# Chapter 1
# Commentary

## Data coverage and comparability

Sampling and coverage in the collection of the data are important issues in the interpretation of national data. For example, treatment report data are derived from systems that may only have partial coverage of the national treatment capacity or only cover particular sectors of the drug treatments available in Member States. For treatment demand data and first treatment demand data, double-counting of the same individual in registers is also an issue, although most systems attempt to control for this.

Overall data availability for the new Member States of the EU is more limited, with some notable exceptions. The EMCDDA has been working for several years (supported by the PHARE programme) to establish drug information systems. This is reflected in the fact that some of the new Member States have an impressive visibility in the data tables for the more recent years of reporting (2000 onwards).

For many of the tables, the reporting units used or methodological considerations mean that it is difficult to compare prevalence levels and other drug indicator information directly across different countries. The considerable heterogeneity of countries in population size and the differences in the nature of national drug situations are reflected in considerable heterogeneity in the scale of the national absolute figures. The reader should therefore be very cautious in drawing conclusions from overall European trends about the trend for an individual country, or vice versa, because European trends often are heavily influenced by the data from a few large countries. Similarly, the failure of a large country to report in for a particular year can markedly influence the overall European trend for that year and the overall pattern of the trend could be distorted.

From the data in the bulletin the EMCDDA seeks to present a unified picture for the EU Member States and also to highlight important differences. Due to the inherent difficulties in collecting data on illicit drug use, especially with respect to sampling issues, the reader is advised to use caution in drawing conclusions based on small differences. Assessing the significance of differences between countries and changes over time in a more technical fashion is usually impossible with the information currently reported to the EMCDDA. In analysing the data from these tables it is therefore always important to consider the more general picture, to note the overall influence of each particular country and to bear in mind the differences in national trends from overall European trends. Specific caveats on interpretation and comparison are important when looking at these data sets, and the footnotes to each table highlight where there are obvious discrepancies in method and non-comparability of information across different countries. These issues are described more generally in the Commentary section of the 2004 bulletin.

General population surveys are one data source that directly aims to reflect a common phenomenon in each country. Although the detail of the survey methods may be different in each country – as they should be to take account of varying national and local patterns of use and social structures – the estimated general prevalence levels of drug use are a basic marker for all countries. The principal caveat in using such data is to remember that for the most part these are self-reported use levels, not usually backed by pharmacological testing. The following section uses general population survey data from the EU countries in comparison with survey data from the USA.

## Contrasting the US experience

Whilst the data in the bulletin are obviously concerned with the European phenomenon, the US has long been a reference point for countries comparing their position on drug use prevalence with external long-standing drug use patterns. In this section, some general comments on the contrasts between the overall EU and the US experience are made. The European data presented below are taken from the general population survey data presented in the bulletin tables GPS-9, GPS-11 and GPS-13, relating to the younger adult

population; the European average presented is a prevalence figure weighted by the population size in each country, representing the total European-wide population of younger adults.

For purposes of making contrasts the US prevalence figures are obtained from the 2003 United States national survey on health and drug use (SAMHSA, 2003), and age-specific data have been collated to give prevalence figures for the population aged 16 to 34. This should be a close comparison point for the EMCDDA's European population data with a standardised younger adults age band of 15 to 34.

Levels of drug use in the USA have historically been considerably higher than those in European countries. In many of these countries, widespread drug use occurred later than in the USA, and this may be reflected in the higher USA lifetime (ever-use) prevalence estimates. To a large extent, this remains true today, and overall, the European population average remains lower than the US average on all measures. But prevalence estimates from general population surveys are closer in some areas, and in particular the comparison of data on recent use (last year prevalence) suggests that in a few European countries levels of cannabis, ecstasy and cocaine use among young adults are now similar to those in the USA (see graphics below).

### Cannabis

Among young adults in the US and in Europe, there is little evidence from these prevalence measures that the relative patterns of use are changing. Cannabis prevalence levels, traditionally high in the US, show that ever-use of cannabis in the US is indeed higher than any of the reporting EU countries and approaches around 1.5 times the EU average level of ever-use (Figure 1).

Looking at more recent use of cannabis, the relative position of the US is hardly changed in relation either to the overall EU picture or to the general levels of the individual countries, maintaining a high rate of use. Among the ever-users of cannabis in the US young adults population, about half have used recently (last year prevalence), a figure broadly comparable with the general EU experience.

### Ecstasy

In terms of ever using ecstasy, apart from the UK, where a strong connection with the drug has prevailed and has led to a present lifetime (ever-use) prevalence rate that is higher even than that in the US, the proportion of people who have ever used ecstasy in EU countries is below American levels and the average prevalence across Europe is about half the US level (Figure 2).

In the case of the recent use of ecstasy by young adults, US prevalence falls close to the EU average and is below the estimated prevalence levels in several European countries. This is a possible consequence of the strong connection of many European countries with the recent development of the use of this drug. In particular it should be seen in conjunction with the proportion of ever-users whose use has persisted into the last year, which is much lower in the US than in the EU generally (see Figure 2), suggesting a decline in the US relative to the EU experience of the use of the drug in very recent years.

### Cocaine

Overall, the lifetime prevalence of cocaine use (ever use) is greater among the general population in the USA than in even the higher prevalence countries in Europe, and only the UK (England and Wales) has levels exceeding even half the US level. Figure 3 shows this for the younger part of the population, but data for the whole population show an even greater difference in life-time prevalence compared with the US - the 2003 United States national survey on health and drug use (SAMHSA, 2003) showed 14.7 % of all adults (12 years or older) reported lifetime experience of cocaine use, equalling that of young adults.

However, this difference is based on a cumulative lifetime experience of any use of cocaine and to some extent represents use in the past that may not have persisted to the present. The difference is not as apparent for recent use measures (use in last year), with at least two European countries now reporting estimates approaching the American figures, and a general tendency among the EU countries to shift upwards relative to the US, narrowing the gap in recent use.

Figure 1 (part i): Lifetime prevalence of cannabis among young adults (15 to 34 years) in Europe and the USA

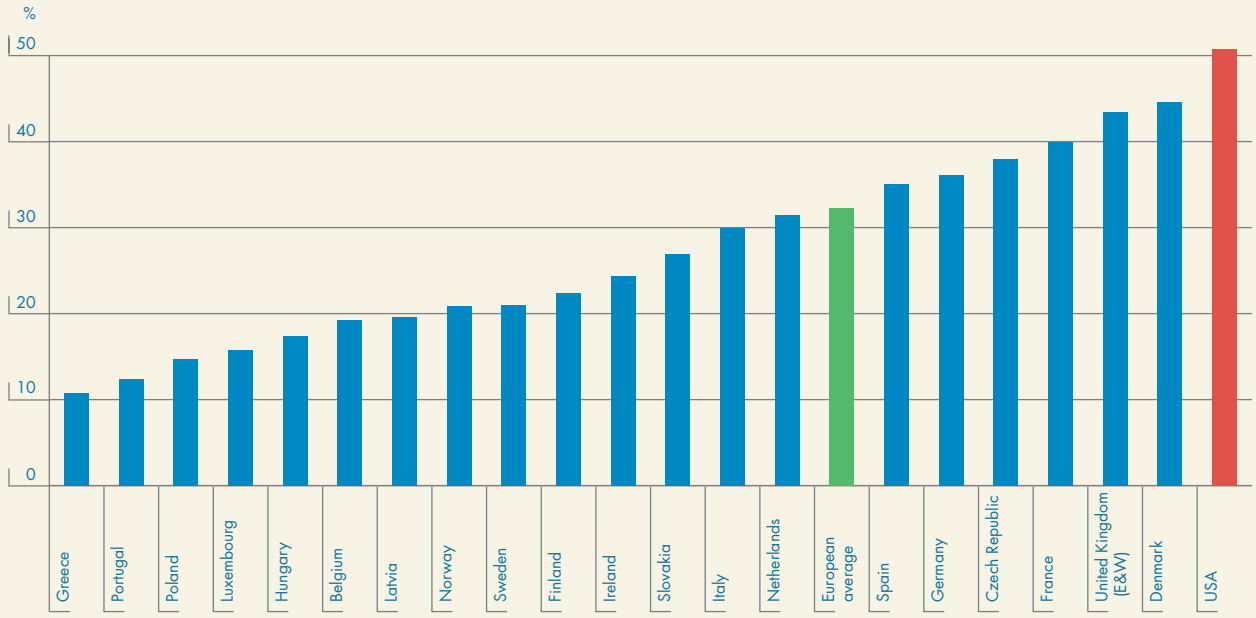
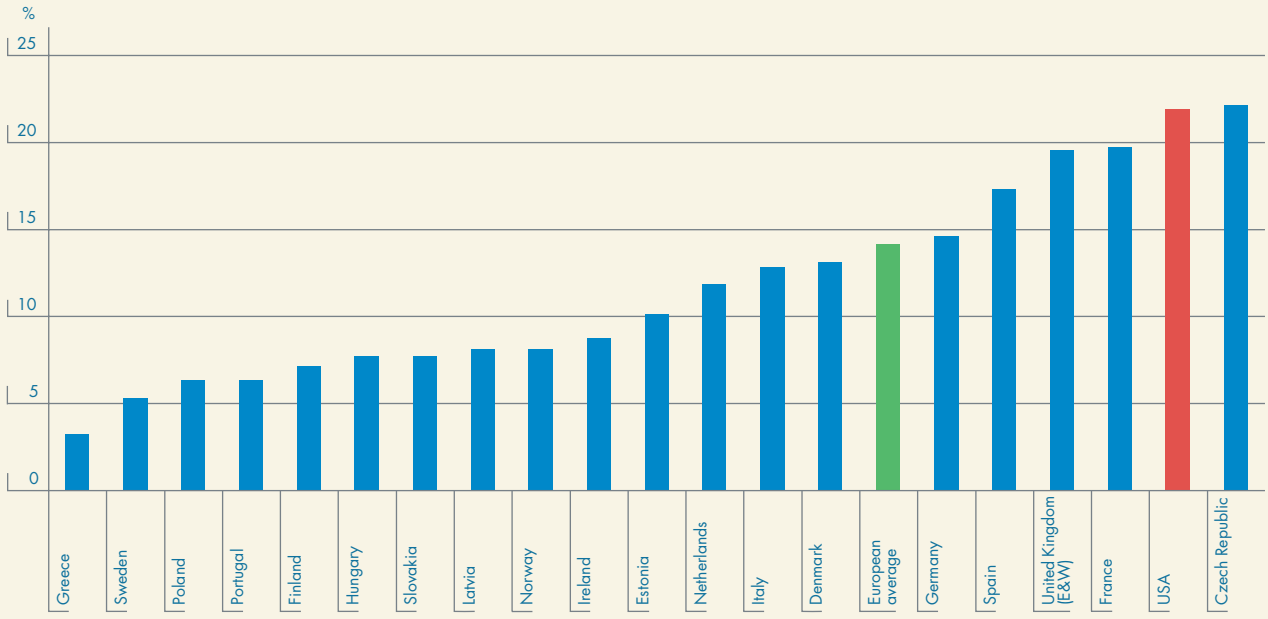



Figure 1 (part ii): Recent (last year) use of cannabis among young adults (15 to 34 years) in Europe and the USA




***Notes:***

In the USA, the survey was conducted in 2003, and the age range is 16 to 34 (recalculated from original data).

In the European countries, most surveys (17 out of 19) were conducted between 2001 and 2004, and the standard age range is 15 to 34 (in some countries the lower end may be 16 or 18 years).

The European average prevalence rate was calculated as the average of the national prevalence rates weighted by national population of 15- to 34-year-olds (2001, taken from Eurostat).

***Sources:***

USA: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2003 (www.samhsa.gov) and (http://oas.samhsa.gov/nhsda.htm#NHSDAinfo).

Europe: Table GPS-11 in the 2005 EMCDDA statistical bulletin (see page 2.28). Based on Reitox national reports (2004).

Figure 2 (part i): Lifetime prevalence of ecstasy among young adults (15 to 34 years) in Europe and the USA

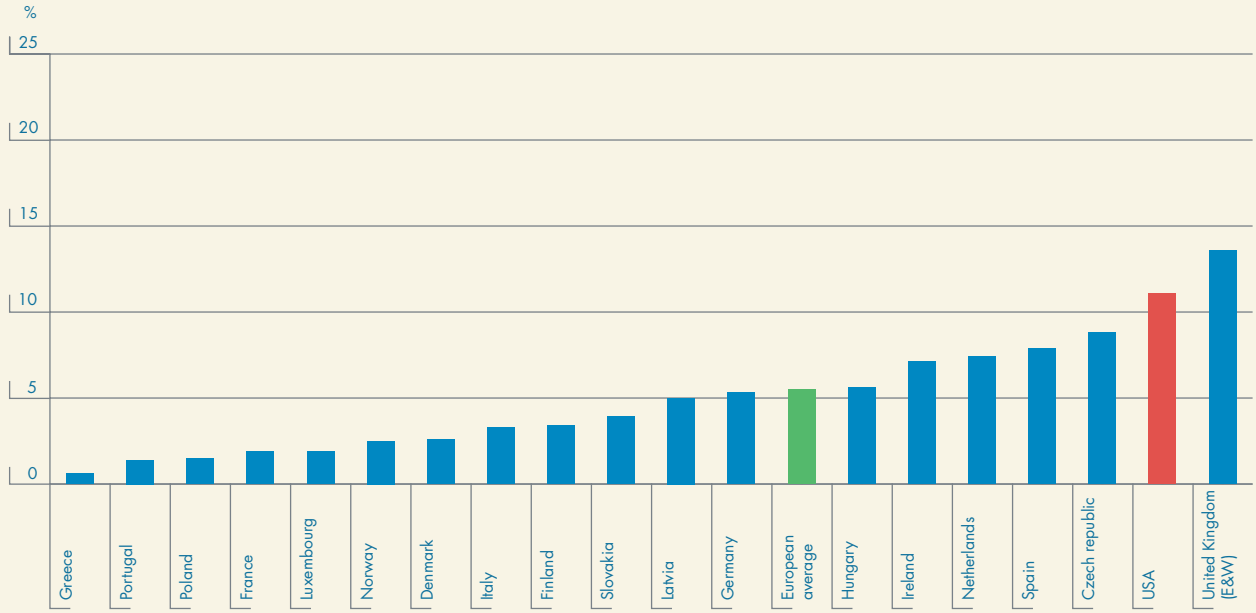
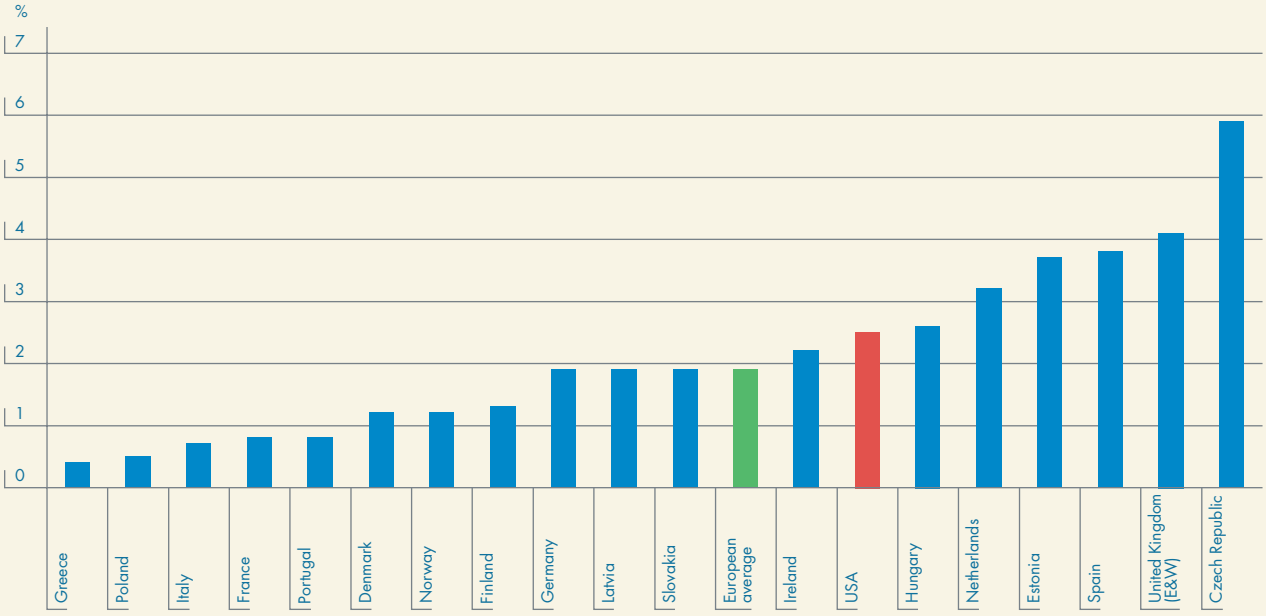



Figure 2 (part ii): Recent (last year) use of ecstasy among young adults (15 to 34 years) in Europe and the USA

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Europe: Table GPS-11 in the 2005 EMCDDA statistical bulletin (see page 2.28). Based on Reitox national reports (2004).

Figure 3 (part i): Lifetime prevalence of cocaine among young adults (15 to 34 years) in Europe and the USA

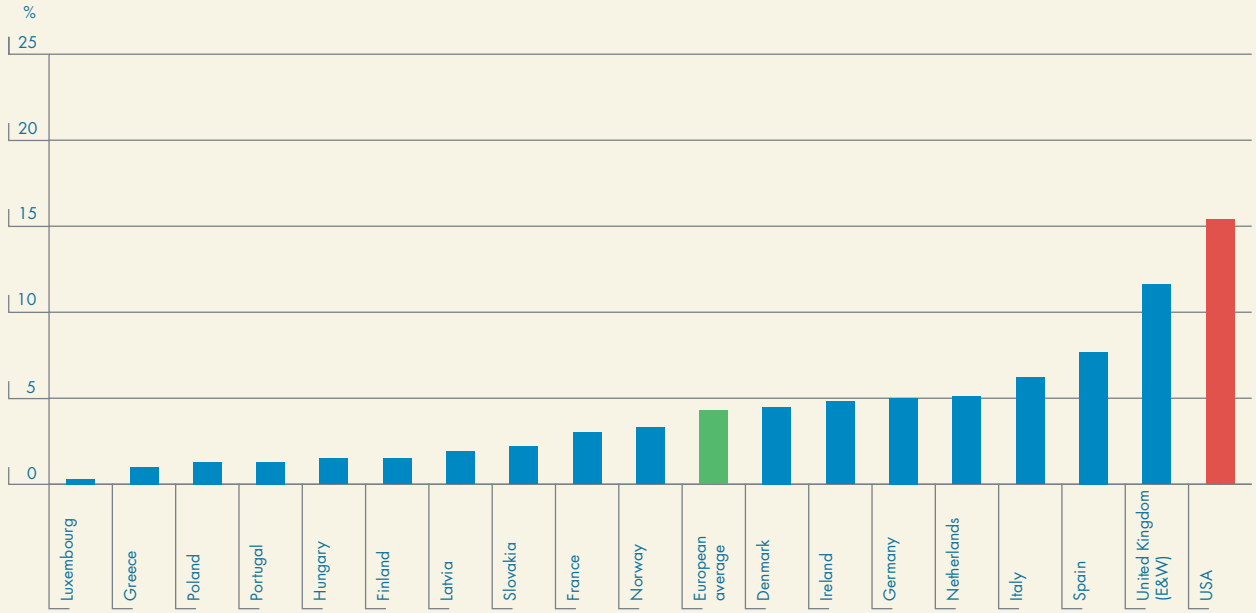
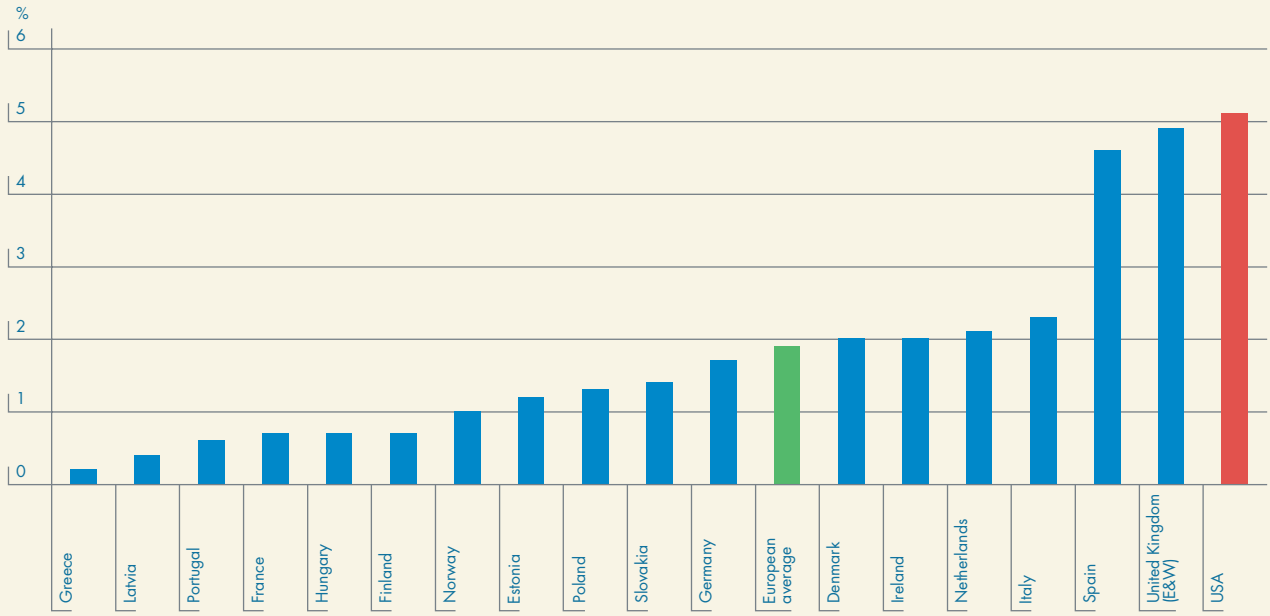



Figure 3 (part ii): Recent (last year) use of cocaine among young adults (15 to 34 years) in Europe and the USA

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