	No	Yes	No	No	Yes	Yes	Yes
France	1995	Yes	Yes	No	Yes	No	No	Yes	Yes	No
	2000	Yes	Yes	No	Yes	No	No	No	Yes	No
	2005	Yes	No	No	Yes	No	No	Yes	Yes	No
Germany	1995	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
	1997	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
	2000	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
	2003	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Ireland	2002/3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2006/7	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Italy	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Latvia	2003	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Lithuania	2004	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Malta	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Netherlands	1997	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Norway	2004	Yes	Yes	Yes	No	Yes	No	No	Yes	No
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Romania	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Scotland	2000	No	No	No	No	No	No	Yes	Yes	Yes
	2003	No	No	No	No	No	No	Yes	Yes	Yes
	2004	No	No	No	No	No	No	Yes	Yes	Yes
	2006	No	No	No	No	No	No	Yes	Yes	Yes

Table 6 continued

Country	Year	Alcohol			Tobacco			Pharmaceuticals		
		LTP	LYP	LMP	LTP	LYP	LMP	LTP	LYP	LMP
Slovakia	2002	No	No	No	No	No	No	No	No	No
	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2006	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Spain	1995	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	1997	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2001	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2003	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
	2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Sweden	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	2006	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 133 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

(⁰) Only 'how often usually taken alcohol drinks?' is included.

(¹) Only current smoking (smoking at present) is assessed; this figure will be close to LMP, but lower than LMP (LMP also includes occasional smokers).

(²) The prevalence of use in the last two weeks and in the past 24 hours is measured.

(³) The prevalence of use in the last two weeks is measured.

LTP: lifetime prevalence

LYP: last year prevalence

LMP: last month prevalence

n.a.: not known/not available.

2.4 Frequency of drug use

2.4.1 Illicit drug use

There is no consensus about the measurement of the frequency of illicit drug use (Table 7). Cyprus, the Czech Republic, Lithuania, Scotland, Norway, Denmark, Belgium, France, Finland (since its 2002 survey), and Ireland comply with both EMQ and WHO guidelines by measuring only last month frequency. These experts agree that last month is the most useful recall period. Some of these countries (e.g. Denmark, Belgium, France) measure last month frequency of cannabis use only, since they assume that the prevalence rates of other illicit drugs are too low to be estimated adequately. The French Health survey measures last year frequency of cannabis use as well.

Whereas countries such as Hungary, Romania, the Netherlands (2005) and Italy measure lifetime, last year and last month frequency, Malta includes no questions about frequency. The Portuguese and Spanish surveys only measure last year and last month frequencies. Because of space limitations the British crime survey is confined to measuring last year frequency. Moreover, the British expert assumes that the last year time period

is the most relevant, as for last month frequency the sample size may be very small and the data not very robust. Finally, Slovakia intends to introduce frequency measurements of illicit drugs in the next survey, to improve the accordance with the EMQ.

In general, the reported frequencies differ not only in terms of duration of drug use (lifetime, last year, last month), but also in terms of measurement (e.g. the number of times/days a drug is used). Finland and Hungary measure frequency of use by the number of times a drug is used. The German survey measures frequency of use by the number of times during lifetime and last year, and the number of days over the last month. The Irish population survey on drug use also measures last month frequency by the number of days on which the drug is used. The Portuguese survey includes two measurements. It measures last month frequency by both the number of days and the number of times, and last year frequency of illicit drug use by the number of times. In order to get an impression of lifetime frequency, a unique criterion is included in the Dutch surveys: those who have used a specific drug 25 times or more in their lifetime are considered 'experienced' users.

Table 7: Frequency of illicit drug use				
Country	Year	Illicit drugs		
		LTF	LYF	LMF
Austria	2004	No	Yes	Yes
Belgium	2001	No	No	No
	2004	No	No	Cannabis
	2008	No	No	Cannabis
Bulgaria	2005	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.
Cyprus	2006	No	No	Yes
Czech Republic	2004	No	No	Yes
Denmark	2000	No	No	No
	2005	No	No	Yes
	2008	No	No	Cannabis
England and Wales	1996	No	No	No
	1998	No	No	No
	2000	No	No	No
	2001/2	No	No	No
	2002/3	No	Yes	No
	2003/4	No	Yes	No
	2004/5	No	Yes	No
	2005/6	No	Yes	No
2006/7	No	Yes	No	
Estonia	2003	n.a.	n.a.	n.a.
Finland	1992	Yes	Yes	Yes
	1996	Yes	Yes	Yes
	1998	Yes	Yes	Yes
	2002	No	No	Yes
	2006	No	No	Yes
France	1995	No	No	No
	2000	Yes	Yes	Yes
	2005	No	Cannabis	Cannabis
Germany	1995	Yes	Yes	Yes
	1997	Yes	Yes	Yes
	2000	Yes	Yes	Yes
	2003	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes
	2004	n.a.	n.a.	n.a.
Hungary	2001	Yes (°)	Yes (°)	Yes (°)
	2003	Yes (°)	Yes (°)	Yes (°)
Ireland	2002/3	No	No	Yes
	2006/7	No	No	Yes
Italy	2001	Yes	Yes	Yes
	2003	Yes	Yes	Yes
	2005	Yes	Yes	Yes
Latvia	2003	No	No	No
Lithuania	2004	No	No	Yes

Table 7 continued				
Country	Year	Illicit drugs		
		LTF	LYF	LMF
Malta	2001	No	No	No
Netherlands	1997	Yes ⁽¹⁾	No	Yes
	2001	Yes ⁽¹⁾	No	Yes
	2005	Yes ⁽¹⁾	Cannabis ⁽²⁾	Yes
Norway	2004	No	No	Yes
Poland	2002	n.a.	n.a.	n.a.
Portugal	2001	No	Yes	Yes
Romania	2004	Yes	Yes	Yes
Scotland	2000	No	No	No
	2003	No	No	No
	2004	No	No	Yes ⁽³⁾
	2006	No	No	Yes ⁽³⁾
Slovakia	2002	No	No	No
	2004	No	No	No
	2006	No	No	No
Spain	1995	No	Yes	Yes
	1997	No	Yes	Yes
	1999	No	Yes	Yes
	2001	No	Yes	Yes
	2003	No	Yes	Yes
	2005	No	Yes	Yes
Sweden	2004	No	No	No
	2005	No	No	No
	2006	No	No	No

NB:

Adapted from the EMCDDA Handbook, p. 134 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

LTF: lifetime frequency

LYF: last year frequency

LMF: last month frequency

⁽⁰⁾ All of them illicit drugs but also injected drugs and medication + alcohol.

⁽¹⁾ For performance enhancing drugs, the number of cures or the number of incidental use (more or less than 25 times) is gauged.

⁽²⁾ The frequency of cannabis use in the heaviest using period.

⁽³⁾ To all last month users, the number of times of the drug most often taken is asked.

n.a.: not known/not available.

2.4.2 Licit drug use

Frequency rates of licit drug use are mostly measured by last year and last month frequency indicators (Table 8). Measurements of lifetime frequency of alcohol, tobacco or pharmaceuticals are rather rare. Indeed, only the Netherlands, Austria and Greece have measured lifetime frequency of alcohol, tobacco and pharmaceuticals. Just as for the frequency measures of illicit drug use, the Dutch survey uses a unique criterion (either fewer or more than 25 times during lifetime) to measure lifetime frequency of licit drug use.

Only Cyprus, the Czech Republic, Ireland, Lithuania and Latvia comply with the EMQ and the WHO guidelines that explicitly include last month frequency of alcohol use. Both last year and last month frequency of alcohol consumption are often included (e.g. Germany, Greece, Malta, Spain, Portugal). The Austrian and the Italian survey include three frequency measurements of alcohol consumption, for the very reason that alcohol policy is high on the agenda. The frequency of alcohol consumption is mostly measured by the number of days during last year, the number of times during last month, or the average frequency during last month. Some

countries (e.g. Hungary, Belgium, France) make a distinction between the frequency of drinking during the week and during the weekend.

Measuring the frequency of tobacco consumption is less common. While France and the Netherlands measure lifetime frequency only, Germany, Ireland and Spain ask about last month frequency only. Greece and Latvia include both lifetime and last month frequency. The Austrian and the Italian surveys include three frequency measurements for tobacco consumption. The national population survey of Portugal measures last year and last month frequency of tobacco consumption. The Czech and Lithuanian surveys measure the number of cigarettes per day to obtain comparative data with previous (health) surveys.

In addition, the Belgian Health survey measures the frequency of tobacco consumption by questioning the prevalence of daily use.

Regarding the consumption of pharmaceuticals, most surveys (e.g. Cyprus, England and Wales, Ireland, Lithuania, Romania, Scotland) follow the EMQ and the WHO guidelines and measure last month frequency by the number of days/times. Some countries also include other frequency indicators. Malta and Germany measure last month as well as last year frequency. The Netherlands also measures lifetime frequency (either more or fewer than 25 times) to detect experienced users of pharmaceuticals. Three frequency measurements are included in the Austrian, the Portuguese and the Czech surveys.

Country	Year	Alcohol				Tobacco				Pharmaceuticals			
		LTF	LYF	LMF	Other	LTF	LYF	LMF	Other	LTF	LYF	LMF	Other
Austria	2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belgium	2001	No	No	No	Yes	No	No	No	No	No	No	No	No
	2004	No	No	No	Yes	No	No	No	No	No	No	No	No
	2008	No	Yes	No	Yes	No	No	No	Yes	No	No	No	No
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Cyprus	2006	No	No	Yes	Yes ⁽²⁾	No	No	No	No	No	No	Yes	No
Czech Republic	2004	No	No	Yes	Yes	No	No	No	Yes	Yes	Yes	Yes	No
Denmark	2000	No	No	No	No	No	No	No	No	No	No	No	No
	2005	No	No	No	No	No	No	No	No	No	No	No	No
	2008	No	No	No	Yes	No	No	No	No	No	No	No	No
England and Wales	1996	No	No	No	Yes ⁽³⁾	No	No	No	No	No	No	No	No
	1998	No	No	No	No	No	No	No	No	No	No	No	No
	2000	No	Yes	No	No	No	No	No	No	No	No	No	No
	2001/2	No	Yes	No	No	No	No	No	No	No	No	No	No
	2002/3	No	Yes	No	No	No	No	No	No	No	No	Yes ⁽⁰⁾	No
	2003/4	No	Yes	No	No	No	No	No	No	No	No	Yes ⁽⁰⁾	No
	2004/5	No	Yes	No	No	No	No	No	No	No	No	Yes ⁽⁰⁾	No
	2005/6	No	Yes	No	No	No	No	No	No	No	No	Yes ⁽⁰⁾	No
2006/7	No	Yes	No	No	No	No	No	No	No	No	Yes ⁽⁰⁾	No	
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	1992	No	No	No	No	No	No	No	No ⁽¹⁾	Yes	No	No	No
	1996	No	No	No	No	No	No	No	No ⁽¹⁾	No	No	No	No
	1998	No	No	No	No	No	No	No	No ⁽¹⁾	Yes	No	No	No
	2002	No	No	No	Yes	No	No	No	No	No	No	No	No
	2006	No	No	No	Yes	No	No	No	No	No	No	No	No

Table 8 continued													
Country	Year	Alcohol				Tobacco				Pharmaceuticals			
		LTF	LYF	LMF	Other	LTF	LYF	LMF	Other	LTF	LYF	LMF	Other
France	1995	No	No	No	Yes	No	No	No	No	No	No	No	Yes
	2000	No	Yes	No	Yes	Yes	Yes	Yes	Yes	No	No	Yes	No
	2005	No	Yes	No	Yes (7)	Yes (6)	No	No	Yes (5)	No	No	No	No
Germany	1995	No	Yes	Yes	Yes (4)	No	No	Yes	No (3)	No	Yes (4)	Yes (4)	No
	1997	No	Yes	Yes	Yes (4)	No	No	Yes	No (10)	No	Yes (4)	Yes (4)	No
	2000	No	Yes	Yes	Yes (4)	No	No	Yes	No (10)	No	Yes (4)	Yes (4)	No
	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes	Yes	Yes	No	Yes	No	Yes	Yes	No	No
	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes	No	No	No	No	Yes (8)	Yes	Yes	Yes	No
	2003	Yes	Yes	Yes	No	No	No	No	Yes (8)	Yes	Yes	Yes	No
Ireland	2002/3	No	No	Yes	No	No	No	Yes	No	No	No	Yes	No
	2006/7	No	No	Yes	No	No	No	Yes	No	No	No	Yes	No
Italy	2001	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No	No
	2003	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No	No
	2005	Yes	Yes	Yes	No	Yes	Yes	Yes	No	No	No	No	No
Latvia	2003	No	No	Yes	No	Yes (9)	No	Yes	No	No	No	No	No
Lithuania	2004	No	No	Yes	No	No	No	No	Yes	No	No	Yes	No
Malta	2001	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes	No
Netherlands	1997	Yes	No	Yes	No	Yes	No	No	No	Yes	No	No	No
	2001	Yes	No	Yes	No	Yes	No	No	No	Yes	No	Yes	No
	2005	Yes	No	Yes	No	Yes	No	No	No	Yes	No	Yes	No
Norway	2004	No	No	No	Yes	No	No	No	Yes	No	No	No	Yes
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	No	Yes	Yes	No	No	Yes	Yes	No	Yes	Yes	Yes	No
Romania	2004	No	No	No	No	No	No	No	Yes (11)	No	No	Yes	No
Scotland	2000	No	No	No	No	No	No	No	No	No	No	Yes (12)	No
	2003	No	No	No	No	No	No	No	No	No	No	Yes (12)	No
	2004	No	No	No	No	No	No	No	No	No	No	Yes (12)	No
	2006	No	No	No	No	No	No	No	No	No	No	Yes (12)	No
Slovakia	2002	No	No	No	Yes	No	No	No	Yes	No	No	No	No
	2004	No	No	No	Yes	No	No	No	Yes	No	No	No	No
	2006	No	No	No	Yes	No	No	No	Yes	No	No	No	No
Spain	1995	No	No	No	No	No	No	Yes	No	No	No	No	No
	1997	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No
	1999	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No
	2001	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No
	2003	No	Yes	Yes	No	No	No	Yes	No	No	No	No	No
	2005	No	Yes	Yes	No	No	No	Yes	No	No	Yes	Yes	No

Table 8 continued													
Country	Year	Alcohol				Tobacco				Pharmaceuticals			
		LTF	LYF	LMF	Other	LTF	LYF	LMF	Other	LTF	LYF	LMF	Other
Sweden	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	2006	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 135 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

LTF: lifetime frequency

LYF: last year frequency

LMF: last month frequency

(⁰) Taking a drug more than once a month (each drug).

(¹) Regular smoker/occasional smoker/non-smoker (not operationalised).

(²) Number of times drunk during LY and LM + during last 6 months: number of times driving after 3–6 drinks or over 6 drinks.

(³) Average frequency, sometimes referring to a certain period.

(⁴) Average frequency, sometimes referring to a certain period.

(⁵) It is asked whether the respondent (current smoker or ex-smoker) ever smoked daily.

(⁶) Daily, once, occasionally.

(⁷) A distinction is made between drinking at weekends and during the week.

(⁸) Regular or occasional use (now and earlier).

(⁹) Tried/regular use/occasional use.

(¹⁰) Regular smoker/occasional smoker/non-smoker (not operationalised).

(¹¹) Number of cigarettes daily.

(¹²) For all last month users, the number of times of the drug (if temazepam or valium is reported) most often taken is recorded.

n.a.: not known/not available.

2.5 Quantity of drug use

2.5.1 Illicit drug use

Questions about the quantity of illicit drug use are rarely included in the surveys (Table 9). Some experts (e.g. Finland, Spain, England and Wales, Italy, Ireland, Lithuania) argue that quantity measurements are not relevant when the prevalence rates of illicit drug use are too low. They further underline the difficulty of measuring the quantity of illicit drug use (e.g. measurements are difficult to determine, extensive training of interviewers is required). Only two countries, the Netherlands and France, have implemented questions about the quantity of illicit drug use. In accordance with the EMQ, WHO and ESPAD, no other country has implemented questions about the

quantity of illicit drug use. The 2000 French Health survey asked about the quantity of use of all illicit drugs, but in the 2005 survey this was restricted to the quantity of cannabis use, as prevalence rates of other illicit drugs proved too low. Moreover, the French national survey among 17-year-olds (ESCAPAD) (Beck et al., 2006) found that almost half of the users had smoked cannabis with friends on the last occasion (with a decreasing proportion among high frequency users). Given the common practice of sharing joints, the French expert declares that the question should be modified and more detailed to improve the reliability. The 2005 Dutch survey included questions on the quantity of cannabis use in order to gain deeper insight into cannabis use itself. Both surveys inquire about the number of joints consumed on an average day (the Netherlands), or on the last occasion (France).

Table 9: Quantity of illicit drug use									
Country	Year	Illicit drugs							
		Cannabis	Ecstasy	Cocaine	Heroin	Amphetamines	LSD	Other illicit	
Austria	2004	No	No	No	No	No	No	No	No
Belgium	2001	No	No	No	No	No	No	No	No
	2004	No	No	No	No	No	No	No	No
	2008	No	No	No	No	No	No	No	No

Table 9 continued								
Country	Year	Illicit drugs						
		Cannabis	Ecstasy	Cocaine	Heroin	Amphetamines	LSD	Other illicit
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Cyprus	2006	No	No	No	No	No	No	No
Czech Republic	2004	No	No	No	No	No	No	No
Denmark	2000	No	No	No	No	No	No	No
	2005	No	No	No	No	No	No	No
	2008	No	No	No	No	No	No	No
England and Wales	1996	No	No	No	No	No	No	No
	1998	No	No	No	No	No	No	No
	2000	No	No	No	No	No	No	No
	2001/2	No	No	No	No	No	No	No
	2002/3	No	No	No	No	No	No	No
	2003/4	No	No	No	No	No	No	No
	2004/5	No	No	No	No	No	No	No
	2005/6	No	No	No	No	No	No	No
	2006/7	No	No	No	No	No	No	No
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	1992	No	No	No	No	No	No	No
	1996	No	No	No	No	No	No	No
	1998	No	No	No	No	No	No	No
	2002	No	No	No	No	No	No	No
	2006	No	No	No	No	No	No	No
France	1995	No	No	No	No	No	No	No
	2000	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	2005	Cannabis	No	No	No	No	No	No
Germany	1995	No	No	No	No	No	No	No
	1997	No	No	No	No	No	No	No
	2000	No	No	No	No	No	No	No
	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	No	No	No	No	No	No	No
	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	No	No	No	No	No	No	No
	2003	No	No	No	No	No	No	No
Ireland	2002/3	No	No	No	No	No	No	No
	2006/7	No	No	No	No	No	No	No
Italy	2001	No	No	No	No	No	No	No
	2003	No	No	No	No	No	No	No
	2005	No	No	No	No	No	No	No
Latvia	2003	No	No	No	No	No	No	No
Lithuania	2004	No	No	No	No	No	No	No
Malta	2001	No	No	No	No	No	No	No

Table 9 continued		Illicit drugs						
Country	Year	Illicit drugs						
		Cannabis	Ecstasy	Cocaine	Heroin	Amphetamines	LSD	Other illicit
Netherlands	1997	No	No	No	No	No	No	No
	2001	No	No	No	No	No	No	No
	2005	Cannabis	No	No	No	No	No	No
Norway	2004	No	No	No	No	No	No	No
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	No	No	No	No	No	No	No
Romania	2004	No	No	No	No	No	No	No
Scotland	2000	No	No	No	No	No	No	No
	2003	No	No	No	No	No	No	No
	2004	No	No	No	No	No	No	No
	2006	No	No	No	No	No	No	No
Slovakia	2002	No	No	No	No	No	No	No
	2004	No	No	No	No	No	No	No
	2006	No	No	No	No	No	No	No
Spain	1995	No	No	No	No	No	No	No
	1997	No	No	No	No	No	No	No
	1999	No	No	No	No	No	No	No
	2001	No	No	No	No	No	No	No
	2003	No	No	No	No	No	No	No
	2005	No	No	No	No	No	No	No
Sweden	2004	No	No	No	No	No	No	No
	2005	No	No	No	No	No	No	No
	2006	No	No	No	No	No	No	No

NB:

Adapted from the EMCDDA Handbook, p. 136 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

2.5.2 Licit drug use

To investigate licit drug use, most countries included some questions about the quantity of alcohol or tobacco consumption (Table 10).

Almost all countries added one or more question about 'binge drinking' during a reference period: last 6 months (e.g. the Netherlands), last year (e.g. Belgium, Malta, Hungary), last month (e.g. Latvia, Ireland, Romania, France, England and Wales). In most European countries, 'binge drinking' is defined as consuming 6 or more drinks on a single occasion. As an exception, the Czech survey measures 'binge drinking' as consuming 5 or more glasses of alcohol on one occasion in the last 30 days. This definition is comparable with the ESPAD study and the WHO guidelines, which also describe 'binge drinking' as consuming 5 or more drinks on one occasion. Furthermore, many European surveys (e.g. France, Belgium, Hungary, Latvia, the Netherlands,

Germany, England and Wales) include questions about the number of glasses/units of alcohol consumed on an average (regularly or special) day or on the last occasion. Some countries (e.g. France, Finland, Portugal) measure the prevalence of drunkenness.

The quantity of tobacco consumption is measured by the average number of cigarettes per day (e.g. France, Hungary, the Netherlands, Belgium, Germany, Ireland). The Portuguese survey measures the quantity of tobacco consumption during last month and last year by the number of cigarettes and the number of packets per day. In addition, the most recent French Health survey measures the quantity of tobacco consumption by inquiring about the number of pipes, cigars and cigarettes smoked per day, per week, per month and per year.

No recent population survey measures the quantity of consumption of any pharmaceutical.

Table 10: Quantity of licit drug use				
Country	Year	Licit drugs		
		Alcohol	Tobacco	Pharmaceuticals
Austria	2004	Yes	Yes	No
Belgium	2001	Yes	Yes	No
	2004	Yes	Yes	No
	2008	Yes	Yes	No
Bulgaria	2005	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.
Cyprus	2006	Yes ⁽⁰⁾	No	No
Czech Republic	2004	Yes	No	No
Denmark	2000	Yes	Yes	No
	2005	Yes	Yes	No
	2008	Yes	No	No
England and Wales	1996	No	No	No
	1998	No	No	No
	2000	Yes	No	No
	2001/2	Yes	No	No
	2002/3	Yes	No	No
	2003/4	Yes	No	No
	2004/5	Yes	No	No
	2005/6	Yes	No	No
2006/7	Yes	No	No	
Estonia	2003	n.a.	n.a.	n.a.
Finland	1992	No	No	No
	1996	No	No	No
	1998	No	No	No
	2002	No	No	No
	2006	No	No	No
France	1995	Yes ⁽¹⁾	Yes	No
	2000	Yes ⁽¹⁾	Yes	No
	2005	Yes	Yes	No
Germany	1995	Yes	Yes	No
	1997	Yes	Yes	No
	2000	Yes	Yes	No
	2003	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	No
	2004	n.a.	n.a.	n.a.
Hungary	2001	Yes ⁽²⁾	Yes	No
	2003	Yes ⁽²⁾	Yes	No
Ireland	2002/3	Yes	No	No
	2006/7	Yes	Yes	No
Italy	2001	No	No	No
	2003	No	No	No
	2005	No	No	No
Latvia	2003	Yes	No	No
Lithuania	2004	Yes	Yes	No

Table 10 continued				
Country	Year	Licit drugs		
		Alcohol	Tobacco	Pharmaceuticals
Malta	2001	Yes	No	No
Netherlands	1997	Yes	No	No
	2001	Yes	Yes	No
	2005	Yes	Yes	No
Norway	2004	Yes	No	No
Poland	2002	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	No
Romania	2004	Yes	No	No
Scotland	2000	No	No	No
	2003	No	No	No
	2004	No	No	No
	2006	No	No	No
Slovakia	2002	No	No	No
	2004	No	No	No
	2006	No	No	No
Spain	1995	Yes	Yes	No
	1997	Yes	Yes	No
	1999	Yes	Yes	No
	2001	Yes	Yes	No
	2003	Yes	Yes	No
	2005	Yes	Yes	No
Sweden	2004	n.a.	n.a.	n.a.
	2005	n.a.	n.a.	n.a.
	2006	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 136 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

(⁰) General frequency of binge drinking (6 or more glasses on the same occasion) + do you think you drink excessively?

(¹) Number of glasses yesterday.

(²) An open-ended question about how much the respondent drank last time is added.

n.a.: not known/not available.

2.6 Other items related to illicit drug use

In most European surveys on drug use, other items related to illicit drug use are restricted to inquiries about the age of onset and the availability of drugs (e.g. Cyprus, Ireland, Latvia, Romania) (Table 11). However, the ESPAD study and the WHO guidelines also include questions on multiple drug use and the mode of administration.

2.6.1 Age of onset

Almost all countries include questions about the age of onset of all (e.g. Cyprus, France, Denmark (¹⁰), Germany, Greece, Hungary, Ireland, Italy, Latvia,

Lithuania, the Netherlands, Norway, Portugal, Romania, Scotland, Spain, Finland, Slovakia) or some (e.g. Malta, Belgium) illicit drugs in order to assess incidence of use and to study the time patterns of getting in contact with drugs. This may be useful for identifying target groups. Only England and Wales and the Czech Republic do not (or only occasionally) include this item. Although the British experts would like to gather more regular information on the age of first use, space limitations restrict the British Crime Survey to asking only occasionally about the age of first use. The Czech expert mentions that age of onset was asked in a few cases only, as relatively low prevalence rates of drug use were expected.

(¹⁰) Age of onset is only included in 2005 owing to financial reasons.

Some countries (e.g. Hungary and Scotland) also ask which illicit drug was used first, in order to either prove or refute the 'gateway theory' (Lessem et al., 2006). This theory assumes that the use of cannabis facilitates the later use of other illicit drugs such as cocaine or heroin.

The Netherlands, Finland, Portugal and Norway add a question on the age of last illicit or licit drug use. This item is considered useful as an indicator of the duration of drug use (length of a drug career). Uncommon in the surveys are questions about the place (e.g. at home, with friends) and the country of first use. Only the Portuguese survey asks after the place of first use (at a party, at the workplace, during a festival, at school, etc.) and how the drug of first use was obtained (e.g. friends, partner, relatives, neighbours).

Some surveys include the age of onset of licit drug use, such as tobacco (e.g. Romania, France), pharmaceuticals (e.g. Latvia), or alcohol (e.g. France). Malta and Portugal focus on the age of onset of all licit drug use (tobacco, pharmaceuticals and alcohol). The French Health survey measures the age of onset of alcohol and tobacco use. In the case of alcohol, only the age of first drunkenness is recorded. For tobacco, the age of first use and the age of first regular use (at least 10 times in 1 month) is measured. Other countries (e.g. Spain) do not include these questions because their experts are of the opinion that the 'age of onset' item is not reliable in the case of licit drugs.

2.6.2 Availability of drugs

The availability of drugs is also a topic of interest in most European surveys. Many experts argue that the inclusion of the 'availability' item is very useful for investigating the general perception of the drug phenomenon in society. Other experts believe that the inclusion of this item may provide information on the drug situation and the drug market in countries where prevalence rates tend to be low. However, differences in questions and response modalities have made comparisons difficult at the EU level. To remedy this, the EMCDDA has launched a project that develops a new (optional) module on drug availability to be included in the European Model Questionnaire. Some national experts (e.g. Belgium, the Czech Republic, Latvia) are now working actively on the development of drug availability questions by conducting a cognitive field test (EMCDDA, 2008a). The Cypriot and the Austrian survey do not yet include questions about availability of use, but intend to include the item in the next survey so as to be in line with the (new module of the) EMQ.

Some countries (e.g. Scotland, Finland, Slovakia) measure availability of illicit drugs on the basis of whether respondents have been offered any particular (illicit) drug. The Irish population survey on drug use measures the number of times a respondent has been offered a particular drug (e.g. cannabis, ecstasy, amphetamines, crack, cocaine, heroin, LSD, solvents, poppers and magic mushrooms) during the last 12 months.

Other countries (e.g. Cyprus, Malta, Portugal, Ireland, Spain) include questions about the (perceived) availability of illicit drugs. The *perceived availability* item refers to the ease or the difficulty to obtain a particular drug within 24 hours. In this respect, one expert (Spain) calls into question the reliability of this interpretation, because perceived availability may be influenced by the mass media. The Irish survey measures perceived availability for a limited number of drugs: cannabis, cocaine, and ecstasy. Malta measures how difficult or easy it is to obtain all illicit drugs, except for LSD. The Norwegian survey measures the perceived availability of illicit drugs differently, because the wording of the question had been used in surveys of adolescents and in general population surveys before the EMQ appeared. It has made small changes in the wording without destroying the comparability. As a result, the Norwegian survey asks how difficult or easy it is to obtain any of the drugs within 2–3 days.

The Czech, Lithuanian and Italian surveys include both interpretations of the 'availability' item because these experts believe that the two interpretations measure different things: *availability* and *perceived availability*. For example, the French Health survey measures the availability of cannabis in a different and more extended way ('*been offered?*', '*how difficult to obtain within 24 hours?*', '*how obtained last time respondent used?*').

Questions about the availability of illicit drugs are sometimes more extended. In some surveys (e.g. Ireland, Latvia, Portugal), the knowledge of places where or of the persons from whom the drug is obtained is investigated. The Irish survey on drug use asks the respondents in which of the listed places (street, school, office, internet, club, etc.) and from which person (family/friend, stranger, etc.) they have obtained cannabis, ecstasy or cocaine. Moreover, users of pharmaceuticals, anabolic steroids, magic mushrooms, methadone or other opiates are questioned on how the drug(s) were obtained on the last occasion of use (bought them in a shop, bought

them on the Internet, got them from someone you know, etc.). The Portuguese survey includes questions about the places of use (at school, in a café, in local clubs, in the street, in a shopping centre, etc.), situations of use (alone, while studying, while working, during the holidays, etc.) and occasions of use (family parties, techno/rave parties, New Year's Eve party, school parties, etc.). The respondent is further asked how he/she obtained the drug the last time he/she used it.

Hungary and Ireland measure the availability of pharmaceuticals. The respondents are asked how they obtained them: from a doctor (with a prescription), from a friend, from a pharmacy (without a prescription). The Romanian survey gauges the availability of tobacco to minors. In order to evaluate the drug policy, respondents under 18 were asked if they were able to buy tobacco products.

2.6.3 Multiple drug use

Asking questions about multiple drug use is uncommon. Only three countries introduce a specific question about multiple drug use. The Maltese and the Hungarian surveys define multiple drug use as the combination of one or more illicit and one or more licit drugs or as the combination of different licit drugs, such as alcohol–medication or alcohol–tobacco, over a whole drug career. The Hungarian survey includes three prevalence indicators of the medication–alcohol combination, because high prevalence rates of this combination are expected. The Maltese survey interprets multiple drug use as the use of more than one drug in the past month. The focus lies on the alcohol–tobacco, and alcohol–medication combinations. The Scottish Crime Survey describes multiple drug use as the simultaneous use of several drugs and the combination of alcohol and drugs among last month users.

2.6.4 Perceived health effects of use

Perceived health effects of use refer to whether the consumption of illicit drugs has influenced the respondent's health (physical, psychological and social effects). However, the inclusion of questions about perceived health effects of use is uncommon, as this item is considered not relevant in population surveys with low numbers of frequent drug users.

However, the Portuguese survey includes several questions about (health) effects of use. Its questions concern the reason for using an illicit drug, the reasons for not using it and dependence. Dependence is measured by questions such as: *'Can you imagine your*

life without the drug?', *'Have you ever felt a strong desire for the product?'*, *'Have you ever felt that the same quantity of this drug produced a weaker effect than before?'*, *'Have you ever had serious problems with your work results, with your behaviour at home and with your health?'*. The Scottish Crime Survey inquires about the difficulty or ease to stop using an illicit drug. Finally, the Irish survey on drug use asks if the respondent has ever taken cannabis, alcohol, cocaine and ecstasy regularly, if and why he/she ever tried to stop taking these drugs (e.g. health reasons, pregnancy, rehabilitation programme).

Many countries (e.g. the Netherlands, France, the Czech Republic) focus on perceived health effects of cannabis use in relation to the high levels of cannabis use recorded across Europe. The 2005 Dutch survey inquires about (possible) emotional, psychological or physical complaints resulting from using cannabis. The survey is also interested in the effects that stopping or decreasing cannabis use may cause. The French Health survey includes questions about unpleasant effects of cannabis use (e.g. bad trip, hallucination), the difficulty of not using cannabis for one day, the influence of parents and friends in reducing the use of cannabis, etc.

2.6.5 Intravenous use

Countries are divided on the 'intravenous use' item. Some countries (e.g. Austria, Finland, England and Wales) do not include questions about intravenous use, because they believe that in a general population survey the prevalence of this use is extremely low. They are also convinced that even if some intravenous users were reached, they would not be willing to reply to the questionnaire. The former argument is confirmed by the Norwegian experts who included this item in their previous survey(s). Other countries (e.g. the Czech Republic, Romania) argue that the inclusion of the 'intravenous use' item will make it possible to assess the risk patterns of use, as the use of syringes is a serious step in a drug career. In general, these experts agree that the inclusion of questions on injecting makes it possible to monitor problematic users and risky drug use, all of which is related to the dissemination of infectious diseases.

Intravenous use is measured in different ways. Some countries (e.g. the Netherlands, Spain, the Czech Republic, Norway, Slovakia) explicitly elicit information about the respondents' injecting behaviour while other countries only survey the mode of administration of one or more particular drugs (e.g. Ireland, France, the

Czech Republic, Italy, Portugal), or just ask which method has ever been used (e.g. Scotland). The Dutch survey explicitly inquires about lifetime prevalence of intravenous use and the products the respondent ever has injected. The Spanish survey measures lifetime and last year prevalence of injecting heroin or cocaine. The Czech survey asks the respondents if they ever have injected amphetamines/methamphetamines, cocaine or heroin. The Norwegian survey assesses the prevalence (never, more than one year ago, 1–12 months since, 0–30 days since) and the last month frequency (number of times) of using syringes, the age of the first injection and the age of the last injection. The Slovakian survey also has questions about injecting behaviour of friends or relatives (e.g. using in a different way, using their own syringes and needles, new or sterilised ones, sharing syringes and needles).

The method(s) by which a person administers a particular drug is a topic of interest in other European surveys on drug use. These general questions are also useful for identifying *common routes* as well as risk factors. While the French Health survey is interested in the method of using heroin, Ireland assesses the methods of using pharmaceuticals, cannabis, cocaine

and heroin among last month users. However, the mode of administration of amphetamines is not inquired here, as the Irish expert finds that the number of amphetamine users is too small. In the Portuguese survey, the respondents are asked which modes of administration they have already tried and how they usually consume the drugs (e.g. cocaine, heroin and amphetamines). The Italian survey includes questions about the method(s) of using heroin and cocaine. Next to some explicit questions about intravenous use, the Dutch population survey on drug use examines the mode of administration of cocaine, amphetamine, ecstasy, LSD, heroin, performance enhancing drugs (e.g. anabolic steroids, EPO, growth hormones) and cannabis.

2.6.6 Other item: susceptibility

Susceptibility is another item that is related to illicit drug use. It is not introduced in this overview, but it still deserves some attention. ‘Susceptibility’ is measured in the Maltese and the Slovakian surveys. It refers to the extent to which respondents would try or use a drug, when offered. In both surveys, the respondents are asked whether they would take a drug when it is offered at a party or a social event.

Table 11: Other items related to illicit drug use

Country	Year	Age of onset	Multiple drug use	Injecting	Availability	Health effects of use
Austria	2004	Yes	No	No	No	No
Belgium	2001	No	No	No	No	No
	2004	Cannabis	No	No	No	No
	2008	Cannabis	No	No	No	No
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	n.a.	n.a.	n.a.	n.a.	n.a.
Cyprus	2006	Yes	No	No	Yes	No
Czech Republic	2004	No	No	Yes	Yes	No
Denmark	2000	No	No	No	No	No
	2005	Yes	No	No	No	No
	2008	Yes	No	No	No	No
England and Wales	1996	No	No	Yes	No	No
	1998	No	No	No	No	No
	2000	No	No	No	No	No
	2001/2	Yes	No	No	No (!)	No
	2002/3	Yes	No	No	No	No
	2003/4	Yes	Yes (!)	No	No	No
	2004/5	Yes	No	No	No	No
	2005/6	No	No	No	No	No
2006/7	No	No	No	No	No	
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.

Table 11 continued						
Country	Year	Age of onset	Multiple drug use	Injecting	Availability	Health effects of use
Finland	1992	No	No	Yes	Yes	No
	1996	No	No	Yes	Yes	No
	1998	Cannabis	No	No	Yes	No
	2002	Yes	No	No	Yes	No
	2006	Yes	No	No	Yes	No
France	1995	No	No	No	Yes	No
	2000	Yes	Yes	Yes	Yes	Yes
	2005	Yes	No	Yes	Yes	Cannabis (°)
Germany	1995	Yes	No	Yes	Yes	Yes
	1997	Yes	No	Yes	Yes	Yes
	2000	Yes	No	Yes	Yes	Yes
	2003	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes	Yes	Yes
	2004	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes	No	No
	2003	Yes	Yes	Yes	No	No
Ireland	2002/3	Yes	No	Yes	Yes	Yes
	2006/7	Yes	No	Yes	Yes	Yes
Italy	2001	No	No	Yes	Yes	No
	2003	Yes	No	Yes	Yes	No
	2005	Yes	No	Yes	Yes	No
Latvia	2003	Yes	No	No	Yes	No
Lithuania	2004	Yes	No	No	Yes	No
Malta	2001	Cannabis	Yes	No	Yes	No
Netherlands	1997	Yes	Yes	Yes	No	No
	2001	Yes	No	Yes	Yes	No
	2005	Yes	No	Yes	Performance enhancing drugs	Cannabis
Norway	2004	Yes	No	Yes	Yes	No
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	Yes	No	Yes	Yes	Yes
Romania	2004	Yes	No	No	Yes	No
Scotland	2000	Yes	No	Yes	Yes	n.a.
	2003	Yes	No	Yes	Yes	n.a.
	2004	Yes	Yes	Yes	Yes	Yes
	2006	Yes	Yes	Yes	Yes	Yes
Slovakia	2002	Yes	No	Yes	Yes	No
	2004	Yes	No	Yes	Yes	No
	2006	Yes	No	Yes	Yes	No
Spain	1995	Yes	No	Yes	Yes	No
	1997	Yes	No	Yes	Yes	No
	1999	Yes	No	Yes	Yes	No
	2001	Yes	No	Yes	Yes	No
	2003	Yes	No	Yes	Yes	No
	2005	Yes	No	Yes	Yes	No

Table 11 continued

Country	Year	Age of onset	Multiple drug use	Injecting	Availability	Health effects of use
Sweden	2004	n.a.	n.a.	n.a.	n.a.	n.a.
	2005	n.a.	n.a.	n.a.	n.a.	n.a.
	2006	n.a.	n.a.	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 137 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

(⁰) Health and social effects of cannabis use (to last year users).

(¹) Availability is in fact measured by the ease of access to drugs (unlike availability!).

(²) Multiple drug use is measured by 'concurrent polydrug use' which means the use of more than one type of drug over their careers (not simultaneous use).

n.a.: not known/not available.

2.7 Respondent attributes

It is quite common to report illicit drug use in relation to respondent attributes (socio-demographic and socio-economic), as this makes it possible to examine the relationship between the attributes and the use of (il)licit drugs (Tables 12 and 13). However, these variables only refer to the present situation and therefore can only be related to current (last year) or recent (last month) patterns of drug use (EMCDDA, 2002). Moreover, in most countries the number of current or recent users is too small to allow an in-depth analysis (e.g. the Netherlands, Latvia, British Crime Survey) (EMCDDA, 2002). The EMQ includes some socio-demographic and socio-economic attributes, such as age, gender, household type, level of education, and employment status. Income is not included, although one or more questions about (personal or family) income are found in most European surveys on drug use.

2.7.1 Socio-demographic attributes

Age and gender are the most basic attributes. A few surveys limit their questions on drug use to particular age groups. The drugs module of the Scottish Crime Survey is only directed at respondents under 60 years of age. In the British Crime Survey, questions about the age of onset and the frequency of drug use, for those who had taken drugs in the last year, were only submitted to respondents between the age of 16 and 24 (see also Section 3: Methodological focus).

Household type refers to the composition of the household (e.g. single with/without children, two partners with/without children). Even though some countries (such as France, the Netherlands, England and Wales, Belgium) measure household type in great detail — e.g. household structure (no children, adults and children, single adult and children), type of tenure

(owner/social renter/private renter), size (number of family members), age of the head of the household — other countries prefer to limit the number of questions. The 'household type' attribute is related to the 'marital status' item (married with/without children, divorced, living together, etc.). Some surveys include both household type and marital status (e.g. Ireland, England and Wales, Malta, Hungary, Belgium), others opt for the implementation of marital status only (e.g. Latvia, Scotland, Finland). The Romanian survey uses individual socio-demographic indicators, rather than 'household type' or 'marital status'.

Questions about *ethnicity* are restricted to a few countries (e.g. Denmark, Belgium, Greece, Ireland, the Netherlands, Norway, Lithuania, Slovakia). These countries argue that the 'ethnicity' item makes it possible to identify certain vulnerable groups. Besides, as immigrants are known to hardly participate in addiction care, a number of experts agree that it is important to know whether this low participation is related to a lower degree of drug use. The Irish surveys examine the ethnic origins of the respondents (e.g. White, Chinese, Pakistani, Indian, Black African, Black Caribbean, Bangladeshi, Irish traveller, Black other, Mixed ethnic group). In the Norwegian survey, the respondent is asked in which country he/she was born and in which country his/her mother and father were born. Response options are: Europe, Asia, Africa, North America, South America, and Australia/Oceania. The 2005 Danish Health survey included the same questions as the Norwegian survey, but also asked respondents (who were not born in Denmark) when they had moved to Denmark. The Portuguese and Belgian surveys include questions about the respondents' (double) nationality and their country of origin. The Lithuanian survey distinguishes four major (ethnic) groups: 'Lithuanian', 'Russian', 'Polish', and 'other'. The British Crime Survey assesses the

prevalence of illicit drug use across 16 different ethnic groups (White British, White Irish, Mixed White and Black Caribbean, Mixed White and Black African, etc.). However, the British expert regrets that the item is not as much used as it should be, because there are many groups for which the sample size is too small, and combining them could be misleading.

Several countries (e.g. Austria) do not include questions about ethnicity because, for pragmatic reasons, it might stimulate xenophobic tendencies when the results are published. Some experts who included this item in their previous survey(s) (e.g. Denmark, Lithuania, Norway) argue that the rates in each group are too low to describe drug use in different ethnic groups. Nevertheless, these experts admit that the item may be used for weighting purposes because the groups are quite underrepresented in the sample.

The 'religion' item is only rarely included (e.g. France, Austria, Denmark, Portugal, Slovakia and Ireland). The Irish questionnaire makes a distinction between 'Catholic' and 'Protestant'. The Austrian survey adds two further categories: 'other religion' and 'no religion'. The French Health survey also includes two 'other' religions: 'Islamic/Muslim' and 'Jewish'. In the French survey, the respondent is asked if he/she regards him/herself as belonging to any particular religion. The Danish Health surveys ask the respondents if they are a member of the Danish National Church or of any other organised religion (e.g. Roman Catholic, Jehovah's Witnesses, Seventh-Day Adventists, Judaism, Islam, Hinduism, Buddhism). The Portuguese survey makes a distinction among 'Catholic', 'any other religion', 'indifferent', 'agnostic', 'atheist', and 'no definite opinion'. Some additional questions concern the frequency of attending church and other practices, such as spells or witchcraft, spirits, astrology, telepathy and UFOs. In addition, it

should be remarked that some of the countries (e.g. Austria, France, Denmark) that include the 'religion' item describe its inclusion as not useful. According to the Danish expert, the item is not useful because the target population consists almost exclusively of members of the Danish National Church.

2.7.2 Socio-economic attributes

Even though some countries (e.g. the Netherlands, France, Scotland, Ireland, Portugal, Belgium) measure the *level of education* and the *employment status* in great detail (e.g. employment status, type of organisation, type of job, total number of school years), other countries prefer a limited number of questions.

Almost all countries consider the *respondent's income* as an item that is useful for the detection of situations of precarity. Drug use is expensive, and early use may be associated with available income. In general, a distinction is made between *family* and *personal income*. The inclusion of family/household income is most common (e.g. Cyprus, England and Wales, Denmark, Scotland, Germany, Portugal, France). Some countries include questions about both family and personal income (e.g. the Netherlands, Norway, Lithuania, Belgium), because family income does not necessarily say anything about an individual's income.

Exceptions to this are Ireland, Finland (2006), the Netherlands (2005), the Czech Republic, Denmark (2008), Italy, Slovakia and Spain. These experts do not include the income item because of space/financial limitations and because of the difficulty of wording the questions. Some countries (e.g. the Netherlands, Ireland) state that questions about income often meet resistance and believe that the level of education is a better indicator of the socio-economic status.

Table 12: Socio-demographic attributes

Country	Year	Socio-demographic					
		Age	Gender	Household type	Marital status	Ethnicity	Religion
Austria	2004	Yes	Yes	Yes	No	No	Yes
Belgium	2001	Yes	Yes	Yes	No	Yes	No
	2004	Yes	Yes	Yes	No	Yes	No
	2008	Yes	Yes	Yes	Yes	Yes	No
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	Yes	Yes	Yes	No	No	No
Cyprus	2006	Yes	Yes	Yes	No	No	No

Table 12 continued							
Country	Year	Socio-demographic					
		Age	Gender	Household type	Marital status	Ethnicity	Religion
Czech Republic	2004	Yes	Yes	No	No	No	No
Denmark	2000	Yes	Yes	Yes	No	No	Yes
	2005	Yes	Yes	Yes	No	Yes	Yes
	2008	Yes	Yes	No	No	No	No
England and Wales	1996	Yes	Yes	Yes	Yes	Yes	No
	1998	Yes	Yes	Yes	Yes	Yes	No
	2000	Yes	Yes	Yes	Yes	Yes	No
	2001/2	Yes	Yes	Yes	Yes	Yes	No
	2002/3	Yes	Yes	Yes	Yes	Yes	No
	2003/4	Yes	Yes	Yes	Yes	Yes	No
	2004/5	Yes	Yes	Yes	Yes	Yes	No
	2005/6	Yes	Yes	Yes	Yes	Yes	No
2006/7	Yes	Yes	Yes	Yes	Yes	No	
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	1992	Yes	Yes	No	No	No	No
	1996	Yes	Yes	No	No	No	No
	1998	Yes	Yes	No	Yes	No	No
	2002	Yes	Yes	No	Yes	No	No
	2006	Yes	Yes	No	Yes	No	No
France	1995	Yes	Yes	Yes	No	No	Yes
	2000	Yes	Yes	Yes	No	Yes	Yes
	2005	Yes	Yes	Yes	Yes	No	Yes
Germany	1995	Yes	Yes	Yes	n.a.	No	No
	1997	Yes	Yes	Yes	n.a.	No	No
	2000	Yes	Yes	Yes	n.a.	No	No
	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes	n.a.	Yes	No
	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes	Yes	No	No
	2003	Yes	Yes	Yes	Yes	No	No
Ireland	2002/3	Yes	Yes	Yes	Yes	Yes	Yes
	2006/7	Yes	Yes	Yes	Yes	Yes	Yes
Italy	2001	Yes	Yes	No	No	No	No
	2003	Yes	Yes	No	No	No	No
	2005	Yes	Yes	No	No	No	No
Latvia	2003	Yes	Yes	No	Yes	Yes	No
Lithuania	2004	Yes	Yes	Yes	No	Yes	No
Malta	2001	Yes	Yes	Yes	Yes	No	No
Netherlands	1997	Yes	Yes	Yes	No	Yes	No
	2001	Yes	Yes	Yes	No	Yes	No
	2005	Yes	Yes	Yes	No	Yes	No
Norway	2004	Yes	Yes	Yes	No	Yes	No
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	Yes	No	Yes	Yes

Table 12 continued		Socio-demographic					
Country	Year	Socio-demographic					
		Age	Gender	Household type	Marital status	Ethnicity	Religion
Romania	2004	Yes	Yes	No	No	No	No
Scotland	2000	Yes	Yes	No	No	No	No
	2003	Yes	Yes	No	No	No	No
	2004	Yes	Yes	No	No	No	No
	2006	Yes	Yes	No	Yes	No	No
Slovakia	2002	Yes	Yes	No	No	Yes	Yes
	2004	Yes	Yes	No	No	Yes	Yes
	2006	Yes	Yes	No	No	Yes	Yes
Spain	1995	Yes	Yes	Yes	No	No	No
	1997	Yes	Yes	Yes	No	No	No
	1999	Yes	Yes	Yes	No	No	No
	2001	Yes	Yes	Yes	No	No	No
	2003	Yes	Yes	Yes	No	No	No
	2005	Yes	Yes	Yes	No	No	No
Sweden	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
	2006	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 138 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

Table 13: Socio-economic attributes		Socio-economic		
Country	Year	Socio-economic		
		Level of education	Employment status	Income
Austria	2004	Yes	Yes	Yes
Belgium	2001	Yes	Yes	Yes (family and personal)
	2004	Yes	Yes	Yes (family and personal)
	2008	Yes	Yes	Yes (family)
Bulgaria	2005	n.a.	n.a.	n.a.
Croatia	2009 (expected)	Yes	Yes	Yes
Cyprus	2006	Yes	Yes	Yes (family)
Czech Republic	2004	Yes	Yes	No
Denmark	2000	Yes	Yes	Yes
	2005	Yes	Yes	Yes
	2008	Yes	Yes	No
England and Wales	1996	Yes	Yes	Yes (family)
	1998	Yes	Yes	Yes (family)
	2000	Yes	Yes	Yes (family)
	2001/2	Yes	Yes	Yes (family)
	2002/3	Yes	Yes	Yes (family)
	2003/4	Yes	Yes	Yes (family)
	2004/5	Yes	Yes	Yes (family)
	2005/6	Yes	Yes	Yes (family)
	2006/7	Yes	Yes	Yes (family)

Table 13 continued				
Country	Year	Socio-economic		
		Level of education	Employment status	Income
Estonia	2003	n.a.	n.a.	n.a.
Finland	1992	Yes	Yes	Yes (personal)
	1996	Yes	Yes	Yes (personal)
	1998	Yes	Yes	No
	2002	Yes	Yes	Yes (family)
	2006	Yes	Yes	Yes (family)
France	1995	Yes	Yes	Yes (family)
	2000	Yes	Yes	Yes (family)
	2005	Yes	Yes	Yes (family)
Germany	1995	Yes	Yes	Yes (family)
	1997	Yes	Yes	Yes (family)
	2000	Yes	Yes	Yes (family)
	2003	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes
	2004	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes (family)
	2003	Yes	Yes	Yes (family)
Ireland	2002/3	Yes	Yes	No
	2006/7	Yes	Yes	No
Italy	2001	Yes	Yes	No
	2003	Yes	Yes	No
	2005	Yes	Yes	No
Latvia	2003	Yes	No	Yes (personal)
Lithuania	2004	Yes	Yes	Yes
Malta	2001	Yes	Yes	Yes
Netherlands	1997	Yes	Yes	Yes (family and personal)
	2001	Yes	Yes	Yes (family and personal)
	2005	Yes	No	No
Norway	2004	Yes	Yes	Yes (family and personal)
Poland	2002	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	Yes (family)
Romania	2004	Yes	Yes	Yes (personal)
Scotland	2000	No	Yes	Yes (family)
	2003	No	Yes	Yes (family)
	2004	No	Yes	Yes (family)
	2006	No	Yes	Yes (family)
Slovakia	2002	Yes	Yes	No
	2004	Yes	Yes	No
Spain	1995	Yes	Yes	No
	1997	Yes	Yes	No
	1999	Yes	Yes	No
	2001	Yes	Yes	No

Table 13 continued				
Country	Year	Socio-economic		
		Level of education	Employment status	Income
	2003	Yes	Yes	No
	2005	Yes	Yes	No
Sweden	2004	Yes	Yes	Yes (family and personal)
	2005	Yes	Yes	Yes (family and personal)
	2006	Yes	Yes	Yes (family and personal)

NB:

Adapted from the EMCDDA Handbook, p. 138 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

2.8 Environment

The 'environment' item refers to whether residential characteristics (e.g. number of inhabitants, typology of places/residential area) are recorded and to whether a respondent is confronted with drug users (Table 14).

This confrontation is measured by the extent of personal acquaintance with users of an illicit drug (e.g. family, friends) or the extent of seeing/observing illicit drug users in the neighbourhood (EMCDDA, 2002). In general, countries are divided on this item.

Most questionnaires include residential characteristics or other geographical variations, such as incivility scale, council/non-council houses, police force area. The typology of places refers to the identification code and the *level of urbanisation*. The perception of the level of urbanisation may differ between countries but, in general, it can be divided into three categories: urban, rural and metropolitan. The *incivility scale* refers to the perception of forms of neighbourhood physical disorder (e.g. street rubbish, vandalism). The British Crime Survey also introduces a 'Classification of Residential Neighbourhoods' (ACORN). This classification groups households into the type of social environment in which they are located, taking into account the demographic, employment and housing characteristics of the area. The Norwegian survey makes a distinction between types of housing: single family house, 2–4 bed roomed detached house, terraced house, high-rise flats, lodgings, or other. A number of countries (e.g. Spain, the Czech Republic, Denmark, Portugal and Scotland) do not include questions about the environment, because of space limitations or because of a lack of interest in this item.

Following the EMQ, many surveys (e.g. Germany, Greece, Hungary, Slovakia, Ireland, Italy, Latvia, Lithuania, Malta, Cyprus, the Czech Republic, Portugal, the 2008 Danish drug survey and Romania) include questions about 'knowing drug users'. This item refers to any personal acquaintance with users of an illicit drug, e.g. friends or family members. 'Do you personally know someone who takes a particular drug?' is frequently asked as a warming-up question. In the Slovakian survey, respondents are asked whether they know anyone socially (e.g. family, friends, neighbourhood, working place) who is or was addicted to marijuana, hashish, cocaine, heroin, LSD or ecstasy. This question assesses the familiarity, the awareness and the (dis)approval of drug use(rs). Experts agree that the inclusion of this item is very useful, as it is associated with personal drug use and directly indicates the extent of the drug problem in a country. In the Slovakian survey, this item is included in order to study the young as a group, as it is assumed that they are more frequently faced with drug addicts. Questions about 'knowing drug users' are most common in national population surveys that only deal with drugs (and/or alcohol, tobacco or pharmaceuticals), such as Hungary, Slovakia, Finland, Ireland, Latvia, Malta, etc. However, other countries, such as France, the Netherlands, Spain, Scotland, and England and Wales, do not include questions about 'knowing drug users', because of space limitations or because the inclusion of this item is considered not particularly relevant, taking into account the media coverage of drugs.

No general population survey inquires about 'seeing drug users' (seeing or observing of users of an illicit drug in one's own neighbourhood).

Table 14: Environment					
Country	Year	Residential characteristics	Confrontation		
			Personal 'knowing drug users' (!)	Neighbourhood 'seeing drug users'	
Austria	2004	Yes	Yes	No	
Belgium	2001	Yes	No	No	
	2004	Yes	No	No	
	2008	No	No	No	
Bulgaria	2005	n.a.	n.a.	n.a.	
Croatia	2009 (expected)	No	Yes	No	
Cyprus	2006	Yes	Yes	No	
Czech Republic	2004	No	Yes	No	
Denmark	2000	No	No	No	
	2005	No	No	No	
	2008	No	Yes	No	
England and Wales	1996	Yes	No	Yes	
	1998	Yes	No	No	
	2000	Yes	No	No	
	2001/2	Yes	No	No	
	2002/3	Yes	No	No	
	2003/4	Yes	No	No	
	2004/5	Yes	No	No	
	2005/6	Yes	No	No	
	2006/7	Yes	No	No	
Estonia	2003	n.a.	n.a.	n.a.	
Finland	1992	Yes	Yes	No	
	1996	Yes	Yes	No	
	1998	Yes	Yes	No	
	2002	Yes	Yes	No	
	2006	Yes	Yes	No	
France	1995	Yes	No	No	
	2000	Yes	No	No	
	2005	Yes	No	No	
Germany	1995	Yes	Yes	No	
	1997	Yes	Yes	No	
	2000	Yes	Yes	No	
	2003	n.a.	n.a.	n.a.	
Greece	1998	Yes	Yes	No	
	2004	n.a.	n.a.	n.a.	
Hungary	2001	Yes	Yes	No	
	2003	Yes	Yes	No	
Ireland	2002/3	Yes	Yes	No	
	2006/7	Yes	Yes	No	
Italy	2001	Yes	Yes	No	
	2003	Yes	Yes	No	
	2005	Yes	Yes	No	
Latvia	2003	Yes	Yes	No	
Lithuania	2004	Yes	Yes	No	

Table 14 continued					
Country	Year	Residential characteristics	Confrontation		
			Personal 'knowing drug users' (!)	Neighbourhood 'seeing drug users'	
Malta	2001	Yes	Yes	No	
Netherlands	1997	Yes	Yes	No	
	2001	Yes	Yes	No	
	2005	Yes	No	No	
Norway	2004	Yes	No	No	
Poland	2002	n.a.	n.a.	n.a.	
Portugal	2001	No	Yes	No	
Romania	2004	Yes	Yes	No	
Scotland	2000	No	No	No	
	2003	No	No	No	
	2004	No	No	No	
	2006	No	No	No	
Slovakia	2002	Yes	Yes	No	
	2004	Yes	Yes	No	
	2006	Yes	Yes	No	
Spain	1995	No	No	No	
	1997	No	No	No	
	1999	No	No	No	
	2001	No	No	No	
	2003	No	No	No	
	2005	No	No	No	
Sweden	2004	n.a.	n.a.	n.a.	
	2005	n.a.	n.a.	n.a.	
	2006	n.a.	n.a.	n.a.	

NB:

Adapted from the EMCDDA Handbook, p. 139 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

(!) Refers to whether personal acquaintance with users of an illicit drug (e.g. family, friends, colleagues) was recorded.

n.a.: not known/not available.

2.9 Lifestyle attributes

In some countries, the questionnaires include questions about entertainment and/or social contacts (Table 15). 'Lifestyle' attributes refer to the number of social contacts (e.g. friends, family) and to various leisure-related activities such as visiting pubs, sports, etc. These 'lifestyle' variables are not included in the European Model Questionnaire, though they are commonly used in the ESPAD studies. Some survey questionnaires (e.g. Cyprus) do not include questions about lifestyle because they do not regard this item as essential for a drug survey. These surveys collect information about lifestyle attributes through school and special population surveys. Other countries do not include this item because of space or financial limitations (e.g. Romania,

Italy, the Czech Republic, 2008 Danish drug survey), or because of the difficulty of wording the questions (Lithuania). However, many countries (e.g. England and Wales, Hungary, Belgium, France, Malta, Portugal, the Netherlands, Sweden) include questions about lifestyle attributes because these responses clearly show the importance of the context in some types of drug use in the general population. According to many national experts, it may also be useful to know whether there is a connection between drug use and social contacts, with a view to developing prevention and intervention methods. It is generally assumed that lifestyle strongly correlates with drug use.

Questions about *entertainment* refer to amusement outside the home, such as visiting dance clubs, pubs, etc. Entertainment sometimes includes further questions

about the extent to which the respondent takes part in sports and other leisure activities (e.g. Malta, Austria). Questions about entertainment form part of the surveys of Finland, Hungary, Belgium, France, Malta, the Netherlands, Portugal, Sweden, Scotland and the British Crime Survey. The Austrian survey defines entertainment in terms of the frequency of practising sports, watching television or surfing the Internet. The Portuguese survey additionally questions respondents on the frequency of meeting people, entertaining friends, going for a walk, visiting friends, going to pubs, etc. Questions about how the respondents spend their nights during the week and the weekend are also included: staying at home, going out at night to meet friends, going out with no definite plans, etc.

A large proportion of surveys (e.g. France, Hungary, Malta, the Netherlands, Slovakia, Portugal, Sweden, Belgium, Danish Health surveys) include questions about

social contacts (e.g. number of friends, visiting relatives). However, the number of questions varies a lot. The Danish Health surveys include three questions: 'How often do you meet your family, friends and acquaintances?', 'Are you ever alone even though you would prefer to be with other people?' and 'How often do you participate in activities in an association or in other leisure activities together with other people?'. While Hungary includes several questions (the number of friends who you feel confident with, the number of close friends, the number of times you have had personal contact with friends during last month, the number of times e-mail/phone contact with friends during last month), in the Portuguese survey the respondent is asked how many friends he/she has and how often he/she meets them. The Dutch survey included a question about social contacts in 2001 but omitted it in the 2005 survey because the survey's commissioner decided it was not an important question.

Table 15: Lifestyle			
Country	Year	Entertainment	Social contacts
Austria	2004	No	Yes
Belgium	2001	Yes	Yes
	2004	Yes	Yes
	2008	Yes	Yes
Bulgaria	2005	n.a.	n.a.
Croatia	2009 (expected)	Yes	Yes
Cyprus	2006	No	No
Czech Republic	2004	No	No
Denmark	2000	No	Yes
	2005	No	Yes
	2008	No	No
England and Wales	1996	Yes	No
	1998	No	No
	2000	Yes	No
	2001/2	Yes	No
	2002/3	Yes	No
	2003/4	Yes	No
	2004/5	Yes	No
	2005/6	Yes	No
2006/7	Yes	No	
Estonia	2003	n.a.	n.a.
Finland	1992	Yes	No
	1996	Yes	No
	1998	Yes	No
	2002	Yes	No
	2006	Yes	No

Table 15 continued			
Country	Year	Entertainment	Social contacts
France	1995	Yes	Yes
	2000	Yes	Yes
	2005	Yes	Yes
Germany	1995	No	No
	1997	No	No
	2000	No	No
	2003	n.a.	n.a.
Greece	1998	No	No
	2004	n.a.	n.a.
Hungary	2001	Yes	Yes
	2003	Yes	Yes
Ireland	2002/3	No	No
	2006/7	No	No
Italy	2001	No	No
	2003	No	No
	2005	No	No
Latvia	2003	n.a.	n.a.
Lithuania	2004	No	No
Malta	2001	Yes	Yes
Netherlands	1997	Yes	Yes
	2001	Yes	Yes
	2005	Yes	No
Norway	2004	No	No
Poland	2002	n.a.	n.a.
Portugal	2001	Yes	Yes
Romania	2004	No	No
Scotland	2000	Yes	No
	2003	n.a.	n.a.
	2004	No	No
	2006	No	No
Slovakia	2002	No	Yes
	2004	No	Yes
	2006	No	Yes
Spain	1995	No	No
	1997	No	No
	1999	No	No
	2001	No	No
	2003	No	No
	2005	No	No
Sweden	2004	Yes	Yes
	2005	Yes	Yes
	2006	Yes	Yes

NB:

Adapted from the EMCDDA Handbook, p. 141 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

2.10 Attitudes and opinions

In some general population surveys, attitudes and opinions concerning drugs are assessed for use by policymakers, politicians or prevention workers (Table 16). Some experts (e.g. Cyprus, Croatia, Spain) contend that these questions are relevant because attitudes and opinions usually correlate inversely with prevalence of use and foresee the trends in drug use. Other experts (e.g. Italy, Hungary) argue that knowledge of attitudes and opinions regarding drug use may be useful to evaluate the impact of preventive campaigns. It is also stated that measuring attitudes and opinions may provide information about the causality between the image of drug use(rs) in the media and attitudes towards drug issues. The EMCDDA has also put forward some questions about attitudes and opinions on drug use. Most of these questions have been selected from the European School Survey questionnaire (ESPAD). A number of countries (e.g. England and Wales, the Netherlands, Scotland, Denmark) do not include questions about attitudes and opinions mainly because of space considerations and/or interpretation problems.

Risk perceptions of health and social issues are measured by presenting the respondent with a list of statements concerning the (dis)approval/tolerance of taking or trying one or more drugs. In other words, the risk perception of harming themselves is assessed. Most countries include questions about the perception of health and/or social risks. The Slovakian survey includes some questions concerning physical and mental risks for people who are experimenting with drugs or taking them regularly. Latvia includes two additional questions about the perceived use of alcohol and drugs to gain a better understanding of the reported risk perception ('How do you perceive the use of alcohol and drugs in your country?' and 'How do you perceive the importance of the problem of the use of alcohol in Latvia?').

Asking about *opinions on drug addicts* is common (e.g. the Czech Republic, Italy, Austria, Greece, Hungary, Ireland, Latvia, Lithuania, Malta, Romania, Portugal, Slovakia). Almost all countries include the question proposed by the European Model Questionnaire, which gauges the perception of a drug addict as a patient or a criminal. Romania and Austria extend their questionnaire with some questions about opinions on drug addicts. The Austrian survey includes two extra questions: 'How would you react if a treatment centre was built near you?' and 'How would you react if a friend used drugs?'. The Romanian questionnaire also asks the respondents if they perceive drug users as drug dealers, if drug users should be accepted just like any other person, and if a person will become an addict when he/she tries a drug once.

Opinions on drug policy, on legal status or interventions in particular, are frequently investigated. Some surveys (e.g. Hungary, Ireland, Greece, the Czech Republic, Portugal, Lithuania, Malta and Scotland) are only interested in opinions on the legislation of some drugs. These surveys gauge whether respondents (dis)agree that one should be permitted to take cannabis or heroin. The same questions are included in the European Model Questionnaire. Additionally, a few countries report about opinions on feasible interventions (e.g. Finland, Germany, Latvia, Romania, Austria, Norway). The Romanian survey questions the respondents on whether they (dis)agree that drug users should be punished by confinement. The Latvian survey is interested in the respondents' opinions on several social policies for managing drug-related problems (e.g. drug tests, compulsory treatment system, criminal punishment). The Norwegian survey asks the respondents about their opinion on clean syringe distribution, injecting rooms, increasing the number of treatment places, etc. In addition, in the Slovakian survey respondents are asked which policies they find the most effective (e.g. economic and social assistance, increasing of police control, school preventive programmes, obligatory treatment).

Table 16: Attitudes and opinions

Country	Year	Risk perception		Opinion	Opinion on drug policy	
		Health	Social	Drug addicts	Legal status	Interventions
Austria	2004	Yes	No	Yes	Yes	Yes
Belgium	2001	No	No	No	No	No
	2004	No	No	No	No	No
	2008	No	No	No	No	No
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.

Table 16 continued						
Country	Year	Risk perception		Opinion	Opinion on drug policy	
		Health	Social	Drug addicts	Legal status	Interventions
Croatia	2009 (expected)	Yes	Yes	No	Yes	Yes
Cyprus	2006	Yes	Yes	No	No	No
Czech Republic	2004	Yes	Yes	Yes	Yes	No
Denmark	2000	No	No	No	No	No
	2005	No	No	No	No	No
	2008	No	No	No	No	No
England and Wales	1996	No	No	No	No	No
	1998	No	No	No	No	No
	2000	No	No	No	No	No
	2001/2	No	No	No	No	No
	2002/3	No	No	No	No	No
	2003/4	No	No	No	No	No
	2004/5	No	No	No	No	No
	2005/6 2006/7	No	No	No	No	No
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	1992	Yes	Yes	Yes	Yes	Yes
	1996	Yes	Yes	Yes	Yes	Yes
	1998	Yes	Yes	Yes	Yes	Yes
	2002	Yes	Yes	Yes	Yes	Yes
	2006	Yes	Yes	No	Yes	Yes
France	1995	Yes	No	Yes	Yes	Yes
	2000	Yes	No	No	Yes	No
	2005	Yes	No	No	No	No
Germany	1995	Yes	Yes	No	Yes	Yes
	1997	Yes	Yes	No	Yes	Yes
	2000	Yes	Yes	No	Yes	Yes
	2003	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	1998	Yes	Yes	Yes	Yes	No
	2004	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2001	Yes	Yes	Yes	Yes	No
	2003	Yes	Yes	Yes	Yes	Yes
Ireland	2002/3	Yes	Yes	Yes	Yes	No
	2006/7	Yes	Yes	Yes	Yes	No
Italy	2001	Yes	No	Yes	No	No
	2003	Yes	No	Yes	No	No
	2005	Yes	No	Yes	No	No
Latvia	2003	Yes	Yes	Yes	Yes	Yes
Lithuania	2004	Yes	Yes	Yes	Yes	Yes
Malta	2001	Yes	Yes	Yes	Yes	No
Netherlands	1997	No	No	No	No	No
	2001	No	No	No	No	No
	2005	No	No	No	No	No
Norway	2004	No	No	No	Yes	Yes

Table 16 continued						
Country	Year	Risk perception		Opinion	Opinion on drug policy	
		Health	Social	Drug addicts	Legal status	Interventions
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	Yes	Yes	Yes	Yes	No
Romania	2004	Yes	Yes	Yes	Yes	Yes
Scotland	2000	Yes	Yes	No	Yes	No
	2003	Yes	Yes	No	Yes	No
	2004	Yes	Yes	No	Yes	No
	2006	Yes	Yes	No	Yes	No
Slovakia	2002	Yes	Yes	Yes	Yes	Yes
	2004	Yes	Yes	Yes	Yes	Yes
	2006	Yes	Yes	Yes	Yes	Yes
Spain	1995	Yes	Yes	No	No	Yes
	1997	Yes	Yes	No	No	Yes
	1999	Yes	Yes	No	No	Yes
	2001	Yes	Yes	No	No	Yes
	2003	Yes	Yes	No	No	Yes
	2005	Yes	Yes	No	No	Yes
Sweden	2004	n.a.	n.a.	n.a.	n.a.	n.a.
	2005	n.a.	n.a.	n.a.	n.a.	n.a.
	2006	n.a.	n.a.	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 140 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

Chapter 3

Methodological focus

This part of the meta-analysis compares and discusses several methodological characteristics of different European surveys, including survey method, sampling and target population. The information is mainly obtained from the national reports or the abstracts of the survey studies. However, there is a large variance among the available English language reports of the surveys: ranging from a short outline overview (e.g. Cyprus) to elaborated expositions with technical reports (e.g. Scotland). As a consequence, it was sometimes necessary to obtain information from the expert review.

3.1 Cross-national comparison of surveys

This methodological meta-analysis of the European population surveys was performed in two steps. First, a comparison of surveys of different countries had to be made. These countries often have their own specific survey traditions and climates, which are not always directly visible. Secondly, the meta-analysis also compares surveys conducted in different time periods, with possibly different survey climates.

Although the EMCDDA set some (intrinsic and) methodological guidelines to enhance comparability, there is still much variation between the studies for the simple reason that these guidelines are not binding. In this respect, De Heer observes that different factors may explain cross-national differences in survey quality and outcomes:

1. General design factors: mode of data collection, panel versus cross-section, proxy allowed, substitution allowed, person or households as sample units, etc.
2. Practical fieldwork strategies: length of fieldwork period, number of contact attempts, use of incentives, use of refusal conversion, etc.
3. Factors related to survey organisation: voluntary participation in surveys, employment condition of interviewers, etc. (Stoop, 2005).

It follows that a simple comparison of the methodology of the different European population surveys is practically impossible. The large amount of information that is needed to conduct a meta-analysis is not always available. However, a transparent, detailed and standardised way of reporting on key features of the survey process should contribute to this analysis.

3.2 General characteristics

3.2.1 Context

The EMCDDA overview classifies surveys in three categories according to their *context*: single, general and multi-context. The vast majority of surveys have a 'single context', which means that they deal with drugs (and/or alcohol and/or tobacco) prevalence only (Table 17).

Drug prevalence questions are less often embedded in a multipurpose survey ('general'). The context of the Estonian survey, for example, is relatively wide in comparison with the other surveys: family, work, leisure, economic situation, livelihood, and health, including drugs. Several countries piggyback drug prevalence measurements to another category ('multi') in their survey. Especially used are a health context (e.g. the Czech Republic, Belgium, Denmark, France, Sweden) and to a lesser degree, a crime/victimisation context (e.g. England and Wales, Scotland).

The expert survey shows that the reasons for choosing a context vary widely.

Validity and reliability concerns are frequently mentioned (e.g. Italy, Austria and the Czech Republic). The Austrian researchers justify the choice for a *single context* survey as follows: *'In order to get sensible answers the area has to be developed step by step leading to specific questions. To ask suddenly if persons consume certain substances after e.g. asking them if they are satisfied with their TV-set yields particularly unreliable results.'* Similarly, the Czech

researchers are concerned that respondents tend to under-report their alcohol and drug consumption when the main focus of the survey is on the health status.

In 1998 and 1999, Northern Ireland conducted a general survey, an 'omnibus survey' as they called it, about the behaviour, lifestyle and views of a representative sample of the people of Northern Ireland⁽¹⁾. In 2002, however, Ireland switched to a single drug prevalence survey in order to remedy the lack of knowledge about drug use in the general population and to meet the (non-binding) request of the EMCDDA to gather comparable and consistent information about drug use in the general population.

Furthermore, as a shorter questionnaire results in better response rates, several countries (e.g. the Czech Republic, Finland) opted for a single questionnaire with fewer questions instead of a piggybacked questionnaire. In 2008, Denmark conducted a single drug survey for the first time, as the Danish Health Interview Survey (HIS) was already quite long and allowed only a limited number of questions concerning alcohol and drug use to be included. Hungary mentions a long questionnaire as a counter-argument for a piggybacked survey. Spain also mentions that drug surveys usually need higher sample sizes than health surveys. In contrast, the experts of the British Crime Survey justify a piggybacking design by pointing out that it offers a very large sample size for limited expenditure. In the Cypriot survey, on the other hand, more pragmatic reasons are given: *'The survey dealt mainly with drugs and was not part of a survey with a wider scope, due to the limitations of competences and duties of the institute commissioning the survey'*. A similar reason is given in the Lithuanian expert survey: there simply was no opportunity to piggyback.

The first condition for *piggybacking* is that the survey must be suitable. Findings from the literature and this meta-analysis show that a health or a crime survey is appropriate. The database of the European Health Interview and Health Examination Surveys⁽²⁾ contains one or more Health Interview Surveys conducted in the year 2000 of every country in our meta-analysis, while exploring the Internet on crime and victimisation surveys mainly gives results for England and Wales and Scotland only. This means that in theory every country has the opportunity to piggyback on a health survey, and to a lesser degree on a crime survey. Nevertheless, most countries have conducted a single

survey. Therefore, the mere existence of a crime or health survey is a necessary condition for piggybacking, but not a sufficient one.

Piggybacking is frequently warranted for obtaining more information about a related item (health and crime) and about the link between drugs and the health burden (Croatia, Sweden, France). Lower costs also constitute a major reason for piggybacking (Denmark 2005, England and Wales, Sweden). Piggybacking on regular surveys such as health or crime surveys also creates an opportunity to gather data on a regular and frequent basis. However, the experts of the British Crime Survey find that the size constraint associated with being piggybacked onto a crime survey is a clear disadvantage.

It should be noted that hardly any survey reports reflect on the (possible) influence of the crime and health-related questions on the responses to drug prevalence questions. Only the British Crime Survey (BCS) report mentions that piggybacking on a crime/victimisation survey may lead to underestimates of drug use. Its experts further explain this possible bias in our expert survey: *'A quick look at the difference between the BCS prevalence rates (a victimisation survey) and those from the Offending Crime and Justice Survey (OCJS is an offending survey) found that the latter were consistently higher (...). It was speculated that if people had already answered questions about offending (in the OCJS) they were more ready to admit illicit drug use than following questions about being victims of crime as in the BCS.'* The influence of the context was (partly) the reason why the Hungarian experts chose for a single survey. In our expert survey they argue that when comparing ESPAD and HBSC data, the latter always reveal lower prevalence rates than the former. Notwithstanding the awareness of the possible bias caused by the context, none of the piggybacking countries have explicitly studied the (possible) impact of the health or crime context. Still, the French researchers stated in our expert survey that *'the bias may be relatively constant from one survey to another'*.

The commissioners/responsible agents, the cooperating partners or the origin of the financial resources can logically also influence the choice for either a single or a piggybacking questionnaire. The Czech experts justify their single survey as follows: *'... the survey was financed by the Office of the Government of the Czech*

⁽¹⁾ As the results of these omnibus surveys are not comparable with the results of the first national population survey on drug use in 2002/3, we decided to exclude these data of the omnibus surveys from our meta-analysis.

⁽²⁾ https://hishes.ipsh.fgov.be/index.php?hishes=survey_search&view_mode=survey

Republic from a budgetary chapter on Expenditures on drug policy.’ The Slovakian expert survey makes a reference to the cooperating partner, the ‘General Secretariat of Board of Ministers for Drug Dependencies and Drug Control’.

3.2.2 Frequency

There is a large variety in the *frequency* of questioning the population (Table 17). Almost every survey is part of a continuous series that aims to identify trends (‘tracking’). Nonetheless, even within this category there is a large difference between annual surveys (e.g. the British Crime Survey is a continuous survey, which is reported on an annual basis) and those with a standard interval (e.g. France every 5 years). Only a few countries (e.g. Germany) have conducted some surveys before, though not as part of a continuous series (‘regular’).

The reasons why a research team chooses to conduct the survey as frequently as indicated in Table 17 are similar for the different countries. Financial feasibility seems to be the main motive (Austria, France, Ireland, Norway, Cyprus, Denmark 2005, England and Wales). Having enough time for data collection and in-depth analysis (France, Denmark 2005, Italy), the EMCDDA recommendation to conduct a survey at least every 4 years (Romania) and alternating with ESPAD surveys (Austria, Hungary), are other reasons given in the expert survey. Although several countries want to identify trends or new developments and gather up-to-date information (e.g. Finland, Ireland, Austria, the Czech Republic, Croatia), the time period between two surveys can be very different (from 2 to 5 years). For example, in Norway every 5 years a drug survey is conducted because ‘most things don’t change very fast’, whereas in Spain drug surveys are carried out more frequently (every 2 years) as ‘the phenomenon of drug use frequently changes’.

Some countries have only recently organised a population survey on drug use for the first time, with the intention of conducting a systematic survey (e.g. Romania and Austria). In this respect, the efforts of new EU members such as Malta, Cyprus, Hungary or Latvia are striking. That does not mean that nothing was known about substance use in those countries before. In the past, some drug-related questions were sporadically inserted into surveys on other topics (e.g. Hungary and Latvia), or drug use was studied among specific target groups, such as ESPAD school surveys (e.g. Hungary, Latvia and Malta). The reason those countries give for starting a regular general prevalence survey, is that it offers a more general perspective on substance use among the general population and as well as meeting the request of the EMCDDA mentioned above.

The ‘current/next survey’ column in Table 17 shows the recently conducted surveys or those planned for the near future. When no report was available yet (e.g. Hungary or Romania), or when the surveys were not yet (fully) completed (e.g. Estonia and Greece), the versions have not been incorporated in our meta-analysis. This information is only offered to present a more complete overview.

3.2.3 Level of analysis

The last column of Table 17 shows the aims of the analyses of the data obtained through general population surveys. The level of analysis varies from descriptive (‘the analysis of results primarily described current situations or trends’) to causal inference (more cross-sectional association between drug use and other factors such as the respondent’s characteristics) to explanatory (systematic explanation of drug prevalence based on theoretical assumptions and empirical observations, e.g. urbanisation) (EMCDDA, 2002). However, some reports state that more profound statistics will be produced later or that more detailed results will be given in the report of a following prevalence study (e.g. Scotland, 2004).

Table 17: General characteristics

Country	Year	Context	Frequency	Current/next survey	Level of analysis
Austria	2004	Single (licit and illicit drugs)	Tracking	2008	Descriptive – causal inference
Belgium	2001	Health	Tracking		n.a.
	2004	Health	Tracking	2012	n.a.
	2008	Health	Tracking		n.a.

Table 17 continued					
Country	Year	Context	Frequency	Current/next survey	Level of analysis
Bulgaria	2005	Single	Single (first)	2008/9	
Croatia	2009 (expected)	Multi-health survey	Single (planned survey, aim is to conduct every 3 to 5 years)	n.a.	n.a.
Cyprus	2006	Drugs (additional mental health questions)	First study (aim is to conduct every 3 years)	2009	Descriptive — causal inference
Czech Republic	2004	Single	First study (aim is to conduct every 3 years)	2008	Descriptive
Denmark	2000	Health	Tracking (every 5 years)	2010/11	Descriptive — causal inference
	2005	Multi-purpose health interview survey	Tracking		Descriptive — causal inference
	2008	Single	First (aim is to conduct every 2 to 3 years)	Not decided yet	Descriptive (primarily)
England and Wales	1996	Multi-crime survey	Tracking	2007/8	Causal inference + explanatory
	1998	Multi-crime survey	Tracking		Causal inference + explanatory
	2000	Multi-crime survey	Tracking		Causal inference + explanatory
	2001/2	Multi-crime survey	Tracking		Causal inference + explanatory
	2002/3	Multi-crime survey	Tracking		Causal inference + explanatory
	2003/4	Multi-crime survey	Tracking		Causal inference + explanatory
	2004/5	Multi-crime survey	Tracking		Causal inference + explanatory
	2005/6	Multi-crime survey	Tracking		Causal inference + explanatory
	2006/7	Multi-crime and victimisation survey	Tracking		Causal inference + explanatory
Estonia	2003	Family, work, leisure, economic situation, livelihood and health including drugs	Tracking (3rd study, every 5 years)	2008	n.a.
Finland	1992	Single	Tracking	2008 (drinking habits) 2010 (drugs)	Causal inference
	1996	Single	Tracking		Causal inference
	1998	Single	Tracking		Causal inference
	2002	Single (alcohol and drugs)	Tracking		Causal inference
	2004	Single (alcohol and drugs)	Tracking (!)		Causal inference
	2006	Single (alcohol and drugs, some questions about tobacco and pharmaceuticals)	Tracking (!)		Causal inference

Table 17 continued					
Country	Year	Context	Frequency	Current/next survey	Level of analysis
France	1995	Multi-health	Tracking	2010	Descriptive + causal inference
	2000	Multi-health	Tracking		Descriptive + causal inference
	2005	Multi-health	Tracking		Descriptive + causal inference
Germany	1995	Single	Regular	2006/9	Descriptive + causal inference
	1997	Single	Regular		Descriptive + causal inference
	2000	Single	Regular		Descriptive + causal inference
	2003	Single	Regular		Descriptive + causal inference
Greece	1998	Single	Regular	2009	Descriptive + causal inference
	2004	Multi-health	Tracking (with some exceptions, every 5 years)		Descriptive + causal inference
Hungary	2001	Single (alcohol and drugs)	First study	2007/11	Descriptive + explanatory
	2003	Single (alcohol, tobacco and drugs)	Tracking		Descriptive + explanatory
Ireland	2002/3	Single	First study	2010/11	Descriptive + causal inference
	2006/7	Single	Tracking (aim is a survey every 4 years)		Descriptive + causal inference
Italy	2001	Single (alcohol and drugs)	Tracking	2007/9	Descriptive
	2003	Single (alcohol and drugs)	Tracking		Descriptive + explanatory
	2005	Single (alcohol and drugs)	Tracking		Descriptive + explanatory
Latvia	2003	Single	First study	n.a.	n.a.
Lithuania	2004	Single	First (aim is a survey every 4 years)	2008	Causal inference
Malta	2001	Single	First study	Possibly 2011	n.a.
Netherlands	1997	Single	Tracking	Probably 2009	Descriptive + causal inference + explanatory
	2001	Single	Tracking		Descriptive
	2005	Single (web survey) Multi (CAPI survey)	Tracking		Descriptive
Norway	2004	Single main focus on alcohol	Tracking (every 5 years)	2009	Descriptive + causal inference + explanatory

Table 17 continued					
Country	Year	Context	Frequency	Current/next survey	Level of analysis
Poland	2002	Single (drugs and alcohol)	First study	n.a.	n.a.
Portugal	2001	Single (licit and illicit psychoactive substances)	First study, will be repeated	2007	n.a.
Romania	2004	Single	First study (aim is a survey every 3 years)	2007/10	Descriptive + causal inference
Scotland	2000	Multi-crime survey	Tracking	n.a.	n.a.
	2003	Multi-crime survey	Tracking		n.a.
	2004	Multi-crime and victimisation survey	Tracking		n.a.
	2006	Multi-crime and victimisation survey	Tracking		n.a.
Slovakia	2002	Single (alcohol and smoking)	Tracking (every 2 years from 1994 onwards)	2008	Descriptive + causal inference
	2004	Single (alcohol and smoking)	Tracking		Descriptive + causal inference
	2006	Single (alcohol, tobacco and drugs)	Tracking		Descriptive + causal inference
Spain	1995	Single	Tracking	2007/9	Descriptive + causal inference
	1997	Single	Tracking		Descriptive + causal inference
	1999	Single	Tracking		Descriptive + causal inference
	2001	Single	Tracking		Descriptive
	2003	Single	Tracking		Descriptive
	2005	Single	Tracking		Descriptive
	2006	Single	Tracking		Descriptive
Sweden	2004	Multi-health	First study (aim is a bi-annual survey)	2007/8	Descriptive
	2005	Multi-health	Tracking		Descriptive
	2006	Multi-health	Tracking		Descriptive

NB:

Adapted from the EMCDDA Handbook, p. 124 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

(!) The 2004 and 2006 studies were also part of the alcohol panel studies conducted in 2003, 2004, 2005 and 2006.

n.a.: not known/not available.

3.3 Commissioners and responsible agents

Policymakers need reliable and accurate data about the nature and the extent of the drug phenomenon in their country in order to be able to define priorities, to plan efficient interventions, and to evaluate long-term policies. Therefore, it only seems rational that the

commissioner — the authority or institute that initiates and commissions the population survey — is in most cases the national government, in particular the Ministry of Health (Table 18). Sometimes a research institute under the Ministry (e.g. STAKES in Finland or OKANA in Greece) commissions the survey. In Scotland, for example, the national research agency 'Scottish Executive Social Research' is the

commissioner. In none of the studied surveys is the commissioner a private or commercial enterprise. Neither is it a Ministry of Justice, which implicitly confirms that drug surveys are generally conducted from a health point of view ('health problem') rather than from a crime point of view ('illegal drug use').

The *agent responsible* for the survey — the body that is in charge of the organisation and the analysis of the survey — is usually a university. Given the practical and theoretical expertise of methodological and intrinsic aspects of conducting a (drug) survey, this seems reasonable. In several of the studied surveys, the responsible agent cooperated with commercial institutes for the data gathering (e.g. Austria, the

Netherlands 2001, France 2005, England and Wales). In Scotland and Spain, for example, a commercial research agency executed the survey.

In some countries, the national focal point was the commissioner (e.g. Bulgaria, Croatia, the Czech Republic, Italy) and/or the agent responsible (e.g. Belgium, France 1995 and 2000, Austria, Germany, Greece) for the general population survey. In Belgium, Slovakia and Sweden, the National Statistical Office (Federal Public Service Economy — Directorate-General Statistics Belgium, Statistical Office of the Slovak Republic, and Statistics Sweden respectively) played a major part in commissioning and/or conducting the survey.

Table 18: Agencies and authors of main survey reports

Country	Year	Commissioned by		Responsible agent	
		Type	Name	Type	Name
Austria	2004	G	Federal Ministry of Health and Women	G P	Federal Ministry of Health and Women Support in planning: Austrian Reitox focal point (ÖBIG) and Alcohol Coordination and Information Centre (AKIS) Execution: Market Institute Analysis: Ludwig Boltzmann Institute for Addiction Research
Belgium	2001	G	Federal and regional authorities	G A G	Scientific Institute of Public Health, Epidemiology Unit External cooperation from Department Biostatistics, Limburgs Universitair Centrum (LUC) and Federal Public Service Economy, Directorate-General Statistics Belgium
	2004	G	Federal and regional authorities	G A G	Scientific Institute of Public Health, Epidemiology Unit External cooperation from Department Biostatistics, Limburgs Universitair Centrum (LUC) and Federal Public Service Economy, Directorate-General Statistics Belgium
	2008	G	Federal and regional authorities	G A G	Scientific Institute of Public Health, Epidemiology Unit External cooperation from Department Biostatistics, Limburgs Universitair Centrum (LUC) and Federal Public Service Economy, Directorate-General Statistics Belgium
Bulgaria	2005		National focal point and National Centre for Addictions Financed by National Anti-Drug Strategy 2003–08		Centre for social strategies and initiatives, Sofia; National centre for investigating public opinion National focal point (methodological guidance)
Croatia	2009 (expected)	G	National focal point and International Relations Department – Office for Combating Narcotic Drugs Abuse of the Government of the Republic of Croatia	n.a.	n.a.

Table 18 continued					
Country	Year	Commissioned by		Responsible agent	
		Type	Name	Type	Name
Cyprus	2006	G	Cyprus Anti-Drug Council (semi-governmental body under the auspices of the Ministry of Health)	A	Intercollege Research Centre and Institute for Social Innovation
Czech Republic	2004	G	Czech national focal point (part of the Office of the Government)	G	Institute of Health Information and Statistics (UZIS CR, part of the Ministry of Health) Czech national focal point
Denmark	2000	A G-N	National Institute of Public Health, University of Southern Denmark and Ministry of the Interior and Health Questions about drugs were financed by the National Board of Health	A	National Institute of Public Health, University of Southern Denmark
	2005	A	National Institute of Public Health, University of Southern Denmark	A	National Institute of Public Health, University of Southern Denmark
	2008	G-N	The National Board of Health	A G-N	The National Board of Health National Institute of Public Health, University of Southern Denmark
England and Wales	1996	G	Home Office	G	Home Office, Research and Statistics Directorate
	1998	G	Home Office	G	Home Office, Research and Statistics Directorate
	2000	G	Home Office	G	Research Development and Statistics Directorate (part of the Home Office)
	2001/2	G	Home Office	G	Research Development and Statistics Directorate
	2002/3	G	Home Office	G	Research Development and Statistics Directorate
	2003/4	G	Home Office	G	Research Development and Statistics Directorate
	2004/5	G	Home Office	G	Research Development and Statistics Directorate
	2005/6	G	Home Office	G	Research Development and Statistics Directorate
	2006/7	G	Home Office	G P	Analysis: Research Development and Statistics Directorate Fieldwork: BMRB (British Market Research Bureau)
Estonia	2003	n.a.	n.a.		Institute of International and Social Studies
Finland	1992	G	Ministry of Social Affairs and Health	A	Department of Public Health, University of Helsinki
	1996	G	Ministry of Social Affairs and Health	A	Department of Public Health, University of Helsinki
	1998	G	Research & Development Centre for Welfare and Health (STAKES) (sector research institute under the Ministry of Social Affairs and Health)	G	Research & Development Centre for Welfare and Health (STAKES)

Table 18 continued					
Country	Year	Commissioned by		Responsible agent	
		Type	Name	Type	Name
	2002	G	Research & Development Centre for Welfare and Health (STAKES)	G	Research & Development Centre for Welfare and Health (STAKES)
	2004	G	Research & Development Centre for Welfare and Health (STAKES)	G	Research & Development Centre for Welfare and Health (STAKES)
	2006	G	Research & Development Centre for Welfare and Health (STAKES)	G	Research & Development Centre for Welfare and Health (STAKES)
France	1995	G	Ministry of Social Affairs and Health	P	Comité Français d'Éducation pour la Santé (CFES) (private organisation dedicated to improving the health of the French population through education and research)
	2000	G	Ministry of Social Affairs and Health	P G	Comité Français d'Éducation pour la Santé (CFES) + Observatoire Français des Drogues et Toxicomanies (OFDT) (national focal point for the European Reitox network, coordinated by the EMCDDA)
	2005	A	National Institute for Prevention and Health Education (INPES) (academic institution with public funding)	A P	National Institute for Prevention and Health Education (INPES) & ATOO (research agency)
Germany	1995	G	Ministry of Health		Institut für Therapieforschung (ITF)/Institute for Therapy Research (Reitox national focal point)
	1997	G	Ministry of Health		Institut für Therapieforschung (IFT)
	2000	G	Ministry of Health		Institut für Therapieforschung (IFT)
	2003	G	Ministry of Health (BMGS: Bundesministerium für Gesundheit und Soziale Sicherung, Federal Ministry for Health and Social Security)		Institut für Therapieforschung (IFT)
Greece	1998		OKANA (Organisation against Drugs) (governed by private law and reporting to the Ministry of Health and Social Solidarity)	A	University Mental Health Research Institute (U.M.H.R.I.) (Greek national focal point)
	2004		OKANA (Organisation against Drugs)	A	University Mental Health Research Institute (U.M.H.R.I.)
Hungary	2001	G	Ministry of Youth and Sports ISM	A	Budapest University of Economic Sciences and Public Administration, Behaviour Research Centre
	2003		National Research and Development Project	A P	Corvinus University of Budapest, Faculty of Social Sciences, Centre for Behaviour Research MIMIKRI Ltd
Ireland	2002/3	G	National Advisory Committee on Drugs (NACD) in Ireland and Drug and Alcohol Information and Research Unit (DAIRU) within the Department of Health, Social Services and Public Safety in Northern Ireland	G P	National Advisory Committee on Drugs via a research advisory committee MORI MRC (research agency)

Table 18 continued						
Country	Year	Commissioned by			Responsible agent	
		Type	Name	Type	Name	
	2006/7	G	National Advisory Committee on Drugs (NACD) in Ireland and Drug and Alcohol Information and Research Unit (DAIRU) within the Department of Health, Social services and Public Safety in Northern Ireland	G P	National Advisory Committee on Drugs via a research advisory committee MORI MRC (research agency)	
Italy	2001		Italian Observatory on Drugs and Drug Addiction, Ministry of Labour and Social Policy (the Observatory was formerly located in the Department for Social Affairs of the Presidency of the Council)	A	Epidemiological Section of the Institute of Clinical Physiology, National Research Council	
	2003		Italian Observatory on Drugs and Drug Addiction (OIDT), Ministry of Labour and Social Policy	A	Epidemiology Section of the Institute of Clinical Physiology, National Research Council	
	2005	A	Italian Observatory on Drugs and Drug Addiction, Epidemiology Section of the Institute of Clinical Physiology, National Research Council	A	Epidemiology Section of the Institute of Clinical Physiology, National Research Council	
Latvia	2003		2000 Phare National Programme for Latvia	A	Institute of Philosophy and Sociology, University of Latvia	
Lithuania	2004	G	National focal point Drug Control Department under the Government of the Republic of Lithuania	P	Institute of Sociology; Market Analysis and Research company RAIT Ltd.	
Malta	2001	G	National Commission on the abuse of drugs, alcohol and other dependencies, Ministry for Social Policy	A	University of Amsterdam, Bonger Institute of Criminology	
Netherlands	1997	G	Ministry of Health	A	Centre for Drug Research (CEDRO – Amsterdam University)	
	2001	G	Ministry of Health, Welfare and Sports	A P	Centre for Drug Research (CEDRO – Amsterdam University) & NIPO (field work partner)	
	2005	G	Ministry of Health, Welfare and Sports	A	IVO (Addiction Research Institute Rotterdam) Statistics Netherlands (CBS)	
Norway	2004	A	Norwegian Institute for Alcohol and Drug Research (SIRUS)	A	SIRUS Field work by MMI	
Poland	2002		National Bureau of Drug Prevention			
Portugal	2001		IPDT (Instituto Português da Droga e da Toxicodependência – Institute for Drugs and Drug Addiction)	A	CEOS – Investigações Sociológicas / UNL (Universidade Nova de Lisboa)	
Romania	2004	G	National Anti-drug Agency (subordinated to the Ministry of Administration and Interior)	G	National Anti-drug Agency	
Scotland	2000	G	Scottish Executive Central Research Unit	P	Company MVA Ltd.	
	2003	G	Scottish Executive Social Research	P	TNS Social Research + MORI Scotland (survey companies)	

Table 18 continued					
Country	Year	Commissioned by		Responsible agent	
		Type	Name	Type	Name
	2004	G	Scottish Executive Social Research	P	TNS Social Research + MORI Scotland (survey companies)
	2006	G	Scottish Government Social Research	P	BMRB Social Research (survey company)
Slovakia	2002	G	Statistical Office of the Slovak Republic (SO SR)	G	Institute for Public Opinion Research at the SO SR
	2004	G	Statistical Office of the Slovak Republic (SO SR)	G	Institute for Public Opinion Research at the SO SR
	2006	G	Statistical Office of the Slovak Republic (SO SR)	G	Institute for Public Opinion Research at the SO SR
Spain	1995	G	Plan Nacional de Drogas	P	EDIS/PND
	1997	G	Plan Nacional de Drogas	P	Sigma Dos (research agency)/PND
	1999	G	Plan Nacional de Drogas	P	Sigma Dos/PND
	2001	G	Plan Nacional de Drogas (Ministerio del Interior)	P	Sigma Dos
	2003	G	Plan Nacional de Drogas (Ministerio de Sanidad y Consumo)	P	Sigma Dos
	2005	G	Plan Nacional de Drogas	P	Sigma Dos
Sweden	2004	G	National Institute of Public Health (state agency under the Ministry of Health and Social Affairs)	G G	National Institute of Public Health Statistics Sweden (central government authority for official statistics and other government statistics)
	2005	G	National Institute of Public Health	G G	National Institute of Public Health Statistics Sweden
	2006	G	National Institute of Public Health	G G	National Institute of Public Health Statistics Sweden

NB:

Adapted from the EMCDDA Handbook, p. 125–126 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

Type of commissioner/responsible agent:

G: Government

A: Academic institution

P: Private/commercial company

n.a.: not known/not available.

3.4 Target population characteristics

3.4.1 Target population

a. Age restriction

The target population is mainly defined by age (Table 19). The lower age limits vary from 12 to 19 years and the upper limits start at 59, which means that studies do not diverge much from the setting recommended by the EMCDDA (15–64 years). A few studies do not have an upper age limit (e.g. Denmark, Poland, Norway, and Slovakia), and the Belgian HIS has no age restriction at all. All inhabitants of Belgium can

take part, although the written questionnaire, with more sensitive subjects such as AIDS, suicide, trauma and drugs, can only be completed by respondents over 15.

Most survey reports do not account explicitly for the specific age restriction of the target population, but when they do, they refer to the reasons given by the EMCDDA (for not questioning the elderly due to memory effects and/or their low prevalence rates for the use of prohibited drugs) or to the existence of school surveys (for not questioning youngsters). This is the case in the Hungarian survey of 2003. Further information about the definition of the target population was obtained through our expert survey.

In the Austrian survey, people up to 100 years old were questioned, because the survey focus was on alcohol and tobacco use, which the researchers believe is relevant to the *elderly* also. The Norwegian, Slovakian and Danish expert surveys show an interest in the alcohol/drug habits (or health) of the whole population, and not just of the target population set by the EMCDDA. A similar rationale is offered in the Swedish expert survey. The Danish experts argue that the elderly is an interesting group to study because in Denmark they drink more than in other countries. The United Kingdom implements an upper age restriction (59 years), but only for the drug part of the crime survey. A similar age restriction is made in Scotland. In 2003, the Scottish Crime Survey was administered to adult respondents only, as this made the administration easier for the interviewers and as it was also felt that there are likely to be increasing numbers of older adults with experience of drug use. However, in 2006 the drug module was again restricted to people under the age of 60.

In the Czech survey, *youngsters* under 18 years old were excluded from the target population, because the researchers assumed that youngsters would under-report their substance consumption in face-to-face interviews, especially when their parents were present during the interview. In addition, the 15–18 age group had already been questioned about drugs in school surveys. Nevertheless, the EMCDDA recommends the inclusion of youngsters in the general population sample in order to compare the results of the general population survey with those of the school survey. However, questioning youngsters may be restricted for several reasons. In Germany, for example, the interviewing of teenagers under the age of 18 is legally restricted, whereas in Sweden, youngsters of 16 years can participate without their parents' approval. Furthermore, an age restriction may have implicit social grounds. In Turkey, for instance, youngsters are not questioned about drug use, because the researchers do not want to incite or encourage them to use drugs.

Some countries *changed the definition of the target population* in the course of the successive waves. Over three surveys Finland lowered the minimum age and the upper age limit from 18 to 15 years and from 74 to 69 years respectively. The experts argue that the 15 to 69 year age range is consistent with their alcohol surveys. They also state that there are no drug users among people over 70, whereas some 15-year-olds have already tried drugs. Italy, on the other hand, raised the upper age limit from 44 to 64 years over three waves to bring the age of the target population in line with the recommendations of the EMCDDA. The

same reason is given by the experts of the Netherlands for the introduction of 64 years as an upper age limit. In the 2008/9 British Crime Survey, the upper age limit was also extended to 69 years to conform to the EMCDDA standard. The British will further test extending the age range to include children, but it is not certain yet whether this younger age group will be interviewed about drugs, since school surveys already provide drug information about this age group and '(...) *there are recognised problems with asking children of this age questions about drug use in their homes (e.g. possible impact on response if parents see these questions as intrusive; possible tendency to under-report if feel that parents might see responses).* However, there are some possible benefits: asking young people at the top of the age range these questions would provide a way of calibrating the two sets of prevalence (those from school surveys being higher than those from household surveys); the BCS provides regional prevalence rates whereas the school survey design only provides national estimates.'

b. Other restrictions

Several countries impose other restrictions on the target population besides age limits. For example, Austria, Ireland, the Netherlands, Cyprus, the Czech Republic, Lithuania, Romania, Norway, Scotland, Spain, Finland, France, Hungary and England and Wales excluded institutionalised people, including people in prison, nursing homes or clinics. The same applies to the Belgian survey, although elderly people living in old people's homes and (psychiatric) nursing homes were included in the sample, because of the main interest of the survey, i.e. health. Except for Romania, all these countries also mention that they did not interview homeless people. Although several countries recognised that those groups may be of interest for their potentially higher rates of drug use, they excluded them for practical reasons (groups are not covered by the sampling frame or are difficult to reach) in advance. Austria, France, Cyprus, the Czech Republic, the Netherlands, Spain and Germany limit their target population to native speakers, for practical and budgetary reasons. For obvious reasons, deaf people are excluded from the telephone survey in France.

c. Explicit versus implicit exclusion

A remark on the definition of the target population is called for. Defining or restricting the target population in advance is obviously only possible when the sampling frame contains the information that is needed to do so. For example, being deaf or the

language the respondent speaks, are pieces of information that are generally not available in a sampling frame. For that reason, some people are implicitly excluded from the sample. Findings from our expert survey illustrate this. Even though no groups were intentionally excluded from the Slovakian sampling frame, the expert survey finds that ‘*some marginalised or socially excluded persons (prisoners, homeless or hospitalised people) are difficult to reach*’. The implicit exclusion of these groups is also observed in the Austrian expert survey and may apply to other countries as well. A better standardised registration of the target population and the sample frame could help to explain the implicit/explicit exclusion.

3.4.2 Reasons for oversampling

a. High prevalence rates

Some specific target groups are often oversampled (Table 19). The main reason for oversampling is a higher prevalence of drug use in oversampled groups such as youngsters, city areas, and ethnic minorities.

Youngsters are oversampled most often. For example, the 15–39 age group was oversampled in the Spanish survey as the researchers wanted a high number of respondents in a group that is characterised by the highest vulnerability for drug consumption. Similarly, in the next survey of the Czech Republic the 15–29 age group will be oversampled to gather valuable information on drug availability, cannabis markets and intensive cannabis use (new modules in the next survey). In several other surveys youngsters were oversampled for precisely that reason (e.g. Denmark 2008, Croatia, Cyprus: 15–24 and 25–34 years, Finland: 15–34 years, Lithuania: 15–24 years, England and Wales, Hungary: 18–34 years). In Slovakia, the 15–17 age group was oversampled owing to the specific samples of 18+ and 15–29.

Furthermore, some countries oversampled city areas. The Romanian survey oversampled Bucharest because of its high prevalence of illegal drug use. For the same reason, the Hungarian surveys oversampled some cities or regions.

In recent meetings of the EMCDDA, the oversampling of youngsters and inner city or urban areas has been recommended with a view to a more cost-effective use of the sample (EMCDDA, personal communication, 2008c).

Finally, *ethnic minority groups* are sometimes oversampled. In addition to a young persons boost sample, the Scotland surveys contain an ethnic minority boost sample. Similar boost samples were drawn in the annual editions of the British Crime Survey (from 2001/2 onwards) ⁽¹³⁾. As the Home Office wanted separate estimates for ethnic minority groups, a boost sample was drawn in the main black and Asian minority populations ⁽¹⁴⁾. Again, higher expected prevalence figures in these groups were the reason for introducing the two boost samples in the British Crime Surveys. By oversampling these groups, the progress of the drug strategy could be monitored more efficiently.

b. Detailed information

Besides higher expected prevalence rates, the wish to obtain more detailed information about a specific group/region may be a reason for oversampling. In the Austrian survey, the province of Carinthia was oversampled because an extra budget was available for a special analysis of the province. In Spain, low-populated regions were oversampled in order to make more precise estimates at a regional level. The same applies to the Italian survey and the Irish survey of 2006/7, which oversampled some (small) geographical areas. In the Netherlands, the 12–18 age group and big cities were oversampled because the researchers wanted to present outcomes per stratum of 2 years/per city.

c. Low response rates

Finally, low response rates in certain groups can also be a reason for oversampling. In the Italian survey youngsters were oversampled as the response rate in the age group below 18 years tends to be low. In the next Estonian survey the young urban male population will be over-represented, since as a rule the response rate among them is the lowest. On the other hand, elderly women will be under-represented, since the response rate among them is the highest.

⁽¹³⁾ The ethnic boost was discontinued in 2006/7 because the increased sample size in the previous year already resulted in a large enough ethnic sample in the main survey.

⁽¹⁴⁾ Drawing samples in other ethnic minority groups was evaluated as not cost-effective given their size and dispersal within the general population.

Table 19: Target population characteristics			
Country	Year	Target population	Oversampling
Austria	2004	14–100 years Excluding non-native speakers, institutionalised people, homeless people and youngsters below 14 years	Yes: province of Carinthia
Belgium	2001	All inhabitants with no restrictions for age, nationality or legal status, except for the sensitive questions only 15+ years Excluding institutionalised people	Yes: the regions of Antwerp, Hainaut, Luxembourg and Limburg
	2004	All inhabitants with no restrictions for age, nationality or legal status, except for the sensitive questions only 15+ years Excluding institutionalised people	Yes: the elderly and the regions of Luxembourg and Limburg
	2008	All inhabitants with no restrictions for age, nationality or legal status, except for the sensitive questions only 15+ years Excluding institutionalised people	Yes: the elderly
Bulgaria	2005	18–60 years	No
Croatia	2009 (expected)	15–64 years	Yes: youngsters
Cyprus	2006	15–64 years Excluding non-native speakers and institutionalised people	Yes: 15–24 and 25–34 age groups
Czech Republic	2004	18–64 years Excluding non-native speakers, institutionalised and homeless people	No
Denmark	2000	16+ years	No
	2005	16+ years	No
	2008	16+ years	Yes: youngsters
England and Wales	1996	16–59 years (for drug section)	Yes: inner-city areas and ethnic booster (n=1995)
	1998	16–59 years (for drug section)	Yes: inner-city areas
	2000	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: ethnic boost sample
	2001/2	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: ethnic and youth boost samples
	2002/3	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: ethnic and youth boost samples
	2003/4	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: ethnic and youth boost sample
	2004/5	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: ethnic and youth boost sample
	2005/6	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: ethnic and youth boost sample
	2006/7	16–59 years (for drug section) Excluding institutionalised and homeless people	Yes: youth boost sample
Estonia	2003	15–69 years	n.a.

Table 19 continued			
Country	Year	Target population	Oversampling
Finland	1992	18–74 years Excluding institutionalised and homeless people	No
	1996	16–74 years Excluding institutionalised and homeless people	No
	1998	15–69 years Excluding institutionalised and homeless people	No
	2002	15–69 years Excluding institutionalised and homeless people	Yes: 15–34 age group
	2004	15–69 years Excluding institutionalised and homeless people	Yes: after 500 completed surveys, the age group of 15–34 is oversampled
	2006	15–69 years Excluding institutionalised and homeless people	Yes: 15–34 age group
France	1995	18–75 years	No
	2000	12–75 years	No
	2005	12–75 years, French-speaking (15+ for sensitive parts such as illicit drug use) Excluding homeless, deaf people and those living in institutions	No
Germany	1995	18–59 years, German-speaking	No
	1997	18–59 years, German-speaking	No
	2000	18–59 years, German-speaking	No
	2003	18–59 years, German-speaking	No
Greece	1998	12–64 years, Aegean and Ionian Islands excluded	Yes: 12–24 age group
	2004	12–64 years, Aegean and Ionian Islands excluded	Yes: 12–24 age group
Hungary	2001	18–65 years Excluding non-native speakers, institutionalised and homeless people	Yes: Budapest
	2003	18–54 years Excluding non-native speakers, institutionalised and homeless people	Yes: 18–34 age group in Budapest and bigger cities
Ireland	2002/3	15–64 years, living in private households	No
	2006/7	15–64 years, living in private households	Regions with smaller populations
Italy	2001	15–44 years	Youngsters (<18 years) and urban areas (Abruzzo, Liguria, Veneto)
	2003	15–54 years	Youngsters (<18 years) and urban areas (Abruzzo, Liguria, Veneto, Sicilia)
	2005	15–64 years	Youngsters (<18 years)
Latvia	2003	All residents aged 15–64 years	Yes: 15–24 years
Lithuania	2004	15–64 years Excluding institutionalised and homeless people	15–24 years
Malta	2001	18–65 years	Yes

Table 19 continued			
Country	Year	Target population	Oversampling
Netherlands	1997	12+ years	Yes: age group 12–18 years and 4 largest cities
	2001	12+ years Excluding homeless persons and illegal residents	The cities of Amsterdam, Rotterdam (these samples were not taken in NPO 2001 for budget reasons) + 12–19 age group
	2005	16–64 years Excluding non-native speakers, institutionalised and homeless people (for face-to-face survey) (!)	No
Norway	2004	15+ years	No
Poland	2002	16+ years	Some regions and cities
Portugal	2001	15–64 years	No
Romania	2004	15–64 years, non institutionalised	Bucharest
Scotland	2000	16–59 years (drug part) Excluding institutionalised people	Ethnic minority ‘boost’ sample & young person sample (12–15 age group)
	2003	16+ years Excluding institutionalised people	Young person sample (12–15 age group)
	2004	16+ years Excluding institutionalised people	n.a.
	2006	16–59 years (drug part) Excluding institutionalised people	n.a.
Slovakia	2002	Two specific samples: 18+ years and 15–29 years (2)	Yes: 15–17 age group
	2004	15+ years	No
	2006	15+ years	No
Spain	1995	15+ years People living in institutions, community establishments, homeless and non-native speakers excluded	Yes: 15–39 age group
	1997	15–65 years People living in institutions, community establishments, homeless and non-native speakers excluded	Yes: some regions and 15–39 years
	1999	15–65 years People living in institutions, community establishments, homeless and non-native speakers excluded	Yes: some regions with small population and 15–39 age group
	2001	15–64 years People living in institutions, community establishments, homeless and non-native speakers excluded	Yes: some regions with small population and 15–39 age group
	2003	15–64 years People living in institutions, community establishments, homeless and non-native speakers excluded	Yes: some regions with small population and 15–39 age group
	2005	15–64 years People living in institutions, community establishments, homeless and non-native speakers excluded	Yes: some regions with small population and 15–39 age group

Table 19 continued			
Country	Year	Target population	Oversampling
Sweden	2004	All people living in Sweden, 18–84 years	No
	2005	All people living in Sweden, 16–84 years	No
	2006	All people living in Sweden, 16–84 years	No

NB:

Adapted from the EMCDDA Handbook, p. 128 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

(¹) See Table 20: Survey methods applied.

(²) As there is a growing demand for treatment in the 22–25 age group, there was a specific sample of the 15–29 age group in the Slovakian drug survey of 2002.

n.a.: not known/not available.

3.5 Survey methods

3.5.1 Interviewing and completion modes

Most surveys used the face-to-face *interviewing mode* with the pen and paper (P&P) *questionnaire completion modes* (e.g. Greece, Spain and Norway) (Table 20). No more than a few countries used computers to assist the interviewer: CATI (Computer Assisted Telephone Interviewing) in France and CAPI (Computer Assisted Personal Interviewing) in the Netherlands, Denmark and Scotland and only the UK used CASI (Computer Assisted Self Interviewing). However, the EMCDDA has the impression that nowadays the CAPI and CASI completion modes are used more than Table 20 indicates (EMCDDA, personal communication, 2008c). Furthermore, Estonia, Italy, Sweden, Finland and Germany conducted a mail survey. Telephone surveys seem unpopular interviewing modes for drug surveys. Only France used a telephone survey to interview the general population but will consider the opportunity of an online survey for their next survey (in 2010). Online surveys are used even less. Apart from the online access panel in the 2005 Dutch survey, this method is never found to have been utilised in the analysed studies.

Some surveys combine different interviewing and questionnaire completion modes ('mixed mode design'). In some countries both the interviewer and the respondent each completed specific parts of the survey. For example, in the British Crime Survey, the more sensitive parts of the questionnaire (drugs and domestic violence) were completed by the respondents themselves. A similar questionnaire completion mode was used in Austria, Belgium, Spain, Scotland, Hungary, Denmark and Norway. In the Latvian survey the respondents only completed the survey by themselves when full privacy could not be ensured during the interview. In the German

survey of 2006, subjects who had not completed the questionnaire after the third reminder, were invited to answer the questions by phone (¹⁵).

3.5.2 Arguments for the choice of interviewing and completion modes

Now and then a survey report explains the choice of a specific interviewing and completion mode, sometimes considering the experience from previous studies and current pilot questioning (e.g. Hungary and Norway). Again, our expert survey extracted some extra information.

a. Face-to-face surveys

Face-to-face surveys are mostly chosen for their high response rates and the capacity to manage the (non-) response (Cyprus, the Czech Republic, Lithuania, Denmark 2005, Hungary). For example, Cyprus defends the choice of a (*Pen & Paper*) face-to-face survey as follows: '*financial feasibility, completion control, the impact on response rate, identification of non-response rate and dealing with non-response items*'. Austria justifies the use of the same method by referring to the support and trust the presence of an interviewer can create during the interview. High data quality of face-to-face surveys is brought forward in the Danish expert survey. Moreover, social or cultural contexts and traditions may require the researcher to use a (*Pen & Paper*) face-to-face survey, as the Lithuanian and Slovakian expert surveys illustrate.

Only a few countries used computers to assist the interviewer during the face-to-face interviews. A lack of equipment or trained interviewers was the reason for not conducting computer assisted interviews in the Czech Republic, Cyprus, Norway, Spain, Hungary, Ireland (2002/3), Lithuania and Slovakia. In our expert

(¹⁵) The German general population survey of 2006 was not further studied in the meta-analysis.

survey Cyprus, Norway, Denmark, Hungary, Lithuania and Slovakia are found to refer to the prohibitive costs of CASI or CAPI. However, the Slovakian experts are planning to conduct a computer-assisted survey in the future. The Hungarian and the Lithuanian experts also point out that the general population is not familiar enough with computers for computer-assisted interviews to be conducted.

Besides, in face-to-face surveys, and irrespective of whether a computer or Pen & Paper is used, drug and other sensitive questions are frequently completed by the respondent himself ('self-administered') to safeguard confidentiality (e.g. Austria, Belgium, Denmark 2005, England and Wales, Spain, Hungary). The experts of the British Crime Survey illustrate this as follows: *'The main survey mode is CAPI but for sensitive topics (drugs, domestic violence and sexual assault) CASI is used to encourage reporting. This is particularly important for young people living with their parents who might be reluctant to disclose activities about which their parents may not be aware, for fear of being overheard.'* Reasons why surveys are (partly) administered by the interviewer are the low reading comprehension of the target population (Austria) and *'to ensure that all the questions are answered and well understood'* (the Czech Republic).

b. Telephone surveys

One could list several arguments against telephone surveys. Irrespective of the use of either a telephone register or random digit dialling to select the sample, telephone surveys often have an unknown coverage, as some members of the target population have no telephone or cannot be reached by phone (under-coverage), while some households have more than one telephone (over-coverage). The spread of mobile phones, with unregistered phone numbers, also presents a challenge to telephone surveys. Finally, telephone numbers of companies and other institutions that are not part of the target population, also risk to be included in the sample (Beck et al., 2004). These arguments appear to be translated in the near absence of telephone surveys in our meta-analysis.

The only country to conduct a telephone survey was France. To legitimate their choice of a telephone survey, the French researchers performed several studies. In 1991 a pilot study comparing a computer assisted face-to-face survey with a telephone survey was carried out. Its conclusion was that the advantages of a face-to-

face survey did not justify its high financial costs (Beck and Guilbert, 2007). A later study investigated not only those groups that are usually not reached by telephone surveys (those who are ex-directory, those who are difficult to reach, and those with only a mobile telephone), but also the (possible) differences between fixed and mobile phone users. The researchers came to the following conclusion: *'Overall, taking into account "ex-directory", "difficult-to-reach" or "mobile-only" respondents had only a minor impact on prevalence estimates. However, our results also underline the importance of investigating these individuals with particular socio-demographic profiles and lifestyles (...).'* (Beck et al., 2004). Moreover, by using the reverse directory, the addresses corresponding to the numbers can be identified. In this way commercial numbers can be deleted from the sample, as in the Baromètre Santé 2000 and the Baromètre Santé 2005 (Beck et al., 2004). In our expert survey the French researchers account for their use of Computer Assisted Telephone Interviewing (CATI) by referring to the absence of population registers on the one hand and a high level of (mobile) phone penetration on the other. In addition, financial aspects, the ease to monitor interviewers, and acceptable response and participation rates, were further reasons for opting for a telephone survey. Nevertheless, for its next survey France will introduce the internet as an alternative data collection mode for those who refuse the telephone survey.

c. Mail surveys

Despite their low response rates, the lower costs of mail surveys may force the researcher to choose this data collection method (Finland, Denmark 2008). Furthermore, the respondents' privacy is more protected as they do not have to tell their answers to the interviewer. In this respect the Finnish experts state: *'People tend to answer sensitive questions more honestly in mail surveys than in personal contact in face-to-face or telephone surveys. (...) Despite lower response rates we have got higher prevalence rates of cannabis use in mail surveys than in face-to-face surveys (1992 and 2000) (16).* A similar reason is given in the Estonian national abstract of 2008: *'The response rate is below 50 %. (...) Many people simply refuse to answer. However, this is the only way to arrange a survey concerning drug use in Estonia, since it is impossible to ask these questions within the framework of an interview — there is reason to believe that people will fail to give honest answers.'*

(16) The surveys of 1992 and 2000 focused on alcohol use and drinking habits, but also included some drugs questions.

d. Online surveys

Online surveys are not a very popular way to conduct a general population survey on drug use, mainly because they lack a representative sample frame (e.g. the Czech Republic). Nevertheless, some countries have already tried out online surveys. The experience in the Netherlands is discussed below. Hungary conducted an online survey in 2007, but the response rate was disappointingly low.

3.5.3 Changes in interviewing and completion modes

Most countries that have already conducted several surveys, keep applying the same interviewing and completion modes, mainly to avoid unpredictable effects on the results (e.g. Norway). However, the Netherlands, Denmark, Scotland and Ireland, have made some adjustments in their most recent surveys.

In 2001, the Netherlands conducted a pilot study with a Multi Method (MM) way of data collection together with a Computer Assisted Personal Interviewing method (CAPI). In this MM, respondents could choose between a mail questionnaire (P&P), a questionnaire on diskette, a questionnaire on the internet (URL), or a telephone interview (reminder session). The CAPI method generally revealed lower drug prevalence rates than the MM. These differences were statistically significant, but small. The consistently lower CAPI prevalence rates could indicate mode effects, such as socially desirable answers. The results of the logistic regression also suggested that the MM and CAPI groups were not very different.

Because of the high costs and increasing non-response rates with CAPI on the one hand and a high Internet penetration in the Netherlands on the other, the Netherlands added an online access panel to the face-to-face survey (CAPI) in 2005⁽¹⁷⁾. The researchers came to the conclusion that the face-to-face survey offered more advantages than drawbacks. The CAPI method had a more representative sample, because of a better sample frame⁽¹⁸⁾, a higher response rate, and fewer indications for selective non-response. Therefore, the researchers decided to use only the data of the CAPI method in the analysis, and to leave aside the data of the online access panel. Nevertheless, the

authors of the 2005 report realised that because of the dropping response rates and the high costs of CAPI, other research methods should be taken into consideration. The self-completed online panel survey is a possible (low-cost) solution despite the relatively high self-selection and selective non-response. In a publication of Rodenburg et al. (2007), the researchers recommend using both the CAPI and the online access panel method for the next prevalence survey. The current online access panels can be used for identifying trends (increase or decrease of drug use). However, in our expert survey it is stated that only online access panels based on population registers will be used to control for selection bias.

Financial limitations also had an impact on the data collection mode in the most recent Danish drug survey (2008). The researchers argue that a web-based survey is generally cheaper than mail surveys, but delivers generally lower response rates. Therefore, a mixed mode method was chosen. Compared with the mail survey, the web-based survey reached fewer elderly. Youngsters and middle-aged people were reached equally numerous in the mail and in the web based survey. Whether these different methods also generate different prevalence rates (and thus bias) had not yet been established when this report was written.

It was not until 2006 that the Scottish Crime Survey was administered with CAPI. Previously, the P&P method, or as the authors call it 'PAPI' (Paper and Pen Interviewing), was used. The Scottish researchers concluded that the CAPI methodology yields more complete and accurate responses, diminishes the levels of (item and unit) non-response, and increases the proportion of people willing to admit to sensitive behaviours. Indeed, in the CAPI survey (2006), 37 % of the respondents aged between 16 and 59 admitted that they had taken an illegal drug at some point in their lives, whereas in the 2004 P&P survey this was only 24 %. However, it must be observed that this conclusion can only be drawn under the presupposition that the level of drug use remained stable in this period and that the different prevalence rates do not reflect any real increase in drug use.

In the Irish drug use survey of 2006/7, the pen and paper interviewing technique was replaced with

⁽¹⁷⁾ In 2006, only 54 % of the households had an Internet connection in Belgium versus 80 % in the Netherlands. Source: FOD Economie, KMO, Middenstand en Energie — Algemene Directie Statistiek en Economische Informatie, (z.d.), Communicatiemedia en audiovisuele media, [WWW] http://statbel.fgov.be/figures/d75_nl.asp [17/03/2008]

⁽¹⁸⁾ For the CAPI part of the survey, the Dutch Municipal Population Registry was used as sampling frame (known sampling frame). For the online survey, the sampling frame was the online access panel of SSI, a bureau for online field research. Therefore, this online sample of voluntary participants is drawn from an unknown sampling frame and is not representative for the general Dutch population.

computer assisted personal interviewing (CAPI). The researchers argue that this has several advantages: 'interviews can be administered more quickly, human error is minimised yielding higher-quality data, and

data input is managed more efficiently, thus cutting costs' ⁽¹⁹⁾. Moreover, the response rate is better and the data cleaning is supported by technological possibilities, still according the Irish researchers.

Table 20: Survey methods applied

Country	Year	Mode of interviewing	Survey methods specifications	Questionnaire completion	
				Interviewer	Respondent
Austria	2004	Face-to-face	P&P	No ⁽¹⁾	Yes ⁽¹⁾
Belgium	2001	Face-to-face	P&P	No ⁽¹⁾	Yes ⁽¹⁾
	2004	Face-to-face	P&P	No ⁽¹⁾	Yes ⁽¹⁾
	2008	Face-to-face	P&P	No ⁽¹⁾	Yes ⁽¹⁾
Bulgaria	2005	Face-to-face	n.a.	n.a.	n.a.
Croatia	2009 (expected)	Not decided yet	Not decided yet	Not decided yet	Not decided yet
Cyprus	2006	Face-to-face	P&P	No	Yes
Czech Republic	2004	Face-to-face	P&P	Yes	No
Denmark	2000	Face to face	P&P	No ⁽²⁾	Yes ⁽²⁾
	2005	Face-to-face	P&P	No ⁽²⁾	Yes ⁽²⁾
	2008	Mail online survey	n.a.	No	Yes
England and Wales	1996	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	1998	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	2000	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	2001/2	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	2002/3	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	2003/4	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	2004/5	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
	2005/6	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾
2006/7	Face-to-face	CASI ⁽¹⁾	No ⁽¹⁾	Yes ⁽¹⁾	
Estonia	2003	Mail	P&P	No	Yes
Finland	1992	Mail	P&P	No	Yes
	1996	Mail	P&P	No	Yes
	1998	Mail + telephone (small sample)	P&P	Yes	Yes
	2002	Mail	P&P	No	Yes
	2004	Mail	P&P	No	Yes
	2006	Mail	P&P	No	Yes

⁽¹⁹⁾ National Advisory Committee on Drugs (NACD) and Drug and Alcohol Information and Research Unit (DAIRU) 2008, *Drug use in Ireland and Northern Ireland, first results from the 2006/7 drug prevalence survey* (URL: http://www.nacd.ie/publications/survey_Final_25thJan.pdf) (Last accessed on 30 January 2008).

Table 20 continued					
Country	Year	Mode of interviewing	Survey methods specifications	Questionnaire completion	
				Interviewer	Respondent
France	1995	Telephone	CATI	Yes	No
	2000	Telephone	CATI	Yes	No
	2005	Telephone	CATI	Yes	No
Germany	1995	Self-administered mail	P&P	No	Yes
	1997	Self-administered mail	P&P	No	Yes
	2000	Self-administered mail	P&P	No	Yes
	2003	Self-administered mail	P&P	No	Yes
Greece	1998	Face-to-face	P&P	Yes	No
	2004	Face-to-face	P&P	Yes	No
Hungary	2001	Face-to-face	P&P	No (!)	Yes (!)
	2003	Face-to-face	P&P	No (!)	Yes (!)
Ireland	2002/3	Face-to-face	P&P	Yes	No
	2006/7	Face-to-face	CAPI	Yes	No
Italy	2001	Mail	P&P	No	Yes
	2003	Mail	P&P	No	Yes
	2005	Mail	P&P	No	Yes
Latvia	2003	Face-to-face	n.a.	Yes	No ⁽³⁾
Lithuania	2004	Face-to-face	P&P	No	Yes
Malta	2001	Face-to-face	n.a.	n.a.	n.a.
Netherlands	1997	Face-to-face	CAPI	Yes	No
	2001	Multi method: open choice methodology Face-to-face	P&P, diskette & URL (CATI and mail in reminder session) CAPI	No	Yes
		Face-to-face	CAPI	Yes	No
2005	Face-to-face	CAPI & PAPI for sensitive subjects	Yes (CAPI)	Yes (PAPI)	
	Online access panel	Web-based survey	No	Yes	
Norway	2004	Face-to-face	P&P	No ⁽⁴⁾	Yes ⁽⁴⁾
Poland	2002	Face-to-face	n.a.	n.a.	n.a.
Portugal	2001	Face-to-face	P&P	Yes	No
Romania	2004	Face-to-face	P&P	Yes	No
Scotland	2000	Face-to-face	P&P	No ⁽⁵⁾	Yes ⁽⁵⁾
	2003	Face-to-face	P&P	No ⁽⁵⁾	Yes ⁽⁵⁾
	2004	Face-to-face	P&P	No ⁽⁵⁾	Yes ⁽⁵⁾
	2006	Face-to-face	CAPI	No ⁽⁵⁾	Yes ⁽⁵⁾
Slovakia	2002	Face-to-face	P&P	Yes	No
	2004	Face-to-face	P&P	Yes	No
	2006	Face-to-face	P&P	Yes	No

Table 20 continued					
Country	Year	Mode of interviewing	Survey methods specifications	Questionnaire completion	
				Interviewer	Respondent
Spain	1995	Face-to-face	P&P	No (!)	Yes (!)
	1997	Face-to-face	P&P	No (!)	Yes (!)
	1999	Face-to-face	P&P	No (!)	Yes (!)
	2001	Face-to-face	P&P	No (!)	Yes (!)
	2003	Face-to-face	P&P	No (!)	Yes (!)
	2005	Face-to-face	P&P	No (!)	Yes (!)
Sweden	2004	Mail	n.a.	n.a.	n.a.
	2005	Mail	n.a.	n.a.	n.a.
	2006	Mail	n.a.	n.a.	n.a.

NB:

Adapted from the EMCDDA Handbook, p. 127 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

Survey methods specifications:

CAP: Computer Assisted Personal Interviewing

CASI: Computer Assisted Self Interviewing

CATI: Computer Assisted Telephone Interviewing

PAPI: Paper and Pen Interviewing

P&P: Pen & Paper

(¹) Drug section/socially or legally sanctioned behaviours are completed by the respondent; other sections are completed by the interviewer.

(²) Sensitive questions (e.g. about drugs and sexual behaviour) are collected by a self-administered questionnaire, delivered at the interview, and afterwards returned by mail by the respondent.

(³) In cases where it was not possible to ensure full privacy during the interview, the most sensitive part of the questionnaire (relating directly to drug use) was completed by the respondents themselves.

(⁴) Questions about illegal drugs were not asked, but presented on a separate sheet. The respondent could answer the questions unseen by the interviewer. The completed paper was put into a sealed envelope by the respondent.

(⁵) For the self-completed component (about drugs and violence) only; other sections were completed by the interviewer. Adults under the age of 60 years are asked about their exposure to and use of drugs (and experience of domestic violence). In 2003, it was decided to administer the self-completion questionnaire to all adult respondents. This implies a rise of the costs for data collection, but it makes administration easier for the interviewers. It was also felt that there are likely to be increasing numbers of older adults with drug use experience. However, in 2006 the drug module was again restricted to those under the age of 60.

The Young Person Self-Completion questionnaire was administered to all people aged 12 to 15 years resident in the respondent's household where the permission of a parent or guardian was granted ('boost sample').

n.a.: not known/not available.

3.6 Sampling characteristics

3.6.1 Sample frame

As a sample frame must give the best possible coverage of the target population, including or excluding certain demographic groups from the target population may influence the choice of sampling frame. Most countries do not deviate much from the recommended age setting of the EMCDDA (15–64 years) (Table 21). Election registers are thus not appropriate as a sampling frame because they leave youngsters out of the sample. Therefore, the absence of election registers as sampling frames in Table 21, with the exception of the Czech Republic and Malta, seems reasonable.

On the other hand, population registers and household address registries (e.g. postcode address files) are

frequently used as sampling frame. Such registers do not give a full representation of the entire population of a country, as they often exclude marginalised people. However, as most studies concentrate on people living in private households and exclude institutionalised or homeless people (e.g. Ireland, the Netherlands, Romania, Scotland, Finland, France and England and Wales), this does not present much of a problem.

France is the only country that has conducted a telephone survey. Taking advantage of technological changes, both a fixed phone and a mobile only survey were conducted in 2005 in order to reach the increasing number of people with only a mobile phone (Beck and Guilbert, 2007). For the fixed phone survey, the researchers used a telephone register as sampling frame, but only as a starting point. The randomly selected numbers were modified by adding '1' to the

final digit. For the mobile only survey, all numbers were randomly generated. By using randomly generated phone numbers, people with private numbers or with unregistered mobile numbers can also be reached. However, integrating people with private numbers may be problematic, as that group may be the least willing to cooperate in a telephone survey. Furthermore, those people of the target group without any kind of phone remain out of reach.

3.6.2 Sampling method

The choice of sampling method depends on the mode of data collection and the availability of specific and accurate sampling frames (Table 21). In line with the recommendation of the EMCDDA, almost every country used a random or probability sample. Non-probabilistic sampling methods, such as quota sampling in the surveys of Slovakia, are used less often. By contrast, the type of probability sample is more varied: from basic simple random sampling to stratified, clustered and multi-stage sampling.

A remark must be made regarding (simple) random sampling. Every individual in the target population has a known probability different from zero of being included in a probability sample. In simple random sampling, every individual in the population must have the identical probability of being included in the sample. In other random sampling methods, such as cluster sampling, the probability of being selected in the sample varies. Even though researchers may intend to select a (simple) random sample, it may turn out differently in reality. Indeed, the use of boost samples to select sufficient respondents among groups with low expected response rates or to select more respondents among relevant groups (youngsters, in the case of drug use) influences the selection probability of the individuals in the target population. Weighting of the survey data to ensure that the sample is representative of the general population or the replacement of those who refuse to cooperate or those who could not be contacted, also influences the selection probability. Furthermore, the sampling frame can contain one single individual several times, so that the selection probability is not equal for every

individual. For example, when using (randomly generated) telephone numbers to select respondents, people with one or more fixed phone(s) and/or one or more mobile phone(s) have several opportunities of being selected in the sample.

Survey reports often contain information about oversampling or weighting. The possible replacement of survey respondents is less well documented. In this respect, a standardisation of a detailed registration of the sampling method can be a valuable way to obtain more profound and accurate information about the sampling method.

3.6.3 Weighting

The last column of Table 21 indicates whether and how the results were weighted. Statistical weighting may be needed when certain groups are under- or over-represented in the sample carried out compared with the population distribution.

'No' indicates that no weighting was done. Only a few countries, including Italy or Finland, did not weight the survey data. This means that the responses were either considered representative (and no weighting was needed) or that the results may not accurately reflect the population (and no weighting was done to correct this).

In almost every study the results were weighted (indicated by 'yes' in Table 21). Weighting corrects sampling and response biases and makes the survey results representative for the target population. For example, to compensate for the oversampling of the province of Carinthia in the Austrian survey, the results were weighted by province.

Weighting variables should be closely linked with the study's main variables. In drug research, therefore, age, gender and region are relevant weighting variables as drug use has proven to be related to these variables. The findings in Table 21 (partly) confirm this. Especially age, gender and geographical characteristics (state, region or address density) are used as weighting variables. Kind of dwelling, household size, marital status, and ethnicity are used as weighting variables to a lesser extent.

Table 21: Sampling characteristics				
Country	Year	Sampling frame	Sampling method(s)	Weighting
Austria	2004	Addresses	Route random approach, within household: last birthday method	Yes: provinces
Belgium	2001	National register	Multi-stage probability sample, stratified by region, province and community Household as sampling unit	Yes: household, age, sex, date of the interview
	2004	National register	Multi-stage probability sample, stratified by region, province and community Household as sampling unit	Yes: household, age, sex, date of the interview
	2008	National register	Multi-stage probability sample, stratified by region, province and community Household as sampling unit	n.a.
Bulgaria	2005	Population registry	Two-stage randomised sampling procedure	Yes: age
Croatia	2009 (expected)	n.a.	n.a.	n.a.
Cyprus	2006	Geographical maps	Multi-stage proportionate stratified random sampling Geographical maps used for the selection of starting points. Selection and distribution of starting points based on area type and district, taking into consideration the density of population.	Yes: age, gender
Czech Republic	2004	Election registry	Random stratified sampling (strata: age, sex, region and education)	No
Denmark	2000	Central personal register (population registry)	Simple random sampling	Yes: country
	2005	Population, single individual registry	Random sampling of individuals in the 5 main administrative regions, with same number of sampled citizens in each of the regions	Yes: region
	2008	Population registry	Region and age stratified random sample	Yes: region and age
England and Wales	1996	Postcode address file (PAF)	Stratified face-to-face Within households: simple random	Yes: inner city, dwelling unit, individual, ethnic minority I, ethnic minority II (ethnic booster)
	1998	Postcode address file (PAF)	Stratified face-to-face Within households: simple random	Yes: inner-city areas, individuals living in households of different sizes
	2000	Postcode address file (PAF)	Cluster sampling (post code sector), stratified by police force area	Yes
	2001/2	Postcode address file (PAF)	Cluster sampling (post code sector), stratified by police force area (disproportionately) and other socio-demographic variables	Standard weighting + calibration weighting (designed to adjust for known differentials in response rates across age, gender and regional sub-groups)

Table 21 continued				
Country	Year	Sampling frame	Sampling method(s)	Weighting
	2002/3	Idem study 2001/2	Idem study 2001/2	Idem study 2001/2
	2003/4	Idem study 2001/2	Idem study 2001/2	Idem study 2001/2
	2004/5	Idem study 2001/2	Idem study 2001/2	Idem study 2001/2
	2005/6	Idem study 2001/2	Idem study 2001/2	Idem study 2001/2
	2006/7	Idem study 2001/2	Idem study 2001/2	Idem study 2001/2
Estonia	2003	Population register	Random sample	Yes: by age, gender
Finland	1992	Central population register	Simple random	No
	1996	Central population register	Simple random	No
	1998	Central population register	Simple random	No
	2002	Central population register	Simple random	Yes: age, gender, region
	2004	Central population register	Simple random sample	Yes: age, gender, region
	2006	Central population register	Simple random sample of individuals (not households)	Yes: age, gender, region
France	1995	Randomised dialling (Telephone files)	Simple random; within household: birthday	Yes: age, gender, geographical region, kind of dwelling
	2000	Randomised dialling (Telephone files)	Simple random; within household: birthday	Yes: age, gender, geographical region, kind of dwelling
	2005	Fixed phone survey: telephone list Mobile only survey: random generation of mobile numbers	Fixed phone survey: simple multi-stage probability sample (geographical area, household, individual); next birthday method Mobile only survey: random generation of mobile numbers, stratification by operator (filter question excluded people with a fixed phone)	Yes: sex, age, region, urban category, occupation
Germany	1995	Household randomly selected via random route; questionnaires dropped off/picked up	Multi-stage probability sample (1313 sampling points); stratified by region; household person with the most recent birthday	Yes: age, gender, federal state, household size
	1997	Household randomly selected via random route; questionnaires dropped off/picked up	Multi-stage probability sample (1313 sampling points); stratified by region; household person with the most recent birthday	Yes: age, gender, federal state, household size
	2000	Household randomly selected via population registry; questionnaires sent and returned by mail	Multi-stage probability sample stratified by region	Yes: age, gender, federal state, household size
	2003	Population lists in the community	Two stages: community-respondent, systematic sampling in the second stage	Yes: gender, age, region (old Bundesländer vs. new Bundesländer)

Table 21 continued				
Country	Year	Sampling frame	Sampling method(s)	Weighting
Greece	1998	Household addresses	Face-to-face: town, flats, dwelling unit within household: random, using Kish selection grid Multi-stage probability sample	Yes: age
	2004	Household addresses	Multi-stage stratified probability sample	Yes: age, gender, geographical stratum
Hungary	2001	Database of the Central Data Processing, Registration and Election Office	Random stratified sampling: Budapest sub-sample: one-step sampling layered by districts; Countryside sub-sample: two-step sampling layered by the location and size of municipalities, individuals selected by simple random sampling	Yes : National sample by location; Budapest sample by age and gender
	2003	Database of the Central Data Processing, Registration and Election Office	Random stratified sampling by location and size of municipalities and age groups	Yes: National sample: by age groups, location and size of municipalities; Budapest sample: 18–34 age group also weighted by gender
Ireland	2002/3	Postcode address file (PAF) (N. Ireland) GeoDirectory (≈ PAF; Ireland)	Multi-stage sampling: stratified (by health board) random selection of primary sampling units (areas: electoral Divisions). Households selected at random from within each primary sampling unit. Individuals selected by 'last birthday rule'	Yes: age, gender, area
	2006/7	Postcode address file (PAF) (N. Ireland) GeoDirectory (≈ PAF; Ireland)	Multi-stage sampling: stratified (by health board) random selection of primary sampling units (areas: electoral Divisions). Households selected at random from within each primary sampling unit. Individuals selected by 'last birthday rule'	Yes: age, gender, area
Italy	2001	Register of the resident population	Stratified random sampling from resident population	No
	2003	Register of the resident population	Stratified random sampling from resident population	No
	2005	Register of the resident population	Multi-stage stratified random sample	No
Latvia	2003	National population register	Multi-stage stratified random sampling (regions and type of settlement, residential addresses, respondent)	Yes: age
Lithuania	2004	2001 Population and Housing Census, Department of Statistics to the Government of the Republic of Lithuania	Multi-stage stratified random sample	Yes: age, gender

Table 21 continued				
Country	Year	Sampling frame	Sampling method(s)	Weighting
Malta	2001	Electoral register	Stratified random sampling	Yes: age, gender, local council, marital status, education, employment and financial situation
Netherlands	1997	Municipal population registry	Two-stage stratified sample (municipalities, persons)	Yes: age, gender, marital status, address density
	2001	Dutch Municipal Population Registry (GBA)	Two-stage (municipalities, persons) proportional stratified probability sample (gender, age and education level)	Yes: address density, age, gender, marital status
	2005	Dutch Municipal Population Registry Online access panel of SSI (bureau for online field research)	Two-stage (municipalities, persons) stratified sampling (gender, age, education level, region and cultural origin) Stratified sampling (gender, age, education level, region and cultural origin)	Yes: age, gender, marital status, address density, household size, response month Yes: demographic variables (\approx CAPI)
Norway	2004	Household register (addresses)	Stratified sampling (stratified on geography, community size and community type), random addresses in communities, random person	By age, gender and stratum (community type)
Poland	2002	n.a.	n.a.	To balance overestimation of some regions and cities and additionally by gender, age, city-village and educational level
Portugal	2001	List of statistical sections, National Statistics Institute	Multi-stage random sample	By age, gender and geographical region
Romania	2004	Household registry	Probabilistic, stratified and multi-stage (stratification variables were the size and type of habitat)	Yes: age group, gender, geographical area, habitat type (size: rural, small urban, big urban)
Slovakia	2002	Data from Census 2001	Quota sample with randomisation in the last step	No
	2004	Data from Census 2001 and Balance of Population Motion 2003	Quota sample with randomisation in the last step	No
	2006	Census 2001 and Balance of Population Motion 2005	Quota sample with randomisation in the last step	No
Scotland	2000	Postcode Address File (PAF)	Probability sample selected according to a multi-stage stratified design; clustered	Yes: to compensate for design elements of the survey and for non-response bias
	2003	PAF Postcode Address File	Probability sample selected according to a multi-stage stratified design; within household: random, using Kish selection grid; clustered	Yes: to compensate for design elements of the survey and for non-response bias
	2004	Idem	Idem	Idem
	2006	Idem	Idem	Idem

Table 21 continued				
Country	Year	Sampling frame	Sampling method(s)	Weighting
Spain	1995	Household addresses	Multi-stage: electoral districts within autonomous communities Quotas and random walks	Yes: age, gender, region
	1997	Household addresses	Multi-stage: electoral districts within autonomous communities Quotas and random walks	Yes: age, gender, region
	1999	Household addresses	Multi-stage: electoral districts within autonomous communities Quotas and random walks	Yes: age, gender, region
	2001	Household addresses	Multi-stage sampling, stratified according to congregations, with previous selection of primary units (councils) and secondary units (sectors) following a proportional random method and the selection of the final units (individuals) by means of a systematic selection of the homes and then selecting individuals by an aleatory numbers table	Yes: age, gender, territorial habits (regions)
	2003	Household addresses	Multi-stage sampling, stratified according to congregations, with previous selection of primary units (census sections) and secondary units (autonomous) following a proportional random method and the selection of the final units (individuals) by an aleatory numbers table	Yes: age, gender, territorial habits (regions)
	2005	Census sections registry and household registry	Three-stage random design (census sections, households, individuals): Census sections selected by stratified random sampling (stratified by autonomous community) Households selected by non-probabilistic method (systematic random routes procedure) Subjects selected by stratified random sampling (stratified by age)	Yes: age, gender, autonomous community
Sweden	2004	Population registry	Random sampling	Yes: country, for age, gender, country of birth, marital status, income, living in large city
	2005	idem	idem	idem
	2006	idem	idem	idem

NB:

Adapted from the EMCDDA Handbook, p. 129–130 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

n.a.: not known/not available.

3.7 Sample characteristics

3.7.1 Sample size

To evaluate the sample size, it is necessary to know the size of the target population. In a large number of population surveys the exact size of the target population was unknown or was not assessed (Table 22). Extra information was obtained by the expert survey. Table 22 presents the *estimated size of the target population*. As one would expect, this size depends on the population figures and the delineation of the target population. The higher the population figure on the one hand and the more broadly-defined the target population on the other, the higher the size of the target population.

In addition, the *sample size* varies significantly among countries, often due to the diverse sizes of the target populations. However, there is no clear-cut connection between the (estimated) sizes of the population and the sample sizes. For example, in the Maltese study with a population of 0.2 million people, the sample size was 2 828, while Hungary and Sweden had a similar sample size (respectively 2 500 and 3 000 respondents) for a much larger target population (respectively 7.8 million and 6.0 people). The evaluation of the sample size should also take into account the low expected prevalence rates of drug use and the increasingly high non-response rates. These latter two elements require higher sample sizes. In this respect, several countries have recently raised their sample size or indicated that the sample size will be increased in the next survey (Spain 2005, Slovakia). However, not all countries find it easy to raise their sample sizes. The 2003 national abstract of Bulgaria, for instance, states that financial aspects are an important problem for the sample size.

For the expert survey we asked how the sample size had been determined. For Austria, England and Wales, France, Finland, Norway, the Czech Republic, Denmark (2008) and the Netherlands a *good precision* of the prevalence rates, even on different levels (regions, age ranges, etc.) was a major factor in the determination of the sample size. Countries such as Finland and Lithuania also report that *low expected drug prevalences* require higher sample sizes. Finland, Italy, Norway, Spain, Romania and the Netherlands declare that the available *financial sources* were a decisive factor for determining the size of the sample. In practical terms this means that the sample size is lower than the ideal size because of an inadequate

budget. Finally, in the Czech, Slovakian, Irish and Norwegian survey, a *statistical rule* determined the sample size.

3.7.2 Response rates

a. Need for standardisation

High response rates are generally seen as a major quality criterion in surveys. Indeed, besides the selectivity of the non-response, response rates are important to evaluate the non-response error. Response measurements also serve as quality benchmarks across different surveys, including this meta-analysis.

However, the EMCDDA states that *'differences in rates may be due to different concepts rather than real differences in response'* (EMCDDA, 2002). With the exception of some studies with extended technical reports (e.g. Ireland), the information about the definition of (non-)response rates and the calculation of these rates are missing. As a result, it is not always clear what the concept 'sample size' actually refers to: to the sample drawn from the frame, to the sample that was approached or to the sample that was actually questioned in the field. Frame errors may be included or excluded, and the figures of sample size, net response and response rate sometimes differ slightly depending on the publication. In the Scottish Crime Survey of 2003 (McVie et al., 2005) these differences are explained as follows: *'It is important to note that all figures presented in this report are the result of fresh analysis of the data, including the re-analysis of previous sweeps of the survey. This has resulted in some figures presented here being slightly different from previously published findings.'*

Therefore, in order to use response rates as quality measurements and to compare response rates across different surveys rather than merely registering all response rates, it may be useful to provide standard tables and definitions, such as those of the American Association of Public Opinion Research (AAPOR). In 2008, the AAPOR published an update of 'Standard definitions, Final dispositions of case codes and outcome rates for surveys', which develops specific standard definitions and formulas for calculating response rates for three different types of sampling modes (random-digit dial telephone surveys, in-person household surveys and mail surveys of specifically named persons ⁽²⁰⁾) (AAPOR, 2008). Standardised response rates can be reported by following three steps:

⁽²⁰⁾ In the future, AAPOR will expand the report with modern sample modes such as internet-based surveys.

First, the survey cases must be divided into four main groups:

1. Interviews
 - a. partial
 - b. complete
2. Eligible cases that are not interviewed (non-respondents)
 - a. refusals/break-offs
 - b. non-contacts
 - c. other (e.g. dead, language problem)
3. Cases of unknown eligibility (no interview)
4. Cases that are not eligible (e.g. out of sample)

Second, based on these categories, outcome rates such as response rate ⁽²¹⁾, cooperation rate ⁽²²⁾, refusal rate ⁽²³⁾ and contact rate ⁽²⁴⁾ can be calculated.

Third, standardisation is also needed on the meta-data level. Comparing the outcome rates of different surveys will only be possible if survey-specific features like the sampling unit, the use of substitution ⁽²⁵⁾ or proxies ⁽²⁶⁾, and the data collection process, are well defined (AAPOR, 2008; De Keulenaer, 2007).

However, the use of standard definitions is not always very self-evident. For example, considering that the standards of AAPOR sometimes result in response rates that are much lower than what can be estimated using less rigorous procedures, Johnson and Owens (2003) conclude that *'while a relatively high survey response rate alone may not be sufficient to guarantee a paper's acceptance for publication, a relatively low rate may be enough to guarantee rejection. Consequently, the current lack of standards on the part of many journals, along with a general recognition that high survey nonresponse may be a barrier to publication, establishes an environment in which full disclosure is not encouraged.'*

Nevertheless, if researchers want to monitor and improve the survey process and to analyse, compare and enhance response rates, they should report the following at the least: (1) the total sample size, with breakdowns by number interviewed, (2) the number eligible but not interviewed, (3) the number ineligible, and (4) the number with undetermined eligibility. All

these numbers should be based on standard definitions such as theses of the AAPOR (AAPOR, 2008; Stoop, 2005).

b. *Low/decreasing response rates*

The *net response* — the number of people that actually participate in the population survey — and the *response rates* fluctuate greatly: from less than fifty percent to nearly one hundred percent of the sample. Not only do these numbers indicate a big variance between response rates of the different surveys, but also the high response percentage of some studies is striking. There are several possible explanations for the big variance in response rates. The mode of interviewing is one of them. Mail surveys tend to produce lower response rates than face-to-face surveys. However, a clear connection between the interviewing mode and the response rate cannot be found in this meta-analysis. For example, the Finnish mail survey yields response rates that are comparable with those of the face-to-face surveys, while the Italian mail surveys only reached a response rate of about 35 %. However, in view of the discussion mentioned above, comparing non-standardised response rates is delicate and may lead to rash conclusions.

It is important to mention that in the 2007 and 2008 national abstracts of the EMCDDA (EMCDDA, 2007; EMCDDA 2008b), and in our expert survey, several countries bring up decreasing and/or low response rates as an important recurrent problem (Denmark, Estonia, Finland, Germany, Greece — Denmark, Finland, Germany — Norway, Romania, Hungary). For example, in the Austrian survey, no fewer than 79 % of the selected persons refused to cooperate. In most Finnish and Danish surveys (the Health Interview Survey as well as the Alcohol and Drug Survey), non-response rates were particularly high for young men. In the Hungarian survey, response rates were also the lowest in the younger age group (18–35 years). The researchers explain this by the high unregistered residential mobility of this age group. On the other hand, in the Finnish survey of 2006 response rates were highest among the oldest age group (63–69 years). This could lead to an underestimation of drug use, as the prevalence of illegal drug use is generally the highest among young men and the lowest among the older age groups.

⁽²¹⁾ 'The number of complete interviews with reporting units divided by the number of eligible reporting units in the sample.'

⁽²²⁾ 'The proportion of all cases interviewed of all eligible units ever contacted.'

⁽²³⁾ 'The proportion of all cases in which a housing unit or respondent refuses to do an interview, or breaks-off an interview of all potentially eligible cases.'

⁽²⁴⁾ 'The proportion of all cases in which some responsible member of the housing unit was reached by the survey.'

⁽²⁵⁾ 'The replacement of an originally sampled unit by another unit.'

⁽²⁶⁾ 'The use of one individual to report on an originally sampled person.'

Some countries have made some efforts to remedy the low response rates. In the 2003 survey, Germany conducted a short telephone survey to investigate the response bias introduced by non-responders. Almost 70 % (68 %, to be precise) of the non-responders were reached. In the 2006 German survey, those who had not completed the mail survey after several reminders were invited to answer the survey questions by

telephone (mixed mode design). Moreover, Germany is considering other initiatives to increase response rates in the future. Giving incentives and adapting the length of the questionnaire are possible options. Hungary intends to increase the response rates of their 2007 survey by combining the face-to-face interviewing mode with postal and web based contacting/ interviewing modes.

Table 22: Sample characteristics

Country	Year	Estimated size of target population (millions)	Original sample size (n) (sample size minus frame errors)	Net response	Response rate (%)
Austria	2004	6.5	21 600	4 546	21 %
Belgium	2001	n.a.	10 000 (!)	12 050 (!)	n.a.
	2004	n.a.	12 600 (!)	12 945 (!)	n.a.
	2008	n.a.	11 000	not app.	not app.
Bulgaria	2005	n.a.	n.a.	1 036	n.a.
Croatia	2009 (expected)	4.4	2 000	not app.	not app.
Cyprus	2006	0.5	9 734 (5 405)	3 504	64.8 %
Czech Republic	2004	6.8	5 433 (5 170)	3 526	68.2 %
Denmark	2000	4.3	22 484	16 688	74 %
	2005	4.3	21 832	14 566	67 %
	2008	4.4	7 000	4 015	57.4 %
England and Wales	1996	35.0	Core sample: 19 808 Drug section: 11 244	Core sample: 16 348 Drug section: 10 940	Core sample: 82.5 % Drug section: 97.3 %
	1998	35.0	Core sample: 18 983 Drug section: 10 293	Core sample: 14 947 Drug section: 9 988	Core sample: 78.7 % Drug section: 97.0 %
	2000	n.a.	Core sample: 26 291 Drug section: 13 300	Core sample: 19 411 Drug section: 13 021	Core sample: 73.8 % Drug section: n.a.
	2001/2	n.a.	Core sample: 32 797 Drug section: 21 946	Core sample: n.a. Drug section: 20 1462 (2)	Core sample: 74 % Drug section: n.a.
	2002/3	n.a.	Core sample: 36 479 Drug section: 24 604	Core sample: n.a. Drug section: 23 5863 (3)	Core sample: 74 % Drug section: n.a.
	2003/4	n.a.	Core sample: 37 891 Drug section: 25 533	Core sample: n.a. Drug section: 24 4224 (4)	Core sample: 74 % Drug section: n.a.
	2004/5	n.a.	Core sample: 46 810 Drug section: 29 713	Core sample: n.a. Drug section: 28 5095 (5)	Core sample: 75 % Drug section: n.a.
	2005/6	n.a.	Core sample: 46 810 Drug section: 31 627	Core sample: n.a. Drug section: 29 9326 (6)	Core sample: 75 % Drug section: n.a.
2006/7	n.a.	Core sample: 47 203 Drug section: 31 130	Core sample: n.a. Drug section: 29 1447 (7)	Core sample: 75 % Drug section: n.a.	

Table 22 continued					
Country	Year	Estimated size of target population (millions)	Original sample size (n) (sample size minus frame errors)	Net response	Response rate (%)
Estonia	2003	n.a.	4 000 (3 982)	1 633	Below 50 %
Finland	1992	3.5	4 892	3 458	70.7 %
	1996	3.5	4 429	3 009	67.9 %
	1998	3.5	Mail 3 250 Phone 550	Mail 2 143 Phone 425	Mail 65.9 % Phone 77.2 %
	2002	3.6	4 033	2 541	63.0 %
	2004	3.6	2 207 (panel 1 786)	1 178 (panel 1 355)	53.2 % (panel 75.9 %)
	2006	3.6	5 488 (panel 989)	3 029 (panel 885)	55.2 % (panel 89.5 %)
France	1995	40.0	4 116 (3 484)	1 993	75.5 %
	2000	45.0	28 162 (21.803)	13 685	70.8 %
	2005	46.0	67 019 fixed phone + 34 778 mobile only (50 066 fixed phone + 10 589 mobile only)	30 514 (26 672 fixed phone & 3 842 mobile only)	63.1 %
Germany	1995	48.9	12 052	7 833	65 %
	1997	48.5	12 358	8 020	65 %
	2000	n.a.	n.a.	8 139	51 %
	2003	n.a.	n.a.	8 061	55 %
Greece	1998	7.5	4 960 (4 682)	3 752	80.1 %; 22.2 % substituted
	2004	n.a.	n.a.	n.a.	n.a.
Hungary	2001	7.8 (1.2 Budapest & 6.6 countryside)	2 500 (1 000 Budapest & 1 500 countryside)	2 359 (862 Budapest & 1 479 countryside)	94.4% (86.2 % Budapest & 99.8 % countryside)
	2003	5.4 (0.96 Budapest & 4.4 countryside)	4 012 (854 Budapest & 3 158 countryside)	3 675 (604 Budapest & 3 071 countryside)	91.6 % (70.7 % Budapest & 97.2 % countryside)
Ireland	2002/3	3.7 (2.7 I & 1.0 N-I)	8 474 I & 8 135 N-I (7 037 I & 5 612 N-I)	8 434 (4 918 I & 3 516 N-I)	70 % I & 63 % N-I
	2006/7	n.a. (2.9 I & - N-I)	n.a. (7 677 I & - N-I)	n.a. (4 967 I & 2 002 N-I)	65 % I & 62 % N-I
Italy	2001	24.0	7 000	2 580	37.0 %
	2003	31.6	36 979	11 869	34.4 %
	2005	38.6	84 004	27 995	3.3. %
Latvia	2003	n.a.	6 500 (6 162)	4 534	74 %
Lithuania	2004	2.3	7 272 (*)	4 207	56.4 %
Malta	2001	0.2	2 828 (2 569)	1 755	62.1 % (68.3 % corrected for frame errors)

Table 22 continued					
Country	Year	Estimated size of target population (millions)	Original sample size (n) (sample size minus frame errors)	Net response	Response rate (%)
Netherlands	1997	13.2	41 766 (36 684)	21 959	59.9 %
	2001	11.4	40 573 (37 507) (32 512 MM & 8 061 CAPI)	17 655	47.1 % (48.7 % CAPI & 46.8 % MM)
	2005	11.0	7 204 57 125	4 516 20 282 (12 715 EMCDDA & 7 567 CBS)	62.7 % 35.5 %
Norway	2004	ca 3.7	3 191	n.a.	n.a.
Poland	2002	n.a.	n.a.	n.a.	n.a.
Portugal	2001	n.a.	n.a.	n.a.	n.a.
Romania	2004	22	3 500	n.a.	67 %
Scotland	2000	n.a.	7 760 (7 179)	Core sample: 5 059 Drug section: 2 886	Core sample: 71.0 % Drug section: ~40.2 % ^(?)
	2003	n.a.	8 190 (7 405)	Core sample: 5 041 Drug section: 4 665	Core sample: 68.1 % Drug section: 63.0 %
	2004	n.a.	8 485 (7 327)	Core sample: 5 007 Drug section: 4 424	Core sample: 68 % Drug section: 63.7 %
	2006	n.a.	n.a. (7 125)	Core sample: 4 988 Drug section: 4 701	Core sample: 70.0 % Drug section: 66.0 % ^(?)
Slovakia	2002	4.3	1 492	1 402	94.0 %
	2004	4.4	1 600	1 526	95.4 %
	2006	4.5	1 600	1 521	95.1 %
Spain	1995	31.0	10 000	9 984	80 % of people selected 20 % after substitution
	1997	27.0	9 000	12 515	n.a. ⁽¹⁰⁾
	1999	27.3	12 455	12 488	n.a. ⁽¹⁰⁾
	2001	27.9	14 113 ⁽¹¹⁾	14 113	n.a. ⁽¹⁰⁾
	2003	28.8	12.033 ⁽¹¹⁾	12 033	49.0 %
	2005	29.6	27 934 ⁽¹¹⁾	27 934	49.9 %
Sweden	2004	6.9	20 000	12 166	61 %
	2005	7.0	10 000	6 024	60 %
	2006	7.0	10 000	5 995	60 %

NB:

Adapted from the EMCDDA Handbook, p. 131 (EMCDDA, 2002).

Data from the 2001 EMCDDA overview is indicated in grey.

⁽¹⁾ The aim was to obtain a sample of more than 10 000 respondents. As the household is the sample unit and maximal 4 individual respondents per household are selected for the HIS, the net response may exceed the original sample size.⁽²⁾ Additional sample of 1 536 16- to 24-year-olds, response rate for the young boost was 72 %.⁽³⁾ Additional sample of 1 491 16- to 24-year-olds, response rate for the young boost was 75 %.⁽⁴⁾ Additional sample of 2 332 16- to 24-year-olds, response rate for the young boost was 72 %.⁽⁵⁾ Additional sample of 2 653 16- to 24-year-olds, response rate for the young boost was 74 %.⁽⁶⁾ Additional sample of 2 259 16- to 24-year-olds, response rate for the young boost was 69 %.⁽⁷⁾ Additional sample of 2 089 16- to 24-year-olds, response rate for the young boost was 75 %.⁽⁸⁾ Valid gross sample size is not available. Field work agency did not count frame errors.⁽⁹⁾ The drug questions in the self completion module were only asked of respondents aged 16–59; thus not everyone who participated in the survey completed this module.⁽¹⁰⁾ Before 2003, the response rate was not well known.⁽¹¹⁾ One can consider that the original sample size is the same as the net sample, because with random route sampling it is not easy to know the frame errors.

n.a.: not known/not available.

not app.: not applicable.

Chapter 4

Financial focus and timetable

We reviewed the financial sources and the timetable of the European general population surveys (Tables 23, 24 and 25). Most of the (technical) reports in the surveys contained no financial data and only limited time data. Neither are these aspects assessed by the EMCDDA. It was thus difficult to collect sufficient information, and in the expert survey additional information was requested. As this information can be very detailed and of a sensitive nature, we only asked for the financial data of the most recent survey we studied and we left the experts free not to reveal the exact financial information in this report ⁽²⁷⁾. As 'time' and 'money' are interrelated, the analysis of the timetable was also restricted to that same survey.

4.1 Financial sources

Table 23 gives an overview of the financial resources of the surveys. Most of this information had to be requested by our expert survey. Somehow, finances remain a taboo topic. Many countries asked not to release their financial information in this meta-analysis or simply did not reply to the financial questions. Drawing conclusions is therefore not easy.

Information about the survey method and the (standardised) sample size is crucial when the size of a survey budget is evaluated. A face-to-face survey with a large sample size is generally more expensive than a mail survey with an equally large sample size. However, our meta-analysis does not reveal any clear relationship between sample size and sample method on the one hand, and the survey budget on the other. Furthermore, when comparing budgets, the standard

of living in the different countries must be borne in mind. For instance, wages in Hungary or Romania are undoubtedly much lower than in Belgium. Therefore, as personnel costs are a substantial part of the cost of a survey, especially face-to-face surveys, the absolute figures may be misleading. It may be more effective to establish what percentage of the total national research budget is spent on drug research. Of course, this is beyond the scope of this meta-analysis.

Comparing surveys from different countries may therefore be difficult. However, one constant element to emerge from this meta-analysis is that data collection is not only a very expensive phase in the survey process (Table 24), but also requires a large number of staff (Table 25).

The EMCDDA 2007 and 2008 national abstracts (EMCDDA, 2007; EMCDDA 2008b) show that several countries consider the funding of the survey to be a serious concern (Bulgaria, the Czech Republic, Italy, Malta, Greece, and Austria respectively). This comes as no surprise, as general population surveys are expensive and repetitive surveys require sustained funding. As our expert survey shows, this sometimes leads to restrictions on the length of the questionnaire and the sample size (Netherlands, Norway and Romania).

About the finances there is a more general consensus. Almost every population survey was funded by the national or the regional government. Academic institutions and private or commercial enterprises hardly play any financial part.

⁽²⁷⁾ See questionnaire expert survey at <http://www.emcdda.europa.eu/publications/thematic-papers/gps/questionnaire>

Table 23: Financial sources					
Country	Year	Financer		Budget (EUR)	
		Type	Name	Type	Amount
Austria	2004	G-N G-R	Ministry of Health and Women Local government of Carinthia	-	-
Belgium	2008	G	Federal authorities, Flemish Community, French Community, Walloon Region, Brussels Capital Region	G	1 414 266
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	-	-	-	-
Cyprus	2006	G-N	Cyprus Antidrug Council (Ministry of Health)	G-N	50 000
Czech Republic	2004	G-N	Office of the Government of the Czech Republic, within the budgetary chapter on Expenses on Drug Policy	G-N	38 800 (only field data collection and data entry into a database, other costs are n/a)
Denmark	2005	G-N	The National Institute of Public Health, University of Southern Denmark and the Ministry of Welfare		-
	2008	G-N	National Board of Health		-
England and Wales	2006/7	G-N	Home Office	-	-
Estonia	2003	n.a.	n.a.	n.a.	n.a.
Finland	2006	G-N	STAKES	n.a.	n.a.
France	2005	A	National Institute for Prevention and Health Education INPES (public funds)	G-N	870 000 (for the fieldwork)
Germany	2003	n.a.	n.a.	n.a.	n.a.
Greece	2004	n.a.	n.a.	n.a.	n.a.
Hungary	2003	G G	National Research and Development Project Ministry of Youth and Sport		58 000
Ireland	2006/7	-	-	-	(2002/3: ca 650 000)
Italy	2005	G-N	Presidenza del Consiglio dei Ministri and National Research Council	G-N	300 000
Latvia	2003	n.a.	n.a.	n.a.	n.a.
Lithuania	2004	-	-	-	-
Malta	2001	n.a.	n.a.	n.a.	n.a.
Netherlands	2005	G-N	Ministry of Health, Welfare and Sports	G-N	330 000
Norway	2004	G-N G-N	SIRUS State Alcohol Monopoly (Vinmonopolet, a government institution, under the same department as SIRUS)		SIRUS: 100 000 (excl. VAT) for fieldwork Vinmonopolet: ca 100 000
Poland	2002	n.a.	n.a.	n.a.	n.a.
Portugal	2001	n.a.	n.a.	n.a.	n.a.
Romania	2004	G O	Government The Global Found Project in Romania	O	30 000

Table 23 continued					
Country	Year	Financer		Budget (EUR)	
		Type	Name	Type	Amount
Scotland	2006	n.a.	n.a.	n.a.	n.a.
Slovakia	2006	-	-	-	-
Spain	2005	G-N	Government Office for the National Plan on Drugs	G-N G-R	691 500 81 154
Sweden	2006	G	Swedish National Institute of Public Health	-	-

NB:

Type of financer:

G-N: Government, national level

G-R: Government, regional level

A: Academic institution

P: Private/commercial company

O: Other

n.a.: not available/do not know.

:- no reply given, reply not to be released in this report.

Table 24: Average costs per activity in EUR					
Country	Year	Data collection	One single interview	Data analysis and data set	Whole study
Austria	2004	-	-	-	-
Belgium	2004	631 103	n.a.	278 077	n.a.
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	40 000–80 000	-	-	-
Cyprus	2006	-	-	-	49 123
Czech Republic	2004	38 800	n.a.	n.a.	n.a.
Denmark	2005	-	n.a.	n.a.	n.a.
	2008	-	-	-	-
England and Wales	2006/7	-	-	-	-
Estonia	2003	n.a.	n.a.	n.a.	n.a.
Finland	2006	-	-	-	-
France	2005	870 000	30	n.a.	n.a.
Germany	2003	n.a.	n.a.	n.a.	n.a.
Greece	2004	n.a.	n.a.	n.a.	n.a.
Hungary	2003	44 000	12	8 000	ca 60 000
Ireland	2006/7	-	-	-	-
Italy	2005	200 000	2.5	100 000	300 000
Latvia	2003	n.a.	n.a.	n.a.	n.a.
Lithuania	2004	-	-	-	-
Malta	2001	n.a.	n.a.	n.a.	n.a.
Netherlands	2005	134 000 (66 000 CAPI, 62 000 online and 6 000 miscellaneous)	22	180 000	315 000
Norway	2004	ca 200 000	ca 63	n.a.	n.a.

Country	Year	Data collection	One single interview	Data analysis and data set	Whole study
Poland	2002	n.a.	n.a.	n.a.	n.a.
Portugal	2001	n.a.	n.a.	n.a.	n.a.
Romania	2004	-	-	-	-
Scotland	2006	n.a.	n.a.	n.a.	n.a.
Slovakia	2006	-	-	-	-
Spain	2005	n.a.	27.66	n.a.	n.a.
Sweden	2006	-	-	-	-

NB:

n.a.: not known/not available.

-: no reply given, reply not to be integrated in the report.

Country	Year	Senior researchers		Junior researchers		Interviewers		Other (secretary, etc.)	
		FTE	Time (months)	FTE	Time (months)	FTE	Time (months)	FTE	Time (months)
Austria	2004	1	6	0	0	512	-	0	0
Belgium	2008	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Bulgaria	2005	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Croatia	2009 (expected)	-	-	-	-	-	-	-	-
Cyprus	2006	1	2	3	1/2	31	2 (!)	1	1
Czech Republic	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Denmark	2005	3	27 (!)	4	30 (!)	175	n.k.	1	3
	2008	n.a.	-	n.a.	-	0	0	n.a.	-
England and Wales	2006/7	-	-	-	-	-	-	-	-
Estonia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Finland	2006	2	4	0	0	-	-	1	2
France	2005	25	2	15	4	150	5	1	3
Germany	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Greece	2004	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Hungary	2003	1	18	1	8	285	1,5	2	5
Ireland	2006/7	-	-	-	-	-	-	-	-
Italy	2005	2	12	3	12	-	-	10	12
Latvia	2003	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Lithuania	2004	-	-	-	-	-	-	-	-
Malta	2001	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Netherlands	2005	0.2 0.8 0.1 0.2	10 9 10 9	0	not app.	-	-	0.1 0.1 0.05	10 9 9

Country	Year	Senior researchers		Junior researchers		Interviewers		Other (secretary, etc.)	
		FTE	Time (months)	FTE	Time (months)	FTE	Time (months)	FTE	Time (months)
Norway	2004	n.a.	n.a.	n.a.	n.a.	n.a.	1	n.a.	n.a.
Poland	2002	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Portugal	2001	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Romania	2004	-	-	-	-	-	-	-	-
Scotland	2006	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Slovakia	2006	-	-	-	-	-	-	-	-
Spain	2005	0.2	12	0.5	12	n.a.	5	0.2	12
Sweden	2006	-	-	-	-	-	-	-	-

NB:

(!) Time period the entire research staff worked on it.

n.a.: not known/not available.

not app: not applicable.

-: no reply given, reply not to be released in the report.

4.2 Timetable

Although data gathering is an important element in the timetable of a survey, other elements such as instrument development, sampling and selecting, training or supervising staff, must also be taken into consideration. As inquiring about all of these elements separately was too detailed for our expert survey, we confined ourselves to the time scope of the entire survey, the duration of the data gathering and the average duration of the administration of one questionnaire (Table 26).

There proves to be much variation between the time scope of the various surveys: from a half year (Slovakia) to two years (Ireland). As a result, some studies were at variance with the WHO recommendation for completing a survey within about one year.

The data collection period mainly depends on the interviewing mode and the sample size. Face-to-face surveys require a longer data collection period than mail surveys. This is certainly the case with large sample sizes. Most of the studies in this meta-analysis are face-to-face administered, a very time consuming method. The sample size, on the other hand, is more varied (Table 26). For example, in the 2005 French study, data of a sample of roughly 102 000 respondents were gathered in about four months. Whereas in the 2004 Scottish study, only about 8 500 respondents were questioned over the same

time period. However, the data in France were gathered by telephone and in Scotland through face-to-face interviews. But even when the same survey method is applied, the data collection period may fluctuate significantly. For instance, in the Scottish studies only about half as many respondents were questioned as in the 2002/3 Irish survey, even though the data were gathered in about the same time period and with the same survey method (face-to-face interview). Of course, various other factors (e.g. the number of interviewers and the length of the questionnaire) have an impact on the length of the data collection period.

In the literature it is found that in holiday periods the respondents' drug use may be untypical and their willingness to cooperate may also be lower. This may also influence the validity of the data, although this may be offset by (nearly) continuous data gathering, as in the United Kingdom (England and Wales) and Belgium, or by interrupting the data collection during holiday periods. In Spain, for example, the data were collected between November 2005 and April 2006, but no surveys were administered in January, to avoid any influence a holiday season might have on the drug consumption in the past 30 days.

The average duration of the administration of one questionnaire depends on the interviewing mode and its length. However, the general rule is 'the shorter, the better', as a lengthy questionnaire may have a negative impact on both the response rate and the

quality of the answers. For example, in the French expert survey it is mentioned that the duration of the questionnaire (45' for the fixed phone survey and 20' for the mobile phone survey) is very long for a telephone interview. This is confirmed by Amelia Roman, researcher at the Institute for Labour Studies of Tilburg University. She argues that similar lengthy telephone surveys are not possible in the Netherlands, because people drop out. The Norwegian experts mention that the length of the questionnaire was adapted to the capabilities of the respondents (and thus mainly to obtain higher response rates) but also to reduce costs.

As for the timetable findings in our expert survey, some final remarks must be made. As with the report on response rates, the concepts of 'whole survey', 'data collection period' and 'average duration of one questionnaire' may have been interpreted differently by the different experts. To allow us to draw any conclusions, this should perhaps have been examined in more detail in our expert survey. Moreover, when the study is conducted for the first time, the preparation of the survey (defining target population, selecting sampling frame, sampling method and data collection method, etc.) and conceivably even data collection and data analysis will take more time than in a practised survey.

Table 26: Timetable				
Country	Year	Time scope whole study	Duration data collection	Average duration one questionnaire
Austria	2004	24 months (January 2004 → December 2005)	2 July → 19 October 2004	60'
Belgium	2008	48 months	12 months	n.a.
Bulgaria	2005	n.a.	n.a.	n.a.
Croatia	2009 (expected)	not app.	not app.	not app.
Cyprus	2006	9–10 months	2–3 months	20'
Czech Republic	2004	12 months	2 weeks	n.a.
Denmark	2005	36 months	12 months	50' face-to-face 25' self-administered
	2008	12 months	2 months	12'
England and Wales	2006/7	-	April 2006 → March 2007	50' (44' non-victim, 66' victim)
Estonia	2003	n.a.	n.a.	n.a.
Finland	2006	-	September–October	-
France	2005	36 months	4 months (14 October 2004 → 12 February 2005)	45' fixed phone survey 20' mobile phone survey
Germany	2003	n.a.	n.a.	n.a.
Greece	2004	n.a.	n.a.	n.a.
Hungary	2003	18 months	1.5 months	69'
Ireland	2006/7	24 months	8 months	-
Italy	2005	24	12	20'
Latvia	2003	n.a.	n.a.	n.a.
Lithuania	2004	-	1 month (19 November–3 December)	40'
Malta	2001	n.a.	n.a.	n.a.

Table 26 continued				
Country	Year	Time scope whole study	Duration data collection	Average duration one questionnaire
Netherlands	2005	20 months	6 months	n.a.
Norway	2004	Unlimited	About 1 month	n.a.
Poland	2002	n.a.	n.a.	n.a.
Portugal	2001	n.a.	n.a.	n.a.
Romania	2004	12 months	2 months	60' with abuse history, 32' without abuse history
Scotland	2006	n.a.	June → December 2006	n.a.
Slovakia	2006	6 months	1 month	90'
Spain	2005	12 months	3–5 months (November 2005 → April 2006)	45'
Sweden	2006	9 months (January → September)	5 months (March → June)	-

NB:

n.a.: not known/not available.

not app.: not applicable.

-: no reply given.

Chapter 5

Utilitarian and valorisation focus

The distribution of documentation about the fieldwork and the data on the one hand and the original data set on the other, is necessary to valorise the results. In this respect, data must be easily available and accessible to interested people (e.g. researchers, companies, general public). The meta-analysis of existing general population surveys and the expert questionnaire enabled us to evaluate the degree of accessibility to all survey data (Table 27).

5.1 Accessibility of the fieldwork and data documentation

5.1.1 Publication form and language

To collect the information for our meta-analysis, we first used the Internet to look up the survey reports of the population surveys. Detailed reports on the drug situation on the national level, compiled by each Reitox focal point, have been available on the EMCDDA website since 2000 ⁽²⁸⁾. These reports describe the new developments, trends and in-depth information on selected drug issues, and present summary accounts of drug use in the general populations. This made it easy for us to find the references of the most relevant studies. However, it remained hard to find (legible) national prevalence studies on drug use. Many websites and survey reports are available in the native language only. Conversely, when the website (and the report) was available in English, it was usually confined to the general results. The technical reports and the original questionnaire were hardly accessible. When the report was not available in English and when the technical report or questionnaire was not obtainable, the national expert was contacted. Many experts responded positively and sent us the requested information, if available. Further, some survey reports have been published in a book or in scientific articles,

or presented at international conferences. Clearly, all countries have made efforts to improve the accessibility of the survey report(s).

The fact remains, however, that the acquisition of legible survey reports (translations or summaries) for our meta-analysis has proven to be a time consuming and sometimes frustrating process, which caused some delay in the meta-analysis. It is also clear that the survey reports are hardly accessible to the wider public. To improve the valorisation of data, it is recommended to report in a common international language, e.g. English. It is striking that countries such as Italy, Austria and Spain fail to publish their results in English, in contrast with some new European Member States (e.g. Latvia, Hungary and Romania).

5.1.2 Content

The EMCDDA guidelines recommend that the survey report must be clear about the topic and objectives of the research, the methods used, the research findings, and its (policy) recommendations. However, the survey reports of the different countries vary widely. Most reports give a proper and clear description of the study design (objectives of the survey, sampling design, non-response data, etc.) and the drug prevalence data. In some cases references, contact details of the experts, or a copy of the original questionnaire(s) are added (e.g. Ireland, Hungary, Scotland, England and Wales). As mentioned above, a detailed survey report is sometimes available only in the national language, with the consequence that non-native speakers have to resort to the summaries of the survey reports (e.g. Malta). On the other hand, some countries present elaborate research reports. Findings from the drug part of the British Crime Survey, for example, are published in a separate report and even contained a statistical bulletin. The Irish population survey on drug use publishes not only several bulletins with findings, but also an extensive

⁽²⁸⁾ <http://www.emcdda.europa.eu/>

technical report including methodological aspects of the survey design, instructions for the interviewer and the questionnaire.

5.1.3 Time

Another problem that may have a negative impact on accessibility is the distribution of the documentation long after finishing the study. Some countries do not manage to finish the survey report in a short period of time (e.g. France, Ireland, the Czech Republic). Results of the French and Irish survey were not published until two years after finishing the study. The publication of the Czech survey results took about 18 months. Most countries publish the survey report within one year after finishing the survey: Austria (1 year), Norway (8 months), Denmark (9 months), Spain (6–10 months), Italy (6 months), Cyprus (2–3 months), etc.

Of course, the whole time scope of the survey must be taken into consideration. A survey report may be published in a reasonable time period after finishing the data analysis, but the survey preparation or the fieldwork each may have taken more than a year.

5.2 Accessibility of data set

The availability of original data gives a surplus value to scientific research. However, our expert survey shows that many countries, including Austria, Cyprus, Hungary and the Netherlands, do not release the data set to interested people other than the data managers themselves. Sometimes access is restricted to the national focal point and the EMCDDA (Ireland and Romania). Other countries give more open access to the data set.

The released data sets can be explored or analysed on an aggregate level (data can be analysed for both sexes, different social classes, etc.) or on micro/individual level (data can be analysed for every single respondent).

In the first case, access to the full data set is restricted. For example, the data of the Belgian HIS can be consulted by the general public via an interactive web-based application on the following website: <http://www.iph.fgov.be/EPIDEMIO/hisia/index.htm>. The application does not require any knowledge of the statistical package, and interested users have access after simple registration. The data cover the three tied-up Belgian Health surveys (1997, 2001 and 2004). However, only limited descriptive analyses can be made and any analysis is restricted to a number of indicators (prevalence, frequency, age of onset, etc.), distributed by several parameters (geographical level, gender, age, level of education, etc.). The user can directly generate tables, figures or graphs online for different variables. On the other hand, several countries in our meta-analysis make the data set available for analysis on micro/individual level. Table 27 gives an overview of several features of the data sets. As this information was acquired by our expert survey itself, only those countries that cooperated are represented in the table.

In Belgium, Denmark, France, Italy, Norway, Spain and Sweden data sets are released by the drug researchers themselves, while in England and Wales they are distributed by an archive. The data are mostly provided in well known formats, such as SPSS or SAS. Other formats are STAT and ASCII (Belgium). Most academics and students have access (1) after signing an agreement with some standard conditions for using data sets and their documentation, (2) after signing an agreement with specific conditions set out by the depositor or (3) after obtaining a written permission from the depositor. Except for academics, ministerial officers, and students, access is usually not free. In most cases the users of the data sets are obliged to specify their use of the data and to mention the original source of the data set in their publications. All data sets guarantee the privacy of the respondents, for instance, by not entering names and addresses in the database.

Table 27: Accessible data archives										
Country	Year	Who has access	How distributed	Procedure	Free	Need to inform researchers	Formats	Predefined variables	Privacy	Number of users
Austria	2004									
Belgium	2004	Commissioners and research institutes	Researchers	Specific agreement	Only free on certain conditions (for administrations and commissioners' ministries)	Yes	SPSS, SAS, STAT, ASCII	n.a.	Yes	n.a.
Croatia	2009 (expected)	not app.	not app.	not app.	not app.	not app.	not app.	not app.	not app.	not app.
Cyprus	2006									
Czech Republic	2004									
Denmark	2005	Academics, politicians, students	Researchers	Specific agreement	Only free on certain conditions (free for non-profit organisations and students)	Yes (aim of the project and publication form)	SPSS, SAS	Yes	Yes	100–150
England and Wales	2006/7	Academics, students (in theory everyone who has a satisfactory research proposal)	Data archive	Standard agreement	Only free on certain conditions (free for academics)	Yes (notify the data archive)	-	Yes	Yes (No variables that allow identification are included)	-
Finland	2006									
France	2005	Academics, students	Researchers	Standard agreement	Always free	Yes (inform the researchers of publication)	SPSS, SAS, strata	-	Yes	About 50
Hungary	2003									
Ireland	2006/7	Only NADC and focal point								
Italy	2005	Everyone (but only in Italian)	Researchers	After registration	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.

Table 27 continued

Country	Year	Who has access	How distributed	Procedure	Free	Need to inform researchers	Formats	Predefined variables	Privacy	Number of users
Lithuania	2004									
Netherlands	2005									
Norway	2004	Academics, students	Researchers	Written permission	Never free access	No	SPSS	-	Yes (Personal data, e.g. names, addresses are not provided by the fieldwork organisation, these data are destroyed after 3 months)	No
Romania	2004	Only EMCDDA and national focal point								
Slovakia	2006									
Spain	2005	Academics	Researchers	Written permission, only for specific institutions or persons	Only free in certain conditions	Yes (on request it is necessary to specify the use of the data and in the publications the original source must be mentioned)	SPSS	-	Yes (no personal identification data in the questionnaire)	No
Sweden	2006	Academics, students	-	Only for specific institutions or groups	-	-	SPSS, SAS	-	Yes	-

NB:

-: no answer given.

n.a.: not known/not available.

not app.: not applicable.

■ These countries do not have an accessible data set for external users.

Conclusion

Many countries decided to follow the intrinsic and methodological EMCDDA guidelines in order to improve the cross-national comparability. Most countries (e.g. Lithuania, Austria, France, Cyprus, Finland, Denmark, the Czech Republic, Spain, and Hungary) describe their national population survey(s) as highly compatible with the European Model Questionnaire. However, in many cases additional items (lifestyle attributes, age of onset, etc.) are included because of extended information needs. Most of these countries aim to obtain comparative data through other surveys (Health surveys, ESPAD surveys, etc.) carried out in their country. The wording of some questions and the spectrum of drugs is frequently based on these surveys. In particular, the ESPAD surveys serve as an important source of information on the use of new drugs. Besides, in some countries (e.g. Italy, Norway, Finland), the commissioner of the national population survey on drug use is also responsible for the national ESPAD survey. Some surveys describe themselves as moderately comparable with the EMQ (e.g. England and Wales). As most of these surveys pre-date the

EMQ and thus possess a long survey tradition, they do not wish to interrupt this in any major way. The extent of compatibility with the European Model Questionnaire also depends on the survey context. Many surveys that include their questions on drug use in a crime and health survey only include a limited number of items, due to space limitations. In general, we may conclude that the number of questions and the number of items vary widely among the countries. Furthermore, declining and low response rates sometimes force the countries to modify their survey design so that comparability with previous surveys on the one hand and those of other countries on the other decreases. The same is true when difficulties with (repetitive) funding occur. Face-to-face surveys are known to be a very costly data collection method. Finally, differences in the interpretation of concepts discussed in this meta-analysis — and thus also the report on those concepts — (response rate, sampling design, etc.) may hamper the comparability of European surveys. Therefore, a standardisation of the report on at least the intrinsic and methodological information would be helpful.

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