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Problematic drug use and drug use disorders in EU countries and Norway: An overview of the epidemiology☆

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Abstract

Objective: To estimate the prevalence of drug use disorders in the European Union and Norway. *Method:* Based on a systematic literature search and an expert survey, publications after 1990 on prevalence of drug use disorders (DUD, defined as drug dependence and drug abuse or harmful use) in EU countries and Norway were reviewed. The search included both direct estimations based on general population surveys using the DSM-IIIR, DSM-IV, or ICD-10 definitions of DUD; and indirect estimates based on other epidemiological methods, such as multiplier procedures based on treatment or legal data and capture–recapture techniques. The indirect methods did not use diagnostic criteria, but criteria based on duration and pattern of use, labelled as problematic drug use as a meaningful approximation. *Results:* The majority of DUD as estimated from direct methods using general population surveys were cannabis use disorders, usually not included in indirect estimates. The prevalence of thus defined disorders can be as high as 3%. For disorders other than cannabis use disorders (i.e. opioid, cocaine and amphetamine use disorders), indirect estimates of prevalence were consistently higher than those based on direct estimates, and ranged between 0.3% and 0.9% in European Union countries and Norway. Men have higher prevalence rates of DUD than women, but the difference was much less pronounced in general population surveys. Younger age (18–25 years) is the age group with the highest estimates. *Conclusion:* General population surveys typically result in a serious underestimation of the prevalence of DUD other than cannabis use disorders, because many people with DUD are not reached by these surveys (hidden populations). Based on the more valid indirect estimates, it is concluded that problem drug use constitutes a relatively high burden of disease and social problems in Europe.
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1. Introduction

The recently published Comparative Risk Analysis (CRA) led by the World Health Organization (WHO) estimated that 2.1% of the burden of disease in European countries with very low mortality and 1.6% of all European countries in the year 2000 were attributable to illegal drug use, as estimated by combining injection opioid, cocaine, and amphetamine use (WHO, 2002;

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Ezzati et al., 2002; for a categorization of countries into mortality strata WHO, 2000). The overwhelming majority of countries of the old EU and Norway falls into this category of very low mortality, with the countries joining in 2004 being scattered in different mortality categories. This indicates a considerable public health burden, although it is clearly smaller than the disease burden attributable to use of alcohol (10.2% of all disease burden in Europe) or tobacco (12.4% of European burden; both numbers recalculated from WHO, 2002). Before further discussing the meaning of this burden, however, we need to understand the nature and validity of the underlying prevalence rates.

The WHO CRA estimates are based on the UN Drug Control Program's (UNDCP, 2000) Global Illicit Drug Trends for persons over the age of 15 years and the additional assumption, that 28% of all users in the past year were problematic users, the latter fraction being derived from an Australian national survey (Hall et al., 1999). The resulting prevalence estimates were around 0.1% for problematic opioid use and cocaine use each, and between 0.1% and 0.2% for problematic amphetamine use. In addition, there was considerable overlap between problematic use of these substances (Degenhardt et al., 2001). The definition of problematic drug use by UNDCP depends on "the extent to which use of a certain drug leads to treatment demand, emergency room visits (often due to overdose), drug related morbidity (including HIV/AIDS, hepatitis etc), mortality and other drug-related social ills" (UNDCP, 2000; Degenhardt et al., 2001).

While this definition contains elements of defining drug use disorders (DUD) according to ICD-10 (WHO, 1993; see Rehm et al., 2005) or DSM-IV (American Psychiatric Association, 2000), and while the operationalization of Degenhardt et al. (2001) described above makes use of this overlap, problematic drug use is less concretely operationalized than the terms "drug dependence" and "drug abuse" or "harmful use" with respect to severity and duration of symptom load. In fact, the UNDCP data have been often criticized for using rather vague operationalizations, and one of the answers to this critique has been that on a global scale, the use of stringent criteria such as ICD-10 criteria is impossible because of the lack of epidemiologic data. This, however, may change globally with the introduction of standardized surveys in many countries (e.g. the World Mental Health Survey, cf. World Mental Health Survey Consortium, 2004), and in fact it has changed already for the European Union (EU) countries and Norway where several adequate general population surveys are available. We, therefore, can use prevalence estimates of ICD-10 and DSM-IV DUDs from population surveys as part of our review.

For this review, we restricted ourselves to studies where the fieldwork was conducted after 1990 for two reasons. First, DUD or problematic drug use prevalence rates tend to fluctuate rather quickly; so quickly that sometimes even terms like "epidemic" are used for describing the rapid increase and later decrease of rates (e.g., Agar and Reisinger, 2002; see also Hartman and Golub, 1999). Second, the concept of DUD, the diagnostic criteria and the assessment instruments have changed substantially over the past 25 years (e.g. Room, 1998). In the past, many different non-converging definitions were used in different classification systems. In contrast, the newest definitions of drug dependence (DD) in ICD-10 (WHO, 1993) and DSM-IV (1994; see American Psychiatric Association, 2000) converge and have been shown to be relatively stable across standard assessments and cultures, with the exception of cannabis dependence (e.g. Üstün et al., 1997; Compton et al., 1996; Rounsaville et al., 1993). Unfortunately, the definitions (see Rehm et al., 2005) for harmful use according to ICD-10, and for drug abuse (DA) according to DSM-IV are less stable and comparable across cultures and instruments (e.g. Üstün et al., 1997; Rounsaville et al., 1993). In the following review, we will thus distinguish between dependence and harmful use/abuse.

DSM-IIIR, DSM-IV and ICD-10 diagnoses of DUD will generally lead to similar prevalence rates (e.g. Rounsaville et al., 1993; Pull et al., 1997; see also Table 2 below). We therefore accepted papers from DSM-IIIR onwards. In terms of diagnostic instruments, the most common was the Composite International Diagnostic Interview (CIDI). The CIDI has been shown to generate data very similar to those obtained by the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) in the WHO/NIH cross-national reliability and validity study (e.g. Üstün et al., 1997; Pull et al., 1997). We decided to include only studies using these instruments.

Assessment instruments like the CIDI are typically used in household surveys, e.g. in the current World Mental Health Survey (World Mental Health Survey Consortium, 2004). Based on the nature of illegal behaviour, household surveys will not reach many illegal drug users for various reasons. Most importantly, many users are not living in households but are institutionalized (e.g., in inpatient treatment or in prison) or homeless. To give one example from a recent study in Sweden: of the problematic heavy drug users in Stockholm in contact with the legal or treatment system, only 46% had a fixed living place (Olsson et al., 2001). In addition, for people living in their own homes and not being in contact with either the treatment or legal system, it may be difficult to admit to a problematic use of illegal drugs for reasons of social pressure.

To reach this so-called hidden populations, indirect estimation methods are used based on treatment records, policy and legal data, back calculation from mortality and/or HIV/AIDS data, or the combination of multiple data sources in the capture/recapture method (see Kraus et al., 2003, for short descriptions; see also EMCDDA, 2003).

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