



E.M.C.D.D.A.



## FINAL REPORT

### Co-ordination of an Expert Working Group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU. Follow up of EMCDDA project CT.96.EP.08

#### EMCDDA project CT.97.EP.09

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**Please use the following citation:**

European Monitoring Centre for Drugs and Drug Addiction. Co-ordination of an expert working group to develop instruments and guidelines to improve quality and comparability of general population surveys on drugs in the EU. Follow up of EMCDDA project CT.96.EP.08 (CT.97.EP.09), Lisbon, EMCDDA, September 1999.

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# **COMPARABILITY OF GENERAL POPULATION SURVEYS**



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# PREFACE

The final report of the project to Co-ordinate an Expert Group to Improve the Comparability of National General Population Surveys on Drug Prevalence (project CT.97.EP.09) starts with several considerations about different aspects of surveying (chapter I), which can and will influence survey bias and therefore affect comparability of prevalence data. This is followed in chapter II by our recommendations regarding the items, variables and questions to be included in a model prevalence survey. The resulting questionnaire is summarised in chapter III. In chapter IV we present the main conclusions from the pre-tests of this model questionnaire in five countries. These four chapters continue on the lines of exploration that we have set in the preceding project CT.96.EP.08 in which we already discussed many topics of the application of survey instruments and presented a first draft of the model questionnaire.

The report concludes in chapter V with an account of the construction of a joined data file from the original data files of seven countries, based on the model of chapter II. This was first of all intended to test the feasibility of harmonisation of existing data files which by themselves are not comparable. Even when countries are willing and able to implement the model presented in this report in their national surveys, it will take a long time before we have really comparable time series of the EU Member States about prevalence data. Considering the fact that general population prevalence is a key indicator for monitoring the drug situation in the European Union, it will be necessary for the time being to manipulate existing data sets of individual countries.

In the framework of project CT.97.EP.09 Ludwig Kraus, Sven Jünger, Petra Kümmler, Osmo Kontula, François Beck and Dirk Korf have carried out some experimental analyses (in the text referred to as Joint Analysis) on this joined European file to assess the analytical potential of a European dataset based on a standardised approach to prevalence surveys. The exercises not only support the need for harmonisation of prevalence surveys but also justify the efforts to join existing survey data as far as possible. However, the experimental nature of the experimental analyses does not match all requirements for scientific comparisons of national prevalence data. To avoid disputes about prevalence figures of individual countries as such, which might distract from the real content matter of this report, results of the analyses are not included in this final report.

The final report includes a set of annexes, which present among others translations of the model questionnaire into French, German, Dutch, Swedish, Finnish and Greek, an overview of the contents of the combined European data file used for the Joint Analysis and the reports of the pre-tests of the model questionnaire.

At this stage only parts of the final reports of project CT.97.EP.09 and the preceding project CT.96.EP.08 can be labelled as guidelines or manual for prevalence surveys. Nevertheless we expect that our explorations about the subject will contribute to a gradual harmonisation of prevalence survey practices, which ultimately result in comparable data and better insights in the nature of drug use in the European Union.

As co-ordinator of the project I like to acknowledge the very constructive co-operation of the expert group. Apart from all the results we produced, I consider the serious and pleasant co-working of experts from different countries with different backgrounds as one of the major benefits of the project. At the end of the day all attempts to harmonise data and research methods in the European Union will depend on the possibility to establish such active cross-country co-operations. Let's hope we get many followers.

Ruud Bless  
Project Co-ordinator





# I. SURVEY DESIGN

## 1. INTRODUCTION

We first discuss in Chapter I a number of themes about surveying, which can have a direct impact on the construction and design of the model questionnaire presented in Chapter II. Many survey aspects have already been discussed in the final report of the preceding project CT.96.EP.08. We do not attempt to repeat those discussions here. Instead we focus only on aspects which have not yet been elaborated or which can now be placed in a more direct relationship to the recommended model.

As a framework for Chapter I we view the organisation of a prevalence survey as a process of consecutive decisions in which the questionnaire is embedded. The process starts with the identification of survey aims. This is followed by an identification of the target population and the survey mode. As a next step we need to consider how the survey will be presented to the general public and finally, we have to decide how and with whom to organise the survey. The development of a questionnaire runs parallel to this process, but a final questionnaire will only exist when the whole preparatory process has been completed.

## 2. SURVEY AIMS

Any survey should start with a specification of the aims, which the organisers want to pursue by means of the data collection. Data can be collected to present statistics or reports or to allow scientific research with regard to a particular phenomenon. In the case of statistics and reports we need to know which formats and detail are required, in the case of research we need to know which analytical design we want to elaborate. Report and research demands define the data we need to collect and in consecutive steps we then can decide on data collection methods and instruments.

This might seem pretty obvious, but in reality the actual work process often goes the other way around. That is, the process often starts with the design of a questionnaire based on a general notion of the survey topic. Then follows the choice of a data collection method, and after the data have been collected, one starts thinking about how to report and what to analyse.

The risk of course is that we might find that the data collected do not fully respond to demands.

In the proceedings of our project we started with a comparison of the questionnaires of national prevalence surveys, which have been carried out in the last decade. Apart from similarities and differences, we found that on one hand many data have been collected, which have not been reported or analysed, and on the other hand many data had not been collected which in retrospect seem necessary or relevant for reporting or analysis.

Based on this consideration the expert group has tried to keep the project going by continuously asking, “why we would want to collect particular data”, and if so, “what could be a relevant use or interpretation of these data”, and both in the context of European cross-country comparison.

Our final recommendations about model survey items reflect the consensus within the expert group about the main objectives of comparative data collection on prevalence of illicit drugs in the general population. These main objectives can be stated as follows.

- (1) to report prevalence and continuation rates of the most common illicit drugs in the general population by gender and age groups;
- (2) to allow cross-country assessment of relationships between general patterns of use of illicit and licit drugs;
- (3) to allow the assessment of relationships between particular population attributes and the use of illicit drugs.

#### *ad (1)*

The first objective implies the reporting of prevalence rates according to the formats specified by EMCDDA (see Annex 2). It requires measures for lifetime, last year and last month prevalence, as well as age and gender as core variables.

The expert group however decided on a more limited number of illicit drugs than specified in the EMCDDA report formats as not all of them were considered to be 'common' on a European scale. We also did not incorporate "illicit" use of medicines, i.e. without prescription or medical need, because of definition problems.

#### *ad (2)*

The second objective implies collection of data about the use of licit drugs. Tobacco, alcohol and two kinds of pharmaceutical drugs (sedatives and tranquillisers) have been chosen as the most appropriate, although there are also other reasons to include them (see Part 2).

As indications of patterns of use we decided upon a general behavioural pattern related to last year for licit drugs and a general pattern during last month for both licit and illicit drugs. As we did not expect to find many regular users of illicit drugs in a population survey, we omitted a general last year pattern for illicit drugs.

#### *ad (3)*

It proved to be more complicated to decide on relevant attributes, apart from the obvious age and gender. As core variables we recommend only data to describe household situation, level of education, main ("professional") activity and degree of urbanisation. Although we discussed several other options, more research would be needed to achieve a consensus on relevant socio-economic, cultural or behavioural attributes in the context of illicit drug use.

Attitudes, opinions and perceptions have also been considered. We recommend to include some standard questions about opinions and perceptions, but acknowledge at the same time that more studies will be needed to identify what we are actually measuring in this way and to what extent this will help to understand prevalence and patterns of illicit drug use. In the Joint Analysis we included a tentative approach to clarify this issue.

The modest implicit survey objectives that we defined for our task to improve comparability of general population surveys, result in this final report in a limited number of core variables and questions. Many more have been discussed, but have been rejected, as we could not identify clear objectives for collecting and comparing across Europe.

As such this report only intends to set minimum standards from a European point of view.

### **Context**

It should also be acknowledged that in many countries the assessment of the prevalence of illicit drugs is included in a survey, which focuses on other items. We can assume that this "context" not only influences response but also can have an effect on the demands for data illicit drugs and the questions needed to collect this information.

People might respond differently depending on whether the survey deals with illicit drugs only or mainly, with the use of all kinds of licit and illicit substances or with health risks and health problems in general.

If the survey pursues other aims as well, there might be a need for other or more detailed data about illicit drugs due to analytical designs that aim to answer different types research questions. The reality that drug prevalence is often embedded in wider research aims proved to be one of the obstacles to reach an easy consensus about the core items and questions.

Individual countries would still have to elaborate their own data demands. As a result they might decide to extend the model presented here with more items, variables and questions. Such decisions should be made on the basis of clearly specified report demands and/or elaborated a priori research designs.

## **3. TARGET POPULATION**

In theory a general national population survey will have the whole population of a country as its target population. In reality however some segments of the population will be excluded.

Very young people will be excluded because we do not expect any drug use among them or because they can only be interviewed with their parent's consent, which might bias the results.

In many cases older people are also excluded because we don't expect any drug use or because we realise that interviews might be complicated and biased due to health and mental problems. In most cases people who do not speak the native language of the country will be excluded as well. In general the increase in survey costs will not justify doing otherwise. These costs not only regard translations and interviewers who speak other languages, but also an increase in organisational costs as we usually only find out that an intended respondent does not speak the native language when we encounter the respondent. However, excluding non-native speakers can bias the survey results, in particular in areas with concentrations of ethnic minorities.

In the Joint Analysis we restricted ourselves to the age group of 18-59 years, which was the common divide of the target populations of the national surveys included in the analysis.

These age limits do not correspond with the present report format of the EMCDDA tables (see Annex 2), where the lower limit is set to age 15 and the upper limit to age 64.

It should be noted however that including young people of age 15, 16 and 17 can create problems. Most professional survey agencies follow national or international codes of conduct that inhibits the interviewing of 15-year olds and sometimes 16-17 years olds. They could be interviewed when their parents do not object, but this is a rather complicated procedure in a survey process. For this reason the under 16- or 18-year olds will often be excluded from a survey.

Nevertheless, youngsters of 15-17 years are an interesting group for prevalence surveys as the first use of illicit drugs often starts at this age. To some extent there might be an alternative because the age group will be partly covered by the European School Surveys (ESPAD), but this excludes those young people who already left school, which can be a sizeable group in some countries. Also those who already have left school at this age might be a particular risk group with regard to drug use. Although we recognise the practical problems of including young people in general populations surveys we still recommend to include them if possible.

Including older people in a survey could imply increasing numbers of inaccurate answers or missing values. Measuring prevalences depends on memory recall, which can be a problem for older people. At present we do not know much about the extent of such memory effects and as a consequence upper age limits in surveys are usually defined on the basis of common sense of practical considerations.

As most drug use in Europe only started in the 60s among young people, we would not expect today to find (life-time) prevalences among people over 60/65, which corresponds to the present upper limit of EMCDDA or the common divide of the surveys included in our project. The argument to include older people because they increasingly might use medical drugs does not apply as long as we focus on illicit drugs. In a prevalence survey about illicit drugs, the use of medicines, like alcohol and tobacco, a context variable, not a research item as such.

However, as time goes by, there might be arguments to raise the upper limit as the 65-years of today are the over 70 of tomorrow. Ultimately any upper limit should be based on better insights in memory effects with increasing age.

Considering the above we recommend for the time being to define the target population for general population prevalence surveys as the population of 15-64 years, in accordance with the present report formats of EMCDDA.

## **4. SURVEY MODE**

Choosing which mode to apply is a crucial decision in designing a survey. We discussed this topic in general terms in the final report of project CT.96.EP.08. Each survey mode will generate a particular bias in both response rates and item response and comparing survey data collected by different modes can be complicated because of the differences in mode bias.

In drug research there has always been a lot of attention to mode related bias in survey results. For one reason because we know that we deal with a sensitive topic –illicit drug use, which we can expect that people only are willing to reveal when they feel confident about their anonymity. Another reason is that we can control the bias to some extent by selecting the right mode, whereas we can not always influence other factors that may affect survey bias, like the interaction between interviewers and respondents or media attention for the survey subject at the time of the interviews.

Although it has not been the task of our project to investigate which mode(s) are the most suitable for prevalence surveys, we have to consider mode effects in the development of standard questionnaires. We discuss a few aspects below and in Chapter II we list mode implications with regard to the recommended core items of the model questionnaire.

### ***Mode and phrasing of questions***

The formulation of questions should be adapted to the survey mode applied. Sometimes the wording and phrasing of questions might be acceptable in situations where the respondent can read the questions, but the same text can sound awful when posed verbally by an interviewer. In general a question to listen to should be a pretty short colloquial sentence, whereas a question that one can read might be more complex and formal.

We also need to consider that a question to be read by the respondent from screen or paper will be the same for all respondents. But a question to be asked by interviewers will always somehow change in the course of the survey process. If the question has some length or has to be phrased in a not very spontaneous way, most interviewers will not be able to stick to the same wording over and over again. Even if questions are pretty simple and short, but at the same time have a repetitive character within the questionnaire, as is the case for most prevalence questions, the wording might change during the interview. In our fieldwork experience face-to-face pen-and-paper questionnaires incite more variations than computer aided interviews.

Besides, many interviews will not evolve as a simple question-answer interaction. Respondents will make in-between remarks, which the interviewer cannot always ignore, but will affect the way next questions are asked. CAPI and face-to-face interviews will be more affected than CATI, as the telephone setting creates more distance and anonymity between interviewer and respondent. One should be aware that questionnaires in most cases have to be initially developed from a perspective of the respondent reading the question. These initial formulations should always be tested in a real audience before adaptation to modes where the respondent has to listen to the questions.

### ***Mode, survey introduction, joining texts, instructions and referrals***

A real questionnaire will have a proper introduction about the nature and the reasons for the survey. Presented on paper the respondent can carefully read and re-read this. In a face-to-face setting the text will be shorter, or if not, can raise comments forcing the interviewer to more detailed explanations which might or might not be correct. CATI will usually limit the possibilities for extensive introductions anyway.

The same remarks hold for so called joining texts between different items of a survey.

Most instructions about the completion of the questionnaire, being it for the respondent or the interviewer, are by nature mode dependent. Referrals, e.g. the GO TO's following particular answers, will usually work well in computer aided modes as the referral is built into the programme, but they can easily cause confusion in pen-and-paper formats. When such a mode is chosen, the referrals have to be as simple as possible.

### ***Mode and questionnaire structure***

Pen-and-paper self-completion modes imply that the respondent can view all the questions before starting to complete the questionnaire. This can affect his or her willingness to respond or response pattern. Admittedly both in a positive or negative way.

With interviewer completion the respondent does not know in advance what will be asked, which can be advantage or disadvantage.

In computer aided interviews there is usually no possibility to have second thoughts about previous answers, as one cannot skip back or skipping back is limited to one or two questions. In fact computer aided surveys, in particular CATI, call for spontaneous direct answers. That might be what we actually want, for instance with regard to opinions, but sometimes we hope for some reflection which in the speed of the process we might not get.

### ***Mode and response categories***

An important implication of survey mode deals with the answer categories for each question. Reading from paper (questionnaire or show card) or screen will cause no problems, but when the interviewer has to list the possibilities verbally the options will be limited. With too many categories the respondent might forget some of them. Without listing the categories the interviewer might allocate the spontaneous responses incorrectly or be forced to type the full answer, which causes as many problems as interviewers are usually not selected on behalf of their fast typing skills.

In particular CATI limits the number of optional categories. The usual solution of creating dichotomous questions for each category will not always yield the same results as the a priori presentation of all options.

Ideally a questionnaire should be developed after the selection of a survey mode. In practice most researchers will copy questions from other questionnaires or use model questions as presented here. In such cases it is recommended to carefully adapt and test the full design in the selected mode before starting the survey fieldwork.

## **5. PRESENTATION**

Both general response and item response can be influenced by the way the survey is presented to the general public. Although this topic has been discussed in the expert group we cannot provide a standard model for the introduction of a drug prevalence survey. Presentation and introduction not only depends on the mode chosen for the survey but also on the context in which the drug prevalence questions are embedded.

Based on the pre-tests and the experiences of the expert group of the project we can however formulate some general principles.

### ***Survey aims***

It is important to explain the general aim of the survey. Obviously this needs to be pretty concise and understandable, even if it will be mentioned in a letter preceding the interview. Details can be omitted. The information should be accurate and honest, but some 'window-dressing' might be allowed to prevent that the respondents will be scared off from the start.

Introducing the survey as an assessment of illicit drug use or addictive behaviour does not seem helpful to gain co-operation, so this will usually change into an assessment of the use of all sorts of substance use, lifestyles, health risks, etc. But such window-dressing should then also be justified by the questionnaire, which sometimes means to include questions, which might be obsolete for the real survey aims.

Ideally the survey aim should be formulated in such a way that the respondent might feel that his or her opinions or fact do matter for a cause of public interest.

### ***Survey commission***

Fieldwork agencies will usually not mention the name of their client for a survey, unless the client's name can be thought to contribute to the willingness to respond. If a government body or non-governmental organisation commissions the survey, mentioning the client might improve response as it indicates a public interest. But it might also have an adverse effect if the name of the organisation already hints in a direction that scares off the respondent.

A study commissioned by the Tax Office is not likely to call for initial co-operation, but the same holds if the commissioner's name contains a reference to drugs (which most people still associate with 'illicit' drugs) or addiction.

Nevertheless if a respondent asks for the information, the interviewer has to give an answer. It should be carefully considered what will be answered. For instance, if a survey is commissioned by a drug agency that in the end acts on behalf of a government body, it is justifiable to mention that government organisation instead of the drug agency.

### ***Anonymity***

The respondent must be ensured that his responses will remain confident. For this it is not enough to tell this, but it should also follow from the setting of the interview or the traceable procedures of the handling of completed surveys. A classic example is the printing of identification numbers on postal questionnaires. Many people will right or wrong interpret this as a link to their name and will therefore not respond.

Finally, it is generally considered good practice to mention in the introduction the name of the interviewer and the survey agency and to inform the respondent about the expected length of the interview.

## 6. FIELDWORK

After the initial decisions about a survey design, including the questionnaire, have been made an agency has to be selected to carry out the fieldwork. This can be the research organisation responsible for the survey, but in most cases a commercial market research company will be contracted.

In general the further elaboration and fine-tuning of the survey design and questionnaire will be accomplished in co-operation between the researchers and the fieldwork agent. In particular with regard to all sorts of bias control it makes little sense to elaborate the whole process in an academic research setting without accounting for the practical constraints of a particular fieldwork company or the contract that can and will be concluded.

The choice of and the arrangements with a fieldwork company are among the most crucial, though often neglected, factors with regard to bias in and reliability of survey outcomes. A perfect survey design can be ruined if it is not matched by the reality of the fieldwork.

Below we list some important aspects to consider in the process of selecting a fieldwork company and making arrangements for the fieldwork execution and the deliverables thereof.

### **Quotation**

The price of the fieldwork will of course be a main criterion to select a company. Research companies should have some general ideas about price levels before they even start to design a survey, otherwise they risk to find that their design choice of mode, length of questionnaire and intended net response will not be manageable within the budget available.

A price quotation should specify at least the desired mode, the length of the questionnaire and the required net response. It is not advisable to accept quoted which just fit into the budget. Having no margins to cope with last minute changes, unexpected problems or adaptation will inevitably result in compromises that affect the results. Specifying every aspect of a survey in detail in advance is often not practical, but inserting detail later on will be constrained by the budget. Fieldwork is business and nothing goes for free.

It often makes sense to test the expected interview time of the questionnaire in advance. Most agencies calculate on the number of questions and a net interview time per hour. Open-ended questions are usually calculated separately, both for interview time and data entry / recoding.

In our experience 30-40 questions can be asked in about 10 minutes, but when there are many filter questions the number of questions in the same time can be much higher. The pre-tests of the model questionnaire, which had –including the 61 questions listed in Chapter II- in total 83 questions, the average interview time was below 10 minutes in all modes.

The effective interview time per hour depends on mode but can also differ considerably between agencies. In a CATI unit with many extensions net interview time can reach up to 50 minutes per hour, whereas face-to-face interviewing can slow down to less than 10 minutes per hour, depending on the dispersion of sample addresses and the efficiency of routing systems.

### **Sampling**

In practice the actual choice of sampling frames and sampling methods will be made by the fieldwork company in accordance with their professional standards and general criteria for stratification and clustering defined by the researchers. In most cases there will be no other alternative. This does not have to be a problem if the exact procedures are known and communicated. However, more often than not, this is not the case. A simple statement that multistage systematic sampling has been applied will usually not be sufficient. As a result frame and sampling biases are not really known. It is advisable to ask companies already in the stage of quotations to specify the frames and sampling methods they will and can use.

In any case the exact proceedings should be specified in a technical survey report.

### **Pre-testing and instructing the interviewers**

Although preliminary pre-tests might have been done by the researchers, it is recommended to have a pre-test done by the selected fieldwork agency as well. One reason is that each company has their own type of more or less skilled interviewers. For a major survey pre-tests should be carried out in a real life situation, mimicking the actual survey process, and not just among the interviewers themselves. Ideally the commissioning researchers should be able to observe the pre-tests.

Obviously the interviewers need to be instructed. This is a task of the company but again the responsible researchers should be able to observe the proceedings.

In both cases the main reason is not to control the agency, but to understand the problems involved in the questionnaire and facilitate necessary decisions about changes and adaptations or conclusions about inevitable biases in the design.

### ***Survey control***

Interviewers and, if applicable data entry, will be controlled by the fieldwork company. The procedures need to be clear and written down. Selecting only certified companies according to an ISO or market research quality standard can ensure this.

Survey control also includes specified rules about how to handle when unexpected problems are encountered during the survey process and in particular whether or not the commissioning researchers will be involved in the decisions made to solve the problems. It can be very frustrating if you only find out afterwards that some aspects of the survey have not been executed as originally arranged.

### ***Data management***

It is advisable to make quite specific arrangements about the data that the fieldwork company has to deliver. Of course they have to deliver the survey data, but they will not spontaneously deliver the file in the format that the researcher would like to handle. Variable names and codes usually differ from those on the questionnaire. Often response code will each be delivered as a separate variable, in particular with CATI and depending on the programme used. More important are the specifications of missing values and the procedures used in cleaning the data. When no clear arrangements are made the initial data handling can take a lot of valuable research time.

### ***Survey accountability***

Another point to consider is the account that the fieldwork company will present of the survey process. Ideally, a full technical report should be delivered, which describes the problems encountered during the survey, the way in which these problems have been solved and last but not least a full account of the response. Again, such report is not always presented spontaneously and consequently many aspects of survey bias cannot be evaluated properly.

The scheme which we have presented in the final report of CT.96.EP.08 and is here included as Annex 3 can be used as a guideline for the reporting of both problem solving solutions and response account.

As minimum standards we recommend to specify:

#### *process*

- the frame used
- description of potential frame bias
- sampling method (with definition of terminology)
- description of potential sampling bias
- routing of interviews
- recontact procedures
- replacement procedures

#### *response*

- (estimate of) size of target population
- initial size of survey sample (total and per stratum/cluster if applicable)
- final sample size (initial size plus added samples or replacements)
- number of encountered frame errors
- size of actually contacted sample
- non response by type of non response
- net response

At present response rates of national prevalence surveys can hardly be compared, due to different methods of calculation. We recommend calculating the rate always as net response divided by total sample size minus frame errors. Therefore non-contacts will be included in the nominator, as well as refusals etc.





## II. ITEMS OF A MODEL SURVEY ON DRUG PREVALENCE

### 1. INTRODUCTION

In this chapter the expert group presents a model for national population surveys about drug prevalence in the EU Member States. The model is first of all the result of the discussions within the expert group. The structure of other surveys on the topic as well as personal experiences of the members of the group with the execution and analysis of prevalence surveys played an important role in these discussions. In the final design of the model we have also taken into account the efforts to construct a European file for the Joint Analysis and the evaluation of the pre-tests, which have been carried in different modes with a draft version of the model.

In the following sections we provide an overview of the elements that we propose as core items of a model survey and the questionnaire, which will implement this model.

The overview of core items starts with a short discussion per item and then specifies the variables related to the item, the questions that will generate these variables, mode implications related to the questions, recommended data manipulations and acceptable alternatives with regard to the questions or questionnaire design.

The discussion of core items is followed by the English version of the model questionnaire and a summary of the pre-tests of this model. In Annex 1 we present the model questionnaire in the other languages -French, German, Dutch, Swedish, Finnish, Greek- of the countries represented in the expert group.

#### **Discussions per item**

We restrict ourselves here to the main arguments that played a role in the final selection of variables and questions. Detailed discussions about the different items have already been reported in the final report of the first comparability project (CT.96.EP.08) and the interim report of the follow-up project CT.97.EP.09. It should be noticed that we focus in this report on the items chosen, not on the items, which after discussion and evaluation have been left out.

#### **Core variables and categories**

In the early stages of the project it has already been acknowledged that comparability of national population surveys not necessarily implies that the questionnaires of different countries have to be identical. We don't compare questions but the data resulting from these questions. We therefore first define the data or variables that we want to be comparable across countries and for each variable we define the categories which we consider relevant for comparative analysis.

In many cases we have deliberately chosen for ordinal scales, partly because this facilitated consensus about the categories, partly because we believe that such scales are sufficient for cross-country analysis. So we rather intend to compare for example frequent drug users between countries than people who use drug in the same frequency or quantity.

#### **Core questions**

As a next step we present the questions which will result in answers that classify the respondents to the categories of the core variables. Depending on the nature of the variables and categories required, the questions have to be more or less precise in their phrasing and wording.

With regard to the prevalence variables the most important is that the questions call for the same concept and refer to the same periods of time. Hence we choose for example "taking substances" instead of using or consuming them, because the latter might by some, in some languages, be interpreted as a sort of a habit and therefore not invite to reveal incidental or occasional "use".

On the contrary, with regard to respondent's attributes, the wording or phrasing of questions will not always matter, as long as we can unambiguously identify the attributes. In fact we here only provide for these attributes some tentative questions, realising that national surveys most likely will apply their own traditional sets of questions to assess such attributes.

On the other hand, with regard to opinions we only present core questions without defining the individual or conceptual scale variables that can be assessed by these questions.

### **Mode implications**

The wording and phrasing of questions cannot be independent of the survey mode applied. A question that sounds clear and unambiguous when the respondent can read the sentence might sound odd or confusing when asked by an interviewer. Although we have tried to find formulations, which can be generally applied, in some modes specific instructions or variations in wording might be needed. For each item the most obvious implications and complications will be mentioned.

### **Data manipulations**

An attempt to harmonise variables, categories and questions might still not bring comparable data when the researchers apply different rules for data manipulation with regard to missing data or inconsistencies. For instance, we will do not get real figures for item non-response when people who rightly have skipped a question are labelled the same as those who should have provided an answer but did not do so.

We recommend a uniform approach in which skipped questions always return a value on the variable concerned. In our proposal we use code 8888, which means that the question has been skipped according to the referrals in the questionnaire. In some statistical analysis it might be needed to recode this value into a logical category of the variable concerned. For the real item non-response we propose code 9999, though this might be split in subcategories, e.g. refusals. Based on our experiences in handling national data for the Joint Analysis we recommend not accepting so called "system" missing values in data files. In general missing values should only be declared in the context of specific statistical procedures and not as a fixed label in the data set.

Also both interviewers and respondents can make mistakes or be inaccurate in completing questionnaires, which can result in inconsistencies. Again, our data will not be comparable if one researcher deletes cases with inconsistent answers whereas another corrects them.

Where appropriate we propose standard routine to handle inconsistent cases. The routines have been derived from the procedures used in the construction of the data set for the Joint Analysis.

### **Alternatives**

Finally, we discuss for each item acceptable alternatives with regard to the question formats.

These alternatives basically deal with two issues.

Some countries traditionally collect more detailed information regarding (frequency of) substance use than we propose, and they might prefer to continue to do so. We consider the effects with regard to comparability, but it must be remarked that we do not have research evidence about these effects.

Secondly, computer assisted interview modes today tend more and more to reduce questions to simple yes-no answers. Many CATI programmes are already structured in this way and actually return dichotomous variables for each category of all variables. In this case too we have to consider the implications, but again without evidence about the effects.

### **Optional items**

In the interim report and the final report of the preceding project we already mentioned several optional items. We expect that many countries will include optional items depending on national demands. In fact we expect that for the time being, the model presented here is more likely to be incorporated in national surveys, than to be used as the starting point for national surveys. For this reason we do not summarise previous discussions on optional items in this report.

### **Model questionnaire**

The model questionnaire presented in different languages at the end of this section is limited to the questions we have defined, that is excluding questions related to respondent's attributes.

For practical reasons we present the questionnaire without internal referrals, interviewer or respondent instructions or sentences that "join" the questions. In real life the mode and context of a survey, as well as the working practices of the survey agencies involved will determine the phrasing of these texts. However, these aspects should be carefully considered, as they will have an impact on survey outcomes.

## 2. TOBACCO

### DISCUSSION

In the context of a prevalence survey about illicit drugs questions about tobacco consumption have a dual purpose:

- (1) Starting first with questions about the use of licit drugs makes it easier to address the item of illicit drug use. In this sense, questions about the use of licit drugs act as a sort of 'warming up' for the questions about illicit drugs, which are considered more sensitive to the general public.
- (2) It is expected that there are relations between the use of licit and illicit drugs, being both psychoactive substances. Inclusion of questions about licit drugs will enable to study these relations.

Both arguments however do not imply that the model questionnaire about prevalence of illicit drugs should aim at a detailed assessment of smoking habits. Only a basic distinction between active smokers, quitters and abstainers needs to be made. This requires two questions that can be merged into a single variable.

The questions are purposely formulated in a rather casual manner. They should result in the type of answer the respondent would give when asked "do you smoke" or "have you ever smoked" in a social setting. Different ways of smoking tobacco are mentioned to make the question more concrete.

The expert group has considered various questions on tobacco use. Although other routes of administration (e.g. the nasal use of snuff) were discussed, the core item remains restricted to smoking of tobacco. The alternative formulation "are you a smoker" was judged to be less objective and more subject to changing general attitudes towards smoking.

More detailed answer categories have been considered as well, for example the format used in several surveys, which differentiates between 'regular' or 'occasional' smoking. These options were judged either unnecessary or too complex. Although they might yield slightly different results, they can be taken as alternatives, see below.

### CORE VARIABLES

#### SMOKING

Label	Self-labelled 'status' with regard to smoking of tobacco		
Categories	1	<b>active smoker</b>	= does smoke
	2	<b>quitter</b>	= did smoke in the past
	3	<b>abstainer</b>	= never smoked
	9999	<b>missing</b>	= no answer

### MODEL QUESTIONS

**Q1** *Do you smoke tobacco, such as cigarettes, cigars or a pipe?*

- 1    **yes**    ▶ skip Q2
- 2    **no**
- 9999 **else**   ▶ skip Q2

**Q2** *Have you ever smoked in the past?*

- 1    **yes**
- 2    **no**
- 9999 **else**

**MODE IMPLICATIONS** none

**DATA MANIPULATION** SMOKING needs to be calculated from Q1 and Q2 as follows

All modes

IF (Q1 = 1) SMOKING = 1

IF (Q1 = 9999) SMOKING = 9999

IF (Q2 = 1) SMOKING = 2

IF (Q2 = 2) SMOKING = 3

IF (Q2 = 9999) SMOKING = 9999

## ALTERNATIVES

### Applying the general prevalence model

One may use the standard prevalence questions instead, e.g. asking for lifetime, last year and last month prevalence. Active smoking should then be set equal to last month smoking and quitters will be those who did smoke ever or in the last year, but not in the last month.

It can be expected however that we get slightly different results in classification of respondents.

People who have given up smoking less than 30 days ago, or more important people who do not consider themselves as 'smokers', might still be classified as active smokers.

The prevalence questions might also yield more quitters, as people who once or twice in their life tried a cigarette might not consider themselves as "having ever smoked", when asked in the more casual manner of our proposal.

### Differentiating intensity

As already mentioned above, many surveys differentiate between regular and occasional smoking, either or both with regard to active smoking and past smoking.

If a question about regular or occasional use follows a "yes" on the model questions Q1 or Q2, the differentiation has no effect on the model. When the differentiation is included in the categories of Q1 and Q2, both regular and occasional should be read as a single "yes". However, we do not really know if we will get the same results. An occasional (past) smoker might not consider himself as a smoker, hence he will respond "no" to the phrasing of Q1 or Q2. Confronted with the alternatives of regular and occasional, he might opt for occasional and we will get more active smokers and/or fewer abstainers.

## 3. ALCOHOL

### DISCUSSION

Questions about the consumption of alcohol do have the same purposes as discussed above with regard to tobacco. Therefore, the model questions about alcohol are not intended as a detailed assessment of drinking habits.

Nevertheless, the expert group decided on more detail about alcohol than about smoking. One reason for this is the fact that in many countries the assessment of illicit drug use is incorporated in a long-standing tradition of alcohol surveys. Another reason might be that intervention structures often cover both addiction to alcohol and illicit drugs, but not really deal with smoking, hence a greater focus on alcohol than on tobacco.

In principle the proposed model only differentiates between drinkers and non-drinkers and between heavy drinking and normal or occasional drinking. The first is achieved by measuring last year and last month prevalence, the latter by including questions about general drinking

behaviour taken from the Alcohol Use Disorders Identification Test (AUDIT, Saunders et al., 1993). These questions relate to general patterns of drinking and binge drinking, whereby binge drinking is indicated by drinking 6 glasses or more at one occasion. If this standard in alcohol research will change in the future to another number of glasses, it is meant that our model will change accordingly. Last month frequency is included to assess a sort of persistence of a general pattern.

It should be noticed that the proposed model questions do not measure alcohol intake as such. We only establish a comparable measure for drinking habits on an ordinal scale. Identical scale values, for instance drinking 2-3 times a week, might imply a different intake of alcohol in one country compared to another, depending on the usual type of alcoholic drink and the standard volume of a typical 'drink'.

In fact the complications of standardising questions about frequency and intensity of use resulting in comparable figures of alcohol intake, facilitated the consensus about the ordinal scales to differentiate habits as presented below.

## CORE VARIABLES

### LYP\_ALC

Label	Last year prevalence of alcohol	
Categories	<b>1</b>	<b>did drink drunk any alcohol during last 12 months</b>
	<b>2</b>	<b>did not drink any alcohol during last 12 months</b>
	<b>9999</b>	<b>missing</b>

### DRINKING

Label	General frequency of alcohol	
Categories	<b>1</b>	<b>4 times a week or more often</b>
	<b>2</b>	<b>2 to 3 times a week</b>
	<b>3</b>	<b>2 to 4 times a month</b>
	<b>4</b>	<b>once a month or more seldom</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

### BINGING

Label	General frequency of drinking 6 glasses or more of an alcoholic drink at one and the same occasion	
Categories	<b>1</b>	<b>daily or almost daily</b>
	<b>2</b>	<b>every week</b>
	<b>3</b>	<b>every month</b>
	<b>4</b>	<b>more seldom than once a month</b>
	<b>5</b>	<b>never</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

### LMP\_ALC

Label	Last month prevalence of alcohol	
Categories	<b>1</b>	<b>did drink drunk any alcohol during last 30 days</b>
	<b>2</b>	<b>did not drink any alcohol during last 30 days</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

## LMF\_ALC

Label	Last month frequency of alcohol drinking	
Categories	<b>1</b>	<b>daily or almost daily</b>
	<b>2</b>	<b>several times a week</b>
	<b>3</b>	<b>at least once a week</b>
	<b>4</b>	<b>less than once a week</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

### MODEL QUESTIONS

**Q1** *During the last 12 months, have you drunk beer, wine, spirits or any other alcoholic drink?*

- 1**     **yes**
- 2**     **no**     ▶ **skip Q2, Q3, Q4, Q5**
- 9999** **else**   ▶ **skip Q2, Q3, Q4, Q5**

**Q2** *How often do you drink alcohol?*

- 1**     **4 times a week or more often**
- 2**     **2 to 3 times a week**
- 3**     **2 to 4 times a month**
- 4**     **once a month or more seldom**
- 9999** **else**

**Q3** *How often do you drink 6 gasses or more of an alcoholic drink on the same occasion?*

- 1**     **daily or almost daily**
- 2**     **every week**
- 3**     **every month**
- 4**     **more seldom than once a month**
- 5**     **never**
- 9999** **else**

**Q4** *During the last 30 days, have you drunk any alcohol?*

- 1**     **yes**
- 2**     **no**     ▶ **skip Q5**
- 9999** **else**   ▶ **skip Q5**

**Q5** *During the last 30 days, on how many days did you drink any alcohol?*

- 1**     **daily or almost daily**
- 2**     **several times a week**
- 3**     **at least once a week**
- 4**     **less than once a week**
- 9999** **else**

### MODE IMPLICATIONS    Questions require mode-dependent instructions

Self-completion	Q2, Q3, Q5: respondents should be instructed to choose the pre-coded answer that applies to them best
Interviewer completion	Q2, Q3, Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

### Self-completion modes

IF (Q5 < 8888) Q4 = 1  
IF ((Q4 = 1) and (Q5 = 8888)) Q5 = 9999  
IF ((Q4 > 1) and (Q5 = 9999)) Q5 = 8888

Q5 LMF_ALC	Q4 LMP_ALC			
	1	2	8888	9999
1-4		Q4 = 1	Q4 = 1	Q4 = 1
8888	Q5 = 9999			
9999		Q5 = 8888	Q5 = 8888	Q5 = 8888

IF (Q2 = 1) Q1 = 1  
IF ((Q1 > 1) and (Q2 = 9999)) Q2 = 8888  
IF ((Q4 = 1) and (Q2 = 8888)) Q2 = 9999

Q2, DRINKING	Q3	Q1 LYP_ALC			
		1	2	8888	9999
1-4		Q1 = 1	Q1 = 1	Q1 = 1	
8888	Q2 = 9999				
9999		Q2 = 8888	Q2 = 8888	Q2 = 8888	

IF (Q3 < 5) Q1 = 1  
IF ((Q1 > 1) and (Q3 > 4)) Q3 = 8888  
IF ((Q4 = 1) and (Q3 = 8888)) Q3 = 9999

Q3 BINGING	Q1 LYP_ALC			
	1	2	8888	9999
1-4		Q1 = 1	Q1 = 1	Q1 = 1
5		Q3 = 8888	Q3 = 8888	Q3 = 8888
8888	Q3 = 9999			
9999		Q3 = 8888	Q3 = 8888	Q3 = 8888

IF (Q4 = 1) Q1 = 1  
IF ((Q1 > 1) and (Q4 > 1)) Q4 = 8888  
IF ((Q1 = 1) and (Q4 = 8888)) Q4 = 9999

Q4 LMP_ALC	Q1 LYP_ALC			
	1	2	8888	9999
1		Q1 = 1	Q1 = 1	Q1 = 1
2		Q4 = 8888	Q4 = 8888	Q4 = 8888
8888	Q4 = 9999			
9999		Q4 = 8888	Q4 = 8888	Q4 = 8888

### All modes

LYP\_ALC = Q1  
DRINKING = Q2  
BINGING = Q3  
LMP\_ALC = Q4  
LMF\_ALC = Q5

## ALTERNATIVES

### Differentiation by types of alcoholic drinks

In some countries there is tradition to ask questions about alcohol consumption for different types of alcoholic drinks separately. In such cases LYP\_ALC and LMP\_ALC should be calculated by accounting for the answers on all corresponding questions regarding each type of drink. We might get slightly different results. Some people might respond "no" on a general question about any alcohol, but would be triggered to say "yes" in some cases when confronted with the different modalities.

When also Q2, Q3 and Q5 are asked separately for each drink, the core variables DRINKING, BINGING and LMF\_ALC could be set equal to highest frequency specified for any drink. This method has been applied in file construction for the joined European file (see chapter V). It can be an underestimation however, as we don't know if some people combine or alternate their drinking of different drinks.

A compromise would be to include a summing up variable after questions about individual alcoholic drinks. This approach has been applied for instance in the German survey of 1995. The summing up would then read like "let's summarise all your answers above, did you...." etc.

### **Splitting Q2, Q3, Q5 in separate questions per answer category**

As mentioned before Q2, Q3 and Q5 require that the respondent knows all answer categories before responding. In self-completion modes this will not cause any problems, but interviewer completion supposes that the interviewer reads all possibilities first. This can easily cause errors. If the questions need to be followed by specifying the answer categories, the interviewers will have problems to stick to the exact wording. On the other hand the respondent might not properly hear the differences between the answers he can give.

For this reason survey agencies will often prefer to split these questions in separate ones with regard to each of the answer categories, to be asked in following order (i.e. the higher frequencies first).

The result might not be the same however. Not knowing the alternatives, the respondent could wait too long before answering “yes” to any of the questions or respond too promptly. As a result we might get less or more binge or frequent drinkers compared to self-completion modes.

### **Alternative answer categories for Q5**

The AUDIT questions incorporated in our model measure last month frequency on an ordinal scale. Several countries however will prefer to continue traditional interval measures based on an exact number of days of drinking during the last 30 days. In such case data can be made comparable by using the recode scheme we applied in the Joint Analysis.

20 + days = Daily or almost daily  
10-19 days = Several times a week  
4-9 days = At least once a week  
< 4 days = Less than once a week

Asking for the number of drinking days will be more in line with the approach that we have chosen for the illicit drugs. It also avoids the problems of having to read the answer categories first.

It should be noticed that asking for the *number of times* instead of days of alcohol drinking will not produce comparable results, as drinking many times on a day might result in a different classification of respondents. The expert group considers the number of times a substance has been taken not as a recommendable frequency measure.

## **4. PHARMACEUTICALS**

### **DISCUSSION**

The inclusion of questions about the use of medicines (“pharmaceuticals”) has been a topic in several meetings of the expert group. The issue proved to be rather complicated.

Although many drug prevalence surveys in the past had some questions on this item, there are not yet many studies that investigate the meaning of taking medicines in the context of illicit drug use. Also the method of questioning about medicines shows more variations than the assessment of the prevalence of illicit drugs.

The expert group concluded that the item in principle has the same purpose as the items of tobacco and alcohol. That is, to provide information about a behavioural pattern rather than an assessment of prevalence. Also, it was concluded that in the context of illicit drug use the item could be restricted to sedatives and tranquillisers. As it is assumed that many people might not really know the difference between these substances, the group decided on question formats, which combine both, i.e. by asking about “sedatives and/or tranquillisers”.

In the context of a drug prevalence survey we are not really interested in the use of these substances for medical purposes, i.e. prescribed by a doctor to cure an illness. Including regular medication might imply that we measure morbidity instead of behaviour.

However, we acknowledged that the required phrasing to identify non-medical and non-prescribed use can become quite confusing, in particular when people actually do both. Also we have to realise that comparability would still not be achieved as countries differ with regard to availability without prescription of sedatives and tranquillisers, as well as with regard to prescription practices of medical doctors.



The expert group therefore decided on formulations that comprise both medical and non-medical and prescribed and non-prescribed use. As an indication of a potential pattern of non-prescribed use a question has been added which refers to the last time the respondent had used the substance(s).

In the final model the item of pharmaceuticals has been placed before the questions about illicit drugs. This is in accordance with the background context nature of the item, but also avoids that respondents interpret sedatives and tranquillisers as another type of illicit drugs.

## CORE VARIABLES

### LYP\_MED

Label	Last year prevalence of sedatives and/or tranquillisers	
Categories	<b>1</b>	<b>did take sedatives and/or tranquillisers during last 12 months</b>
	<b>2</b>	<b>did not take sedatives and/or tranquillisers during last 12 months</b>
	<b>9999</b>	<b>missing</b>

### MEDHABIT

Label	General frequency of taking sedatives and/or tranquillisers	
Categories	<b>1</b>	<b>4 times a week or more often</b>
	<b>2</b>	<b>2 to 3 times a week</b>
	<b>3</b>	<b>2 to 4 times a month</b>
	<b>4</b>	<b>once a month or more seldom</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

### LMP\_MED

Label	Last month prevalence of sedatives or tranquillisers	
Categories	<b>1</b>	<b>did take sedatives and/or /tranquillisers during last 30 days</b>
	<b>2</b>	<b>did not take sedatives and/or tranquillisers during last 30 days</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

### LMF\_MED

Label	Last month frequency of taking sedatives or tranquillisers	
Categories	<b>1</b>	<b>daily or almost daily</b>
	<b>2</b>	<b>several times a week</b>
	<b>3</b>	<b>at least once a week</b>
	<b>4</b>	<b>less than once a week</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

### LASTMED

Label	Source of last time used sedatives and/or tranquillisers	
Categories	<b>1</b>	<b>on prescription by a doctor</b>
	<b>2</b>	<b>from someone known</b>
	<b>3</b>	<b>from pharmacy or drugstore without prescription</b>
	<b>4</b>	<b>other source</b>
	<b>8888</b>	<b>skipped</b>
	<b>9999</b>	<b>missing</b>

## MODEL QUESTIONS

- Q1** *During the last 12 months, have you taken any sedatives or tranquillisers?*
- 1 yes
  - 2 no ▶ skip Q2, Q3, Q4, Q5
  - 9999 else ▶ skip Q2, Q3, Q4, Q5
- Q2** *How often do you take sedatives or tranquillisers?*
- 1 4 times a week or more often
  - 2 2 to 3 times a week
  - 3 2 to 4 times a month
  - 4 once a month or more seldom
  - 9999 else
- Q3** *During the last 30 days, have you taken any sedatives or tranquillisers?*
- 1 yes
  - 2 no ▶ skip Q4
  - 9999 else ▶ skip Q4
- Q4** *During the last 30 days, on how many days did you take sedatives or tranquillisers?*
- 1 daily or almost daily
  - 2 several times a week
  - 3 at least once a week
  - 4 less than once a week
  - 9999 else
- Q5** *The last occasion you took sedatives or tranquillisers, how did you obtain them?*
- 1 I bought or got them on a prescription by a doctor for myself
  - 2 I got them from somebody else I know
  - 3 I bought them without a prescription in a pharmacy or drugstore
  - 4 none of the above applies
  - 9999 else

## MODE IMPLICATIONS Questions require mode dependent instructions

All modes	Q1-Q5: the generic names 'sedatives' and 'tranquillisers' can be substituted by a more colloquial substance name (e.g. sleeping pills, calming pills). Moreover, it is recommended to add to both substances common brand names as examples
Self-completion	Q2, Q4: respondents should be instructed to choose the pre-coded answer that applies to them best Q5: respondents should be instructed to choose only one answer
Interviewer completion	Q2, Q4, Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

### Self-completion modes

IF (Q4 < 8888) Q3 = 1  
IF ((Q3 = 1) and (Q4 = 9999)) Q4 = 8888  
IF ((Q3 > 1) and (Q4 = 8888)) Q4 = 9999

Q4 LMF_MED	Q3 LMP_MED			
	1	2	8888	9999
1-4		Q3 = 1	Q3 = 1	Q3 = 1
8888	Q4 = 9999			
9999		Q4 = 8888	Q4 = 8888	Q4 = 8888

IF (Q2 = 1) Q1 = 1  
IF ((Q1 > 1) and (Q2 = 9999)) Q2 = 8888  
IF ((Q1 = 1) and (Q2 = 8888)) Q2 = 9999

Q2 MEDHABIT	Q1 LYP_MED			
	1	2	8888	9999
1-4		Q1 = 1	Q1 = 1	Q1 = 1
8888	Q2 = 9999 Q3 = 9999			
9999		Q2 = 8888 Q3 = 8888	Q2 = 8888 Q3 = 8888	Q2 = 8888 Q3 = 8888

IF (Q4 = 1) Q1 = 1  
IF ((Q1 > 1) and (Q4 > 1)) Q4 = 8888  
IF ((Q1 = 1) and (Q4 = 8888)) Q4 = 9999

Q4 LMP_MED	Q1 LYP_MED			
	1	2	8888	9999
1		Q1 = 1	Q1 = 1	Q1 = 1
2		Q4 = 8888	Q4 = 8888	Q4 = 8888
8888	Q4 = 9999			
9999		Q4 = 8888	Q4 = 8888	Q4 = 8888

### All modes

LYP\_MED = Q1  
MEDHABIT = Q2  
LMP\_MED = Q3  
LMF\_MED = Q4  
LASTMED = Q5

## ALTERNATIVES

### Differentiation between sedatives and tranquillisers

Although the model does not intend to distinguish between sedatives and tranquillisers, separate sets of questions can be asked for each substance. In such cases LYP\_MED and LMP\_MED should be calculated by accounting for the answers on the corresponding questions about sedatives and tranquillisers. As discussed before with regard to alcohol, we might get slightly different results. When also Q2 and Q4 are asked separately for each substance, the core variables MEDHABIT and LMF\_MED could be set equal to highest frequency specified for either substance. As for alcohol, this method can produce underestimation. When Q5 is asked for each substance the model variable LASTMED should equal the lowest code that applies to either substance.

Apart from this, the distinction can produce very different results when people don't know the difference between the two substances.

### Splitting Q2, Q4, Q5 in separate questions per answer category

As Q2, Q4 and Q5 require that the respondent knows all answer categories before responding, survey agencies will often prefer to split these questions in separate ones with regard to each of the answer categories, to be asked in following order. The implications have been discussed before. Again, we can expect different results because the respondent, not knowing the alternatives, might answer too promptly or wait too long.

### Alternative answer categories for Q5

Instead of general last month frequency on an ordinal scale some prefer to continue traditional interval measures based on an exact number of days of taking sedatives or tranquillisers. As in the case of alcohol data can be made comparable by using the recode scheme we applied in the Joint Analysis.

20 + days = Daily or almost daily  
10-19 days = Several times a week  
4-9 days = At least once a week  
< 4 days = Less than once a week

Asking for the number of days of taking substances is more in line with the approach we have chosen for the illicit drugs. It also avoids the problems of having to read the answer categories first.

Again, it should be noticed that asking for the *number of times* would not produce comparable results, as taking sedatives and/or tranquillisers several times a day can result in a different classification of the respondents.

## 5. ILLICIT DRUGS

### DISCUSSION

A number of possible questions were considered for breaching the subject of illicit drugs. “Have you ever heard of” has been discussed as an optional filter question for each individual drug. Not having heard of a drug does not exclude that one has taken that drug, and the filter has been rejected.

Instead the expert group decided to start the questions for each individual illicit drug with a *warming-up* question. The final model question “do you personally know people who take” was preferred over the alternative to ask “do you have friends or acquaintances who take” as the latter phrasing might put the respondent on the defensive. The model question has been intentionally phrased in the present tense to avoid reference to the past or hearsay.

A side benefit of the model warming-up question could also be to arrive at an additional or an alternative *prevalence estimate*. Such would be particularly useful in the case of drugs, which are taken by only a small number of respondents. The answers could further be interpreted as *risk factors* or *predictors* for drug use.

Warming-up questions are followed by questions about respondents’ personal use of drugs. For all drugs we include the standard prevalence measures, life time, last year and last month, and one ordinal frequency measure related to the last month.

The expert group decided not to include a measure for lifetime frequency in the proposed model. Such questions enable to distinguish between sporadic and more frequent use and could be informative about the nature of the ‘drug epidemic’. However, the interpretation was thought to be pretty complex and its analytical potential therefore limited.

A general frequency measure to establish behavioural patterns, similar to those related to last year for tobacco, alcohol and pharmaceuticals, was not considered to add more information about drug taking habits than already provided by last month frequency, due to the expected low prevalence rates for illicit drugs.

Only with regard to cannabis the expert group proposes to include a question about the age of onset since it is the illicit drug most often taken and started with. The question should be raised immediately after the question about lifetime prevalence. It is advised to ask for an exact age rather than an age range in which cannabis might have been taken for the first time. Though the expert acknowledge that age of onset might be imprecise due to failing memory, exact ages might still be accurate at an aggregate level and allow more sophisticated analysis.

The expert group proposes to include the following illicit drugs in the model questionnaire: cannabis, ecstasy, amphetamines, cocaine, heroin and LSD. Including other drugs can be optional, though one should be aware of possible questionnaire fatigue due to the repetitive nature of the questions.

The proposed core selection is based on a consensus about which drugs would be relevant for all EU Member States. It is recommended to ask about cannabis first, as it is the most common illicit

drug and thought not to be very intrusive nowadays. Ecstasy should be placed before amphetamines to avoid that people already interpret ecstasy as a form of amphetamines.

Most experts would like to differentiate between cocaine and crack-cocaine. The model however does not make this distinction and a separate question about crack is not considered cost-effective in a general population survey, which at best will reveal very low prevalences. In any case crack should not be mentioned as an example of cocaine. In a similar way 'other opiates' should not be mentioned in connection to heroin, and 'other hallucinogens' not in connection with LSD.

In computer aided survey modes it is possible to alternate the following order of the drugs in the questionnaire to avoid a bias on a particular drug that comes at the end. However, randomisation of the following order should still comply with the recommendation that cannabis will be the first and that ecstasy precedes amphetamines.

In principle (other) colloquial names of the substances concerned can be added. The phrasing of the question for interviewer completion modes should then be exactly specified. When there are many alternative names, the phrasing can become rather clumsy and confusing.

Instead so it is better that the interviewer has a list of synonyms available. On the basis of this list he can accept or reject the answers when the respondent spontaneously asks if a particular colloquially named substance is meant.

The usual mentioning of alternative names between brackets, which should works well in self-completion modes, is not sufficient for interviewer completion modes, where it will be an invitation to interviewers to make up their own phrasings.

It is also recommended by the expert group to include a dummy drug. In the model we have chosen for the name, Relevin, used in the standard European School Survey (ESPAD). A dummy drug enables the researchers to evaluate the reliability of the answer patterns of respondents. Preferably it should be placed between the other drugs investigated, which makes it seem more like a 'real' drug. Its name can be replaced by another one that sounds like an illicit drug. We do acknowledge however that the inclusion of a dummy drug might be disputed. We have no proof that people who claim to have used the dummy should not be considered reliable with regard to their answers on other questions. The pre-tests of the model questionnaire suggest that people who are aware that Relevin must be a non-existing drug might doubt the reliability or seriousness of the survey.

## CANNABIS

### CORE VARIABLES

#### KNO\_CAN

Label	Personally knowing people who take cannabis
Categories	<b>1</b> knows people who take cannabis <b>2</b> does not know people who take cannabis <b>9999</b> missing

#### LTP\_CAN

Label	Lifetime prevalence of cannabis
Categories	<b>1</b> has ever taken cannabis <b>2</b> has never taken cannabis <b>9999</b> missing

## AGE\_CAN

Label Age of onset of taking cannabis

Categories **nn** age in years  
**8888** skipped  
**9999** missing

## LYP\_CAN

Label Last year prevalence of cannabis

Categories **1** did take cannabis during last 12 months  
**2** did not take cannabis during last 12 months  
**8888** skipped  
**9999** missing

## LMP\_CAN

Label Last month prevalence of cannabis

Categories **1** did take cannabis during last 30 days  
**2** did not take cannabis during last 30 days  
**8888** skipped  
**9999** missing

## LMF\_CAN

Label Last month frequency of taking cannabis

Categories **1** daily or almost daily  
**2** several times a week  
**3** at least once a week  
**4** less than once a week  
**8888** skipped  
**9999** missing

## MODEL QUESTIONS

For the model questions it is recommended to use "hashish or marihuana" instead of the generic name "cannabis"

**Q1** *Do you personally know people who take cannabis?*

**1** yes  
**2** no  
**9999** else

**Q2** *Have you ever taken cannabis yourself?*

**1** yes  
**2** no ▶ skip Q3, Q4, Q5, Q6  
**9999** else ▶ skip Q3, Q4, Q5, Q6

**Q3** *At what age did you take cannabis for the first time?*

**nn** (age)  
**9999** else

**Q4 During the last 12 months, have you taken cannabis?**

- 1 yes
- 2 no ▶ skip Q5, Q6
- 9999 else ▶ skip Q5, Q6

**Q5 During the last 30 days, have you taken cannabis?**

- 1 yes
- 2 no ▶ skip Q6
- 9999 else ▶ skip Q6

**Q6 During the last 30 days, on how many days did you take cannabis?**

- 1 daily or almost daily
- 2 several times a week
- 3 At least once a week
- 4 Less than once a week
- 9999 else

<b>MODE IMPLICATIONS</b>	Q6 requires mode dependent instructions none
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Self-completion	Q6: respondents should be instructed to choose the pre-coded answer that applies to them best
Interviewer completion	Q6: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

<b>DATA MANIPULATION</b>	Pen-and-paper modes require consistency corrections. Core variables can be computed from questionnaire items
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Pen-and-paper modes

IF (Q6 < 8888) Q5 = 1  
 IF ((Q5 = 1) and (Q6 = 8888)) Q6 = 9999  
 IF ((Q5 > 1) and (Q6 = 9999)) Q6 = 8888

Q6 LMF_CAN	Q5 LMP_CAN			
	1	2	8888	9999
1-4		Q5 = 1	Q5 = 1	Q5 = 1
8888	Q5 = 9999			
9999		Q6 = 8888	Q6 = 8888	Q6 = 8888

IF (Q5 = 1) Q4 = 1  
 IF ((Q4 > 1) and (Q5 > 1)) Q5 = 8888  
 IF ((Q4 = 1) and (Q5 = 8888)) Q5 = 9999

Q5 LMP_CAN	Q4 LYP_CAN			
	1	2	8888	9999
1		Q4 = 1	Q4 = 1	Q4 = 1
2		Q5 = 8888	Q5 = 8888	Q5 = 8888
8888	Q5 = 9999			
9999		Q5 = 8888	Q5 = 8888	Q5 = 8888

IF (Q3 = 1) Q2 = 1  
 IF ((Q2 > 1) and (Q3 > 100)) Q3 = 8888  
 IF ((Q2 = 1) and (Q3 = 8888)) Q3 = 9999

Q3 AGE_CAN	Q2 LTP_CAN			
	1	2	8888	9999
nn		Q2 = 1	Q2 = 1	Q2 = 1
8888	Q3 = 9999			
9999		Q3 = 8888	Q3 = 8888	Q3 = 8888

IF (Q4 = 1) Q2 = 1  
 IF ((Q2 > 1) and (Q4 > 1)) Q4 = 8888  
 IF ((Q2 = 1) and (Q4 = 8888)) Q4 = 9999

Q4 LYP_CAN	Q2 LTP_CAN			
	1	2	8888	9999
1		Q2 = 1	Q2 = 1	Q2 = 1
2		Q4 = 8888	Q4 = 8888	Q4 = 8888

8888	Q4 = 9999			
9999		Q4 = 8888	Q4 = 8888	Q4 = 8888

All modes

- KNO\_CAN = Q1
- LTP\_CAN = Q2
- AGE\_CAN = Q3
- LYP\_CAN = Q4
- LMP\_CAN = Q5
- LMF\_CAN = Q6

## ALTERNATIVES

### Splitting Q6 in separate questions per answer category

As Q6 requires that the respondent knows all answer categories before responding, survey agencies will often prefer to split these questions in separate ones with regard to each of the answer categories, to be asked in following order. The implications have been discussed before. Again, we can expect different results because the respondent, not knowing the alternatives, might answer too promptly or wait too long.

### Alternative answer categories for Q6

Instead of general last month frequency on an ordinal scale some prefer to continue traditional interval measures based on an exact number of days of taking cannabis. As in the case of alcohol, data can be made comparable by using the recode scheme we applied in the Joint Analysis.

- 20 + days = Daily or almost daily
- 10-19 days = Several times a week
- 4-9 days = At least once a week
- < 4 days = Less than once a week

Again, it should be noticed that asking for the *number of times* would not produce comparable results, as taking cannabis several times a day can result in a different classification of the respondents.

## ECSTASY

### CORE VARIABLES

#### KNO\_XTC

- Label Personally knowing people who take ecstasy
- Categories
  - 1** knows people who take ecstasy
  - 2** does not know people who take ecstasy
  - 9999** missing

#### LTP\_XTC

- Label Lifetime prevalence of ecstasy
- Categories
  - 1** has ever taken ecstasy
  - 2** has never taken ecstasy
  - 9999** missing

#### LYP\_XTC

- Label Last year prevalence of ecstasy



Categories      1      **did take ecstasy during last 12 months**  
                   2      **did not take ecstasy during last 12 months**  
                   8888   **skipped**  
                   9999   **missing**

## LMP\_XTC

Label            Last month prevalence of ecstasy

Categories      1      **did take ecstasy during last 30 days**  
                   2      **did not take ecstasy during last 30 days**  
                   8888   **skipped**  
                   9999   **missing**

## LMF\_XTC

Label            Last month frequency of taking ecstasy

Categories      1      **Daily or almost daily**  
                   2      **several times a week**  
                   3      **At least once a week**  
                   4      **Less than once a week**  
                   8888   **skipped**  
                   9999   **missing**

## MODEL QUESTIONS

**Q1    *Do you personally know people who take ecstasy?***

1      **yes**  
 2      **no**  
 9999   **else**

**Q2    *Have you ever taken ecstasy yourself?***

1      **yes**  
 2      **no      ► skip Q3, Q4, Q5**  
 9999   **else    ► skip Q3, Q4, Q5**

**Q3    *During the last 12 months, have you taken ecstasy?***

1      **yes**  
 2      **no      ► skip Q4, Q5**  
 9999   **else    ► skip Q4, Q5**

**Q4    *During the last 30 days, have you taken ecstasy?***

1      **yes**  
 2      **no      ► skip Q5**  
 9999   **else    ► skip Q5**

**Q5    *During the last 30 days, on how many days did you take ecstasy?***

1      **daily or almost daily**  
 2      **several times a week**  
 3      **At least once a week**  
 4      **Less than once a week**  
 9999   **else**

## MODE IMPLICATIONS

Q5 requires mode dependent instructions

Self-completion

Q5: respondents should be instructed to choose the pre-coded answer that applies to them best

Interviewer completion

Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

### Pen-and-paper modes

IF (Q5 < 8888) Q4 = 1  
IF ((Q4 = 1) and (Q5 = 8888)) Q5 = 9999  
IF ((Q4 > 1) and (Q5 = 9999)) Q5 = 8888

Q5 LMF_XTC	Q4 LMP_XTC			
	1	2	8888	9999
1-4		Q4 = 1	Q4 = 1	Q4 = 1
8888	Q5 = 9999			
9999		Q5 = 8888	Q5 = 8888	Q5 = 8888

IF (Q3 = 1) Q4 = 1  
IF ((Q3 > 1) and (Q4 > 1)) Q4 = 8888  
IF ((Q3 = 1) and (Q4 = 8888)) Q4 = 9999

Q4 LMP_XTC	Q3 LYP_XTC			
	1	2	8888	9999
1		Q3 = 1	Q3 = 1	Q3 = 1
2		Q4 = 8888	Q4 = 8888	Q4 = 8888
8888	Q4 = 9999			
9999		Q4 = 8888	Q4 = 8888	Q4 = 8888

IF (Q3 = 1) Q2 = 1  
IF ((Q2 > 1) and (Q3 > 1)) Q3 = 8888  
IF ((Q2 = 1) and (Q3 = 8888)) Q3 = 9999

Q3 LYP_XTC	Q2 LTP_XTC			
	1	2	8888	9999
1		Q2 = 1	Q2 = 1	Q2 = 1
2		Q3 = 8888	Q3 = 8888	Q3 = 8888
8888	Q3 = 9999			
9999		Q3 = 8888	Q3 = 8888	Q3 = 8888

### All modes

KNO\_XTC = Q1  
LTP\_XTC = Q2  
LYP\_XTC = Q3  
LMP\_XTC = Q4  
LMF\_XTC = Q5

## ALTERNATIVES

See alternatives for Q6 under Cannabis

## AMPHETAMINES

### CORE VARIABLES

#### KNO\_AMP

Label Personally knowing people who take amphetamines

Categories **1** knows people who take amphetamines  
**2** does not know people who take amphetamines  
**9999** missing

#### LTP\_AMP

Label Lifetime prevalence of amphetamines

Categories    **1**    **has ever taken amphetamines**  
                   **2**    **has never taken amphetamines**  
                   **9999** **missing**

## LYP\_AMP

Label           Last year prevalence of amphetamines

Categories    **1**    **did take amphetamines during last 12 months**  
                   **2**    **did not take amphetamines during last 12 months**  
                   **8888** **skipped**  
                   **9999** **missing**

## LMP\_AMP

Label           Last month prevalence of amphetamines

Categories    **1**    **did take amphetamines during last 30 days**  
                   **2**    **did not take amphetamines during last 30 days**  
                   **8888** **skipped**  
                   **9999** **missing**

## LMF\_AMP

Label           Last month frequency of taking amphetamines

Categories    **1**    **daily or almost daily**  
                   **2**    **several times a week**  
                   **3**    **at least once a week**  
                   **4**    **less than once a week**  
                   **8888** **skipped**  
                   **9999** **missing**

## MODEL QUESTIONS

The word amphetamines in the questions can be changed into "amphetamines or speed or pep pills"

**Q1**    *Do you personally know people who take amphetamines?*

**1**    **yes**  
**2**    **no**  
**9999** **else**

**Q2**    *Have you ever taken amphetamines yourself?*

**1**    **yes**  
**2**    **no**    ▶ **skip Q3, Q4, Q5**  
**9999** **else** ▶ **skip Q3, Q4, Q5**

**Q3**    *During the last 12 months, have you taken amphetamines?*

**1**    **yes**  
**2**    **no**    ▶ **skip Q4, Q5**  
**9999** **else** ▶ **skip Q4, Q5**

**Q4**    *During the last 30 days, have you taken amphetamines?*

**1**    **yes**  
**2**    **no**    ▶ **skip Q5**  
**9999** **else** ▶ **skip Q5**

**Q5**    *During the last 30 days, on how many days did you take amphetamines?*

**1**    **daily or almost daily**  
**2**    **several times a week**  
**3**    **at least once a week**  
**4**    **less than once a week**  
**9999** **else**

## MODE IMPLICATIONS

Q5 requires mode dependent instructions

Self-completion	Q5: respondents should be instructed to choose the pre-coded answer that applies to them best
Interviewer completion	Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

### Pen-and-paper modes

Consistency corrections equal those listed for ecstasy

### All modes

KNO\_AMP = Q1  
LTP\_AMP = Q2  
LYP\_AMP = Q3  
LMP\_AMP = Q4  
LMF\_AMP = Q5

## ALTERNATIVES

See alternatives for Q6 under Cannabis

# HEROIN

## CORE VARIABLES

### KNO\_HER

Label	Personally knowing people who take heroin
Categories	<b>1</b> knows people who take heroin <b>2</b> does not know people who take heroin <b>9999</b> missing

### LTP\_HER

Label	Lifetime prevalence of heroin
Categories	<b>1</b> has ever taken heroin <b>2</b> has never taken heroin <b>9999</b> missing

### LYP\_HER

Label	Last year prevalence of heroin
Categories	<b>1</b> did take heroin during last 12 months <b>2</b> did not take heroin during last 12 months <b>8888</b> skipped <b>9999</b> missing

## LMP\_HER

Label	Last month prevalence of heroin		
Categories	1	<b>did take heroin during last 30 days</b>	
	2	<b>did not take heroin during last 30 days</b>	
	8888	skipped	
	9999	missing	

## LMF\_HER

Label	Last month frequency of taking heroin		
Categories	1	<b>daily or almost daily</b>	
	2	<b>several times a week</b>	
	3	<b>at least once a week</b>	
	4	<b>less than once a week</b>	
	8888	skipped	
	9999	missing	

## MODEL QUESTIONS

**Q1** *Do you personally know people who take heroin?*

- 1 yes
- 2 no
- 9999 else

**Q2** *Have you ever taken heroin yourself?*

- 1 yes
- 2 no ▶ skip Q3, Q4, Q5
- 9999 else ▶ skip Q3, Q4, Q5

**Q3** *During the last 12 months, have you taken heroin?*

- 1 yes
- 2 no ▶ skip Q4, Q5
- 9999 else ▶ skip Q4, Q5

**Q4** *During the last 30 days, have you taken heroin?*

- 1 yes
- 2 no ▶ skip Q5
- 9999 else ▶ skip Q5

**Q5** *During the last 30 days, on how many days did you take heroin?*

- 1 **daily or almost daily**
- 2 **several times a week**
- 3 **at least once a week**
- 4 **less than once a week**
- 9999 else

## MODE IMPLICATIONS

Q5 requires mode dependent instructions

Self-completion Q5: respondents should be instructed to choose the pre-coded answer that applies to them best

Interviewer completion Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

### Pen-and-paper modes

Consistency corrections equal those listed for ecstasy

### All modes

KNO\_HER = Q1

LTP\_HER = Q2

LYP\_HER = Q3

LMP\_HER = Q4

LMF\_HER = Q5

## ALTERNATIVES

See alternatives for Q6 under Cannabis

## COCAINE

### CORE VARIABLES

#### KNO\_COC

Label Personally knowing people who take cocaine

Categories **1 knows people who take cocaine**  
**2 does not know people who take cocaine**  
**9999 missing**

#### LTP\_COC

Label Lifetime prevalence of cocaine

Categories **1 has ever taken cocaine**  
**2 has never taken cocaine**  
**9999 missing**

#### LYP\_COC

Label Last year prevalence of cocaine

Categories **1 did take cocaine during last 12 months**  
**2 did not take cocaine during last 12 months**  
**8888 skipped**  
**9999 missing**

#### LMP\_COC

Label Last month prevalence of cocaine

Categories **1 did take cocaine during last 30 days**  
**2 did not take cocaine during last 30 days**  
**8888 skipped**  
**9999 missing**

#### LMF\_COC

Label Last month frequency of taking cocaine

Categories **1 daily or almost daily**

2 several times a week  
 3 at least once a week  
 4 less than once a week  
 8888 skipped  
 9999 missing

## MODEL QUESTIONS

**Q1** *Do you personally know people who take cocaine?*

1 yes  
 2 no  
 9999 else

**Q2** *Have you ever taken cocaine yourself?*

1 yes  
 2 no ▶ skip Q3, Q4, Q5  
 9999 else ▶ skip Q3, Q4, Q5

**Q3** *During the last 12 months, have you taken cocaine?*

1 yes  
 2 no ▶ skip Q4, Q5  
 9999 else ▶ skip Q4, Q5

**Q4** *During the last 30 days, have you taken cocaine?*

1 yes  
 2 no ▶ skip Q5  
 9999 else ▶ skip Q5

**Q5** *During the last 30 days, on how many days did you take cocaine?*

1 daily or almost daily  
 2 several times a week  
 3 at least once a week  
 4 less than once a week  
 9999 else

## MODE IMPLICATIONS

Q5 requires mode dependent instructions

Self-completion

Q5: respondents should be instructed to choose the pre-coded answer that applies to them best

Interviewer completion

Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

Pen-and-paper modes

Consistency corrections equal those listed for ecstasy

All modes

KNO\_COC = Q1  
 LTP\_COC = Q2  
 LYP\_COC = Q3  
 LMP\_COC = Q4  
 LMF\_COC = Q5

## ALTERNATIVES

See alternatives for Q6 under Cannabis

## RELEVIN

### CORE VARIABLES

#### KNO\_REL

Label Personally knowing people who take relevin

Categories **1** knows people who take relevin  
**2** does not know people who take relevin  
**9999** missing

#### LTP\_REL

Label Lifetime prevalence of relevin

Categories **1** has ever taken relevin  
**2** has never taken relevin  
**9999** missing

#### LYP\_REL

Label Last year prevalence of relevin

Categories **1** did take relevin during last 12 months  
**2** did not take relevin during last 12 months  
**8888** skipped  
**9999** missing

#### LMP\_REL

Label Last month prevalence of relevin

Categories **1** did take relevin during last 30 days  
**2** did not take relevin during last 30 days  
**8888** skipped  
**9999** missing

#### LMF\_REL

Label Last month frequency of taking relevin

Categories **1** daily or almost daily  
**2** several times a week  
**3** at least once a week  
**4** less than once a week  
**8888** skipped  
**9999** missing

### MODEL QUESTIONS

Instead of “relevin” another name for a dummy drug can be chosen

**Q1** *Do you personally know people who take relevin?*

**1** yes  
**2** no



9999 else

**Q2** *Have you ever taken re Levin yourself?*

1 yes  
2 no ▶ skip Q3, Q4, Q5  
10000 else ▶ skip Q3, Q4, Q5

**Q3** *During the last 12 months, have you taken re Levin?*

1 yes  
2 no ▶ skip Q4, Q5  
9999 else ▶ skip Q4, Q5

**Q4** *During the last 30 days, have you taken re Levin?*

1 yes  
2 no ▶ skip Q5  
9999 else ▶ skip Q5

**Q5** *During the last 30 days, on how many days did you take re Levin?*

1 daily or almost daily  
2 several times a week  
3 at least once a week  
4 less than once a week  
9999 else

## MODE IMPLICATIONS

Q5 requires mode dependent instructions

Self-completion

Q5: respondents should be instructed to choose the pre-coded answer that applies to them best

Interviewer completion

Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

## DATA MANIPULATION

Pen-and-paper modes require consistency corrections.  
Core variables can be computed from questionnaire items

Pen-and-paper modes

Consistency corrections equal those listed for ecstasy

All modes

KNO\_REL = Q1

LTP\_REL = Q2

LYP\_REL = Q3

LMP\_REL = Q4

LMF\_REL = Q5

## ALTERNATIVES

See alternatives for Q6 under Cannabis

# LSD

## CORE VARIABLES

### KNO\_LSD

Label Personally knowing people who take LSD

Categories **1** knows people who take LSD  
**2** does not know people who take LSD  
**9999** missing

### LTP\_LSD

Label Lifetime prevalence of LSD

Categories **1** has ever taken LSD  
**2** has never taken LSD  
**9999** missing

### LYP\_LSD

Label Last year prevalence of LSD

Categories **1** did take LSD during last 12 months  
**2** did not take LSD during last 12 months  
**8888** skipped  
**9999** missing

### LMP\_LSD

Label Last month prevalence of LSD

Categories **1** did take LSD during last 30 days  
**2** did not take LSD during last 30 days  
**8888** skipped  
**9999** missing

### LMF\_LSD

Label Last month frequency of taking LSD

Categories **1** daily or almost daily  
**2** several times a week  
**3** at least once a week  
**4** less than once a week  
**8888** skipped  
**9999** missing

## MODEL QUESTIONS

The word LSD in the questions can be changed into "LSD or acid or trips" (but *not* into: "LSD or other hallucinogens")

**Q1** *Do you personally know people who take LSD?*

**1** yes  
**2** no  
**9999** else

**Q2** *Have you ever taken LSD yourself?*

**1** yes  
**2** no ▶ skip Q3, Q4, Q5  
**10001** else ▶ skip Q3, Q4, Q5

**Q3** *During the last 12 months, have you taken LSD?*

**1** yes

2 no ▶ skip Q4, Q5  
 9999 else ▶ skip Q4, Q5

**Q4** *During the last 30 days, have you taken LSD?*

1 yes  
 2 no ▶ skip Q5  
 9999 else ▶ skip Q5

**Q5** *During the last 30 days, on how many days did you take LSD?*

1 daily or almost daily  
 2 several times a week  
 3 at least once a week  
 4 less than once a week  
 9999 else

**MODE IMPLICATIONS** Q5 requires mode dependent instructions

Self-completion Q5: respondents should be instructed to choose the pre-coded answer that applies to them best

Interviewer completion Q5: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies

**DATA MANIPULATION** Pen-and-paper modes require consistency corrections. Core variables can be computed from questionnaire items

Pen-and-paper modes

Consistency corrections equal those listed for ecstasy

All modes

KNO\_LSD = Q1  
 LTP\_LSD = Q2  
 LYP\_LSD = Q3  
 LMP\_LSD = Q4  
 LMF\_LSD = Q5

**ALTERNATIVES**

See alternatives for Q6 under Cannabis

**6. OPINIONS**

**DISCUSSION**

The expert group had many discussions about the incorporation of questions about attitudes and opinions in the model prevalence questionnaire. The consensus about the proposals below has not been reached without difficulties.

At first some experts argued for excluding all attitude and opinion questions, considering them too complex and too ideologically charged for a European model questionnaire. Some disputed if such questions should be asked at all in prevalence surveys on drug use. Others held an opposite position, regarding these questions as a vital part of a model questionnaire, resulting in information that allows a better understanding of cross-cultural differences in drug use patterns.

The main problem with regard to item of attitudes and opinions proved to be that we do not yet have a clear view on what, why and how to measure. In a general sense, questions about attitudes and opinions in surveys will not result in individual variables, but will be combined in scales to measure some relevant attribute of the respondent.

Although several drug prevalence surveys of the past include sets of questions, which a priori or a posteriori allow the construction of scales, research on the items is still rather limited and often scales have not yet been validated.

The discussions about the issue have also been complicated by the initial approach of the project, which focussed on model questions rather than 'model' concepts. Obviously, the wording of this type of questions in a manner that can be read and understood in the same way in different languages and countries can be quite problematic. In particular because in a survey context we have to use colloquial language and cannot allow ourselves intricate academic formulations.

Nevertheless the expert group reached a consensus on the questions listed below, though it should be remarked that we do not conclude that the discussions are closed. In fact we explored the topic in more detail in the Joint Analysis, but within the planning of our project the results could not be used by the expert group for a reconsideration of the present recommendations.

At this stage we cannot recommend on *core variables* with regard to the item. Even if a single question might result in a meaningful attribute of the population, at present we have no evidence about this. Moreover, it is likely that only particular sets of questions combined in a scale will yield such core variables. This should still be a subject for further research.

Most of the model questions have been selected from the European School Survey questionnaire (ESPAD), which already represents a European standard. It must be acknowledged however, that the questions concerned belong to more cohesive sets of questions and that the selection by the expert group was based on a face-value consensus, not on an analysis of the most relevant ones.

The model questions relate to three different sub-items:

- opinions about drug addicts
- opinions about drug policies
- opinions about other people's behaviour
- perceptions about the risks of some behaviours

The questions are grouped below accordingly. Mode implications are mentioned. The questions do not require specific data manipulations.

It should also be noticed that the phrasing of all questions is very mode dependent. This aspect has not been thoroughly discussed in the expert group meetings. In particular the original ESPAD phrasing caused problems in the pre-tests. The classroom self-completion format of the ESPAD questionnaire proved not always to be suitable in other survey modes.

## OPINIONS ABOUT DRUG ADDICTS

**Q1** *Do you perceive a drug addict more as a criminal or more as a patient?*

- 1** more as a criminal
- 2** more as a patient
- 3** neither a criminal nor a patient
- 4** both a criminal and a patient
- 5** don't know / cannot decide
- 9999** else

## MODE IMPLICATIONS Q1 requires mode dependent instructions

Self-completion Q1: respondents should be instructed to choose the pre-coded answer that represents their opinion

Face-to-face Interviews Q1: interviewers should present a show card with the answer categories, so the respondent can choose between the alternatives

CATI

Q1: the interviewer should be instructed to read the acceptable answer categories. One should realise however that many interviewers will not always do this, but instead score the respondent's answer according to what the interviewer believes the respondent means to say. This may result in an overestimate of "don't know's" as respondents might not always be spontaneously clear whether they actually hold the opinions 3 or 4

## OPINIONS ABOUT DRUG POLICIES

**Q2** *To what extent do you agree or disagree with the following statement, "People should be permitted to take hashish or marihuana"?*

- 1 fully agree
- 2 largely agree
- 3 neither agree nor disagree
- 4 largely disagree
- 5 fully disagree
- 9999 else

**Q2** *To what extent do you agree or disagree with the following statement, "People should be permitted to take heroin"?*

- 1 fully agree
- 2 largely agree
- 3 neither agree nor disagree
- 4 largely disagree
- 5 fully disagree
- 9999 else

## MODE IMPLICATIONS

Q2, Q3 require mode dependent instructions

Self-completion

Q2, Q3: respondents should be instructed to choose the pre-coded answer that represents their opinion

Face-to-face Interviews

Q2, Q3: interviewers should present a show card with the answer categories, so the respondent can choose between the alternatives

CATI

Q2, Q3: the interviewer should be instructed to read the acceptable answer categories. One should realise however that many interviewers will not always do this, but instead score the respondent's answer according to what the interviewer believes the respondent means to say. This may result in an overestimate of "don't know's" as respondents might not always be spontaneously clear whether they actually hold the opinions 3 or 4

## OPINIONS ABOUT BEHAVIOUR

**INTRO:** *Individuals differ in whether or not they disapprove of people doing certain things. I will mention a few things which some people might do.*

*Can you tell me if you would not disapprove, disapprove or strongly disapprove when people do any of these things?*

**Q4** *Trying ecstasy once or twice?*

- 1 do not disapprove
- 2 disapprove
- 3 strongly disapprove

- 4 don't know  
9999 else
- Q5** *Trying heroin once or twice?*
- 1 do not disapprove  
2 disapprove  
3 strongly disapprove  
4 don't know  
9999 else
- Q6** *Smoking 10 or more cigarettes a day?*
- 1 do not disapprove  
2 disapprove  
3 strongly disapprove  
4 don't know  
9999 else
- Q7** *Having one or two drinks several times a week?*
- 1 do not disapprove  
2 disapprove  
3 strongly disapprove  
4 don't know  
9999 else
- Q8** *Smoking hashish or marihuana occasionally?*
- 1 do not disapprove  
2 disapprove  
3 strongly disapprove  
4 don't know  
9999 else

## **MODE IMPLICATIONS** Q4-Q8 require mode dependent instructions

Self-completion	Q4-Q8: The intro should be adapted to the situation that the respondent reads this himself. Respondents should also be instructed to choose the pre-coded answer that represents their opinion
Face-to-face Interviews	Q4-Q8: Although the interviewer will read the mandatory intro, he should also present a show card with the answer categories, so the respondent can choose between the alternatives
CATI	Q4-Q8: Although the interviewer already mentions the acceptable answers in the intro, he should be instructed that he might have to repeat this for consecutive questions. One should realise however that many interviewers will not always do this, but instead score the respondent's answer according to what the interviewer believes the respondent means to say. This may result in imprecise answers as both respondents and interviewers can easily get confused about the difference between the double negative "do not disapprove" and "disapprove".

Although the expert group decided for the ESPAD categories of questions Q4-Q8, it should be acknowledged that these categories are not really suitable for CATI. In the pre-tests the phrasings caused a lot of confusion. When the respondent cannot read himself the intended option "do not disapprove" he might in reality interpret this as "approve" or misinterpret this as "disapprove". Hence we will get incorrect results.

## PERCEPTIONS OF RISKS

**INTRO:** *Now I would like to know how much you think that people risk harming themselves, physically or in other ways, if they do certain things. I will again mention a few things, which some people might do.*

*Please tell me if you consider it to be no risk, a slight risk, a moderate risk or a great risk, if people do such things?*

**Q9** *Smoke one or more packs of cigarettes per day?*

- 1 no risk
- 2 slight risk
- 3 moderate risk
- 4 great risk
- 9999 else

**Q10** *Having five or more drinks each weekend?*

- 1 no risk
- 2 slight risk
- 3 moderate risk
- 4 great risk
- 9999 else

**Q11** *Smoke hashish or marijuana regularly?*

- 1 no risk
- 2 slight risk
- 3 moderate risk
- 4 great risk
- 9999 else

**Q12** *Try ecstasy once or twice?*

- 1 no risk
- 2 slight risk
- 3 moderate risk
- 4 great risk
- 9999 else

**Q13** *Try cocaine or crack once or twice?*

- 1 no risk
- 2 slight risk
- 3 moderate risk
- 4 great risk
- 9999 else

### MODE IMPLICATIONS

Q9-Q13 require mode dependent instructions

Self-completion

Q9-Q13: The intro should be adapted to the situation that the respondent reads this himself. Respondents should also be instructed to choose the pre-coded answer that represents their opinion

Face-to-face Interviews

Q9-Q13: Although the interviewer will read the mandatory intro, he should also present a show card with the answer categories, so the respondent can choose between the alternatives

CATI

Q9-Q13: Although the interviewer already mentions the acceptable answers in the intro, he should be instructed that he might have to repeat this for consecutive questions.

Although we have to realise that many interviewers will not always do this, the pre-tests indicate that respondents have no problems in differentiating between no, slight, moderate and great risks.

## ALTERNATIVES

At the present stage no alternatives for the questions about opinions will be presented.

## 7. RESPONDENT ATTRIBUTES

### DISCUSSION

In the earlier stages of the project the expert group discussed many attributes that were considered to be relevant as background variables for prevalence patterns.

Existing national surveys often include a great variety of respondent characteristics. Some of these characteristics appear one way or the other in all surveys, many are restricted to only a few countries. A lot of these variables do not show up in the research reports based on these surveys which makes it difficult to assess the relevance in the context of drug prevalence surveys. One reason might be that the available detail about respondents usually only refers to the present situation and therefore can only be related to current or recent patterns of drug use. In most countries however the number of current (last year) or recent (last month) users of most drugs in a survey is too small to allow in depth analysis based on attributes.

At present question formats also differ considerably between countries. In the construction of the Eurofile for the Joint Analysis we often could not obtain perfect matches.

The expert group decided to include only those attributes into the standard model, which have found to be present in all or most national surveys that had been investigated in earlier stages of the project. Also we decided to specify only a few basic categories for these attributes.

This rather practical solution does not imply however that the selected attributes and categories are thought to be the most relevant compared to others to be included in comparable prevalence surveys among the general population.

Even this restriction to a sort of common divide of attributes will not be without complications. Apart from the obvious age and gender, basic attributes about household, employment, education and area of residence are difficult to standardise on a European level in terms of the questions needed to assess the categories of the attributes in an unambiguous manner. It should also be acknowledged that many countries already apply national standards for attributes like household composition, educational level or employment status. Demands for consistency with previous and other surveys will limit the possibilities to introduce new standards.

With regard to the model we therefore only present a minimum set of defined variables and categories. For sake of completeness we add some tentative questions related to them. The questions themselves however cannot be considered to be part of the model and therefore they are not included in the overview model questionnaire of chapter III.

In principle individual countries should make their own decisions on which questions in their circumstances would be needed to obtain the required information. In most cases this will involve country specific data manipulations.

In further developments of the model it seems advisable to take into account the results of efforts in other fields of research to harmonise cross-country question formats. In particular ongoing projects by Eurostat should be considered.



## CORE VARIABLES

### SEX

Label	Gender of the respondent	
Categories	<b>1</b>	<b>male</b>
	<b>2</b>	<b>female</b>
	<b>9999</b>	<b>missing</b>

### AGE

Label	Age of the respondent	
Categories	<b>nn</b>	<b>(age)</b>
	<b>9999</b>	<b>missing</b>

### HOUSHOLD

Label	Indication of the type of household to which the respondent belongs	
Categories	<b>1</b>	<b>one person living alone</b>
	<b>2</b>	<b>two partners without children at home</b>
	<b>3</b>	<b>two partners with children at home</b>
	<b>4</b>	<b>one adult with children at home</b>
	<b>5</b>	<b>other situation</b>
	<b>9999</b>	<b>missing</b>

**NOTE** Initially the expert group only decided on three categories, “living alone”, “living with some kind of family” and “other”. In the Joint Analysis we found that the second category “living with some kind of family” cannot be reconstructed from the usual question formats applied by individual countries. The classification above however comes closest to the type of differentiation intended. But even this differs from the traditional formats of most countries and might be difficult to reconstruct. The definition of the variable might have to be reconsidered in the future, preferably based on research results that indicate the relevance of the variable in the context of drug prevalence studies.

### ACTIVITY

Label	Indication of the main activity status of the respondent in terms of the categories listed below and according to country specific definitions of these categories	
Categories	<b>1</b>	<b>employed or self-employed</b>
	<b>2</b>	<b>full-time student</b>
	<b>3</b>	<b>unemployed</b>
	<b>4</b>	<b>other</b>
	<b>9999</b>	<b>missing</b>

**NOTE** Each category should be defined according the common standards of the country concerned. This implies for instance that some countries will restrict “employed” to people who have a regular job of 12 and more hours a week, others might include any paid work. Some will define “unemployed” to those registered at job agencies, others will define them as those looking for a paid job of a minimum number of hours per week. In cross-country comparisons we can therefore only compare along a status as perceived in the individual countries, not on the basis of a general concept.

## EDUCAT

Label Level of highest education completed by the respondent

Categories	<b>1</b>	<b>primary education or less</b>
	<b>2</b>	<b>lower secondary education</b>
	<b>3</b>	<b>higher secondary education</b>
	<b>4</b>	<b>higher education</b>
	<b>5</b>	<b>cannot be classified</b>
	<b>9999</b>	<b>missing</b>

<b>NOTE</b>	<p>We recommend to use the ISCED coding scheme to assess the categories. The correspondence will be:</p> <table> <tr> <td>primary or less</td> <td>= ISCED 1</td> </tr> <tr> <td>lower secondary</td> <td>= ISCED 2</td> </tr> <tr> <td>higher secondary</td> <td>= ISCED 3</td> </tr> <tr> <td>higher education</td> <td>= ISCED 5,6,7</td> </tr> </table> <p>The ISCED coding has also been used in the Joint Analysis but it should be noted that no perfect match could be achieved for most countries. main reason is that the ISCED implies a more detailed specification of types education than most countries realistically can include in a general population survey. The ISCED coding scheme is presented in the Annex 4 of this report.</p>	primary or less	= ISCED 1	lower secondary	= ISCED 2	higher secondary	= ISCED 3	higher education	= ISCED 5,6,7
primary or less	= ISCED 1								
lower secondary	= ISCED 2								
higher secondary	= ISCED 3								
higher education	= ISCED 5,6,7								

## URBANISATION

Label Level of urbanisation of the area of residence of the respondent

Categories	<b>1</b>	<b>metropolitan</b>
	<b>2</b>	<b>urban</b>
	<b>3</b>	<b>rural</b>
	<b>4</b>	<b>cannot be classified</b>
	<b>9999</b>	<b>missing</b>

<b>NOTE</b>	<p>The expert group did not define the categories of this variable. Countries may therefore use any national classification, which results in the three categories listed. For the time being a cross-country comparison can only compare on the basis of country perceptions of the concepts metropolitan, urban and rural.</p>
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## MODEL QUESTIONS

Questions below should be taken only as examples

Q1 *Please indicate if you are a male or a female*

1	male
2	female
9999	else

Q2 *What is your age?*

nn	(age)
9999	else

Q3 *Which of the following describes the composition of the household to which you belong?*

1	one person living alone
2	two partners without children at home
3	two partners with children at home
4	one adult with children at home
5	other situation

- 9999 else
- Q4 *Which of the following applies best to you?*
- 1 you are employed or self-employed
  - 2 you are a full-time student
  - 3 you are unemployed
  - 4 none of the above applies
  - 9999 else
- Q5 *What is the highest level of education that you have completed?*
- nn (code corresponding to type of education)
  - 9999 else
- Q6 *What is the <identification code> of your home address?*
- nn (address identification code)
  - 9999 else

## MODE IMPLICATIONS

Formulation of questions Q1-Q5 is mode dependent

Self-completion

Q1, Q3-Q5: respondents should be instructed to choose the pre-coded answer that applies. As the list of pre-coded answers cannot be made too long, Q5 will need the option of a free-format answer. For Q6 the respondent should specify either part of an area (e.g. postal) code or the name of his municipality or community

Face-to-face

Q3,Q4: interviewers should be instructed to present a show card or read the answer categories one by one in following order and mark the first one that applies. For Q5 the interviewer should present a show card with categories to choose from but also allow a free format answer. Q6 should be codes by the interviewer from the address he visits or, in case of site interviews, ask the respondent to specify part of his area code or the name of his municipality.

CATI

Q3,Q4: interviewers should be instructed to read the answer categories one by one in following order and mark the first one that applies. For Q5 only an open format answer will be feasible.  
Q6: the programme should record an area code from the telephone number or the interviewer should ask the respondent to specify part of his area code or the name of his municipality.

## DATA MANIPULATION

Q4 and Q5 will need coding and further data manipulations after data entry to obtain the required variables.

## ALTERNATIVES

As the questions about attributes are not considered to be part of the model, we do not discuss alternatives.



# III. MODEL QUESTIONNAIRE (ENGLISH)

Below we present an overview of the recommended questions of Chapter II. French, German, Dutch, Finnish, Swedish and Greek translations of this questionnaire are presented in Annex 1. Questions are listed in the recommended following order. Answer categories corresponding to “don’t know”, “don’t want to answer”, etc. are not indicated. Please note also that the questionnaire format below does not indicate the internal referral systems.

## TOBACCO

1. Do you smoke tobacco, such as cigarettes, cigars or a pipe?

1  yes  
2  no

2. Have you ever smoked in the past?

1  yes  
2  no

## ALCOHOL

3. During the last 12 months, have you drunk any alcohol?

1  yes  
2  no

4. How often do you drink alcohol?

1  4 times a week or more often  
2  2-3 times a week  
3  2-4 times a month  
4  once a month or more seldom

5. How often do you drink six glasses or more of an alcoholic drink on the same occasion?

1  daily or almost daily  
2  every week  
3  every month  
4  more seldom than once a month  
5  never

6. During the last 30 days, have you drunk any alcohol?

1  yes  
2  no

7. During the last 30 days, on how many days did you drink any alcohol?

1  daily or almost daily  
2  several times a week  
3  at least once a week  
4  less than once a week

## PHARMACEUTICALS

8. During the last 12 months, have you taken any sedatives or tranquilliser?

- 1  yes  
2  no

9. How often do you take sedatives or tranquillisers?

- 1  4 times a week or more often  
2  2-3 times a week  
3  2-4 times a month  
4  once a month or more seldom

10. During the last 30 days, have you taken any sedative or tranquilliser?

- 1  yes  
2  no

11. During the last 30 days, on how many days did you take sedatives or tranquillisers?

- 1  daily or almost daily  
2  several times a week  
3  at least once a week  
4  less than once a week

12. The last occasion you took sedatives or tranquillisers, how had you obtained them?

- 1  I bought or got them on a prescription by a doctor for myself  
2  I got them from somebody else I know  
3  I bought them without a prescription in a pharmacy or drugstore  
4  non of the above applies

## ILLICIT DRUGS

### CANNABIS

13. Do you personally know people who take hashish or marihuana?

- 1  yes  
2  no

14. Have you ever taken hashish or marihuana yourself?

- 1  yes  
2  no

15. At what age did you take hashish or marihuana for the first time?

.....

16. During the last 12 months, have you taken hashish or marihuana?

- 1  yes  
2  no

17. During the last 30 days, have you taken hashish or marihuana?

- 1  yes  
2  no

18. During the last 30 days, on how many days did you take hashish or marihuana?

- 1  daily or almost daily
- 2  several times a week
- 3  at least once a week
- 4  less than once a week

## ECSTASY

19. Do you personally know people who take ecstasy?

- 1  yes
- 2  no

20. Have you ever taken ecstasy yourself?

- 1  yes
- 2  no

21. During the last 12 months, have you taken ecstasy?

- 1  yes
- 2  no

22. During the last 30 days, have you taken ecstasy?

- 1  yes
- 2  no

23. During the last 30 days, on how many days did you take ecstasy?

- 1  daily or almost daily
- 2  several times a week
- 3  at least once a week
- 4  less than once a week

## AMPHETAMINES

24. Do you personally know people who take amphetamines?

- 1  yes
- 2  no

25. Have you ever taken amphetamines yourself?

- 1  yes
- 2  no

26. During the last 12 months, have you taken amphetamines?

- 1  yes
- 2  no

27. During the last 30 days, have you taken amphetamines?

- 1  yes
- 2  no

28. During the last 30 days, on how many days did you take amphetamines?

1	<input type="checkbox"/>	daily or almost daily
2	<input type="checkbox"/>	several times a week
3	<input type="checkbox"/>	at least once a week
4	<input type="checkbox"/>	less than once a week

## COCAINE

29. Do you personally know people who take cocaine?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

30. Have you ever taken cocaine yourself?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

31. During the last 12 months, have you taken cocaine?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

32. During the last 30 days, have you taken cocaine?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

33. During the last 30 days, on how many days did you take cocaine?

1	<input type="checkbox"/>	daily or almost daily
2	<input type="checkbox"/>	several times a week
3	<input type="checkbox"/>	at least once a week
4	<input type="checkbox"/>	less than once a week

## HEROIN

34. Do you personally know people who take heroin?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

35. Have you ever taken heroin yourself?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

36. During the last 12 months, have you taken heroin?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no

37. During the last 30 days, have you taken heroin?

1	<input type="checkbox"/>	yes
2	<input type="checkbox"/>	no



38. During the last 30 days, on how many days did you take heroin?

- 1  daily or almost daily
- 2  several times a week
- 3  at least once a week
- 4  less than once a week

## RELEVIN

39. Do you personally know people who take relevin?

- 1  yes
- 2  no

40. Have you ever taken relevin yourself?

- 1  yes
- 2  no

41. During the last 12 months, have you taken relevin?

- 1  yes
- 2  no

42. During the last 30 days, have you taken relevin?

- 1  yes
- 2  no

43. During the last 30 days, on how many days did you take relevin?

- 1  daily or almost daily
- 2  several times a week
- 3  at least once a week
- 4  less than once a week

## LSD

44. Do you personally know people who take LSD?

- 1  yes
- 2  no

45. Have you ever taken LSD yourself?

- 1  yes
- 2  no

46. During the last 12 months, have you taken LSD?

- 1  yes
- 2  no

47. During the last 30 days, have you taken LSD?

- 1  yes
- 2  no

48. During the last 30 days, on how many days did you take LSD?

1	<input type="checkbox"/>	daily or almost daily
2	<input type="checkbox"/>	several times a week
3	<input type="checkbox"/>	at least once a week
4	<input type="checkbox"/>	less than once a week

## OPINIONS

49. Do you perceive a drug addict more as a criminal or more as a patient?

1	<input type="checkbox"/>	more as a criminal
2	<input type="checkbox"/>	more as a patient
3	<input type="checkbox"/>	neither a criminal nor a patient
4	<input type="checkbox"/>	both a criminal and a patient
5	<input type="checkbox"/>	don't know, cannot decide

50. To what extent do you agree or disagree with the following statement: "People should be permitted to take hashish or marijuana"?

1	<input type="checkbox"/>	fully agree
2	<input type="checkbox"/>	largely agree
3	<input type="checkbox"/>	neither agree nor disagree
4	<input type="checkbox"/>	largely disagree
5	<input type="checkbox"/>	fully disagree

51. To what extent do you agree or disagree with the following statement: "People should be permitted to take heroin"?

1	<input type="checkbox"/>	fully agree
2	<input type="checkbox"/>	largely agree
3	<input type="checkbox"/>	neither agree nor disagree
4	<input type="checkbox"/>	largely disagree
5	<input type="checkbox"/>	fully disagree

**Instruction:** *Individuals differ in whether or not they disapprove of people doing certain things. I will mention a few things, which some people might do. Can you tell me if you would not disapprove, disapprove or strongly disapprove when people do any of these things?*

52. Trying ecstasy once or twice

1	<input type="checkbox"/>	do not disapprove
2	<input type="checkbox"/>	disapprove
3	<input type="checkbox"/>	strongly disapprove
4	<input type="checkbox"/>	don't know

53. Trying heroin once or twice

1	<input type="checkbox"/>	do not disapprove
2	<input type="checkbox"/>	disapprove
3	<input type="checkbox"/>	strongly disapprove
4	<input type="checkbox"/>	don't know

**54. Smoking 10 or more cigarettes a day**

- |   |                          |                     |
|---|--------------------------|---------------------|
| 1 | <input type="checkbox"/> | do not disapprove   |
| 2 | <input type="checkbox"/> | disapprove          |
| 3 | <input type="checkbox"/> | strongly disapprove |
| 4 | <input type="checkbox"/> | don't know          |

**55. Having one or two drinks several times a week**

- |   |                          |                     |
|---|--------------------------|---------------------|
| 1 | <input type="checkbox"/> | do not disapprove   |
| 2 | <input type="checkbox"/> | disapprove          |
| 3 | <input type="checkbox"/> | strongly disapprove |
| 4 | <input type="checkbox"/> | don't know          |

**56. Smoking marijuana or hashish occasionally**

- |   |                          |                     |
|---|--------------------------|---------------------|
| 1 | <input type="checkbox"/> | do not disapprove   |
| 2 | <input type="checkbox"/> | disapprove          |
| 3 | <input type="checkbox"/> | strongly disapprove |
| 4 | <input type="checkbox"/> | don't know          |

**Instruction:** *Now I would like to know how much do you think that people risk harming themselves, physically or in other ways, if they do certain things. I will again mention a few things, which some people might do. Please tell me if you consider it to be no risk, a slight risk, a moderate risk or a great risk, if people do such things.*

**57. Smoke one or more packs of cigarettes per day**

- |   |                          |               |
|---|--------------------------|---------------|
| 1 | <input type="checkbox"/> | no risk       |
| 2 | <input type="checkbox"/> | slight risk   |
| 3 | <input type="checkbox"/> | moderate risk |
| 4 | <input type="checkbox"/> | great risk    |

**58. Have five or more drinks each weekend**

- |   |                          |               |
|---|--------------------------|---------------|
| 1 | <input type="checkbox"/> | no risk       |
| 2 | <input type="checkbox"/> | slight risk   |
| 3 | <input type="checkbox"/> | moderate risk |
| 4 | <input type="checkbox"/> | great risk    |

**59. Smoke marijuana or hashish regularly**

- |   |                          |               |
|---|--------------------------|---------------|
| 1 | <input type="checkbox"/> | no risk       |
| 2 | <input type="checkbox"/> | slight risk   |
| 3 | <input type="checkbox"/> | moderate risk |
| 4 | <input type="checkbox"/> | great risk    |

**60. Try ecstasy once or twice**

- |   |                          |               |
|---|--------------------------|---------------|
| 1 | <input type="checkbox"/> | no risk       |
| 2 | <input type="checkbox"/> | slight risk   |
| 3 | <input type="checkbox"/> | moderate risk |
| 4 | <input type="checkbox"/> | great risk    |

**61. Try cocaine or crack once or twice**

1	<input type="checkbox"/>	no risk
2	<input type="checkbox"/>	slight risk
3	<input type="checkbox"/>	moderate risk
4	<input type="checkbox"/>	great risk

# IV. PRE-TESTS OF THE MODEL QUESTIONNAIRE

## Introduction

This chapter deals with pre-tests of the model questionnaire. Although most questions of the model already have been applied in some way in previous surveys and the questions have been formulated after sometimes extensive debates in the expert group, pre-testing should be recommended as a key element of good practice. In fact, using model questions, makes pre-testing even more important. Models have either been developed in an abstract context, based on arguments and evaluations of a wide range of experiences, or, they stem from surveys carried out in different times, different countries, for different aims and by different organisations. All these factors can imply that questions, which seemed perfect at their time, context and setting, might not work the same way in another situation.

In particular when questions are copied from surveys carried out in another language or another mode, one has to be cautious. In the previous chapters we already indicated that mode can have effects on the phrasing and wording of questions. In most cases literal translations of questions might also not be feasible due to differences in grammar and semantics, in particular with regard to colloquial language.

In our case we have carried out pre-tests of the model questionnaire as a final check of our recommendations and as an example of what we would consider good practice with regard to pre-testing in general. We have deliberately chosen for a mixture of modes in order to get an impression of mode implications. This however does not imply that future surveyors can refrain from pre-testing their complete – and in many cases extended questionnaires – in their own situation. The expert group too used a more extended questionnaire for the pre-tests. One reason was that we did not expect to find many people with a drug history. By extending the questions about tobacco, alcohol and pharmaceuticals we hoped to test at least the repetitive nature of the drug questions. Besides we introduced a filter question with regard to drugs in order to ease the interview process. Finally, we added a question about the reliability of the response. Of course all model questions have been included as well. The English version of the pre-test questionnaire is presented as Annex 7.

It should be noticed that not all suggestions for change and adaptation resulting of the pre-tests have been incorporated in the final model questionnaire. On one hand because some suggestions apply to a particular mode in a specific country, on the other because some suggested changes actually imply a change in content of the question, which would need another round of consultation and discussion within the expert group.

The pre-tests have been carried out in England, the Netherlands, Germany, France and Greece. We have chosen for a variety of modes in order to be able to adjust for mode effects on question formulation if necessary. For each mode we aimed at a net response of 20. However, the available budget did not allow doing pre-tests in all countries in all modes. The pre-test have been carried out and reported according to a pre-defined format. Most companies followed the formats and have made a serious effort to carry out proper tests targeting to the objectives of the project. The original pre-test reports have been included in Annex 6.

A comparison of modes with regard to answer patterns was not intended, although the executing companies do give their views on the suitability of modes for this kind of survey. For this reason we also do not list the pre-test survey data results of the questions. Mode comparison itself is the main topic of the parallel project CT.97.EP.02.

As the project co-ordinator is a member of Intersearch, the companies involved in the pre-tests have been selected among the members of this European market research association to ensure commitment and acceptable costs. The pre-test reports have been commented upon by the

members of the expert group in the countries concerned. They did not always agree with the changes proposed by the companies. In some cases these changes would indeed imply the move to different meanings of questions. The next paragraphs summarise the main findings.

## **Questionnaire**

The first and main conclusion is that most questions seem to work as intended. Some points for further consideration and discussion are listed below.

The tests confirm the need to keep questions as simple as possible. Every departure from this principle is asking for trouble. First, because many interviewers will inevitably divert from the prescribed phrasing, when a sentence contains more than say 10 words. Second, because many respondents don't really grasp the questions at first hearing, then ask for clarification and thus force the interviewer to some alternative wording. Often this might not be a problem as it not always will change the content of the question, but sometimes the explanations might be correct and hence the answers faulty. These problems are absent with self-completion, but in those modes do not really know to what extent respondents do understand the questions.

One should also be aware that professional interviewing these days is mass production and working against the clock, in particular in the case of CATI. This setting does not allow complicated questions and even more important, does not give the respondents much time to think. As a consequence hesitating respondents might generate unnecessary missing values.

## **Specific questions**

Although most of the model questions comply with the principle of simplicity, some might still need adaptation, partly depending on the mode being used. We refer here to the question numbers in the pre-test questionnaire.

### **Q68-Q72**

All pre-tests conclude that the double negative ("do not disapprove") is confusing. Though this might be less so in the case of self-completion, the phrasing, which had been copied from the ESPAD questionnaire should be reconsidered. As a consequence, the answer categories might have to change as well.

We realise that there might have been good reasons for the present formulation. "Approving" is not the same as "not disapproving", but in the reality of colloquial language the distinctions disappears as an academic semantic dispute.

### **Q66-Q67**

With regard to the questions about "being permitted to take either cannabis or heroin" the expert group had left it deliberately vague what in this context should be understood by "being permitted". But as the respondents in general are quite aware that we talk about something illegal, they react as if they assume that the question is not "complete". Hence they tend to return the question by asking if the interviewer means "permitted by the government", or by asking for an explanation like "does permitted means being legal?".

The chosen vague formulation implied willingly that we do not know how the question has been interpreted. We just wanted a spontaneous answer. But such point of view might not be valid if in retrospect we do not know how the question has been formulated, including extensions and explanations, after all.

### **Q14, Q21 and look-alikes**

The expert group has chosen for general ordinal categories to assess frequencies of use during the last 30 days. In principle these categories will work, provided that the respondent knows what the options are. In the case of self-completion or when show cards can be presented, this should not be a problem. But when interviewers have to read the options it becomes confusing. Either the interviewer does not repeat the categories every time or the respondent makes his own variations, leaving it to the interviewer to categorise. In both cases we might get imprecise answers in the end.

The typical CATI solution to split the question along the answer possibilities not only increases interview time but also increases the repetitive character of the interview, which might after a while distract the respondent.

The initial rejection of asking for the number of days of use might be reconsidered. The recognition that any figure provided might not be correct, can be acknowledged by interpreting the results still as ordinal, instead of interval, values as we have done in the framework of the Joint Analysis.

### **Q11, Q12, Q61**

As explained in the main report, the expert group has chosen the present formulation purposely to assess a general pattern of use of alcohol and pharmaceuticals. Even though the question is only asked when respondents have indicated a last year prevalence, the question itself is not linked to specific period of time. This too proves to be confusing for some respondents. The easiest alternative would be to (re-)establish the link in a similar way as when asking for a use pattern during the last 30 days.

### **Survey mode**

The pre-tests have been carried out in different modes to find out specific implications of mode on question formulations. We did not aim to assess which modes would produce the most reliable results or to assess mode effects on answer patterns as such. Nevertheless, as different modes have been applied anyway, we did ask the fieldwork companies to give their impression about the feasibility of each mode for prevalence surveying. In general the companies address two aspects which need further consideration in the development of general population surveys.

### **Survey control**

#### *Control by the fieldwork company*

Postal surveys, being it based on household drop-off or mail delivery, imply that we don't know who completes the questionnaire. The addressee might have passed it on to another member of the household who is thought to have more knowledge of the subject, or the completion might have been a collective effort of several members of the household, if only because others are consulted to explain some questions. The implicit assumption of self-completion might be an illusion.

Face-to-face surveys at home assume that we only have interviewers who are reliable and honest in all aspects. The main problem is not the possibility of fraud, as most companies will apply instruments to check this, however imperfect in many cases. More difficult is the control over the interview setting. The assumption that face-to-face at home implies an encounter of interviewer and respondent undisturbed by others can as well be an illusion.

#### *Control by the researchers*

An often neglected aspect is the control of the process by of the researchers, i.e. the organisation that has commissioned the survey. Some modes offer better opportunities than others, but the main factor is the type of arrangement that will be made between the researchers and the fieldwork company. In principle researchers should be present at the instructions and the (de)briefings of the interviewers, though they should leave the actual proceedings to the professionals of the fieldwork organisation. The researchers should also be consulted when necessary adaptations have to be made during the survey execution. Ideally all this should be put down in a contract or written agreement to avoid unwanted accomplished facts afterwards.

Besides researchers should demand a complete and detailed account of the survey process, the sampling procedures, the problems encountered and the response. Some organisations always include proper technical reports, but many don't and, again, this should be laid down in contracts and agreements.

Implementing these demands can be expensive relative to the costs of the actual fieldwork. But if we are really concerned about data quality, it might be advisable to accept, if needed for budget reasons, a lower net response in order to obtain proper accounts of the process.

### **Mode and sampling**

Some pre-tests point out that the choice between modes should be more dictated by arguments of sampling than by arguments of interviewer-respondent interaction or assumed reliability of responses. CATI and site interviews will always be selective in some way. For practical reasons they almost inevitably end up as quota samples. The preference of the pre-testing companies for these modes can be considered biased. In social research, where proper assessment of population estimates is more essential than in most commercial surveys, the preference will in general be given to face-to-face surveys at home, which allow random sampling techniques. The costs might be a constraint however.





# V. CONSTRUCTION OF A EUROPEAN PREVALENCE DATA FILE

## Introduction

In this chapter we give an account of the construction of a joined data set of existing prevalence survey data of the Netherlands, France, England and Wales, Germany, Sweden, Finland and greater Athens. These surveys have been conducted in different years between 1993 and 1998. The surveys are different with regard to mode, sample size, response rate, context and questionnaire. An overview of the general characteristics is presented in the table below.

<i>Country</i>	<i>(main) context</i>	<i>mode</i>	<i>sampling</i>	<i>target population</i>
<b>France</b>	health	CATI	simple random private household connections; within households: next birthday method	18-75 yr.
<b>England-and-Wales</b>	crime (victims)	CAPI	stratified random postal addresses; within household simple random	16-59 yr. (for drug questions)
<b>Germany</b>	licit and illicit drugs	postal – delivered & collected by interviewer	stratified random postal addresses; within household next birthday	18-59 yr.
<b>Netherlands</b>	licit and illicit drugs	CAPI	stratified random population register	12+ yr.
<b>Sweden</b>	alcohol	pen-and-paper / CATI / postal	stratified random postal addresses; within household last birthday	15-75 yr.
<b>Finland</b>	illicit drugs	postal – delivered & collected by mail	simple random population register	18-74 yr.
<b>Greece (Greater Athens)</b>	health	pen-and-paper	simple random area selection; within area simple random selection	12-64 yr.

<i>country</i>	<i>over-sampled groups</i>	<i>weighted by</i>	<i>N</i>	<i>response rate *</i>
<b>France</b>	none	age, gender, area, type of housing	1993	76 %
<b>England-and-Wales</b>	deprived areas, ethnic groups	age, gender, area, type of housing	12935	83 %
<b>Germany</b>	none	age, gender, marital status, household size	7833	65 %
<b>Netherlands</b>	12-18 yr.	age, gender, marital status, ethnicity	21959	
<b>Sweden</b>	none	?	3582	70%
<b>Finland</b>	none	not applicable	3009	71 %
<b>Greece (Greater Athens)</b>	12-24 yr.	age	2103	93 %

\* Note: calculation of response rate differs per country

The original data of the country files have been selected and transformed into a common set of variables following procedures described below. Annex 5 to this report gives an overview of the variables in the integrated file (Eurofile).

As mentioned before we have tried to join data of seven different national surveys using different questionnaires. For the purpose of the Joint Analysis we disregard the effects of different sample sizes, interview modes and survey contexts, as well as effects of differently phrased questions on answer patterns.

The joining of the national data sets is based on the awareness that different questions still may result in comparable research variables, directly or by means of combination and manipulation of sets of questions.

Below we explain the general rules applied in the joining process. Where necessary or appropriate, remarks are made about the fitness of the match between the individual country files.

## **Selection of variables**

The starting point for selecting variables of the national files into the Eurofile has been the model questionnaire, which had been presented in the final report of project CT.96.EP.08. Some other variables, corresponding to the later revision of this model have been added as well.

All questions of the model appear in some way in at least one of the national data sets. There are two exceptions however.

The introductory question to the different illicit substances, "Do you personally know someone who takes (a specific) drug", has not been used in any of the surveys. As an alternative we have chosen the introductory, "Have you ever heard of (substance)", even though this one is only present in the England-and-Wales survey.

The other exception is the question about how people had acquired sedatives or tranquillisers the last time they took these. Some surveys do include this issue, partly by asking directly for non-prescribed use, partly by posing separate questions about non-prescribed use. In the latter case however we were unable to transform the resulting variables into a common one corresponding to the model questionnaire.

An overview of all variables included in the basic Joint Analysis Eurofile is presented in Part A of Annex 5. The overview also specifies the common categories for each variable and the variations with regard to these categories in the underlying data sets of individual countries.

Questions about opinions which have been used in the experimental Joint Analysis are listed separately in Part B of Annex 5.

## **Categories**

The coding schemes of the national surveys are all very different. We did not even discover common standards in the labelling of categories (e.g. 1=yes, 2=no). The process of harmonisation therefore required extensive data manipulation, in particular with regard to raw data files from computer aided surveys. CATI and CAPI software programmes often construct dichotomous variables for each answer category of a question, which need to be combined into single variables.

### *Reduction to ordinal scales*

In order to obtain comparable categories we reduced the information content in many cases to simple ordinal scales (e.g. low - medium - high). These scale categories might correspond to different cut-off points or combinations of categories in the data sets of individual countries.

It can be disputed however if, in the context of the construction of comparable data, this should always be interpreted as data reduction, in particular when categories represent quantities or frequencies.

In such cases many surveys will already have build in ordinal scales. These scales vary from 'few' to 'much' or from 'low' to 'high', with cut-off points based on national perceptions about which figures should correspond to the distinguished categories. For example, a certain absolute frequency of cannabis use might in one country be perceived as high or heavy use, whereas in another country the same frequency might be seen as moderate use.

Matching different absolute ranges of individual countries into common European categories is in our opinion not necessarily a reduction of information. Depending on research aims it can even be an improvement with regard to comparability.

It must be noted however that the argument has not been elaborated in the project. In the main report the project group opted in the end for uniform category labels with regard to the prevalence measures. In the construction of the Eurofile we tried to conform to this option as far as possible. Only with regard to the income variables, we attempted to a country context based ordinal scale (see below).

*The argument is similar to the discussion among epidemiologists, e.g. in the Netherlands, about the need for gender-specific categories for binge drinking. Because of different metabolic effects, it is argued that heavy (binge) drinking should be measured for women by a lower number of glasses on one occasion than for men. The traditional “6 glasses on one occasion” might be appropriate for men, whereas women should already be identified as binge drinkers when they consume 5 glasses on one occasion.*

## Missing values

In most cases we could not assess how the managers of the original survey data had handled categories corresponding to answers like ‘don’t know’, ‘no answer’ or coding errors. In the files we used such differentiated categories, if they existed in the original file, might already have been replaced by uniform missing values. Unfortunately sometimes without discriminating between real item non-response (i.e. no answer, don’t know, etc.) and forced item non-response, caused by preceding filter questions.

For practical reasons we therefore decided in the Eurofile on the following general coding scheme for all missing values: The use of the codes 8888, 9999 and –99 applies to all variables in the Eurofile and is not separately listed in the overview of Annex 5.

### Code 8888

Assigned to “missing” values as consequence of one or more preceding filter questions. For most analysis code 8888 does not represent a missing value, but must be interpreted as being equal to the answer ‘no’ or ‘not applicable’.

For instance, when LTP cannabis equals ‘no’, questions about LYP and LMP would have been skipped and result in a ‘missing’ answer. In a logical sense the answers should be ‘no’ however. The value 8888 is assigned instead to differentiate between real ‘no’-answers.

### Code 9999

Answers not corresponding to one of the identified valid categories and therefore to be interpreted as real item non-response. For lack of underlying data this item non-response is not further differentiated

### Code -99

Assigned to all cases of a variable, which is not present in a national subset of the Eurofile. This does not represent item non-response, but only indicates that the variable could not be constructed for a particular country.

## Consistency

Respondents are not always consistent in their answers to questions. Also, survey data will be manipulated by people, who can make errors. Both might result in inconsistent data.

Pen-and-paper modes will result in more inconsistent data than computer aided modes, where the computer programme can prevent inconsistencies by accepting only selected codes and guiding the interviewer or respondent through the questionnaire.

Most researchers will correct for inconsistencies prior to an analysis of the data. We do not know to what extent the files we have used had already been cleaned or corrected, but all files still included some inconsistencies.

In general there are three methods to correct for inconsistencies.

- If an inconsistency is considered as an indication that the respondent is not reliable in his or her answers, one might decide to drop from the file and exclude from analysis all records with any or a specific number of inconsistent answers.

- Inconsistent answers can also be seen as human errors or mistakes. If so, the real answer will be unknown and the researcher will recode the inconsistent answers into a missing value.
- One can also argue that not everybody reads or understands all instructions and that many people tend to skip questions, which at first sight do not seem to relate to them. Such errors will produce inconsistencies, which can be corrected by a logical reinterpretation of the answers on preceding or following questions.

Based on our fieldwork experience we see no reason to adopt the first rather drastic approach. Instead we have chosen for the last method with regard to all prevalence questions and the second method in other cases.

As far as possible we applied for the prevalence measures (LTP, LYP, LMP) a reinterpretation based on logical statements in following order below, where code 8888 indicates that LMP or LYP actually should have been skipped.

IF LMP = YES     —→ LYP = YES  
 IF LYP = NO      —→ LMP = 8888  
 IF LYP = YES     —→ LTP = YES  
 IF LTP = NO      —→ LYP = 8888

Although the total number of corrections by application of this rule is not very high, the effect on prevalence and continuation rates for individual drugs can still be substantial when we deal with very low figures in the general population.

*A closer analysis of missing values patterns might be needed to better understand the meaning of missing values. Item non-response has always been a great concern for drug researchers, as it might indicate that people are unwilling to reveal their drug use. With regard to drug use we find in several cases high numbers of missing values relative to the number of valid answers. But this would not necessarily mean that the resulting prevalences are not reliable.*

*First, the number of missing values for a particular variable depends also on the build-in structure of the questionnaire and the way researchers treat the survey data, in particular when filter questions have been applied. A missing answer on a filter not always causes a skip of the following questions, but the result might be that missing is followed by missing and the missing values accumulate. For the Eurofile the available questionnaires and survey processing programmes did not justify a correction method as described above. As a consequence the number of missing values in the Eurofile might be artificially high.*

*Second, although we did not execute a real missing value analysis, some try-outs indicate that many missing values originate from selected groups of respondents. For example people over or individuals who have answered only a few survey questions. In both cases the resulting item non-response might relate more to the respondent's a lack of understanding the questionnaire (instructions) than an attempt to obscure their real answers on, for example, drug use. If so, the reliability of the outcomes we find for the survey population as whole, would not have been affected very much.*

## Weighting

As mentioned before our experimental Joint Analysis did not require weighting of the data for sample and non-response errors. Nevertheless, the weight factors to raise survey results to the national populations have been included in the Eurofile. Only the Finnish file did not include a weight factor. In the Eurofile, the factor for Finland is made equal to 1 for all cases.

In surveys with no booster samples, the effects of weighting on prevalence figures are quite limited. A major effect is also not very likely as it would imply that the survey process resulted in a selective response, which normally will have been observed and corrected in earlier stages of the fieldwork.

In the Joint Analysis the age range considered has been limited to 18-59 years. This choice already excludes effects from booster samples on young people, which applied to the data sets of the Netherlands and Greece.

## Remarks on individual items and variables

### **Alcohol**

The traditional prevalence measures are not present in all country files. Some countries measure prevalence for different types of alcohol separately. In such cases the prevalence of any alcohol has been assessed by counting the use of any of the separate drinks.

The construction of comparable variables and categories for frequency of alcohol drinking and binge drinking proved to be problematic. Countries differ in the way they count frequencies (as number of times or number of days), in their cut-off points between categories, as well in their reference period for counting. The first two differences will not be a problem for the Joint Analysis as high remains high and low remains low, but unequal reference periods might not justify the harmonisation attempt.

As we indicated frequency of drinking for France by the last week frequency, whereas this for other countries refers to the last month or a frequency in general, the data for France could be an underestimation in comparison to the other countries.

Finland and France measure frequency for different types of alcoholic drinks separately. In the Eurofile we have counted the maximum frequency of any of the listed drinks. This might result in an underestimation of the real frequency of alcohol use.

*An indication of the differences between last month and last week frequencies could be found in the Greek data. Using last week or last month frequency produces very different distributions of high, medium and low drinkers, even if we recalculate last month frequency as four times last week frequency. Such difference between reference periods might not hold in the same way for other countries, but it is likely that last week frequencies are not a valid estimation of missing last month frequencies..*

*In some cases (e.g. Finland, Germany) we can investigate the difference between counting the maximum frequency of any drink and the cumulative frequency of each specified type of drink. Even though the cumulative approach might not be very realistic, as it assumes that people drink different drinks on different days or occasions alternatively, the differences are considerable and the 'maximum of any drink' might imply an underestimation.*

With regard to binge drinking it should also be noticed that for some countries we could only indicate 'binging' by a frequency of drunkenness instead of the traditional six glasses at one occasion. Although getting drunk on an individual basis will mean that one has drunk too much, it does by itself not mean that one is a heavy drinker. The findings of the experimental Joint Analysis indeed do indicate that drunkenness might not be an appropriate indicator for binge drinking.

### **Illicit drugs**

Not all country files include every illicit drug specified in the model questionnaire. Also, not all countries use each of the model prevalence measures. The model introductory question does not appear in any file. A dummy drug is only included in the England-and-Wales file (called Semeron instead of Relevin).

Nevertheless, apart from sometimes complicated data manipulations caused by differences in the file structure, the harmonisation of national data sets with regard to prevalence measures on illicit drugs caused less problems than the similar attempt with regard to alcohol, pharmaceuticals and respondent attributes.

#### *Any drug*

Although a question about the use of any drug is not part of the model, we did include the item in the Eurofile because in some countries the question acts as a primary filter.

Depending on the routing within the questionnaire and the explanations given to the concept of "any drug", the use of this filter can result in under-estimations or inconsistencies. We will have under-estimations of prevalences of specific drugs when questions might have been skipped incorrectly. Inconsistencies can occur when respondents answer 'no' to any drug and 'yes' to for instance cannabis. Inconsistent answers are corrected in the Eurofile by the rule stated above.

#### *Amphetamines and ecstasy*

In the French survey ecstasy is listed in the same group as amphetamines. In the Joint Analysis the researchers have therefore excluded France when dealing with either substance. The Greek survey, dating from 1993, did not yet include ecstasy.

### *Cocaine*

With regard to the model questionnaire the expert group decided not to measure crack use as cocaine use. Some countries already measure prevalence of crack separately. However it is not clear how respondents will have interpreted the separate questions, in particular when questions about crack are placed after questions about cocaine. There will be no problems when we can keep the assumption that crack users also use cocaine in other modalities.

### *Heroin*

Germany and the Netherlands also ask for other opiates. Due to the actual placement in the questionnaire we can assume however, that heroin will not have been understood as including other opiates as well. In Germany the respondent could read that heroin and other opiates have been listed separately, in the Netherlands separate questions have been asked for several types of opiates.

### *LSD*

In France and Greece the questionnaire listed LSD and other hallucinogens together. As a consequence figures for these countries might therefore present an overestimation of LSD prevalence.

The Dutch survey included separate questions for different hallucinogens, among which LSD. In the file we used for the Joint Analysis all hallucinogens had already been combined into one group. Therefore also the Dutch data might present an overestimate of LSD prevalence.

### **Pharmaceuticals**

Constructing common variables from questions about the use of pharmaceutical drugs caused a lot of complications. Partly because in the model we decided to combine sedatives and tranquillisers, whereas none of the country surveys made this combination in the questionnaire. The Netherlands and England-and-Wales use the same format and structure as for illicit drugs. In other countries the questions are structured and formatted very differently, not really intending to measure prevalence. In Greece and England-and-Wales only non-prescribed use of tranquillisers is asked for. Finland, Germany and the Netherlands measure prevalence of sedatives and tranquillisers separately. If applicable, frequency of use is then measured in the Eurofile as the maximum of either substance, which might be an underestimation (see above).

*We have to point out that the prevalence variables of pharmaceuticals also reveal a relatively high number of missing values. Even though most survey questionnaires include explanatory descriptions and/or common brand names of sedatives and tranquillisers, this suggests that the substances concerned or the terminology applied are not so much known among the general public as one might expect.*

*Indeed, the England-and-Wales survey records more people who have not heard of tranquillisers than people who haven't heard of any of the illicit drugs.*

### **Respondent attributes**

Basic attributes like age and gender are present and comparable in each country file. The originally intended differentiation with regard to household composition (living alone, living with some kind of family, other) could not be constructed. Instead we have chosen for a dichotomous household variable (one person, more than one person) and the inclusion of marital status. The latter also makes sense as in some countries marital status is included in the weighting procedure (due to underrepresentation of singles and divorced people in the response).

Other variables of the model could be constructed from each file with the required categories, but we cannot be sure that the categories actually cover the same content. Income variables, which are not included in the model questionnaire, have been put into the Eurofile as a demonstration of the process of creating uniform categories with country specific underlying figures.

### *Main activity*

Main activity usually refers to a self-reported status. However, in England-and-Wales it relates to the respondent's situation in the week prior to the interview.

Although we seemingly obtained a good match between the country files, it should be noticed that the distinguished categories can have different meanings in each country. Also the data manipulations result in relatively high numbers to be assigned to the category 'other'.

### *Education*

All countries measure education as the level of the highest completed education, but none of the countries used the standardised ISCED to pre-code educational levels. For this reason the categories in the Eurofile should only be interpreted as an approximation when comparing between countries.

### *Urbanisation*

The project team did not conclude on any standard or common scale to measure differences in degree of urbanisation, though the relevance of having this variable was not disputed. For the Eurofile we decided to a simple classification into metropolitan, urban and rural. It has not been investigated what these concepts actually cover, but they seem to differentiate with regard to drug prevalence.

### *Income*

As mentioned before, we included income, either personal or household income, in the Eurofile as an example to demonstrate the possibility of building a common scale based on different categories per country.

Income is measured in local currency. Transformation into a common basis, e.g. euros, would not result in comparability between countries however, due to differences in economy. With the same amount in euros, one can be rich in one country and poor in another. But income levels can be made comparable by assessing incomes relative to the national distribution, for instance differentiating between the top, middle and bottom 25 or 33 percent.

As the cut-off points of income categories in the country files do not seem to have been chosen from such a viewpoint, we could only obtain a rough differentiation between high, medium and low income levels. For details, see Annex 5.

### **Survey variables**

The Eurofile includes a few survey variables. The weight factor in the Eurofile equals the country specific weight factor as discussed above.

For Germany we specify two country codes to distinguish between East and West Germany, which in many ways are still two different socio-cultural entities. The included weight factor nevertheless applies to Germany as a whole.

For Sweden we actually have data from three surveys based on different modes. The CATI and postal surveys have been executed in the framework of project CT.97.EP.02, which tackles the mode effects on prevalence rates.

The gender of the interviewer has been included to assess eventual interviewer biases.

We have tested this tentatively on the England-and-Wales data on cannabis prevalence by making combinations of interviewers and respondents by gender. The hypothesis that some combinations might result in different prevalence rates could not be confirmed however.

### **Opinions**

The Eurofile has been extended with selected variables related to opinions and perceptions about drugs of the national data sets of Finland, Sweden, Germany and France. The Dutch and England-and-Wales survey did not include such questions. The Greek survey included only two.

As questions about opinions and perceptions differ considerably between national surveys, both in content and wording, no attempt has been made to transform these variables into a common format. In Annex 5 we list these variables with an approximate translation into English.