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Current situation relating to drug abuse assessment in European countries

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ABSTRACT

An increasing abuse of drugs among young people emerged in north-western Europe during the late 1960s and early 1970s. Since the mid-1970s, the two most important trends have been the substantial increase in heroin abuse in most countries and increasing drug abuse in southern and eastern European countries that had relatively little previous experience with illicit drug use. Drug abuse is assessed using routine statistics, which are available but unreliable, or special epidemiological studies, which are more reliable but also more expensive. There is a need for more systematic and centralized monitoring of routine data from both treatment and enforcement sources; improved co-operation in such activities between European countries would enhance the value and utility of epidemiological work. Common criteria and definitions, as well as data-gathering instruments, need to be adopted so that data on drug abuse will be more comparable. The ways and means through which countries exchange knowledge and experience gained in drug abuse assessment need to be improved.

Introduction

This article describes the major trends in drug abuse that have been reported in various European countries, outlines some of the methods used to assess the nature and extent of drug abuse in those countries and comments on how information gathering and epidemiological research on drug abuse in Europe can be improved. The information available is more detailed for some countries than for others, so this article should not be regarded as a comprehensive review covering all European developments in the field of drug abuse assessment.*

* The author would appreciate receiving comments that would help provide a fuller account of the situation.

Patterns of drug abuse in Europe

The emergence of drug abuse

An increasing use of drugs emerged as a social phenomenon among young people in Europe during the late 1960s and early 1970s. While this was observed in many parts of the continent, it was in the north-western European countries that drug abuse appeared to be most extensive. In southern and eastern Europe, drug abuse at that time was largely restricted to small social groups.

In Denmark, France, the Federal Republic of Germany, the Netherlands and the United Kingdom of Great Britain and Northern Ireland, the primary drugs involved were cannabis and, to a lesser extent, lysergic acid diethylamide (LSD). These two drugs were mainly used by people in bohemian circles and, subsequently, by students and other youth. At the time, cannabis use was associated with the rapid changes in youth cultures that had been gaining momentum throughout the late 1960s. These changes were characterized by the emergence of distinctive styles in dress, music, life-style and political protest that crossed national boundaries. In some cases, the changes were expressly articulated by a counter-culture. More widely, they were incorporated into youth groups on a less intellectual level. Thus, a relatively large number of young people became involved in drug use and other activities that were seen, both by themselves and by their elders, as oppositional to the values of society at large.

Among working-class youth, especially in Sweden, but also in the United Kingdom and the Federal Republic of Germany, the pattern of drug use was different. Amphetamines were the preferred drugs, and in Sweden (but not in the other two countries) those drugs were used by injection. The use of amphetamines at that time can less easily be construed in terms of oppositional values, partly because non-medical use developed out of the then widespread, legitimate supply of amphetamines through medical sources, and partly because amphetamines were used in a more immediately functional fashion.

Within the broader patterns of drug use described above, small heroin-using subcultures emerged, mainly in large cities of north-western Europe such as Amsterdam, Berlin (West), Copenhagen, London and Paris. In London, this took place during the 1960s, partly as a result of excessive prescribing of heroin by a few doctors. In the early 1970s, the increased use and supply of illicit heroin from South-East Asia was evident in the cities of Amsterdam, Copenhagen and London and, subsequently, in Paris. Prior to 1973, the heroin used in Paris originated from France. At Berlin (West), morphine base originating from Turkey and a brew of raw opium and morphine base in acetic acid were used.

The following four general points can be made regarding heroin use during that period:

(a) Heroin was used by injection by people largely belonging to socially marginal subcultures;

(b) The wider population of drug users shared the negative attitudes towards the use of heroin;

(c) There was little evidence of heroin use in southern European countries such as Greece, Italy, Portugal, Spain and Yugoslavia, or in eastern European countries such as the German Democratic Republic, Hungary, Poland and Romania;

(d) In most countries, there was little to suggest that major criminal organizations were involved in drug supply or distribution. The exceptions were France and Italy, where heroin trafficking was largely directed towards the illicit market in the United States of America.

The expansion of drug abuse

During the 1970s, drug abuse continued to grow throughout much of Europe, though the rates and patterns of growth differed between countries. An accurate picture was made difficult by a lack of reliable information, partly due to a misperception of the "drug crisis" and a belief that the problem had been contained. The two most important general trends since the mid-1970s have been the substantial increase in heroin use and increasing abuse of drugs in European countries such as Greece, Italy, Poland and Spain, which had relatively little previous experience with illicit drug use.

Abuse of heroin and other opiates

During the second half of the 1970s, the major change was characterized by a substantial increase in the availability and use of heroin, which until 1976–1977 primarily involved heroin originating from South-East Asia and then from south-west Asia. Poor harvests of opium poppies in South-East Asia and increased heroin production in south-west Asia contributed considerably to that change.

Within this broad trend, there were national variations. To some extent, those variations reflected a cluster of factors relating to the two major sources of supply: South-East Asia and south-west Asia. Thus, in the Federal Republic of Germany, the supply and use of heroin from south-west Asia, which was imported via Berlin (West), rose sharply in 1976 and 1977; the illicit supply of the drug developed on the basis of previous routes for morphine-base trafficking from Turkey. In the United

Kingdom, the supply of heroin from south-west Asia was not significant until 1978–1979, when it became associated with the influx of refugees from the Islamic Republic of Iran. In both countries, however, the increase in heroin supply and use was preceded by a period in which there appeared to be steady growth in the number of addicts using a variety of synthetic opiates, often in combination with barbiturate-type drugs.

The illicit heroin markets in France, the Netherlands and the United Kingdom were also dominated by heroin supply from South-East Asia prior to the expansion of the heroin supply from south-west Asia. In all three countries, there were strong pre-existing cultural and economic links to South-East Asia. In Italy, increased use of heroin originating from South-East Asia was observed in 1973–1974; this heroin was supplied mainly through links with the illicit traffic in France, the Netherlands and the United Kingdom, but rapid escalation did not take place until 1978–1979, when heroin from south-west Asia and heroin produced on Sicily became widely available. In Austria and Switzerland, some increase in heroin use was observed in the mid-1970s, mainly involving heroin from South-East Asia and, subsequently, the use of heroin from south-west Asia considerably increased in the late 1970s. An increase in heroin use did not occur in Ireland until 1979–1980 and in Spain until the early 1980s. It is possible that the use of Spain as a transit country for conveying heroin from South-East Asia was a significant factor in the spread of heroin use in that country.

Not all variations in the spread of heroin use in European countries could be explained in terms of supply. It is very likely that factors that were specific to certain national situations were also important, though it was not easy to specify what such factors might be. For example, although there was a temporary increase in heroin use at Malmö, Sweden, during the late 1970s, there has been no substantial and continued availability or use of heroin in that country. The primary pattern of drug abuse, which is considered "problematic", has continued to be the intravenous injection of stimulants. In Poland, the major concern has been home-produced heroin prepared by users themselves from a poppy decoction (obtained from poppies grown legitimately in Poland for their seeds). In Yugoslavia, there has been some increase in the use of heroin and other opiates, which is partly attributed to the geographical position of the country being used by traffickers for drug transit from south-west Asia to western Europe.

Abuse of other drugs

In all countries, cannabis is the most widely used illegal drug. With the exception of a few countries, such as Sweden, information on cannabis users is not found in data generated by treatment agencies, and, in most countries, the major sources of information are cannabis-related arrests

and seizures in law enforcement statistics and surveys of the general population or population groups such as students and conscripts.

Regarding the severity of the problems that arise following opiate abuse, the abuse of central nervous system stimulants (e.g. amphetamines and cocaine) is the major cause for concern. It appears that in some countries, such as the Federal Republic of Germany, Sweden and the United Kingdom, stimulants are, after cannabis, the most widely used illicit drugs. Several countries, including France, the Federal Republic of Germany, Italy, the Netherlands and Sweden, have noted a recent increase in cocaine seizures, but there is not, as yet, any clear evidence of the use of this drug reaching epidemic proportions or of increased demand for services to deal with cocaine-related problems.

Since the second half of the 1970s, several countries, such as France, the Federal Republic of Germany and the United Kingdom, have reported increased use of volatile solvents (e.g. glue and butane), largely among young males in the "12–16-year" age group. The large number of early adolescent users and the publicity given to the deaths that have occurred have led to a range of measures in certain countries and areas, such as France, and Scotland in the United Kingdom, including attempts to prohibit the supply of certain products to minors. In those areas of Europe where information on the subject is available, such as Hamburg, it appears that the overall prevalence of heavy daily solvent users is relatively low compared to the use of other drugs; the reported figures assume greater significance, however, when the very young age of the users and the severity of the problems associated with such drug use are taken into account.

Regarding barbiturates, it seems that in some countries, such as the Federal Republic of Germany, Ireland and the United Kingdom, the considerable abuse of these drugs by young people that was observed in the 1970s has recently become less prevalent, which is mainly attributed to the increased availability of heroin and to the more appropriate prescribing practices. The use of LSD also does not appear to be as common as it was in the early 1970s, though in some countries, including France, the Netherlands and the United Kingdom, there is evidence of a recent increase in the use of this drug.

Current situation

It is not possible to make direct comparisons between countries in terms of the "true" prevalence and incidence of drug abuse, because in some countries even approximate estimates of such abuse do not exist and estimates, when they exist, are based on different definitions and obtained by different methods. It is possible, however, to make more general comments on the current situation with regard to drug abuse in Europe.

In many countries, the greatest concern is young drug abusers. However, the age range of the people involved, including new users, is wider than it was 10 or 15 years ago. In particular, this appears to be the case in cities with a longer history of drug abuse, such as Amsterdam, Berlin (West), London, Paris and Stockholm, for which data indicate significant numbers of drug-dependent persons who are in their thirties. Data in all countries indicate a predominance of male drug users.

The social characteristics of drug users vary considerably. For example, in Sweden, intravenous drug abuse is concentrated in the working class and in traditional criminal groups. In France, the Federal Republic of Germany and the Netherlands, drug abuse is more evenly spread among the various sections of the population, but with higher levels among certain minority groups. In the United Kingdom, with the exception of cannabis, the use of drugs has generally been rarer among minority groups, though this may be changing. While in some countries it appears that the more harmful patterns of drug abuse are concentrated in the more deprived inner city areas, the quality of the data and the level of epidemiological analysis that has been conducted do not permit conclusions to be drawn regarding the relationship between economic and socio-demographic factors and changing patterns of drug misuse. This is an important area for future studies.

New trends

It appears that the rate of increase in the number of new drug users (incidence) is slowing down in countries that experienced an epidemic spread of heroin use during the mid- and late 1970s. This trend is clearer in certain major cities such as Amsterdam, Berlin (West), Dublin and London. While this is encouraging, it must be remembered that even if the incidence is declining, many countries will continue to be confronted with higher numbers of drug-dependent persons (prevalence) than a decade ago because the number of drug-addicted people who discontinue the illicit use of drugs is smaller than the number of people that become addicts. Furthermore, the experience gained in North America suggests that:

(a) The use of drugs, such as heroin, continues to increase in smaller towns some time after the incidence rate stabilizes or falls in larger cities;

(b) A decrease in the prevalence of the use of one drug may be counterbalanced by an increase in the use of other drugs;

(c) A situation that is apparently stable may subsequently change as new groups in the population fall under the "at risk" category [1, 2].

It has been suggested in Italy and the United Kingdom that drug use in the 1980s should not be characterized as an "oppositional" phenomenon of the margins of society, as it was when illicit drug use first emerged. It

now appears that drugs and drug use may be viewed as a part of the everyday context within which "ordinary" people, especially young people, live. Individuals who use drugs may not see themselves as rejecting society's values or even belonging to a specific drug subculture.

One implication of these trends may be that responses to drug abuse, especially treatment and prevention, should be integrated within general health, social and educational services rather than based on specialized drug-specific agencies that stigmatize drug users as special, intractable and deviant individuals. This view is supported by a study carried out in Paris that suggested that drug users were more willing to approach non-specialized services for help than agencies that exclusively dealt with drug problems [3].

Epidemiological assessment and monitoring of drug abuse

Epidemiological assessment of the nature and extent of drug abuse in a community at a given point in time presents a static "window" for viewing the situation. The disadvantage of such assessment is that it rapidly becomes out of date and it fails to provide the regular feedback that is needed to monitor changes, to evaluate the relative impact of various interventions and to compare trends in different communities.

Monitoring refers to the systematic and continuing collection, collation and interpretation of information at regular intervals. It provides a more dynamic picture of events. This dimension is vital if epidemiological information is to contribute to the evaluation and planning of cost-effective policies and services. Monitoring requires some form of centralized co-ordination and collation to ensure consistency and continuity.

Two levels of epidemiological activity are discernible: monitoring of routine statistics and special epidemiological studies.

Monitoring of routine statistics

Routine statistics include arrests of drug offenders and seizures relating to illicit drugs; the number of drug addicts entering treatment; hospital admissions for drug-related illnesses; and drug-related deaths. Most countries collect at least some of these data.

Routine statistics have many limitations. They are usually very basic and invariably incomplete. As indicators, they are considered to have an association with drug abuse, but the exact nature of that relationship is often unknown. In addition to the extent of drug abuse, routine statistics are influenced by other factors, such as variations in the activities designed to deal with drug problems and drug abuse recording practices in the

institutions concerned: the statistics of different countries are rarely comparable. For these reasons, it is essential to use several indicators that draw on different sources of information and to supplement bare statistical data with an understanding of both the context in which they have been gathered and how they have been gathered.

Since in many countries routine statistics are often the only data available, they tend to be used, without qualification, as indicators of the severity of drug problems. Some of these indicators, especially the quantities of drugs seized and the number of drug-related deaths, carry an emotional and political impact that is out of proportion to their real value.

Drug-related deaths

Drug-related deaths, which are considered an indirect indicator of the extent of drug abuse, are often misinterpreted. A very large increase in the number of drug-related deaths, such as those reported in France, the Federal Republic of Germany and Italy during the late 1970s, probably indicates a real change in the extent of drug abuse, while inference based on smaller variations should be treated with considerable caution. For example, in Berlin (West), Italy and the United Kingdom (London), closer study of the figures reveals periods when the number of drug-related deaths diminished at times when the use of drugs, such as heroin, was still increasing. This was attributed, in the case of Berlin (West), to variations in the quality and purity of heroin and in the use of other drugs in combination with heroin; in the case of Italy, to the use of Naloxone; and in the case of London, to a decrease in use of other drugs, such as barbiturates and dipipanone, and an increase in the use of heroin by smoking rather than by injection.

Similar considerations apply to attempts to compare drug-related death rates between countries. For example, the system of recording drug-related deaths in the Federal Republic of Germany includes deaths that are a direct consequence of drug use (overdose) and those in which toxicological, clinical and circumstantial evidence points to an indirect relationship to drug use. In other countries, for example Sweden, drug-related deaths refer only to those where drug addiction is recorded on the death certificate as the primary or underlying cause of death. A special study encompassing the district of Stockholm revealed 83 drug-related deaths, compared with the official figure of 47 for the whole country. In France, the figures are based on the number of drug-related deaths reported by the police.

Treatment demand

This can be a useful and sensitive indicator as long as treatment services exist and as long as the information is recorded systematically and collated centrally. In particular, first treatment demand is of value since it

often reflects a relatively new drug use. Studies in Paris and London, for example, have used data on the time-lag between first drug use and first treatment demand, which, together with other information, have helped to assess the epidemiological significance of this indicator and to illuminate the process by which drug abusers seek treatment [4, 5].

Indicators of the illicit drug market

Indicators of the illicit drug market include the number and quantities of drugs seized and other information, such as the price and purity of illicit drugs. As with drug-related deaths, seizures of illicit drugs must be interpreted in terms of the resources and priorities of law enforcement agencies and in terms of information such as whether the drugs seized were intended for domestic distribution or were earmarked for another country. If, however, substantial increases in both the number of seizures and the amount of drugs seized occur in a context of falling prices, rising purity and increased demand for treatment (as has happened in the United Kingdom), then it is likely that the data indicate a rise in prevalence rather than an improvement in interception rates.

Police arrests

Police arrests are subject to qualifications similar to those of seizure figures. For example, in Sweden, a marked increase in police arrests over several years has been interpreted as being mainly the result of a considerable increase in police activity. This view is supported by a fall in hospital admissions and by survey data suggesting a broadly stable situation. In other countries, the significance of this indicator depends on examination of the contribution of other factors. Nevertheless, police arrest data can provide information on the basic characteristics of those arrested, such as age and sex, and, when broken down by police district, can provide a better picture of the demographic distribution of drug offences than any obtained using seizure statistics.

Other indicators

Other routine indicators that are used in some, though not all, countries, include data on hepatitis, court sentences, imprisonment and prescriptions of drugs. Generally, these are even more difficult to interpret than the indicators described above.

Comment on indirect indicators

The use of indirect indicators for the assessment of drug abuse is the focus of a study that is being conducted under the auspices of the Pompidou Group of the Council of Europe. This study will be completed later in 1986 and is expected to report on the subject in greater detail. In a

European context, the criteria by which indicators are being assessed include:

(a) The comparability and consistency of the definitions;

(b) The availability and accessibility of data, and the rapidity with which they become available;

(c) The reliability and validity of data;

(d) The relevance of data.

On all these criteria, there is room for great improvement, both within individual countries and within the framework of European co-operation.

Comment on routine monitoring systems

A major problem that can be identified in all countries is the lack of a structure for collecting and integrating routine data from different sources in a consistent and coherent fashion. In many countries, separate data are collected, using different classifications, by such institutions as customs services, the police, hospitals, treatment centres, therapeutic communities and coroners. Sometimes the same cases are reported by different agencies. There is thus an urgent need to improve and formalize the channels for pulling together information on a centralized, systematic and continuous basis. There are examples of co-ordinated monitoring that meet this requirement to some extent, though they either cover only some of the potential range of sources or else are limited to relatively small geographical areas.

At Amsterdam, there is a central registration system for addicts receiving methadone from a wide range of services, such as public health facilities, general practitioners, hospitals and clinics and medical assistance in police stations and prisons. This system, which is still expanding, provides a relatively comprehensive picture of the movement of opiate addicts in and out of treatment facilities.

In Italy, a system of standarized reporting by public health in-patient and out-patient facilities is being developed. Under the new system, each local health district will update its figures monthly and regional and national summaries will be collated on a periodical basis.

In the United Kingdom, the Home Office maintains a national register of all narcotic addicts notified by treatment centres, general practitioners and prison medical officers, though the notified figures understate the numbers of addicted persons seen by doctors and are substantially less than the true total number of addicts. The Home Office also collates statistics on drug convictions and seizures made by Her Majesty's Customs and Excise and the police.

In the Federal Republic of Germany, a system has been developed at the Max-Planck Institute of Psychiatry that collates anonymous basic standarized data on clients seen by a range of public and charitable agencies offering counsel across the country. This is significant in that it represents an attempt to monitor data from non-medical agencies.

Data obtained in London from non-routine sources support the view that such data are most valuable in monitoring the profile of clients seen by front-line non-medical agencies, since they often see drug abusers who may be unwilling to approach formal institutions.

At Hamburg, a register has been maintained of addicts coming to the attention of the police, courts of law and public health institutes. Needle marks and self-reports have mainly been used as evidence for records of the register. A study showed that 80 per cent of addicts who died were already known, suggesting that the register was relatively comprehensive as regards addicts injecting drugs.

At Stockholm, the systematic examination of injection marks among arrested persons has provided an indicator of patterns of injection among criminal groups.

Special epidemiological studies

Special epidemiological studies include case-finding studies, surveys of the general population, students and conscripts, studies of agency populations, ethnographical studies, studies of illicit markets and statistical projections.

Case-finding studies

Case-finding studies have been conducted in Sweden, in the city of Dublin and in several towns in the United Kingdom. Their aim is to identify all heavy drug abusers in a community over a period of 6–12 months. Although expensive, time-consuming and, due to the confidential nature of the information, difficult to carry out, they are useful for establishing a baseline from which subsequent trends may be monitored and for validating the more easily accessible, indirect indicators.

Surveys of the general population, students and conscripts

Surveys of either the general population, students or conscripts have been conducted at the national level in several countries, including Belgium, the Federal Republic of Germany, Greece, Italy, the Netherlands and Sweden, and at the local level in most countries. Such surveys are useful for assessing the prevalence of more commonly used substances

that are not highly stigmatized, such as alcohol, tobacco, cannabis and medicines; however, they are less useful for assessing the prevalence of rarer, more stigmatized substances, such as heroin, the use of which is considered to be more "deviant". A possible exception is the surveys based on the urine tests of a large sample of young men undergoing examination for conscription that have been carried out in Italy.

Studies of agency populations

Detailed studies of drug abusers, based on prospective surveys, or retrospective review of records have been conducted in most countries in selected institutions. At the national level, examples include a survey in Italy and the case-finding studies in Sweden. Such studies are useful for examining risk factors among drug users, but their results cannot be extended to explain the magnitude of drug abuse in a general population.

Ethnographical studies

These employ anthropological techniques to study groups of drug abusers in a community. Such studies complement the assessment of drug abuse based on data obtained from different agencies and services dealing with drug abusers and can provide rich insights into the qualitative aspects of the life-styles of drug users. Such studies have been carried out in France, the Netherlands and the United Kingdom.

Studies of illicit markets

Econometric studies of the structure and dimensions of illicit markets are valuable for understanding the patterns of drug abuse. Such studies have usually been conducted in North America and by international organizations. Relatively little appears to have been done in European countries, though some preliminary work has been carried out in Italy and the United Kingdom.

Statistical projections

Statistical projections are made on the basis of information obtained by different methods used for data gathering, such as the capture-recapture technique, based on the overlap of cases recorded by two or more independent indicators, as applied in Sweden and the United Kingdom.

Evaluation

Evaluation is an issue of particular epidemiological concern. It includes both process evaluation and longer-term outcome evaluation. Evaluation is essential to finding out if what is done makes any difference and if it is cost-effective. Long-term evaluations of both treatment and

prevention programmes appear to be deficient, as well as studies that compare different treatment modalities for different kinds of drug problems. The development of more effective methods of such evaluation requires further epidemiological research.

European co-operation in assessing drug abuse

Activities

In the field of epidemiological co-operation in Europe, two activities are in progress. The first activity, which was initiated by the Pompidou Group in 1982, involves:

(a) A multi-city study examining the utility and comparability of the indicators used in seven major European cities;

(b) A pilot study to develop instruments for conducting comparable school surveys.

The second activity, which was initiated by the European Economic Community in 1984, concerns the pilot studies of comparability of epidemiological instruments that can facilitate the harmonization of basic data on the socio-demographic characteristics and drug use of clients undergoing treatment and the development of guidelines for the basic data needed for follow-up studies.

In addition to the Council of Europe (Pompidou Group) and the European Economic Community, there are several international bodies and organizations that are interested in collecting data on drug abuse in Europe, including the World Health Organization (Regional Office for Europe), the United Nations, the International Criminal Police Organization (ICPO/Interpol), the European Federation of Therapeutic Communities, the European Working Group on Drug Policy Oriented Research and the International Council on Alcohol and Addictions.

While these bodies and organizations focus on different aspects of drug problems, there is the obvious possibility of unnecessary duplication of work. It is not clear how this can be avoided, other than by formalizing the channels for the flow of information on drug-related activities between different countries and between different European bodies and organizations involved in drug abuse assessment.

Comparability

Greater comparability of data is essential to any attempt to promote co-operation between European countries with regard to the collection of data on drug abuse. This requires a concerted effort to adopt common

criteria and definitions relating to drug abuse assessment so that countries can compare the methods used and the results obtained and benefit from a true appreciation of the significance and implications of that work. Any effort to improve comparability should take into account the following three aspects:

(a) Comparability of criteria and definitions: an epidemiological study requires clear criteria and definitions, particularly with respect to what constitutes a case, the population to which the data refer, and the time period involved. Apart from the International Classification of Diseases used in some hospital and mortality data, very little has been done to promote the comparability of data on drug abuse in Europe;

(b) Appropriate interpretation of data: even if identical criteria and definitions are used, in order to obtain comparable information it would still be necessary to interpret the data in terms of what they signify regarding the situation in a given country. For example, the differences between treatment systems are such that the term "treatment" carries many historical and cultural aspects that cannot easily be conveyed through bare statistics;

(c) What is to be compared? This question refers to data that need to be collected and compared, such as the prevalence of drug abuse; the rate of change; the characteristics of drug abuse; the pattern of activity dealing with drug abuse; the magnitude of the problems created by illicit drug supply, drug crimes and the social and economic costs of drug abuse; the reasons for drug abuse; and the impact of various forms of intervention.

Conclusion

It is necessary that the use of the epidemiological method in studying the nature and extent of drug abuse continue and develop. It can make a substantial contribution to:

(a) Policy decisions regarding whether the drug problem is a priority among other social problems;

(b) The designing of interventions appropriate for specific conditions;

(c) The evaluation of the impact of various forms of intervention.

The following are suggestions for making better use of epidemiological studies for the assessment of drug abuse in European countries:

(a) An improvement of the basic routine monitoring of data on drug abuse at the national level;

(b) An improvement of the comparability of data between countries: the relevant international organizations, particularly the World

Health Organization, the Council of Europe and the European Economic Community, have an important role to play in facilitating the development of comparable data;

(c) The promotion of the ways and means of exchanging information on knowledge and experience relating to methods used and results obtained in drug abuse assessment. These are particularly necessary for appropriate interpreting of the cultural and cross-cultural differences in patterns of drug abuse reported in routine statistics or in national studies;

(d) The development of a more effective European programme for collating and disseminating information on drug abuse between countries and between international bodies and organizations. This should include the possibility of translating papers of particular significance from a given European language into other languages, if necessary;

(e) The undertaking of collaborative studies to address specific issues, such as the impact of different forms of intervention, the social and economic costs of drug abuse and the relative importance of risk factors in different countries.

It would seem appropriate at this stage to consider whether these objectives can best be achieved by redeploying the resources in existing institutions or by setting up a new European institute to co-ordinate the activities.

Another important point concerns the relationship between an epidemiological researcher, who is responsible for drug abuse assessment, and those to whom the assessment results are to be directed, such as people providing services, civil servants, politicians, the media and the general public, as well as drug users themselves and people affected by them. There is little point in improving the quality of drug abuse data gathering if its results are not faithfully communicated to those who can use such information in work relating to drug abuse control. A lack of dialogue between research workers responsible for drug abuse assessment and users of the results of such assessment often negates any contribution that this work can make towards the control of drugs. At the same time, it should be noted that researchers have a responsibility to respect the rights of their subjects and to preserve the confidentiality of the information provided by their subjects, who, for their part, may refuse to give information about themselves.

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