18% of the women and 47% of the men in the Swedish medical student sample had used illicit drugs ever, significantly more common than among the Argentinean students. Among interns, 5% reported use of illicit drugs during the preceding 12 months, without gender difference.

Conclusions

Swedish medical students drank more alcohol than Argentinean medical students, but less than Swedish business students. A slight decrease in alcohol intake occurred after graduation, which may indicate a 'normalisation' of consumption. No associations were found between alcohol habits and mental distress. Women had lower intake in all samples.

A half part of Swedish male medical students had used illicit drugs, more common than in Argentinean medical students. Prevalence of recent or regular drug use was low.

Drug use and problem perception in Dutch university students; associations with perceived health and academic performance
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Background

Drug use is known to interfere with functioning in daily life. University students using drugs may experience health problems as well as academic problems. Problem perception is needed to change behaviour. We aimed to investigate associations between perceived health status, academic functioning and using drugs. Next, differences in perceived health status and academic functioning were investigated between students with and without problem perception.

Methods

A tottal of 8258 university students were invited to complete a questionnaire with items about general health, psychological health, social support, study delay and drug use (amongst others cannabis, coke and XTC). Users were asked if they considered their drug use as a problem. Users (U) were compared with non-users (NU), users with (U+) and without problem perception (U-) were compared and U- was compared with NU using multivariate logistic regression analyses.

Results

The questionnaire response was 44%. 25% reported cannabis use, 6% XTC, 3% cocaine, 3% heroine, 1% speed and 0.1% heroine, LSD or GHB. U was associated with a worse health status (OR = 1.4; 95%CI = 1.1–2.0) and more study delay (OR = 1.3; 95%CI = 1.0–1.3). U+ more often reported a worsened health over the past year (OR = 1.9; 95%CI = 1.2–3.2) and did not believe they could solve their psychological problems (OR = 2.9; 95%CI = 1.3–6.6). They wished more social support (OR = 1.9; 95%CI = 1.1–3.3) and more students were in contact with more than two professional helpers (OR = 9.2; 95%CI = 2.2–39.2) compared to U-. U- reported a worse health status (OR = 1.4; 95%CI = 1.0–1.9) and more study delay (OR = 1.3; 95%CI = 1.0–1.5) compared to NU.

Conclusion

Drug use is associated with worse health and academic outcomes in Dutch university students. Users without problem perception report better health outcomes than users with problem perception, but they report worse health and academic outcomes than non-users. This group deserves attention in programmes on prevention of drug use.

Normative beliefs, misperceptions and heavy episodic alcohol consumption in a UK student sample
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Background

Recent research in American college system has demonstrated that student alcohol consumption is partly a result of overestimated perceptions of alcohol use in peers. Correcting these misperceptions and thus reducing alcohol consumption has become the basis for an effective alcohol intervention in the US college system, however such effects have not been studied in UK university students.

Method

An email containing a link to a survey website was distributed to current undergraduate students at a UK university. The survey contained items on individual's personal behaviour and their perception of the level of that behaviour in groups of increasing social distance.

Results

Completed 500 surveys were returned. It was established that there was a significant positive linear trend over the individual's own behaviour and the perceived behaviour in others at increasing social distance for each measure: frequency of drinking ($F(1499) = 169.97$, $P < 0.001$), quantity per occasion ($F(1499) = 195.297$, $P < 0.001$) and frequency of drunkenness ($F(1499) = 93.747$, $P < 0.001$). Post hoc Tukey analysis ($P < 0.05$) confirmed the significant differences between the actual normative behaviour and perceived norm of other students for each of the three outcome measures. There were significant correlations between personal behaviour and the degree of misperception for each behaviour: frequency of consumption ($r = 0.295$, $P < 0.001$), quantity per session ($r = 0.611$, $P < 0.001$) and frequency of drunkenness ($r = 0.247$, $P < 0.001$).

Conclusion

The findings of the study indicate that the normative belief/alcohol consumption processes which have been found on US college campuses also operate in UK university settings. This raises the possibility of applying social norms interventions from the USA to the UK universities and potentially elsewhere in the world. Although the current study focussed on alcohol it is feasible that this approach could be used in relation to other types of drug use.

3.7. Injury Prevention

The Quality of Hospital Discharge Data Used for Injury Surveillance
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Background

One part of the EU co-funded Apollo project was to develop a passive injury surveillance system on the basis of hospital discharge data. Information on more than a dozen countries is now available at the web-query system. For some countries information has already been included for up to 3 years.

Methods

An analysis of the data in the web-query system regarding the quality is made. Several quality indicators are analysed. The results are compared between countries and over time for those countries that allow for this.

Results

Injury coding is usually available at very high percentages. Some countries allow for more than one injury diagnosis.

Injury severity coding was possible at high percentages in most countries. Mechanism coding has a large variation with some countries close to 100% and others with no mechanism coding at all. More than half a million cases with both injury and mechanism information are available. The duration of the hospital stay is practically always known, the changes over time within countries are relatively minor.

Conclusions

The web-query system available at the University of Navarra gives results that have not been available in Europe in this form and extent at such low costs. The quality of the data varies between the different countries. More countries, data sources, and indicators will be added to the system in the future. The system is open to the public at http://www.unav.es/preventiva/apollo/asistente/with User-ID and Password 'Public'.

Non-transmission of death certificates of non-residents to their country of residence: an important bias for comparing injury related deaths between European countries (results from the ANAMORT project)

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Background

Differences in production processes of mortality statistics between European countries could lead to misclassifications of underlying causes of death and lack of data coverage. This could have an influence on data comparability and would limit their interpretation. The ANAMORT project aims to identify biases specifically regarding injury related deaths and to propose recommendations in order to correct them. One of the biases possibly lies in non-transmission of death certificates of non-residents to their country of residence, although transmitting those is recommended by the World Health Organization and Eurostat. The impact of this bias is presented hereafter.

Methods

Within the ANAMORT project, a questionnaire regarding production of mortality statistics has been completed by specialists of mortality or injury statistics in 36 countries in Europe (during first half of 2006). Answers were obtained from the 27 European Union countries, the three candidate countries (Croatia, the Former Yougoslav Republic of Macedonia and Turkey), three European Free Trade Association countries (Iceland, Norway and Switzerland) and three Balkan countries (Albania, Bosnia and Herzegovina and Serbia). A part of this questionnaire is related to methodologies applied by countries about people dying outside of their country of residence.

Results

Eight European countries out of 36 systematically transmitted the medical part of death certificates of non-residents to their country of residence. Among all causes of death, the proportion of non-residents was estimated to be lower than 1% in most countries but in five of them, it was estimated between from 1 to 5%. This proportion of non-residents limited to injury related deaths was estimated to be less than 1% by half of the countries, included between 1 and 9% by 10 countries and 10–24% by three countries. For 31 European countries out of 36, information on country of residence was available in final individual mortality files. When a non-resident dies in a given country, most of the European countries (22 out of 36) collected data in their database and 13 always included them in their published statistics. More than half of European countries never transmitted these cases to Eurostat (24 out of 36).

Conclusions

Exchange of death certificates of non-residents between countries appears to be an important issue for European public health policies. Moreover, the number of European residents travelling or living within Europe outside of their countries of residence increases the importance of this non-transmission. The lack of valuable information, mainly medical cause of death, deprives each European country of a significant number of deaths. This problem is especially important regarding injuries as an important part of deaths of non-residents are related to injuries. According to a recent study (2004), proportion of French residents dying abroad from external causes out of all causes is about 50% whereas this proportion is about 7% for French residents dying in France. The transmission of available information could be implemented as a routine but is obstructed by organizational and regulation matters. In addition, rules have to be settled in order to avoid double-counting of deaths.

How to compare European countries and trends regarding deaths from accidental falls: results from the Anamort project

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Background

Accidental falls are known as an important cause of death accounting for nearly 50 000 deaths reported in the 25 former countries of the European Union in 2003. Production of death statistics is organized in by national medical authorities who are responsible for the medical certification of causes of deaths, as well as their codification and the selection of an underlying cause (when multiple causes exist). Countries follow the International Codification of Diseases (ICD) rules published by the World Health Organisation (WHO). Individual data are aggregated, centralized and disseminated at European level by Eurostat or at world level by WHO. Nevertheless, methods of death statistics production are known to vary from country to countries and over time. The Anamort project has been developed in order to produce recommendations to improve the comparability death statistics in general and more specifically in the field of injuries. The application to deaths from falls is presented here.

Methods

Different methods were used to identify sources of bias in death statistics related to deaths from falls,
1/a questionnaire on death statistics production practices was filled-in by specialists of mortality statistics of 36 European countries; 2/a literature review was performed; 3/a review of the discussions included in the forum for specialists of mortality statistics on codification issues was carried-out.
In addition, trends analysis of mortality data available through Eurostat was performed in order to identify differences over time and between countries. Differences were analysed to differentiate between variations related to the process of statistics production and/or to the epidemiological contexts.