European Monitoring Centre for Drugs and Drug Addiction

MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD

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DELEGACIÓN DEL GOBIERNO PARA EL PLAN NACIONAL SOBRE DROGAS

2012 NATIONAL REPORT (2011 data) TO THE EMCDDA by the Reitox National Focal Point

SPAIN

New Development, Trends and in-depth information on selected issues

REITOX

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SUMMARY

The present report on the drug situation in Spain in 2011 has been elaborated by the Spanish Focal Point, the Government Delegation of National Plan on Drugs (DGPNSD), in accordance with the established guidelines by the European Monitoring Centre on Drugs and Drug Addiction as part of the REITOX grant agreement.

Spain being a country with a decentralized structure, for the elaboration of this report the activities carried out by the different institutions that compose the National Plan on Drugs (General State Administration, Autonomous Administrations and Local Administrations as well as the Non Government Organizations- NGOs) had to be taken into account.

Drug policy: legislation, strategies and economic analysis

The 2009-2016 National Strategy on Drugs as well as its first 2009-2012 Action Plan are currently still in effect in 2011. An evaluation has been made of the First Action Plan, 2009-2012, although its results have not as yet been made public. Besides, work has begun in 2012 on preparing the 2013-2016 Second Action Plan, which will be in force throughout the second half of the National Strategy.

Is should be mentioned that Spain enacted new legislation to control new drugs such as tapentadol and mephedrone as well as a new *Royal Decree 1194/2011 of August 19th, by virtue of which the procedure is set forth in order for a substance to be considered a narcotic at the national level.*

Drug use in the general population and specific targeted groups

A new Household Survey on Alcohol and Drugs in Spain has been conducted in 2011 as a part of a continuing series of surveys which have been being conducted biennially since 1995.

Some changes had already been made on the 2009 questionnaire for the purpose of converging more closely with the standard questionnaire suggested by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA).

The innovation this year is that of questions having been added concerning the use of other substances known as emerging drugs. The substances included are: ketamine, spice, piperazines, mephedrone, nexus, methamphetamine, magic mushrooms, research chemicals, legal highs, salvia divinorum and anabolic steroids.

Also, in 2011, two questions were added for the first time concerning the main channels through which citizens are provided with information on drugs and the main channels through which they would like to be provided with this information.

The results of the 2011 survey show the following trends:

- The psychoactive drugs showing a greater prevalence of use in all of the time-related indicators taken into account are alcohol and tobacco.

- Among the illicit drugs, cannabis is the substance showing the greatest prevalence of use sometime in one's life (27.4%) followed by powder cocaine (8.8%), at levels which, if use within the last 12 months is taken into account, are respectively lowered to 9.6% and 2.2%.

- The trend most worthy of special mention compared to previous years is that of tranquilizers, given that their prevalences of use rose substantially in all of the time-related indicators taken into account.

- For all of the time frequencies included, alcoholic beverage use was lower in 2011 than in 2009 , the year in which the levels of use had rallied for all of the time periods.

- Cannabis continues to be the illicit drug most used among the age 15-64 population legally residing in Spain, despite a slight detected in the three time-related indicators, having a bearing on the stabilization which had been noted over the last few years.

- Regarding cocaine use, in 2011, a break was found to exist with the upward trend which had been taking place for the past ten years and which had reached its peak level in 2009.

- Regarding emerging drugs, the new module added showed, among other results, that in 2011, a total of 3.6% of Spain's age 15-64 population had used emerging drugs sometime in their lives, 0.9% having used them sometime within the last 12 months and 0.4% within the last 30 days immediately prior to being surveyed. Is is also concluded that those who use the substances included in the emerging drug category are, for the most part, poly-users of multiple drugs.

Prevention

Regarding environmental prevention, another model which has started being implemented over the past few years is that of working in cooperation with the **leisure industry** to promote **responsible service** and healthy leisure. In Spain, some Autonomous Communities have unrolled their own programs.

In School prevention there are three types of activities carried out targeting the students at the school level. Firstly, **structured prevention programs, s**econdly, **specific activities** are occasionally carried out from time to time at schools, and also interventions have begun at **universities** with programs for providing information and heightening awareness regarding the risks of alcohol abuse and the use of other drugs.

Family prevention programs are still well widespread and a**t the community level**, most of the prevention-oriented actions target groups in particularly vulnerable situations, either families or the minors in the families or minors in general through alternative leisure-time programs.

Regarding selective prevention the work done by the Autonomic Plans on Drugs is focused mainly on two groups: minors and families in a situation of vulnerability, and the programs are usually carried out at the school level or at the community level.

Problem Drug Use

Spain has introduced and evaluated different scales aimed at measuring problem cannabis use on the ESTUDES survey (2006, 2008 and 2010) and does not rule out the possibility of introducing other scales once validated and adapted to the use of other substances or population groups.

Estimations on problem drug use show a stabilization of problem heroin use and injecting drug use. New research is being done in Spain to improve estimations regarding problem cocaine and cannabis use.

Drug-related treatment: treatment demand and treatment availability

Drug related treatment system is based on the Spanish territorial division in Autonomous Communities and Cities.

In 2010, the number of admissions reported in Spain for treatment for psychoactive substance abuse or dependence (not including alcohol or tobacco) have similar figures than the ones provided in 2009. Regarding the relative importance of each drug in 2010 within the total number of admissions for treatment for psychoactive substance abuse or dependence, cocaine is the illicit drug having been the cause of the largest number of admissions for treatment, followed by opiates and cannabis.

As in previous years, the majority of the patients admitted for treatment for illicit drug abuse or dependence were males and the average age of those admitted for treatment was 33.4 years of age. The poly-drug use pattern is firmly established among those admitted for treatment.

Health correlates and consequences

DRID: HIV/AIDS- Data are available in Spain from different sources of information which, all combined as a whole, aid toward understanding the trends regarding how this phenomenon is evolving as well as the current situation. The chapter describes the methodology and results achieved the main systems of HIV epidemiological surveillance in Spain: population information systems, sentinel networks, in hospital HIV/AIDS survey and the indicator of admissions to treatment for drug abuse or dependence.

Also, it is described the methodology and results of the indicator hospital emergencies among psychoactive substance users during 2010.

DRD: In order to find out the deaths secondary to drugs, there are currently two sources of information in Spain: on one hand, a Specific Death Registry due to acute reactions to drugs and, on the other, the General Death Registry. A description is provided in the chapter of the methodology and the main results of each one and the resulting estimate on combining the two.

Last data available of this indicator are from 2010 for both sources of information.

Responses to Health Correlates and Consequences

The data provided are referred to 2010, being the latest data available to date. The care provided for drug users is dispensed, mainly, at public centers or publicly-funded private centers. In the latter case, Non-Governmental Organisations (NGOs) are the ones managing the centers.

As far as the specific resources for providing care for drug-dependent individuals is concerned, figures are similar than the ones provided for 2009. Care provided in therapeutic communities in existence in Spain in 2010 has dropped compared to 2009.

On the contrary, in the case of the hospital detoxification units, care has risen compared to the previous year.

In 2010, eight safe injection or “drug consumption facilities” were operating in Spain. Also, the needle and syringe exchange and dispensing programs, as well as the dispensing of sanitary kits are carried out in both outreach programs as well as in more institutionalized centers and resources.

As regards maintenance programs with opiate agonists, worthy of special mention is the fact that Buprenorphine+Naloxone (Suboxone®) have recently been included as one of the National Health Service benefits.

Some other figures are reported regarding care provided for alcoholics, psychiatric co-morbidity and activities for the purpose of preventing and reducing traffic accidents related to driving under the influence of alcohol or other drugs.

Social correlates and social reintegration

A description is provided of the different types of resources and programs available in Spain as far as social reintegration is concerned: Social reintegration facilities (residential and non-residential), education and training programs (Standard courses, non standard courses, employment information, counseling and job-hunting actions and vocational training courses) and employment programs**.**

Regarding social reintegration, in 2010, the number of outpatient centers with therapeutic treatment, which also has social reintegration programs decreased. There was also a drop in the number of residential treatment centers (therapeutic communities) which have social reintegration programs. On the contrary, the number of centers which carry out occupational and social reintegration activities, without offering treatment, has significantly increased.

Drug-related crime, prevention of drug related crime and prison

The number of known drug trafficking crimes has been showing a rising trend over the last ten years; on the contrary, the number of arrests related to illicit drug trafficking offenses has dropped compared to the previous year. During the last ten years, cannabis and cocaine are shown as the substances for which most arrests are made.

In 2011, the Operating Plans continued for police response to retail drug dealing and drug use or possession for such a purpose in the areas surrounding schools and in recreational nightlife settings.

Regarding interventions in the criminal justice system, in 2010, the Government Delegation for the National Plan on Drugs has transferred funds to the Autonomous Communities for the consolidation and expansion of the programs for providing assistance to arrestees at police stations and court facilities. Prison population is stabilized and diseases related to injecting drug use are still dropping. As far as interventions are concern, drug free programs are still increasing and, on the other hand, methadone programs continue descending.

Drug markets

Data showed than in 2011 the number of heroin seizures dropped off, while those of hashish and MDMA (ecstasy) increased. Cocaine underwent a slight, barely significant increase. Lesser amounts of hashish, cocaine and ecstasy were seized, whilst greater amounts of heroin were seized.

Also, the seizures of controlled chemical substances (precursors) and non-controlled chemical substances rose considerably.

As far as prices are concern, it is worthy to mention that on the retail by dose market, the prices of cocaine and MDMA-ecstasy rose, while the heroin dose price lowered

SELECTED ISSUES

Residential treatment for drug users in Europe

A description is provided of residential treatment within the context of the care provided for addictions in our country, the different existing resources, its quantification and main figures, the location of residential treatment within the care network, the conceptual models that affect it, the current perception of their usefulness and the challenges facing this treatment.

The following methodology was employed for preparing this report: all responsible for the care provided for the individuals using drugs in the different Autonomous Communities were requested

to complete a questionnaire; also there were conducted In-depth individual interviews with some of them, a discussion group of clients of residential treatments facilities and queries were placed with those responsible for residential treatment facilities.

Therefore, the selected issue contains a comprehensive description of different types of residential treatment units at national level, its availability and the quality criteria for these centers, both as a health centre and as a drug care network centre.

Finally, some challenges for the future are considered such as the impact of the present crisis with the consequent reduction in facilities and the co funding model.

Drug policies of large European cities

This Selected issue makes reference solely to the **ten most highly-populated cities** in Spain, including the capital city, which total, in all, 9,207,859 inhabitants, meaning 19.51% of Spain's population. This cities are: Madrid, Barcelona, Valencia, Zaragoza, Murcia, Palma de Mallorca, Las Palmas (Grand Canary Island), Bilbao, Lastly, Seville and Malaga, located in nine different Autonomous Communities.

Later, the specific case study is related to Madrid (capital City); a summary of the studies on the drug problem in Madrid (City and Autonomous Community) are provided, showing main results.

The chapter explains in detail the City of Madrid new Plan of Addictions 2011-2016 and how the care provided for drug dependences in the city of Madrid is currently organized in terms of the following objectives: Controlling the drug supply and controlling the demand for drugs, focused on prevention and integral care. In the city of Madrid, the Addiction Institute is the main institution regarding both prevention and treatment and reintegration of drug dependencies.

All the structure related to the integral network care for drug dependencies in the City of Madrid is comprehensively reported. Finally, some concerns and challenges for the future are considered.

Part A: NEW DEVELOPMENTS AND TRENDS

1. DRUG POLICY: LEGISLATION, STRATEGIES AND ECONOMIC ANALYSIS

1.1. INTRODUCTION

In Spain, the territory is divided into 17 Autonomous Communities and two Autonomous Cities. An Autonomous Community is a territorial entity which, within Spain's body of constitutional law and in accordance with a sharing out of authorities between the State and Autonomous Communities governed under Spain's Constitution, is vested with legislative autonomy and executive authorities, as well as the power to govern themselves by means of their own representatives.

Therefore, the way in which the territory is set out has a bearing on drug policy, given that the Autonomous Communities and even the smaller Municipal Governments have certain authorities over this matter.

The coordination between the Central Government and the Autonomous Communities is indispensable and of utmost importance. This territorial coordination is carried out by way of an administrative structure which includes:

- Sectorial Conference (political level): Presided by the Minister of Health, Social Services and Equality. Composition: Members of the State Administration and those responsible for the drug policy in the Autonomous Communities and Autonomous Cities.

- Inter-autonomic Commissions (management level): Presided by the Government Delegate for the National Plan on Drugs. Composition, those responsible for the Autonomic Plans on Drugs.

Regarding the purely political and parliamentary level, there is a Joint Congress-Senate Commission for the Study of the Drug Problem, on which members of the political parties represented in Parliament serve.

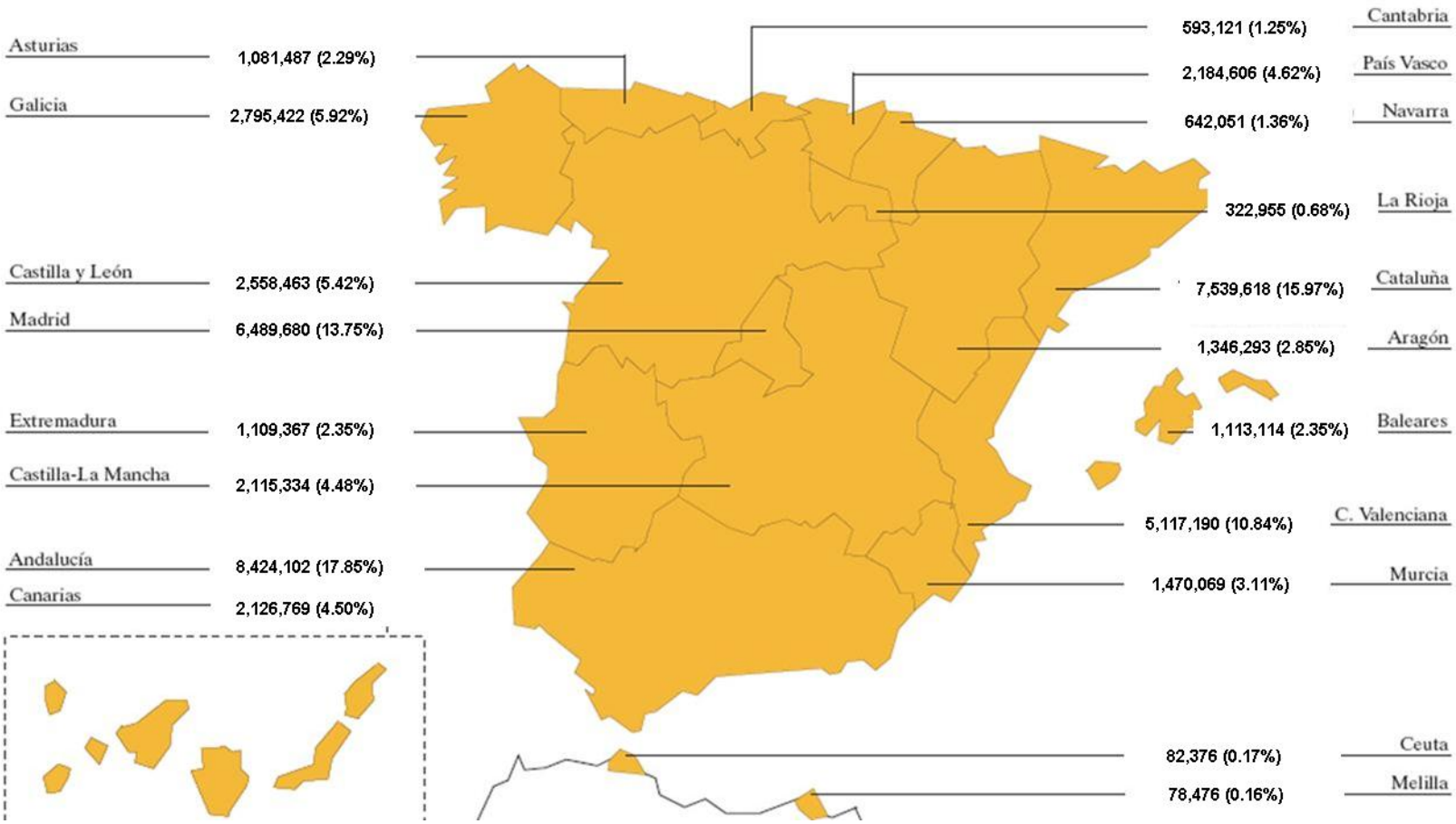
On the other hand, both the 2009-2016 National Strategy on Drugs as well as its First 2009-2012 Action Plan are currently still in effect in 2011. An evaluation has been made of the First Action Plan, 2009-2012, although its results have not as yet been made public.

Besides, work has begun in 2012 on preparing the 2013-2016 Second Action Plan, which will be in force throughout the second half of the National Strategy.

The results of the State Survey on Drug Use Among Secondary School Students (ESTUDES), carried out in 2010, were also made known in 2011.

This Survey is part of a continuing series of surveys which have been being conducted biennially since 1995.

Fig 1.1 Spain, 2011: Population by Autonomous Communities and Autonomous Cities and percentage of the total population



Note: Spain's total population in 2011 is estimated at 47,190,493 inhabitants. The map above shows the population by Autonomous Communities and Autonomous Cities, as well as the percentages over the total population.

1.2. LEGAL FRAMEWORK

In 2011, different national and autonomous community legal standards of interest and importance were enacted which have a bearing on the drug phenomenon in several of its many different aspects.

Thus, within the framework of controlling the supply of such substances, mention must be made, first of all, of the reform carried out by ***Organic Law 6/2011 of June 30th enacted in revision of Organic Law 12/1995 of December 12th on curtailing contraband,*** in which different major changes have been made.

Special mention must be made, firstly, of the classification (as an offense of contraband) which is incorporated into our criminal justice system (provided that the same total a value of 50,000 euros or above) of the activities of importing, exporting, smuggling, dispatching or carrying out any other transaction subject to the control set forth under the community regulations governing foreign trade of drug precursors when these transactions are carried out without the authorizations required under European Council Regulation (EC) No. 111/2005 of December 22, 2004, laying down rules for the monitoring of trade between the Community and third countries in drug precursors and also when the same are obtained by means of requests placed with false documents or data in regard to the nature or ultimate consignee of such products or in any otherwise illicit manner.

Similarly, it must be stressed that both regarding toxic drug contraband (narcotics and psychotropic substances) as well as regarding their precursors, the classification of punishable behaviours is expanded with the legal reform to include all those cases, all those behaviours which are committed out of gross negligence.

Lastly, the reform of the penal legislation on the subject of contraband of toxic drugs or of their precursors has been completed in the aforesaid law – in consonance with the prior reform of the Penal Code carried out in 2010 in this same regard – with the express admission therein of the criminal liability of juridical persons, provided that the circumstances stipulated under Article 31A of the Penal Code – to which express reference is made – concur under the conditions set forth thereunder in the respective action or omission described in this legal standard.

Also, within the regulatory scope of controlling the supply of drugs, one must bear in mind the passage, in the year to which the report makes reference, of ***Royal Decree 1194/2011 of August 19th, by virtue of which the procedure is set forth in order for a substance to be considered a narcotic at the national level.***

The aforementioned Royal Decree is for the purpose of setting forth the procedure so that a natural or synthetic substance not included on Lists I and II of the schedules annexed to the United Nations Single Convention on Narcotic Drugs of 1961 or which have not been officially considered as such at the international level may be considered a narcotic at the national level in Spain and said substance may likewise therefore be subject to the control measures applicable in Spain to all other narcotics.

In turn, in accordance with the above, it must also be noted that, under this same regulatory standard (in the sole supplementary provision thereof), the substance known as ***tapentadol*** has then been made subject to control in Spain for the purpose of placing it under the same control measures set forth under Law 17/1967 of April 8th for which provision is made for the substances included on List I of the schedules annexed to the Single Convention on Narcotic Drugs of 1961.

The substance *tapentadol* has come to be considered a narcotic following the Spanish Medicines and Health Products Agency having carried out the respective evaluation process in keeping with that which is set forth under the Royal Decree proper, the results of which were positive.

Within this same scope of the control of new substances, mention must also be made of the passage of ***Order SPI/201/2011 of February 3rd by virtue of which the substance 4-methyl methcathinone (Mephedrone) is included in Schedule I to Royal Decree 2829/1977 of October 6th governing the manufacture, distribution, prescription and dispensing of psychotropic preparations and substances.***

This regulatory provision is justified on the basis of the report on the risks associated with the use of the aforesaid psychoactive substance prepared on the part of the European Monitoring Centre for Drugs and Drug Addiction, in which *mephedrone* is considered to be a new psychotropic substance having physical effects similar to other stimulants – especially ecstasy (MDMA)- which may be used as an alternative to illicit stimulants and cause dependence, as well as being highly prone to abuse.

As a result of such a report and taking into account that, in the E.U., this substance was not of any established or recognized medicinal value or use, as well as the need of taking all precautions, the European Council adopted *Decision 2010/759/EU of December 2, 2010* on the control of the aforesaid substance, in accordance with Article 1 of which and for compliance therewith, the aforesaid Order was passed in Spain.

Within another regulatory scope different from those dealt with under the aforementioned penal and administrative standards, mention must also be made - due to the major degree of juridical importance thereof in the healthcare-related aspects having to do with the use of (legal and illegal) drugs - of the passage of ***General Public Health Law 33/2011 of October 4th*** .

It must be said that this law does not include any specific mention of the particular problems involved in the drug use phenomenon. Nevertheless, taking into account the object of this law (set forth under Article 1 thereof) and the impact which this use undoubtedly has on human health, it may be concluded that it is completely applicable also to the aforesaid phenomenon.

This law (generally applicable to the government Agencies and to private citizens whenever specifically set forth thereunder) governs public health-related aspects including: the rights, duties and obligations; the measures – including health promotion and monitoring, as well as the prevention of health problems and the determining factors thereof and the protection of the health of the population; planning and coordination; and the violations of the legal standard as well as the respective penalties.

Mention is also warranted of ***Social Economy Law 5/2011 of March 29th***, due to the importance thereof in the field of the social reintegration of drug-dependent individuals.

The basic objective of this law is the configuration of a common legal framework for all of the entities as a whole comprising the social economy, being understood as such the economic and business activities which those entities at the private level, which, in accordance with the principles set forth under Article 4, pursue the general interest of those comprising the same, either the economic or social general interest or both.

As one of the guiding principles of the pursuits of the social economy, the law specifically mentions (under Article 4 thereof) that of the promotion of the *social reintegration of persons at risk of social exclusion*. And the *reintegration companies* are specifically mentioned among the entities comprising part of the social economy.

Lastly, mention must be made as to the aforesaid legal standard recognizing as a task of general interest that of the promotion, stimulation and development of such entities, attributing to the different public powers – within their respective areas of authority- the obligation of meeting certain specific objectives of their policies for the promotion of the social economy.

Continuing the review of the most important legal standards passed in 2011, mention must also be made of ***Royal Decree 840/2011 of June 17th, setting forth the circumstances for enforcing community service sentences and permanent imprisonment at penitentiary facilities, certain security measures, as well as the suspension of the enforcement of the sentences for imprisonment and substitution of sentences.***

This regulatory standard (revoking Royal Decree 515/2005 of May 6th on the same subject) devotes Chapter IV thereof to the procedure for carrying out the suspension of the enforcement of prison sentences of five years of less imposed on drug-dependent persons who had committed an offense due to their dependence on toxic drugs, agreed to by the Judges and Courts in accordance with that which is set forth under Article 87 of the Penal Code when they are no longer drug-dependent or are under treatment for this purpose.

The established procedure requires an individual plan for intervention and follow-up on the person benefitting from the same on the part of the prison Administration, which shall be notified to the competent judicial body for its knowledge for the enforcement without dismissing the possibility of the same becoming immediately enforceable. This programme shall be referred, whenever fitting, to the respective service or centre by said Administration's services managing sentences and alternative measures, so that the person sentenced may start or continue the treatment or programme judicially determined.

During the period throughout which the sentence is suspended, the alternate measures and sentence management services are to supervise the conditions set out in the aforesaid plan.

This legal standard lastly imposes on these same aforementioned services the obligation of informing the body having province over the enforcement based on the observance of the rules of conduct imposed upon the convict, whenever said body so requests or as often as this body may specify and, in any case, every three months.

A thorough review of the regulatory activities (having a bearing on the material scope of drugs) carried out in Spain during the year in question cannot overlook taking into account the most important activities which have been carried out – applicable exclusively solely to the respective territories – on the part of the Autonomous Communities, considering the legislative authorities recognized as pertaining thereto both in the Constitution and in the Statutes of Autonomy.

As a result of the above, this report must necessarily close by making at least a brief mention of the passage in 2011 of several partial reforms of the Autonomous Communities' own legislation in force regarding the subject of alcoholic beverages and tobacco.

In this regard, one must take into account the reforms carried out by **Law 1/2001 of January 14th (second final provision)** and **Autonomous Community of Madrid Law 6/2011 of December 28th** (Article 15)**,** those introduced by the **Autonomous Community of the Basque Country Regional Law 1/2001 of February 3rd** and also that made by **Autonomous Community of Catalonia Law 9/2011 of December 29th (Article 132).**

1.3. NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

National Action Plan and Strategy

The National Strategy on Drugs 2009-2016 approved by a Council of Ministers Resolution passed at the meeting held thereby on January 23, 2009 set forth that in order to develop and to complement the framework set up, two consecutive four-year Actions Plans are to be prepared to cover the entire period throughout which the National Strategy is in effect.

In 2011, the activities for which provision was made in the 2009-2012 Action Plan that develops the National Strategy, which was the result of the consensus among all public and private individuals and sectors involved in working in the field of drug dependence, continued being carried out.

This Action Plan highlights the public health dimension as a social component in the drug policies, marking a staunch commitment to further bettering the interventions and assuring the quality thereof through coordinated activity among all administrations, which, in turn, have the indispensable collaboration of the non-governmental organization for putting the measures set out therein into practice.

Also in 2012, work has begun on preparing the second Action Plan, 2013-2016, developing the actions which are to be carried out throughout the period during which the second part of the National Strategy is carried out.

Implementation and evaluation of national action plan and/or strategy

Evaluation of the first Action Plan, 2009-2012 was begun in 2011 and continued on into 2012, having now been fully completed, although the results thereof have not as yet been made public.

In 2011, the Central Government Administration funded 359 programs through the Government Delegation for the National Plan on Drugs, the Delegation having invested 29,974,064 euros in order to put into practice the 2009-2012 Action Plan. The measures involved encompassed all of the Action Plan's areas of intervention: coordination, reducing the demand (prevention, lowering risk and reducing harm, social integration and assistance), reducing the supply, improving the basic and applied scientific knowledge, training/instruction and international cooperation.

Regarding implementation at the autonomic level, all of the Autonomous Communities has regional drug dependence-related strategies in place regarding which information has been provided in earlier reports. The new developments in 2011 concerning the Autonomous Community Drug Dependence Strategies and Plans are as follows:

- The Autonomous Community of Catalonia's 2011-2015 Health Plan and Master Plan for Mental Health and Addictions. Catalonian Health Department.

- The Autonomous Community of Galicia's 2011-2016 Addictive Disorders Plan. Autonomous Community Government of Galicia. Health Ministry.

- The Autonomous Community of Navarre's Drug Dependence Plan (Currently II Autonomous Community of Navarre Drug Dependence Plan, 2012-2016. Autonomous Community Government of Navarre.

- The Autonomous Community of the Basque Country's VI Drug Dependence Plan, 2011-2015. Autonomous Community of the Basque Country.

Regarding the **advertising campaigns**, the Ministry of Health, Social Policy and Equality presented the Ministry of Health, Social Services and Equality's and the Ramón Rubial Institute-Ideas for Progress Foundation's **2011 campaign for preventing drug use and trafficking when travelling abroad** in two phases (July and December) for warning against the risk of using or trafficking with drugs when travelling abroad in foreign countries.

The campaign slogan was: "If you think that carrying drugs is the solution to all your problems, you'll believe anything". Data related to this media campaign as are follows:

- At November 30, 2011, a total of 2,523 Spanish citizens were still under arrest in foreign prisons. A total of 83.6% (2,100 Spaniards) were imprisoned for offenses related to drug use or drug trafficking.

- Peru, Italy, Colombia, Brazil and Morocco head the ranking of countries where most Spanish citizens are arrested for drugs. In Europe, 31.3% are under arrest.

- Andalusia, Madrid, Catalonia, the Autonomous Community of Valencia and Galicia are, in this order, the autonomous communities having the greatest number of citizens arrested abroad.

- The Ministry of Health insisted upon the need of completely doing away with any misbeliefs regarding the "supposed" permissiveness of other countries regarding trafficking even small amounts of drugs or using drugs.

To get this campaign's messages across, a total of 1,000 posters and 80,000 postcards were sent out. The campaign was physically present at those points throughout the country which are often transited by travellers or by people intending to travel. The campaign is for the purpose of dismantling drug-related misbeliefs, especially regarding the hypothetical existence of countries which are "tolerant" toward possessing and/or using drugs.

Other drug policy developments

▪ In 2011, the results were also presented for the latest **National Survey on Drug Use Among Secondary School Students (ESTUDES) conducted in 2010.**

This Survey has been being conducted every two years since 1995 within the framework of the National Plan on Drugs, a major series continued over the course of time therefore now existing.

The main findings (which will be dealt with in greater detail at a further point in this document) resulting from the analysis of this Survey is:

- Daily tobacco use has declined since 2004. In 2010, 12.3% smoked daily, compared to the 21.5% in 2004.

- Cannabis dropped by 3-4 points (monthly and yearly use). Cocaine use also declined, showing the lowest figures over the last ten years.

- Alcohol consumption showed a stable trend, although the number of individuals having experienced episodes of drunkenness within the last 30 days has risen. In 2010, 3 out of every 10 students admitted having experienced drunkenness within the last 30 days.

- Alcohol, tobacco and inhalable volatile substances are the drugs started earliest (at 13-14 years of age.

- Higher percentages of females use legal drugs than males. On the contrary, illicit drugs are used by higher percentages of males.

- School students consider tobacco to be more dangerous to their health than cannabis. For school students, alcohol is the substance entailing the least degree of risk.

▪ Apart from the above, in September 2011, the Minister of Health presided the signing of the **"National Agreement Against Alcoholic Beverage Consumption on the Part of Minors",** which is aimed at getting the entire society as a whole involved in preventing adolescents from drinking alcohol.

A Manifesto was signed on the part of representatives from different social, educational and business sectors in which they have made a commitment to work at the national level to achieve "zero alcohol consumption among minors". To this end, a working platform was set up in which all of the agents involved took part. This Manifesto is comprised of a set of ten objectives in response to a petition of the Joint Congress-Senate Commission for the Study of the Drug Problem. A total of more than 30 institutions have now also joined in this effort.

- Also worthy of special mention is the publishing of the **Fifth Report from the Clinical Commission of the Government Delegation for the National Plan on Drugs devoted to "Emerging Drugs"** presented in 2011 in Spanish and English. This new report is in response to the need of reviewing the drug policies in terms of the new situations which progressively arise determining a change in drug consumption patterns, one of which is the rise in the use of abuse-related drugs and psychoactive drugs for recreational purposes which is constantly evolving.

The Clinical Commission of the Government Delegation for the National Plan on Drugs addresses the professionals with a practical volume in the form of a compendium of the current knowledge concerning the emerging drugs and their effects on human health and well-being.

- Apart from the above, special mention may also be made of the **"Alcohol and Minors"** seminar having been held at the **Menéndez Pelayo International University** in July 2011. This seminar was offered for the purpose of addressing, from a "multidisciplinary" perspective, the main factors determining juvenile drinking and the patterns thereof as well as the strategies and programs at both the national and international levels which contribute toward alleviating the effects alcohol has on young people's health.

To this end, invitations were extended to the leading authorities on the issue of alcohol from the World Health Organization (WHO) and the European Commission, in addition to Spain's own national experts and those in charge of the health administrations, professionals, experts, researchers and youth representatives.

- In April 2011, the **IV Civil Society Against Drugs Forum,** initially organized in 2005, held its meeting with the participation currently of 60 organizations. Its objective is to create a platform for relations between the Ministry and civil organizations representing the family, youth and the media which will make it possible to allow civil society to play more of a leading role and be better able to take part in the commitment on the part of all of reducing drug use.

Over these years, the Forum has set up three Working Groups: Youth, Family and Media. At this meeting, the studies "Healthy Leisure", "Night-time Leisure" and "Leisure and New Technologies" were presented.

This Forum's contributions are not only a valuable tool for the administrations' preventive policies, but are also, no less importantly, a reflection on a facet of the lives of youths today. This is a reflection which the Forum is aiming to disseminate among society as a whole, a status report making society more aware and more active in taking part toward disseminating messages warning of the dangers and harm involved in using drugs with which young people are faced.

Coordination arrangements

Regarding the activities of the coordinating and collaborating bodies, special mention may be made of the Inter-autonomic Commission having held three meetings in 2001. An open meeting was also held in January 2011 on "Preventing and Treating Drug Dependence in the Working Environment" at the headquarters of the Government Delegation for the National Plan on Drugs.

Apart from the above, the Government Delegation has continued along its line of collaborating with and working more closely with the Joint Congress-Senate Commission for the Study of the Drug Problem. On May 17, 2011, the Joint Congress-Senate Commission published a report approved by the **Presentation on Systems for Treating and Providing Care for Drug Dependence**, said report having been sent to the Congress of Deputies and published in the Spanish Official Gazette (BOE). Deputies and Senators from all of the political groups took part in the presentation, and experts proposed by the different parliamentary groups were present.

The Report takes in the thoughts of the Presentation in view of the complete, interesting contributions of the aforementioned experts in keeping with the following organizational approach:

- Chapter II: General aspects regarding the drug problem
- Chapter III: Trend in drug use over the course of time and the measures aimed at combating drug use in Spain
- Chapter IV: Situation of the leading narcotic substances in our country
- Chapter V: Models for preventing and combating drugs in Spain
- Chapter VI: Summarizing into a ten major points the suggestions made by those appearing regarding the issue of preventing and combating drugs.
- Chapter VII: Conclusions the Presentation draws from the studies conducted, as well as the specific recommendations for political action with regard thereto.

1.4. ECONOMIC ANALYSIS

As has been pointed out in previous reports, the 17 Autonomous Communities and the 2 Autonomous Cities (Ceuta and Melilla) comprising the Spanish State have highly important authorities over all that which has to do with the drug policies in Spain.

Logically, these authorities are reflected in the budgets which these Autonomous Communities and Cities allocated to enforcing these policies. As a result of all of the foregoing, in order to ascertain the economic resources invested in carrying out the drug policies, it is necessary to take recourse to both the information provided by the Central Government as well that by furnished by the Autonomous Community Administrations.

In addition to the above, one must take into account the municipal budgets allocated to carrying out the Municipal Drug Dependence Plans or, at a more general level, to carrying out municipal drug dependence-related activities and programmes, which, in some cases, such as in that of the most more highly-populated cities (Madrid, Barcelona, etc.), total major amounts. Although not even an approximate figure can be provided as to the total budgeting invested in all of Spain's municipalities as a whole under this heading, some data can be found in the Selected Issue which is included in this report on "Drug Policies of Large European Cities".

Nor do these figures furnished in following include the costs due to the healthcare provided to drug users for reasons other than the treatments for drug dependence and rehabilitation, such as is the case of the care provided for drug-use related disorders (including infectious diseases such as AIDS, hepatitis, etc.). This is due to the fact that, on the authorities over healthcare having been transferred from the Central Government to the Autonomous Communities, it is very difficult to itemize the part of the health spending allocated directly to disorders directly related to drug use of the total expenditure invested in overall healthcare.

Regarding AIDS, for example, some estimates indicate that the cost of the highly effective antiretroviral treatments in Spain may amount up to 700 million euro annually (Zum No. 2, December 2011, e-journal published by the Secretariat of the Spanish National Plan on AIDS, Ministry of Health, Social Policy and Equality).

With all of the aforementioned caveats, a series of data for the **year 2010** is provided in following, this being the latest year for which final, complete data is available.

Through the different Ministerial Departments, the Central Government has invested a Budget of 136,649,268 euros, a total of 24,215,000 euros thereof having come from the Fund of Assets Seized for Illicit drug Trafficking or other related Offenses. This Fund has been operating since 1996 and is replenished by the cash and the goods seized as a result of final, non-appealable court decisions in proceedings for drug trafficking and other related offenses.

Of these 136,649,268 euros falling to the different Ministries, the Ministry of Health, Social Policy and Equality transferred to the Autonomous Communities and Autonomous Cities the amount of 28,296,000 euros to be managed directly thereby.

In addition to this sum, the Autonomous Community Administrations have invested a total of 289,029,636 euros charged against their own budgets, thus meaning that, in all, the aforementioned Autonomous Community Administrations have managed 317,325,636 euros for carrying out programmes and activities related to the prevention, providing care, social reintegration and research in drug dependencies. All of which is in terms of the authorities which the Constitution and the central and autonomous community legislation attributes to the Autonomous Communities and Autonomous Cities in regard to drug dependencies.

Thus, in all, the total amount invested by the Central Government and the Autonomous Communities and Autonomous Cities in carrying out the drug policies totalled **425,678,904 euros in 2010.** This figure means a 1.62% decrease compared to the amount invested in 2009 (432,703,103 euros). This figure of **425,678,904** euros can be broken down as follows:

- Budgeting contributed by the Central Government: 136,649,268 euros (this sum including 28,296,000 euros which the Central Government transferred to the Autonomous Communities and Autonomous Cities).

- Budgeting contributed by the Autonomous Communities and Autonomous Cities: 289,029,636.

Regarding the distribution of the aforementioned sums, an estimate can be made as far as the budgeting directly managed by the Autonomous Communities and Autonomous Cities is concerned, in other words, the total of their own budgeting proper plus the amount transferred by the Ministry of Health, Social Policy and Equality, which, in all, as previously mentioned, amounts to the aforementioned sum of 317,325,636 euros. In round figures, this distribution is as follows:

- Prevention: 51.22 million euros (16.14%)

- Social work, healthcare and social reintegration: 251.76 million euros (79.34%)

- Research, documentation and publications: 5.35 million euros (1.69%)

- Institutional coordination: 8.99 million euros (2.83%)

2. DRUG USE IN THE GENERAL POPULATION AND SPECIFIC TARGETED-GROUPS

2.1. INTRODUCTION

The Household Survey on Alcohol and Drugs in Spain (EDADES) Program is a biennial program of household surveys on drug used promoted by the Government Delegation for the National Plan on Drugs in collaboration with the Autonomous Communities, having initially began in 1995 and currently availing of results from nine surveys (1995, 1997, 1999, 2001, 2003, 2005, 2007, 2009 and 2011). Hence, a progressively longer time series is available, affording the possibility of analysing the trend in the prevalence figures for the use of alcohol, tobacco, hypnosedatives and psychoactive drugs sold illicitly, as well as the predominant patterns of use, the user profiles, the social perceptions in view of this problem and the measures which Spain's citizens deem most effective for providing a solution thereto.

Apart from the above, the questionnaire and methodology are quite similar to those used in other European Union countries and in the United States, thus affording the possibility of drawing international comparisons.

In this report, a description is provided of the objectives, the methodology and the main findings of the series of surveys conducted up to 2011.

OBJECTIVES

The overall objective of these surveys is to gather information which will be useful for designing and evaluating policies aimed at preventing drug use and drug-related problems.

The specific objectives common throughout this series of surveys were as follows:

a) Ascertaining the prevalence of use of the different psychoactive drugs

b) Ascertaining the socio-demographic characteristics of those using these drugs

c) Ascertaining the patterns of use of psychoactive substances

d) Ascertaining the degree of availability of drugs perceived by the population and the perceived risk regarding different drug use-related behaviours

e) Ascertaining the visibility of the drug-related problems in the close vicinity where those surveyed reside

f) Ascertaining the opinion of the population concerning the importance of the drug-related problems and the measures for reducing the same

g) Ascertaining the trend over the course of time (since 1995) in regard to the aforementioned aspects

h) Ascertaining those prevalences, associations and relationships among variables on which the Government Delegation for the National Plan on Drugs needs to broaden knowledge or conduct specific studies

METHODOLOGY

Some changes had already been made on the 2009 questionnaire for the purpose of converging more closely with the standard questionnaire suggested by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA).

In all of the surveys from 1999, the methodological changes made in 1997 (sampling by three-phase conglomerates without any substitution, self-administering of all the questions related to drug use) were maintained, thus facilitating direct comparison among the surveys and eliminating the possible impact of the methodological variations on the results.

The innovation this year is that of questions having been added concerning the use of other substances known as emerging drugs.

In any case, for the surveys conducted from 1995, comparability is maintained for the essential indicators, such as the prevalences of use, the perception of risk or the perceived availability.

Universe and sampling framework

The universe or reference population to which the results are planned to be extrapolated is the resident population in Spain ranging from age 15 to 64, all inclusive. The base or sampling framework used for selecting the sample also includes the population from rural areas (municipalities of less than 2,000 inhabitants) and the Autonomous Cities of Ceuta and Melilla. However, solely the population living in family households is included, leaving out of the framework the population residing in institutions (military barracks, convents, prisons, college dormitories or senior citizen living facilities, etc.), the population living in group-living establishments (hotels, boarding houses, etc.) and the homeless population.

Sample

The size of the simple has progressively undergone changes over the course of the years. Hence, in 2011, the sample totalled 22,128 individuals; in 2009, 20,109; in 2007, 23,715; in 2005, 27,934 and within the 1995-2003 period, ranging from 8,000 to 15,000 individuals, depending on the survey in question.

The spread of the sample by Autonomous Communities is not proportional to the population thereof in all of the surveys conducted within the 1995-2011 period, so as to over-represent the smaller communities. Additionally, some communities have funded an expansion of the sample falling to their territory. In 2011, for example, four communities (Balearic Islands, Cantabria, Rioja and Canary Islands) funded expanded samples.

The size of the final simple by communities ranged from 206 individuals surveyed in Melilla to 2,477 individuals surveyed on the Canary Islands, the sample totalling more than 2,000 individuals in 3 communities and ranging from 1,000 to 2,000 individuals in six communities (Table 2.1). The age spread was also disproportionate, the young population (15-39 years of age) being over-represented so as to afford the possibility of making a more detailed analysis of this age group, which is the group exposed to a greater degree to the drugs use under study.

The number of individuals surveyed nationwide totals, all together, more than 1,800 individuals for each five-year group up to age 49, and 1,100 individuals for each five-year group within the 50-64 age range.

A three-phase conglomerate sampling process without substitution was carried out:

- In the first phase, census sections were selected (2,237 in 2011) for a certain number of municipalities (910 in 2011) at random with probability proportional to the size of the section. These sections were layered beforehand according to habitat size, divided into eight categories: less than 2,000 inhabitants; 2,001-10,000 inhabitants; 10,001 – 20,000 inhabitants, 20,001 – 50,000 inhabitants; 50,001 – 100,001 inhabitants; 100,001 – 400,000 inhabitants; 400,001 – 1,000,000 inhabitants and more than 1,000,000 inhabitants. This operation was carried out in a centralized nanner using a computer program.

- In the second phase, households were selected by following a systematic random procedure. This operation was performed by the field workers themselves. For this purpose, they used the roadmap and the street map of the census section as tools. A home was considered to be inhabited and a permanent residence when someone within the 15-64 age range had been living there for at least 8 of the last 12 months or was planning to live there for at least 8 months. Group residences (military barracks, convents, college dormitories or senior citizen living facilities, hotels, etc.), second homes not used as permanent residences, offices, companies and uninhabited homes (confirmed by a third person) were not considered as homes.

  Lastly, in the third phase, after making a note of the details of the home selected on the contact sheet, one individual within each household was selected by using the ad hoc tables of random numbers making it possible to increase the probability of young people within the 15-39 age range being selected.

Table 2.1. Spread of the sample by Autonomous Communities, Spain, 2011

Autonomous Community	National Plan on Drugs	Expansion	Surveys Conducted	Sampling Error
Andalusia	2,209	-	2,209	2.1%
Aragon	871	-	871	3.3%
Asturias	786	-	786	3.5%
Balearic Islands	774	204	978	3.1%
Canary Islands	1,109	1,368	2,477	2.0%
Cantabria	577	415	992	3.1%
Castile-La Mancha	1,064	-	1,064	3.0%
Castile and Leon	1,213	-	1,213	2.8%
Catalonia	2,069	-	2,069	2.2%
Valencia	1,712	-	1,712	2.4%
Extremadura	804	-	804	3.5%
Galicia	1,262	-	1,262	2.8%
Madrid	1,905	-	1,905	2.2%
Murcia	900	-	900	3.3%
Navarra	605	-	605	4.0%
Basque Country	1,117	-	1,117	2.9%
La Rioja	432	317	749	3.6%
Ceuta	209	-	209	6.8%
Melilla	206	-	206	6.8%
Total	**19,824**	**2,304**	**22,128**	**0.7%**

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

No substitutions either of households or individuals were allowed. To cover the surveys which could not be made – refusals to open the door, away for home for a long time, refusal of the person selected, etc. – the sample was initially oversized for the purpose of achieving the target sample. For this purpose, an actual 50% response rate was assumed.

Questionnaire and field work

As previously mentioned, some changes were made as of 2007 aimed, above all, at converging with the model suggested by the European Monitoring Centre for Drugs and Drug Addiction. Within the 1997-2003 period, the same standard questionnaire was used; in 1995, quite a different one; and in 2005, one almost identical to the one used for the 1997-2003 period.

From 1997, the questions on drug use were printed in a separate booklet to be completed by the person surveyed, by themselves, with paper and pencil. To assure confidentiality during this process, the field worker was to stay away from the person surveyed and, once the survey had been completed, was to place the booklet inside an envelope along with the rest of the questionnaire in the presence of the person surveyed. The connection between the two parts of the questionnaire was assured by completing the detail of the household on both through the use of one single same code. Nevertheless, the information of those individuals who refused to complete the survey themselves or who had problems regarding completing the booklet (blind, unable to write, illiterate, etc.) was obtained through a face-to-face interview.

The questionnaire included questions which were classification-related, socio-demographic, health-related, questions on risk perception, perceived availability, visibility of the phenomenon and opinions and responses regarding the problem of drugs. None of the questions in the booklet had filters or breaks (to make it easier to move from one question to the next) and had no “Don’t Know/No Answer” option (so as to force the person surveyed to answer). The section on drinking alcoholic beverages encompassed questions including the number of days on which alcoholic beverages were drunk or on which episodes of drunkenness within the last 12 months, the number of days of use within the last 30 days and, referring to those same last 30 days, the frequency of use of each one of the types of alcoholic beverages (wine/champagne, beer/hard cider, aperitifs/vermouth, mixed drinks/highballs, fruit liqueurs and hard liquor), during the workweek (Monday-Thursday) and on weekends and the average number of glasses or individual drinks of each type of drink which the person surveyed had drunk on each workday and on each weekend as a whole (Friday + Saturday + Sunday) during the aforesaid period.

The questions on hypnosedative use were set out separately for tranquilizers or sedatives (medicines for calming nervousness or anxiety) and for sleeping pills (sleep aid medicines) and referred to use in general (without making any distinction between whether or not they were prescription or non-prescription drugs), although non-prescription use sometime in ones’ life, within the last 12 months, within the last 30 days and the age at which started was later explored for the purpose of maintaining comparability with the 1997-2005 period. In 2011, the questions on hypnosedative use were asked following the questions on alcoholic beverages and tobacco, just as was done on the Survey on Drug Use Among Secondary School Students in Spain (ESTUDES). This change may have modified the response rate, it therefore being important to bear this fact in mind when evaluating the results. Lastly, the questions of illicit drugs (cannabis, powder cocaine, base cocaine or crack, heroin, hallucinogens, ecstasy, amphetamines, speed, volatile inhalable substances and emerging drugs – ketamine, spice, piperazines, mephedrone, nexus, methamphetamine, magic mushrooms, research chemicals, legal highs, salvia divinorum and anabolic steroids) refer to use sometime during one’s life, age at which started use, number of days of use within the last 12 months and within the last 30 days.

In 2011, the response rate was 49.5% on the sample initially selected. The no-responses were spread out as follows: household refusals, including not opening the door and refusal as to anyone in the household being surveyed (23.9%), no members of the household at home (21.1%), refusals on the part of the persons selected (2.6%), the person selected not at home (2.1%). According to the field work protocol, before classifying a household or an individual as being absent from the home, the field worker was to make at least three visits to the home at different times of day on different days.

On the 2011 Household Survey on Alcohol and Drugs in Spain (EDADES) Survey, the field work was done from November 7th to December 15th in 2011 and from February 7th to April 4th in 2012. No surveys were conducted from December 16th to February 7th so as to avoid the influence of the Christmas holiday season on the question regarding use during the last 30 days. In the Autonomous Community of the Canary Islands, no field work was done either from February 16th to March 20th so as to avoid the influence of the Mardi Gras celebrations on the question regarding use within the last 30 days. In Aragon, no field work was done until November 15th so as to avoid the influence of the annual festival honouring the patron saint, the "Virgen del Pilar" celebrations, on the questions regarding use during the last 30 days. As far supervision is concerned, 100% of those conducting the surveys and 27.5% of the interviews were supervised (22.0% by phone and 5.5% in person with a visit to the homes).

Analysis

Due to the initial sample design entailed a non-proportional spread by age and Autonomous Communities; it is not possible to directly aggregate the results, given that some strata would be either over-represented or under-represented. For this reason and for the purpose of making this sample once again representative, the results have been weighted to the actual universe published by the Spanish National Institute of Statistics (INE) in its latest revision of the Municipal Register of inhabitants (January 1, 2011). Thus, the results of each survey have been weighted by autonomous communities (19 groups), municipality size (7 groups), age (7 groups) and gender (2 groups). This made it necessary to individually assign 1260 different weighting coefficients. The weighting by autonomous communities and ages is justifiable based on the sample being disproportionate according to these variables resulting from the sample design itself, the weighting by gender then having been done to balance out the possible disproportionate sample resulting from the greater degree of probability of absence from the home on the part of the males. Lastly, the habitat size was also taken into account for eliminating any possible bias which might arise in the response rate (given that it may be more difficult to find some age ranges in larger-sized habitats).

The analysis presented in following is based mainly of the calculation of the prevalence of use of the different psychoactive drugs using three time-related indicators: sometime in one's life, within the last 12 months and within the last 30 days immediately prior to the survey and every day within the last 30 days immediately prior to the survey. The results are given for the Spain's entire population within the 15-64 age range and then broken down by gender and by age groups. All of the calculations have been made by ruling out from both the numerator and the denominator those individuals entailing unknown values for the variables involved in each cross-tabulation. This approach leads to results somewhat greater than those of the analyses which assign a negative value to the unknown values or which count the "Don't Know /No Answer" as simply another category. In 2011, the percentage of unknown values for the drug use-related questions was quite low.

In the case of alcoholic beverages, a more complete analysis was made by estimating weekend and workday drinking within the last 30 days prevalence indicators, regular drinking indicators (weekly drinking prevalence within the last 12 months and daily drinking prevalence within the last 30 days), problem drinking indicators (prevalence of episodes of drunkenness within the last 12 months and prevalence of individuals who have drunk 5 or more alcoholic beverages for males and 4 or more in the case of females on one same occasion during the last 30 days – binge drinking-).

The sampling error calculations were made assuming a simple random sampling process. Hence, the maximum sampling area for a 95% confidence index for p=q=0.5 was 0.7% for the population within the 15-64 age range, ranging from a 2.0% error for the Canary Islands to a 6.8% error in Ceuta and Melilla. More precisely, the design of the sampling done would have to be taken into account (Table 2.1).

In this regard, it must be stressed that the sample is designed to obtain results providing an acceptable degree of accuracy for all of Spain as a whole. If results are obtained by Autonomous Communities, the confidence intervals for the drugs lesser prevalence in the small Autonomous Communities may be too wide-ranged, meaning that the randomness involved has a great bearing on these estimates and that they may give rise to sawtoothing and misleadingly plotted trend graphs.

Nevertheless, the sample used makes it possible to obtain results to an acceptable degree of accuracy for the prevalence of use of alcohol, tobacco and cannabis by Autonomous Communities, however still does not make it possible to make reliable estimates for drugs of lesser prevalences.

2.2. DRUG USE IN THE GENERAL POPULATION

RESULTS

Extent of drug use

In 2011, the psychoactive drugs showing a greater prevalence of use in all of the time-related indicators taken into account are alcohol and tobacco. Furthermore, among the illicit drugs, cannabis is the substance showing the greatest prevalence of use sometime in one's life (27.4%) followed by powder cocaine (8.8%), at levels which, if use within the last 12 months is taken into account, are respectively lowered to 9.6% and 2.2%. The trend most worthy of special mention compared to previous years is that of tranquilizers, given that their prevalences of use rose substantially in all of the time-related indicators taken into account. A total of 17.1% of the population surveyed had taken tranquilizers sometime in their lives (a 6.1% rise compared to 2009) and taking into account the last 12 months, the prevalence level is 9.8% (a 4.3% rise compared to 2009). With this figure for use within the last 12 months, tranquilizer use surpasses, for the first time, the prevalence of cannabis use and, in this time period, tranquilizers are now the third most used psychoactive substance after alcohol (76.6%) and tobacco (40.2%). Focusing on drug use within the last 30 days, hypnosedatives (tranquilizers and/or sleeping pills) are, for the first time in the historical series in question, the third most widespread psychoactive substance among the population (8.3%), ranked above cannabis, which has lost users (-0.6 percentage points) down to a 7.0% prevalence. The position of hypnosedatives is due mainly to the rise shown by tranquilizers (from 4.0% to 6.9%) and, secondly, to the rise shown by sleeping pills (from 2.7% to 3.4%) (Tables 2.2-2.5).

Table 2.2. Prevalence of drug use sometime in life in Spain's age 15-64 population (percentages). Spain, 1995-2011

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Tobacco	-	69.7	64.9	68.4	68.9	69.5	68.5	75	71.7
Alcohol	-	90.6	87.3	89	88.6	93.7	88	94.2	90.9
Cannabis	14.5	22.9	19.6	23.8	29	28.6	27.3	32.1	27.4
Ecstasy	2	2.5	2.4	4	4.6	4.4	4.3	4.9	3.6
Hallucinogens	2.1	2.9	1.9	2.8	3	3.4	3.8	3.7	2.9
Amphetamines/speed	2.3	2.7	2.2	2.9	3.2	3.4	3.8	3.7	3.3
Powder cocaine	3.4	3.4	3.1	4.8	5.9	7	8	10.2	8.8
Base cocaine	0.3	0.4	0.4	0.5	0.5	0.6	1.8	0.9	0.9
General cocaine	-	-	-	-	-	-	8.3	10.2	8.8
Heroin	0.8	0.6	0.5	0.6	0.9	0.7	0.8	0.6	0.6
Volatile inhalants	0.7	0.8	0.6	0.8	1	0.8	1.1	0.6	0.8
Tranquilizers	-	-	-	-	-	7	13	11	17.1
Sleeping pills	-	-	-	-	-	4.6	6	6.3	7.9
Hypnosedatives*	-	-	-	-	-	8.7	15.4	13.4	19.5

*Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995- 2011).

Table 2.3. Prevalence of drug use within the last 12 months among Spain's age 15-64 population (percentages). Spain, 1995-2011

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Tobacco	-	46.8	44.7	46	47.8	42.4	41.7	42.8	40.2
Alcohol	68.5	78.5	75.2	78.1	76.6	76.7	72.9	78.7	76.6
Cannabis	7.5	7.7	7	9.2	11.3	11.2	10.1	10.6	9.6
Ecstasy	1.3	0.9	0.8	1.8	1.4	1.2	1.1	0.8	0.7
Hallucinogens	0.8	0.9	0.6	0.7	0.6	0.7	0.6	0.5	0.4
Amphetamines/speed	1	0.9	0.7	1.1	0.8	1	0.9	0.6	0.6
Powder cocaine	1.8	1.6	1.6	2.5	2.7	3	3	2.6	2.2
Base cocaine	0.1	0.1	0.2	0.1	0.1	0.2	0.5	0.1	0.2
General cocaine	-	-	-	-	-	-	3.1	2.7	2.3
Heroin	0.5	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Volatile inhalants	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0	0.1
Tranquilizers	-	-	-	-	-	3.9	6.9	5.5	9.8
Tranquilizers (over-the- counter)	-	-	-	-	-	0.9	0.9	1.6	0.9
Sleeping pills	-	-	-	-	-	2.7	3.8	3.6	4.4
Sleeping pills (non-prescription)	-	-	-	-	-	0.8	0.8	1.1	0.6
Hypnosedatives*	-	-	-	-	-	5.1	8.6	7.1	11.4
Hypnosedatives* (non-prescription)	12.3	2.3	2.3	2.8	3.1	1.2	1.3	1.9	1.2

*Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011)

Table 2.4. Prevalence of drug use within the last 30 days among Spain's age 15-64 population (percentages). Spain, 1997-2011

	1997	1999	2001	2003	2005	2007	2009	2011
Tobacco	42.9	40.1	41.4	42.9	38.4	38.8	39.4	37.6
Alcohol	64	61.8	63.7	64.1	64.6	60	63.3	62.3
Cannabis	4.6	4.5	6.4	7.6	8.7	7.2	7.6	7
Ecstasy	0.3	0.2	0.8	0.4	0.6	0.6	0.4	0.3
Hallucinogens	0.2	0.2	0.2	0.2	0.2	0.1	0.2	0.2
Amphetamines/speed	0.2	0.3	0.6	0.2	0.4	0.3	0.3	0.3
Powder cocaine	0.9	0.9	1.3	1.1	1.6	1.6	1.2	1.1
Base cocaine	0	0.1	0	0	0.1	0.3	0.1	0.1
General cocaine	-	-	-	-	-	-	1.3	1.1
Heroin	0.1	0	0	0	0.1	0	0.1	0.1
Volatile inhalants	0.1	0	0.1	0	0.1	0	-	0
Tranquilizers	-	-	-	-	2.7	4.7	4	6.9
Sleeping pills	-	-	-	-	2	2.5	2.7	3.4
Hypnosedatives*	-	-	-	-	3.7	5.9	5.2	8.3

*Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011)

Table 2.5. Prevalence of daily drug use among Spain's age 15-64 population (percentages). Spain, 1997-2011

	1997	1999	2001	2003	2005	2007	2009	2011
Tobacco	34.9	33.6	35.7	36.7	32.8	29.6	31.8	30.4
Alcohol	12.7	13.7	15.7	14.1	14.9	10.2	11	10.2
Cannabis	0.7	0.8	1.5	1.5	2	1.6	2	1.7
Tranquilizers	-	-	-	-	-	2.6	2.3	4
Sleeping pills	-	-	-	-	-	1.1	1.4	1.7
Hypnosedatives*	-	-	-	-	-	3.1	2.7	4.6

*Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997- 2011).

Average age of onset of use

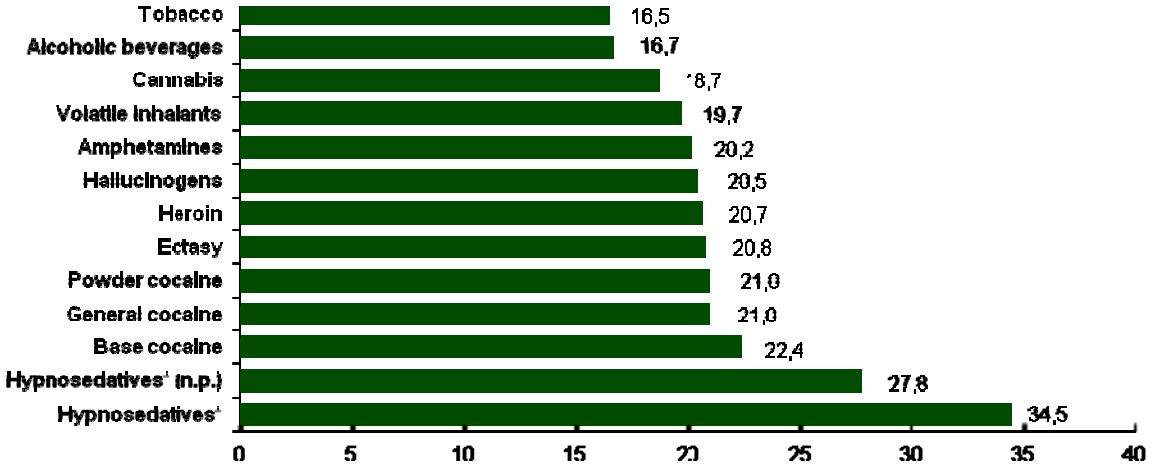
The average age of onset of use of the different substances which was recorded in 2011 remained stable, generally speaking, compared to the year before. The substances shown as being used for the first time at a younger age are those showing the highest prevalence figures, in other words, tobacco and alcoholic beverages (16.5 and 16.7 years of age, respectively). Regarding illicit substances, the substance showing the youngest age of onset of use continues to be cannabis, the age of onset being 18.7 years of age. The greatest change in the age of onset of use compared to 2009 is for heroin, given that the age dropped from 22.9 years of age to 20.7 years of age in 2011. Apart from the above, the substance showing the oldest age of onset is that of the hypnosedatives (34.5 years of age), although this age drops to 27.8 years of age regarding non-prescription hypnosedatives. In this regard, from an overall standpoint, the age of onset of the use of the different drugs is within the 16-21 age range (Table 2.6 and Fig. 2.1).

Table 2.6. Average age of onset of use of the different substances among the age 15-64 population. Spain, 1995-2011

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Tobacco	15.9	16.6	16.7	16.5	16.5	16.4	16.5	16.5	16.5
Alcoholic beverages	-	16.8	16.9	16.9	16.7	16.7	16.8	16.7	16.7
Cannabis	18.3	18.9	18.7	18.5	18.5	18.3	18.6	18.6	18.7
Powder cocaine	21.4	21.3	21.8	20.4	20.9	20.6	20.9	20.9	21
Heroin	20.3	20.1	19	20.7	22	20.2	21.7	22.9	20.7
Amphetamines	19.2	19.4	19.2	18.8	19.6	19.2	19.7	20.1	20.2
Hallucinogens	19.3	19	19.3	18.9	19.9	19	19.9	19.7	20.5
Volatile inhalants	17.7	19	18.1	17.5	17.5	17.8	19.7	19.2	19.7
Base cocaine	21.8	20.6	20.1	19.6	20.1	20.8	21.4	23.1	22.4
General cocaine								20.9	21
Ecstasy	21.1	20	20.7	20.2	20.3	20.1	20.8	20.5	20.8
Hypnosedatives*	-	-	-	-	-	-	33.8	34.5	34.5
Hypnosedatives*(non-prescription)	35.2	28.7	29.2	29.5	30	-	29.1	29.5	27.8

* Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995- 2011)

Fig. 2.1. Average ages of onset of use of different psychoactive drugs among the age 15-64 population. Spain, 2011.



*Tranquilizers and/or sleeping pills
(n.p.) Non Prescription
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

Gender-related differences in drug use

Focusing on the gender-related differences in drug use, psychoactive substances are found to be more widespread among the males than among the females for all of the substances studied as a whole, the hypnosedatives being the only exception, as the use among females is 7.7 percentage points higher than among the males (15.3% and 7.6% respectively viewing the last 12 months). In this regard, both for tranquilizers and for sleeping pills, use among females is approximately double that of the males (male/female ratio of use is 2.1 and 1.9, respectively). Nevertheless, the use of hypnosedatives has grown considerably in both genders (by 6 percentage points in the case of females and by 3 percentage points among males) (Tables 2.7 and 2.8).

Table 2.7. Prevalences of drug use within the last 12 months among Spain's age 15-64 populations, by genders (percentages). Spain, 1995-2011

	1995		1997		1999		2001		2003		2005		2007		2009		2011	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Tobacco	-	-	55	38.7	50.3	39.2	51.5	40.5	53	42.6	47.2	37.5	46	37.6	48.4	37	44.2	36
Alcohol	79.3	58	86.4	70.5	83.2	67.2	85.2	70.9	84.5	68.4	84	69.2	80.4	66.4	84.4	72.7	83.2	69.9
Cannabis	10.7	4.4	10.7	4.7	9.6	4.3	13	5.5	16.2	6.3	15.7	6.6	13.6	6.6	14.8	6.2	13.6	5.5
Ecstasy	1.9	0.7	1.2	0.5	1.2	0.5	2.8	0.7	2	0.8	1.8	0.6	1.6	0.5	1.4	0.3	1	0.4
Hallucinogens	1.1	0.4	1.4	0.4	0.8	0.4	1.2	0.2	0.9	0.3	1.1	0.4	0.9	0.3	0.7	0.2	0.6	0.2
Amphetamines/speed	1.3	0.7	1.4	0.4	1	0.4	1.6	0.6	1.1	0.5	1.4	0.5	1.3	0.3	1	0.3	0.9	0.3
Powder cocaine	2.7	1	2.6	0.6	2.3	0.8	3.8	1.3	4.1	1.2	4.6	1.3	4.4	1.5	4.2	1	3.6	0.9
Base cocaine	0.2	0	0.2	0	0.4	0	0.2	0	0.2	0	0.3	0	0.7	0.1	0.2	0.1	0.2	0.1
General cocaine	-	-	-	-	-	-	-	-	-	-	-	-	4.7	1.6	4.2	1	3.6	0.9
Heroin	0.8	0.3	0.4	0.1	0.2	0	0.2	0	0.2	0.1	0.2	0.1	0.1	0	0.1	0	0.2	0
Inhalants	0.2	0.1	0.3	0	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.1	0.3	0.1	0	0	0.1	0.1
Tranquilizers	-	-	-	-	-	-	-	-	-	-	2.6	5.2	4.7	9.1	3.4	7.6	6.4	13.2
Tranquilizers (non-prescription)	-	-	-	-	-	-	-	-	-	-	0.8	1	0.9	0.9	1.5	1.7	0.9	1
Sleeping pills	-	-	-	-	-	-	-	-	-	-	2	3.5	2.8	4.3	2.6	4.6	3.1	5.9
Sleeping pills (non-prescription)	-	-	-	-	-	-	-	-	-	-	0.7	0.9	0.6	0.8	1.1	1	0.5	0.7
Hypnosedatives*	-	-	-	-	-	-	-	-	-	-	3.5	6.7	6.8	11.5	4.6	9.3	7.6	15.3
Hypnosedatives* (non-prescription)	8.2	1.6	2.3	2.4	2.3	2.4	2.5	3.1	2.9	3.3	1.1	1.3	1.2	1.4	1.9	1.9	1.1	1.2

*Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Table 2.8. Prevalences of drug use within the last 30 days among Spain's age 15-64 population, by genders (percentages). Spain, 1997-2011.

	1997		1999		2001		2003		2005		2007		2009		2011	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Tobacco	51.4	34.4	45	35.2	46.5	36.3	47.9	37.9	43.1	33.6	42.6	34.7	44.7	34	41.4	33.7
Alcohol	75.8	52.1	74.4	49.1	76.4	50.9	75.8	52.1	76	52.9	71.4	49	74	52.2	73.2	51.2
Cannabis	6.7	2.5	6.2	2.8	9.4	3.4	11.3	3.9	12.5	4.7	10	4.2	11	4	10.2	3.8
Ecstasy	0.5	0.1	0.3	0.2	1.3	0.3	0.5	0.2	0.9	0.3	0.6	0.2	0.5	0.2	0.4	0.2
Hallucinogens	0.3	0.1	0.3	0.1	0.4	0.1	0.3	0.1	0.4	0.1	0.1	0	0.2	0.1	0.2	0.1
Amphetamines/speed	0.4	0.1	0.4	0.2	0.9	0.2	0.4	0.1	0.6	0.2	0.4	0.1	0.4	0.2	0.4	0.1
Powder cocaine	1.5	0.2	1.3	0.4	2.2	0.5	1.6	0.5	2.5	0.7	2.5	0.8	2	0.4	1.8	0.5
Base cocaine	0.1	0	0.1	0	0	0	0	0	0.1	0	0.5	0.1	0.1	0	0.1	0.1
General cocaine	-	-	-	-	-	-	-	-	-	-	2.5	0.8	2	0.4	1.8	0.5
Heroin	0.2	0.1	0.1	0	0.1	0	0	0.1	0.1	0	0.1	0	0.1	0	0.1	0
Volatile inhalants	0.1	0	0	0	0.1	0	0	0	0.1	0	0.1	0	0	0	0	0
Tranquilizers	-	-	-	-	-	-	-	-	1.7	3.7	3.3	6.3	2.4	5.7	4.4	9.6
Sleeping pills	-	-	-	-	-	-	-	-	1.3	2.8	2	3	1.9	3.5	2.1	4.7
Hypnosedatives*	-	-	-	-	-	-	-	-	2.3	5.1	4.3	7.6	3.2	7	5.2	11.4

*Tranquilizers and/or sleeping pills
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Focusing on another of the licit substances used “within the last 12 months” – tobacco - the males show a use 8.2 percentage points higher than the females (44.2% and 36.0%, respectively). This is a lesser difference between genders than the one reported in 2009, due mainly to the decline in use taking place among males. For both the last 12 months and for the last 30 days, the percentage of males using tobacco as compared to the percentage of females is the same: 1.23 males per each female.

Regarding alcohol use within the last 12 months, the males show a prevalence of use of 83.2% compared to the 69.9% for the females. The difference is greater for “wtihin the last 30 days”, showing a 22 percentage point differences (73.2% vs. 51.2%), similar to that found for previous years.

Regarding the last 12 months, among the illicit psychoactive substances, the prevalence among males at least doubles the females for all of the substances studied, except for non-prescription hypnosedatives (the cases of hallucinogens or amphetamines being notable, where the number of males using these substances triples the number of females or, in the case of powder cocaine, the number of males using this substance quadruples the number of females.

Regarding the illicit substance most used, which is cannabis, its use is spread throughout 13.6% of the males, compared to the 5.5% of the females, a decline in its use having taken place compared to 2009 in both genders (-1.2 and -0,7 percentage points, respectively, for the time period of the last 12 months). More specifically regarding use within the last 30 days, the prevalence among males totals 10.2% and 3.8% among females, although compared to 2009 the use among males has dropped to a greater extent than among females (-0.8 vs. -0.2 percentage points), the resulting ratio is that there are 2.7 males for every female using cannabis.

Age-related differences in drug use

In Spain, focusing on the “within the last 12 months” period of use, drug use is the most widespread among individuals within the 15-34 age range (Tables 2.9 to 2.11) for both illicit and licit drugs. The exception is regarding sleeping pills and tranquilizers, showing a higher percentage of users within the 35-64 age range, although in the case of tranquilizers, the prevalence is also rising among the 15-35 age group (rising from 3.1% in 2009 to 5.5% of users within the last 12 months in 2011). Thus, taking as a reference both the last 12 months and the last 30 days, for the individuals within the 35-64 age range, after alcohol and tobacco, the psychoactive substance most used are tranquilizers (12.4% for the last 12 months and 9.5% for the last 30 days) whilst for those within the 15-34 age, the drug most used is cannabis (17.0% for the last 12 months and 12.5% for the last 30 days).

With the exception of hypnosedatives, focusing on the last 12 months of use, the age 15-34 group shows no rise in prevalence compared to the data found for 2009 for any of the substances studied (lowering or remaining stable).

Table 2.9. Prevalences of use at some time during their lives among the age 15-64 population, by age groups (percentages). Spain, 1995-2011.

	1995		1997		1999		2001		2003		2005		2007		2009		2011	
	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64
Tobacco	-	-	72.7	66.9	65.2	64.7	69.4	67.6	69.2	68.7	67.9	70.7	66.6	69.8	70.1	78.3	67.8	74.2
Alcohol	-	-	91.4	89.9	87.4	87.2	89.3	88.8	88.9	88.3	93.2	94.1	87.7	88.3	92.2	95.5	89.5	91.7
Cannabis	22.9	6.1	32.4	14.4	28.1	12.3	34.3	15.3	39	21	39.4	20.4	37.5	20.2	42.4	25.2	36.9	21.6
Ecstasy	3.5	0.5	4.8	0.4	4.4	0.7	7.7	1	8.3	1.6	7.6	1.9	7.2	2.2	8.4	2.6	5.7	2.3
Hallucinogens	3.3	0.9	4.7	1.3	2.9	1	4.6	1.3	4.7	1.6	5.4	1.9	5.9	2.3	5.7	2.4	4.4	2
Amphetamines/speed	3.7	1	4.2	1.3	3.1	1.3	4.6	1.5	4.7	1.9	5.2	2	5.6	2.6	5.7	2.4	4.6	2.4
Powder cocaine	5.4	1.4	5.5	1.6	4.7	1.8	7.7	2.4	8.9	3.6	10.4	4.4	11.4	5.5	13.5	7.9	11	7.4
Base cocaine	0.5	0.1	0.7	0.2	0.6	0.2	0.7	0.3	0.7	0.3	0.7	0.6	2.3	1.5	0.9	0.9	0.8	1
Heroin	1.4	0.2	0.9	0.3	0.6	0.3	0.7	0.5	0.8	0.9	0.6	0.7	0.6	1	0.4	0.6	0.4	0.6
Inhalants	1.1	0.3	1.3	0.3	0.9	0.4	1.5	0.2	1.7	0.5	1.2	0.5	1.7	0.8	1	0.4	1.1	0.6
Tranquilizers	-	-	-	-	-	-	-	-	-	-	5.1	8.4	8.8	16	7.1	13.8	10.7	21
Sleeping pills	-	-	-	-	-	-	-	-	-	-	2.9	5.8	3.7	7.6	4	8	3.9	10.3

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Table 2.10. Prevalences of drug use within the last 12 months among the age 15-64 population, by age groups (percentages). Spain, 1995-2011.

	1995		1997		1999		2001		2003		2005		2007		2009		2011	
	15-34	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**
Tobacco	-	-	54.5	39.9	49.5	40.6	52	41.2	52.8	43.8	47.3	38.8	46.2	38.8	45.3	41.1	43.8	37.9
Alcohol	72.9	64.1	82.5	74.9	79	71.8	81.5	75.2	79.5	74.2	79.4	74.7	76.9	71.1	80.1	77.7	79.1	75.1
Cannabis	12.7	2.3	14.2	1.8	12.6	2.2	16.7	3.3	20.1	4.2	19.8	4.7	18.9	3.9	19.4	4.6	17	5.1
Ecstasy	2.4	0.1	1.8	0	1.6	0.1	3.7	0.2	2.9	0.1	2.4	0.4	2.4	0.4	1.8	0.2	1.4	0.2
Hallucinogens	1.3	0.2	1.8	0.1	1.2	0.2	1.3	0.2	1.1	0.2	1.5	0.1	1.4	0.1	1.1	0.1	0.9	0.1
Amphetamines/speed	1.8	0.2	1.8	0.1	1.3	0.2	2.2	0.2	1.6	0.2	1.9	0.3	1.7	0.2	1.4	0.1	1.1	0.3
Powder cocaine	3.1	0.5	2.9	0.5	2.8	0.5	4.5	0.9	4.8	0.9	5.2	1.3	5.3	1.3	4.3	1.5	3.5	1.4
Base cocaine	0.1	0.1	0.2	0.1	0.4	0	0.2	0	0.2	0	0.2	0.1	0.6	0.2	0.2	0.1	0.2	0.2
Heroin	0.9	0.1	0.4	0.1	0.2	0	0.1	0.1	0.2	0.1	0.2	0.1	0.1	0	0.1	0.1	0.1	0.1
Inhalants	0.2	0.1	0.4	0	0.1	0.1	0.3	0	0.2	0	0.2	0.1	0.2	0	0.1	0	0.1	0.1
Tranquilizers	-	-	-	-	-	-	-	-	-	-	2.7	4.8	4.4	8.4	3.1	7.1	5.5	12.4
Sleeping pills	-	-	-	-	-	-	-	-	-	-	1.5	3.6	1.8	4.6	1.9	4.7	2	5.9
Tranquilizers(non-prescription)	-	-	-	-	-	-	-	-	-	-	0.7	0.9	1.1	0.8	1.6	1.5	1	0.9
Sleeping pills (non-prescription)	-	-	-	-	-	-	-	-	-	-	0.6	0.9	0.7	0.7	1	1.1	0.5	0.7

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Table 2.11. Prevalences of drug use within the last 30 days among the age 15-64 population, by age groups (percentages). Spain, 1997-2011.

	1997		1999		2001		2003		2005		2007		2009		2011	
	15-34	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**	**15-34**	**35-64**
Tobacco	49.6	36.9	43.7	36.9	46.3	37.5	47.2	39.5	42.3	35.5	42.2	36.3	40.9	38.4	40.4	35.9
Alcohol	66.7	61.6	64.4	59.4	65.7	62.1	65.8	62.7	66.3	63.4	61.7	59.4	63.1	63.3	63.7	61.5
Cannabis	8.5	1.1	7.9	1.5	11.5	2.3	13.4	2.9	15.4	3.6	13.5	2.8	14.1	3.2	12.5	3.7
Ecstasy	0.6	0	0.5	0	1.5	0.2	0.7	0	1.1	0.2	0.8	0.2	0.8	0.1	0.6	0.1
Hallucinogens	0.4	0	0.3	0.1	0.4	0.1	0.4	0	0.5	0.1	0.2	0	0.4	0	0.3	0.1
Amphetamines/speed	0.5	0	0.5	0.1	1.1	0.1	0.4	0.1	0.8	0.1	0.5	0.1	0.7	0.1	0.5	0.1
Powder cocaine	1.6	0.2	1.5	0.3	2.4	0.5	1.9	0.4	2.8	0.7	2.9	0.7	2	0.7	1.7	0.8
Base cocaine	0.1	0	0.1	0	0	0	0	0	0.1	0.1	0.4	0.2	0.1	0.1	0.1	0.1
General cocaine															1.7	0.8
Heroin	0.2	0.1	0.1	0	0	0	0.1	0	0.1	0.1	0.1	0	0	0.1	0.1	0.1
Inhalants	0.1	0	0	0	0.1	0	0	0	0.1	0	0	0	0	0	0	0
Tranquilizers	--	--	--	--	--	--	--	--	1.6	3.5	2.5	6.2	1.8	5.5	2.8	9.5
Sleeping pills	--	--	--	--	--	--	--	--	0.8	2.9	1	3.6	1.2	3.7	1.3	4.7

SOURCE: Spanish Observatory on Drugs and Drug Addiction.Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

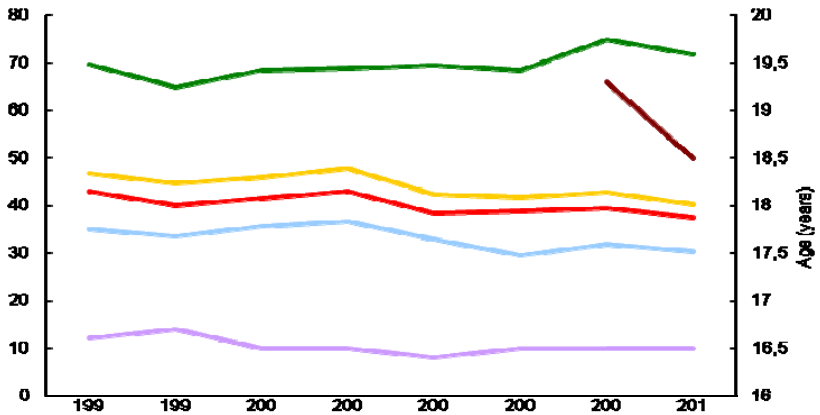
Tobacco

In 2011, a total of 71.1% of the individuals within the age 15-64 age group in Spain had used tobacco at least once in their lives (Fig. 2.2), meaning a drop of 3.3 percentage points compared to the last measurement taken but not reaching the levels of previous years which in no case surpassed 70%.

Focusing on tobacco use within the last 12 months, the degree of prevalence drops to 40.2%, meaning 56.1% of those individuals who had used tobacco sometime in their lives (Fig 2.3). Although this percentage is similar to that reported in for 2009, (57.1% of those who had smoked at some time in their lives had done so within the last 12 months), the degree of prevalence is the lowest for the entire time period analysed. This is likewise the case for the time indicator for within the last 30 days, which shows the lowest level of all the years studied, 37.6% of Spain's age 15-64 population (Fig. 2.2). Lastly, focusing on the daily tobacco use within the last 30 days, the prevalence drops to 30.4%. Worthy of note is the fact that, for calculating the continuity of use, a quotient is calculated between the prevalence for the nearest time horizon and the furthest time horizon to be taken into account. For example, to ascertain how many of those individuals who have smoked within the last 12 months have also smoked within the last 30 days, the prevalence for the last 12 months has been divided by the prevalence for the last 30 days. The average age of onset of use (Fig. 2.2) was 16.5 years of age in 2011, remaining constant over the course of time, whilst the average age of onset for daily tobacco use has lowered to 18.5 years of age (compared to 19.3 years of age in 2009).

Daily smoking is more widespread among males in all age groups (Fig. 2.4), reaching its maximum level in the 34-55 age segment (38.1%) whilst women show the greatest prevalence in the 25-34 age range (31%). The greatest difference between genders is found in the 55-64 age range (27.5% of the males compared to 16.3% of females) whilst the percentages show themselves to be more evenly matched in the 15-24 age range (28.7% of males compared to 24.8% of the females). Daily cigarette smoking among Spaniards within the 15-64 age range within the last month is of 13.6 cigarettes. Males smoke more cigarettes daily (14.6 cigarettes) than women (12.3 cigarettes).

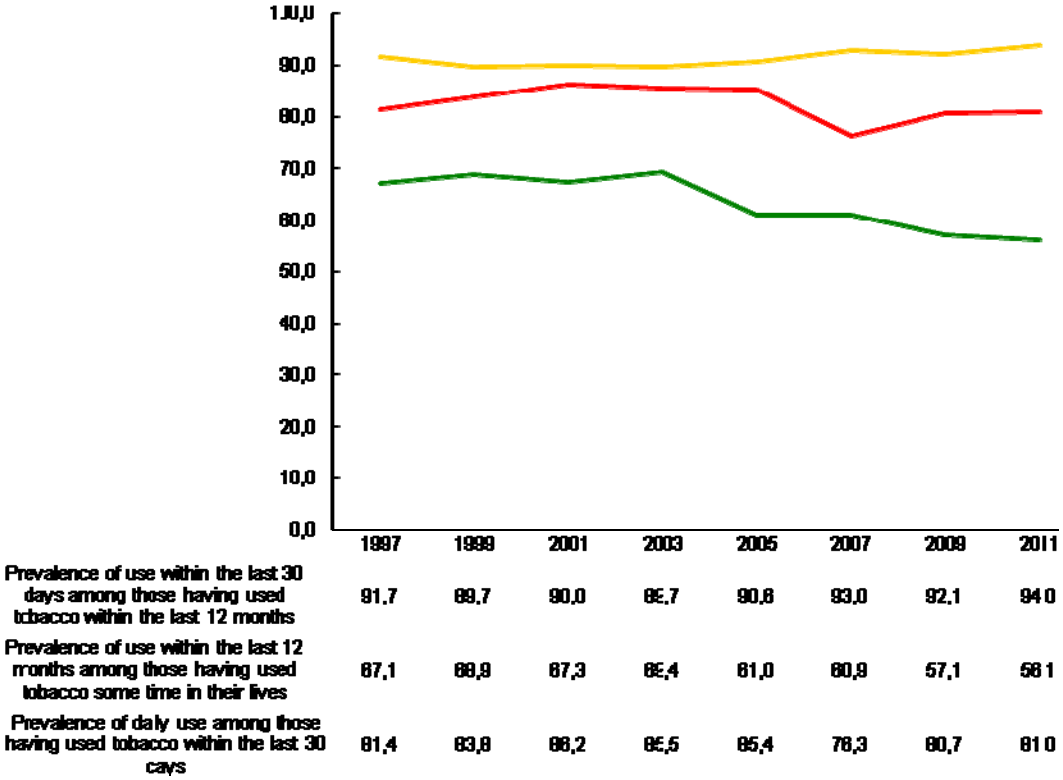
Figure 2.2. Trend in the prevalence of tobacco use among the age 15-64 population (percentages). Spain, 1997-2011.



	1997	1999	2001	2003	2005	2007	2009	2011
Some time in their lives	69,7	64,9	68,4	68,9	69,5	68,5	75	71,7
Within last 12 months	46,8	44,7	46	47,8	42,4	41,7	42,8	40,2
Within last 30 days	42,9	40,1	41,4	42,9	38,4	38,8	39,4	37,6
Daily within last days	34,9	33,6	35,7	36,7	32,8	29,6	31,8	30,4
Average age onset of use	16,6	16,7	16,5	16,5	16,4	16,5	16,5	16,5
Average age onset daily tobacco use							19,3	18,5

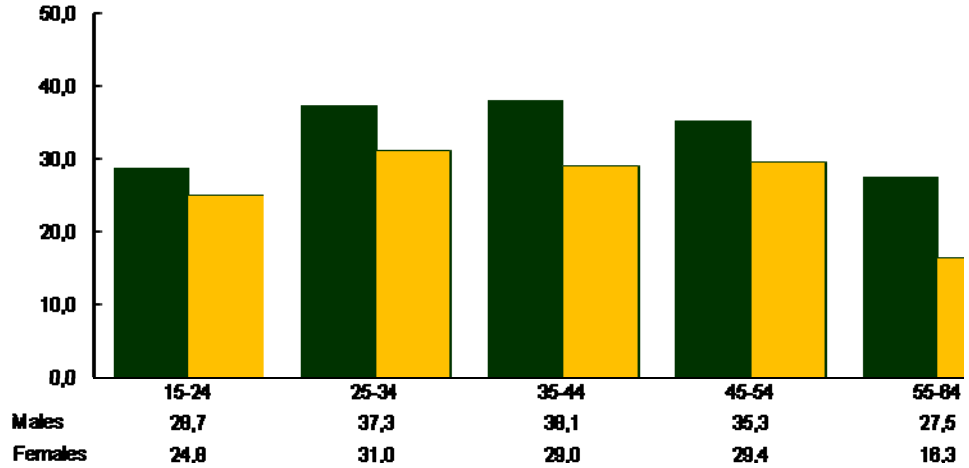
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Fig. 2.3. Trend in the continuity of tobacco use among the age 15-64 population (percentages). Spain, 1997-2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

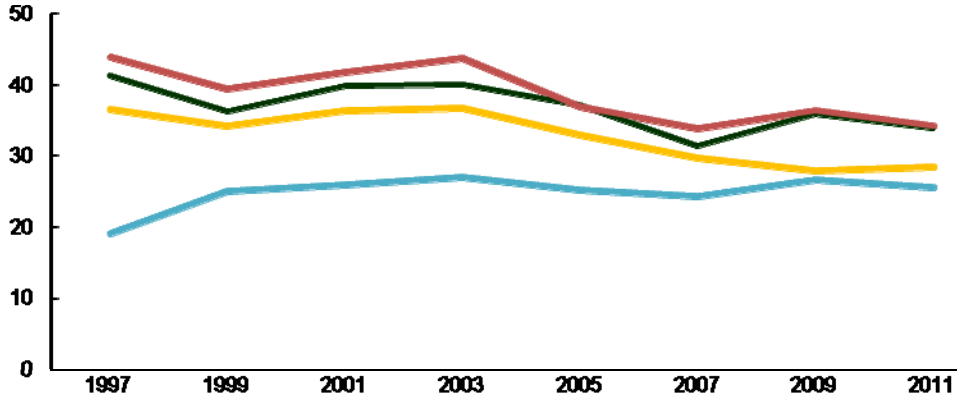
Fig. 2.4. Prevalence of daily tobacco use within the last 30 days among the age 15-64 population, by age group and gender (percentages). Spain, 2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

The trend in daily tobacco use by genders and age groups (Fig. 2.5) shows the lower prevalence which was found in 2011 as compared to 2009 as resulting mainly from the males, both those within the age 15-34 range (35.9% to 33.9%) and those within the age 34-64 range (36.4% to 34.2%). However, this type of use is rising slightly among the age 15-34 females, by half a percentage point (up to 28.5%), breaking with the downward trend which had been being noted in this segment of the population as of 2005.

Fig. 2.5. Trend in the prevalence of daily tobacco use among the age 15-64 population, by age groups and genders (percentages). Spain, 1997-2011.



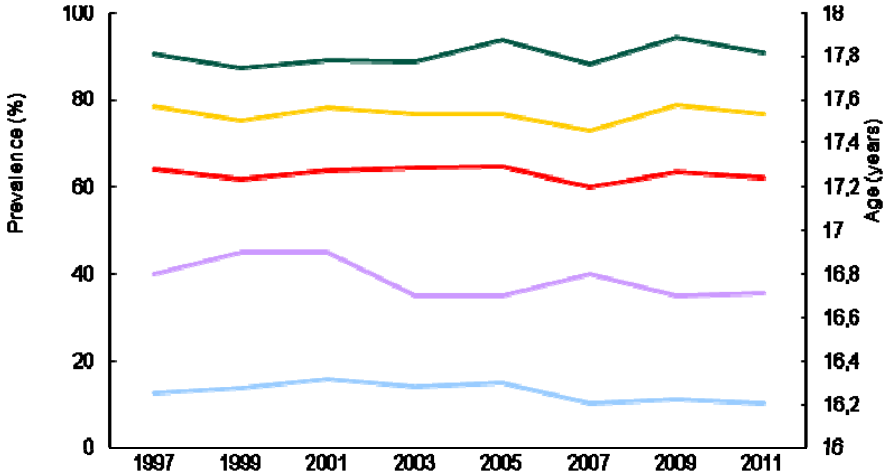
	1997	1999	2001	2003	2005	2007	2009	2011
Males 15-34	41,4	36,3	39,8	40	37,1	31,5	35,9	33,9
Females 15-34	36,5	34,2	36,4	36,8	33	29,7	28	28,5
Males 35-64	44	39,5	41,8	43,7	36,9	33,9	36,4	34,2
Females 35-64	19.1	25.1	25.9	27	25.3	24.4	26.7	25.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Alcohol

Drinking alcoholic beverages is spread throughout practically all of Spain's society. Thus, in 2011, a total of 90.9% of Spain's population within the 15-64 age range had drunk an alcoholic beverage at some time in their lives, 76.6% of the population having admitted drinking alcoholic beverages sometime within the last 12 months and 62.3% having done so within the last 30 days. For all of the time frequencies included, alcoholic beverage use was lower in 2011 than in 2009 (-3.3, -2.1 and -1.0 percentage points, respectively), the year in which the levels of use had rallied for all of the time periods. In 2011, daily alcohol use dropped by 0.8 percentage points compared to 2009, down to 10.2%, thus recouping 2007 levels (Fig. 2.6 and Table 2.12).

Fig. 2.6. Evolution of the prevalence of alcohol use and average age of onset of alcohol use among the age 15-64 population (percentages). Spain, 1997-2011.



	1997	1999	2001	2003	2005	2007	2009	2011
Some time in their lives	90,6	87,3	89	88,6	93,7	88	94,2	90,9
Within the last 12 months	78,5	75,2	78,1	76,6	76,7	72,9	78,7	76,6
Within the last 30 days	64	61,8	63,7	64,1	64,6	60	63,3	62,3
Daily within the last 30 days	12,7	13,7	15,7	14,1	14,9	10,2	11	10,2
Average age of onset of consumption	16,8	16,9	16,9	16,7	16,7	16,8	16,7	16,7

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Table 2.12. Evolution of the prevalence of alcoholic beverage use among the age 15-64 population (percentages). Spain, 1995-2011.

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Some time in their lives	-	90.6	87.3	89	88.6	93.7	88	94.2	90.9
Within the last 12 months	68.5	78.5	75.2	78.1	76.6	76.7	72.9	78.7	76.6
Within the last 30 days	-	64	61.8	63.7	64.1	64.6	60	63.3	62.3
Daily within the last 30 days	-	12.7	13.7	15.7	14.1	14.9	10.2	11	10.2
Never	-	9.4	12.7	11	11.4	6.3	12	5.8	9.1

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011)

For all of the time frequencies studied and for all age ranges, males showed higher prevalence figures for alcoholic beverage use than females. A total of 94.0% of males surveyed had drunk alcohol some time in their lives, compared to 87.7% of females. A total of 83.2% of males had drunk alcohol within the last 12 months, compared to 69.9% of females; and 73.2% of males surveyed had drunk alcohol within the last 30 days compared to 51.2% of females. The prevalence of daily alcoholic beverage use within the last 30 days was 15.3% for males and 5% for females.

As in previous years, the difference in the alcoholic beverage use prevalence figures between males and females becomes progressively greater as time periods closer together in time are reviewed. Thus, the male/female ratio for the prevalence of use sometime in their lives is of 1.07 males for every female; of 1.19 for the prevalence of use within the last 12 months and of 1.43 for the prevalence of consumption within the last 30 days and of 3.06 for daily use within the last 30 days, without any significant changes having been found to exist in this regard in 2011 as compared to 2009 (1.04, 1.16, 1.41, and 3.3, respectively).

Regarding the results by age groups, the 15-34 year-old population segment shows a prevalence of alcohol use within the last 12 months slightly higher than that of the age 35-64 group (79.1% compared to 75.1%). Similarly, if we take only the last 30 days, the prevalence in the first age group surpasses that of the second age group, although with a lesser percentage difference (63.7% compared to 61.5%). If alcoholic beverage use within the last 30 days among those within the 35-64 age range was slightly higher than that shown by those within the 15-34 age range (63.3% vs. 63.1% respectively), 2011 marked a return to the past trend in which the prevalence was higher among the younger group, although the gap between the two age groups has been progressively closing over the course of time.

However, when the indicator is analysed for binge drinking within the last 30 days as compared to Spain's total population surveyed, the prevalence in the 15-34 age group doubles that found for those comprising the 35-64 age group (22.1% vs. 11.0%).

Reviewing the different age ranges broken down to a further degree, it is found that the young people within the 25-34 age range are those showing the highest prevalence of alcoholic beverage use within the last 12 months (79.5%) although not very much higher than that shown by the groups within the 15-24 age range and the 35-44 age range 78.5% and 78.0% respectively). Regarding alcoholic beverage use within the last 30 days, it is also the 25-34 age groups which shows the highest prevalence of use (64.9%), followed by the 45-54 age group (63.6%) and the 35-44 age group (63.1%). The habit of drinking alcoholic beverages (drinking within the last 12 months and within the last 30 days) is therefore found to be spread in quite similar percentages throughout a wide age range.

Apart from the above, taking into account both the genders and ages of those surveyed, the prevalences of alcoholic beverage use among males and females show themselves to be more similar within the 15-24 age range than in the rest of the age groups for all the time-related indicators (Table 2.13).

Daily alcoholic beverage use becomes progressively greater among individuals the older they become, in both genders, the males within the 55-64 age ranges reaching 32.5% prevalence figures compared to the 10.5% figures among the females within the same age group. Hence, it can be said that, as of 25 years of age, there are at least 3 males who drink alcoholic beverages daily for every female who does so.

Table 2.13. Prevalence of alcoholic beverage use among the age 15-64 population, by genders and age groups (percentages). Spain, 2011

	15 - 24		25 - 34		35 - 44		45 - 54		55 - 64	
	M	F	M	F	M	F	M	F	M	F
Some time in their lives	88.1	84.5	94	89	94.7	89	95.6	89.6	96.5	84.6
Within the last 12 months	81.9	75	85.9	72.8	84.1	71.6	83.5	69.7	79.2	59.5
Within the last 30 days	67.3	56.3	74.9	54.4	74.6	50.8	74.6	53	72.2	41.2
Daily within the last 30 days	2.2	1	7.3	2.1	13.8	4.3	21.9	7.1	32.5	10.5
Never	11.9	15.5	6	11	5.3	11	4.4	10.4	3.5	15.4

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011)

The average age of onset of alcoholic beverage use recorded in 2011 is 16.7 years of age, similar to the one reported for previous years. Males start drinking alcoholic beverages one and a half years before (age 16) than females (age 17.5). On analysing the age of onset of alcoholic beverage use by age ranges, it is found that as the age of those surveyed progressively increases, the age of onset of alcoholic beverage use is later, and as younger individuals are surveyed, the age of onset is earlier. Hence, it is found that individuals within the 15-24 age range start drinking alcoholic beverages at as average 15.4 years of age, whilst the 55-64 age segment started at 17.8 years of age (Table 2.14).

Table 2.14. Average age of onset of alcoholic beverage consumption, by genders and age groups. Spain, 2011

	15-25	25-34	35-44	45-54	55-64	Males	Females
Age of onset of alcoholic beverage consumption	15.4	16.2	16.8	17.2	17.8	16.0	17.5

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011

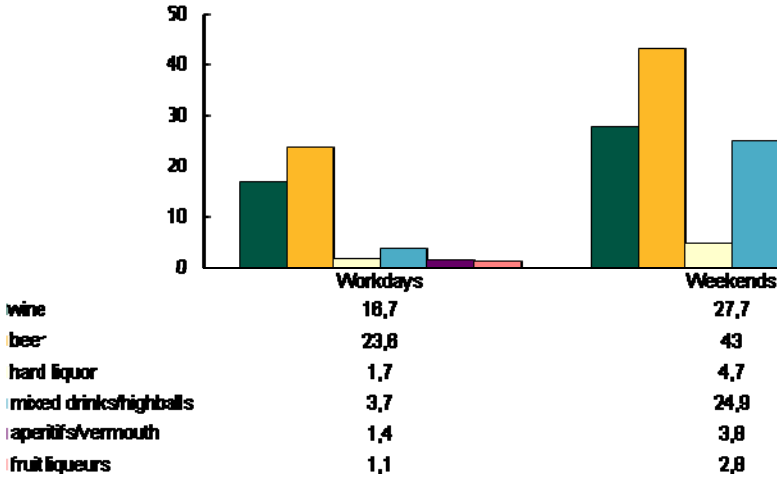
Taking into consideration the different types of beverages and when they are used (workdays/weekends) within the last 30 days, it is found that, generally speaking, the percentage of individuals who drink alcoholic beverages on the weekends is practically double the percentage who drink on workdays (60.2% vs. 31.9%). Table 2.15). This difference is more marked among the young people within the 15-34 age range, given that 24.9% of this groups drinks alcoholic beverages on weekdays whilst 36.3% of the age 35-64 population do so.

The beverage with which the individuals show a habit of making a greater distinction between workdays and weekends are mixed drinks/highballs, which are drunk by 3.7% on workdays whilst they are drunk by one out of every four people (24.9%) within the age 15-64 range who drink on weekends.

Focusing on the last 30 days and on the Spaniards within the age 15-64 range, the alcoholic beverages beverage of choice preferred by the greatest number of people is beer (Fig. 2.7), both on workdays (23.6%) and on weekends (43%), having grown in this regard compared to 2009 (by 3.6 and 1.7 percentage points, respectively) both in the 15-34 age group and in the 35-64 age group.

On workdays (Monday thru Thursday), beer is the beverage of choice on the part of 24.8% of the individuals in the older age group (35-64 years of age) and by 21.6% of those in the 15-34 age range. Wine is the second-ranked beverage of choice on workdays. In this case, there is indeed quite an obvious difference depending on the age of those surveyed, as wine drinking is quite widespread, mainly in the 35-64 age group (22.4%) compared to the 7.4% found in the 15-34 age range (Table 2.15).

Fig. 2.7. Prevalence of alcoholic beverages within the last 30 days, on workdays and on weekends, among the age 15-64 population, by type of beverage (percentages). Spain 2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

On weekends (Friday, Saturday and Sunday), the beverage of choice on the part of the highest percentage of people is also beer (44.1% of those within the 15-34 age range and 42.4% of those within the 35-64 age range). As for workdays, beer is also found to be a highly popular beverage on weekends, regardless of the age segments. However, focusing on wine and mixed drinks (which, in conjunction with beer, are the three alcoholic beverages most consumed on weekends), greater differences are found depending on the age groups in question. Wine shows itself to be more widespread among the age 35-64 group (34.6%) compared to 16.3% among those within the 15-34 age range, whilst mixed drinks are more present among the youngest consumers. Thus, four out of every ten young people within the 15-34 age range (40.4%) have drunk mixed drinks on a weekend within the last 30 days, whilst only 2 out of every ten have drunk mixed drinks in the 35-64 age group. In this regard, it is advantageous to point out that mixed drink use increased both on weekends and on workdays in 2011 among both age groups (15-34 and 35-64 years of age).

Table 2.15. Prevalence of alcoholic beverage use on workdays and on weekends within the last 30 days among the age 15-64 population, by age group and type of beverage (percentages). Spain, 2011.

	15-64 age group		15-34 age group		35-64 age group	
	Workdays	**Weekends**	**Workdays**	**Weekends**	**Workdays**	**Weekends**
Wine/champagne	16.7	27.7	7.4	16.3	22.4	34.6
Beer/cider	23.6	43.0	21.6	44.1	24.8	42.4
Aperitifs/vermouth	1.4	3.8	1.2	3.1	1.5	4.2
Mixed drinks/highballs	3.7	24.9	5.2	40.4	2.8	15.5
Fruit liqueurs	1.1	2.8	1.1	3.5	1.1	2.3
Hard liquor	1.7	4.7	1.6	5.4	1.8	4.2
Any alcoholic beverage	31.9	60.2	24.9	61.6	36.3	59.4

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

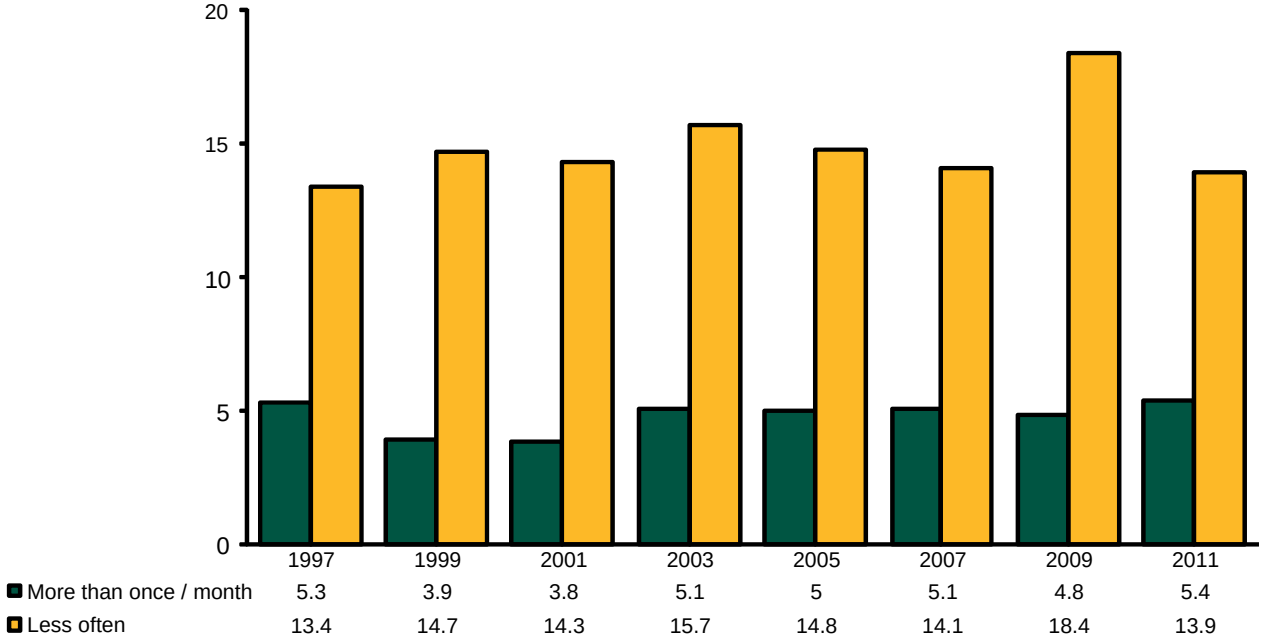
Regarding the information gathered in 2009, alcoholic beverage use on weekends has declined slightly (from 61.9% to 60.2%), whilst it has risen on workdays. This increase could be due to a greater incorporation of the younger segment into drinking alcoholic beverages Mondays through Thursdays. Thus, regarding the data gathered in 2009, there was a remarkable rise in 2001 in the prevalence of alcoholic beverage use on workdays among individuals within the 15-34 age group (a rise of 5.4 percentage points, from 19.5% to 24.9%), a greater deal of use taking place in this regard for all of the beverages studied. It is a known fact that, over the past few years, above all in urban areas, the younger population has begun starting the weekend earlier, weekends now currently starting on Thursday instead of Friday. However, this fact cannot be stated in all accuracy, due to the fact that on the Household Survey on Alcohol and Drugs in Spain EDADES questionnaire asks about "workdays (Monday-Thursday)" and not about each workday separately.

In regard to cases of alcohol poisoning, 19.3% of the age 15-64 population admitted having experienced some episode of drunkenness at some time within the last twelve months on being surveyed (25.9% males vs. 12.6% females). A total of 5.4% acknowledged having experienced drunkenness more than once a month within the last twelve months, whilst 13.9% had done so less often (Fig. 2.8). The comparison of these figures to those found for 2009 reveal a 0.6 percentage point rise in the number of individuals who had gotten drunk more than once a month within the last twelve months, totalling the highest figures since 1995.

The group leading the acute alcohol poisoning prevalence is that of the males within the 15-34 age group, given that 41.3% of them have experienced drunkeness within the last 12 months compared to the 23.5% of females of the same age. The breakdown by both age and gender together shows

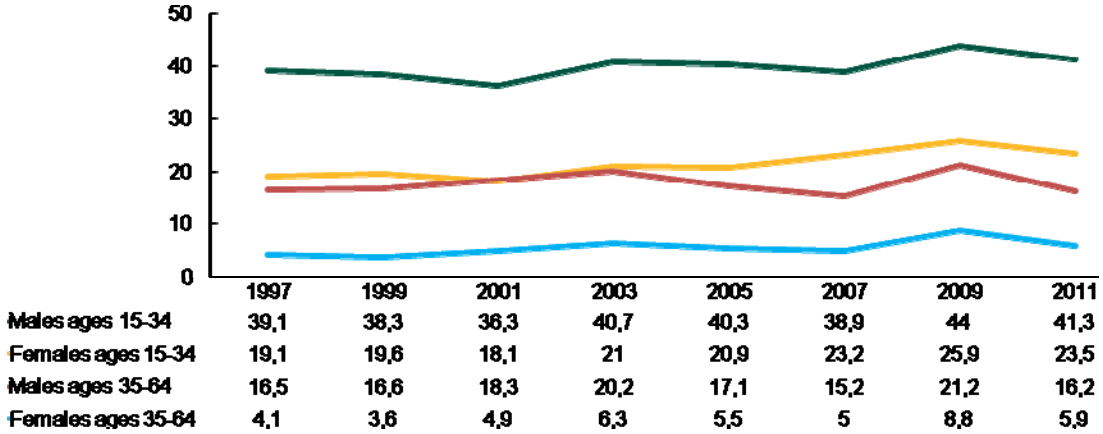
a drop in 2011 of the prevalences of drunkenness in all of the categories studied (Fig. 2.9) as compared to 2009 in which they showed an overall increase.

Fig. 2.8. Prevalence of acute alcoholic poisoning (drunkenness) within the last 12 months in the age 15-64 population (percentages). Spain, 1997-2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997- 2011).

Fig. 2.9. Trend in the prevalence of acute alcoholic poisoning (drunkenness) within the last 12 months among the age 15-64 population, by age groups and genders (percentages). Spain, 1997-2011



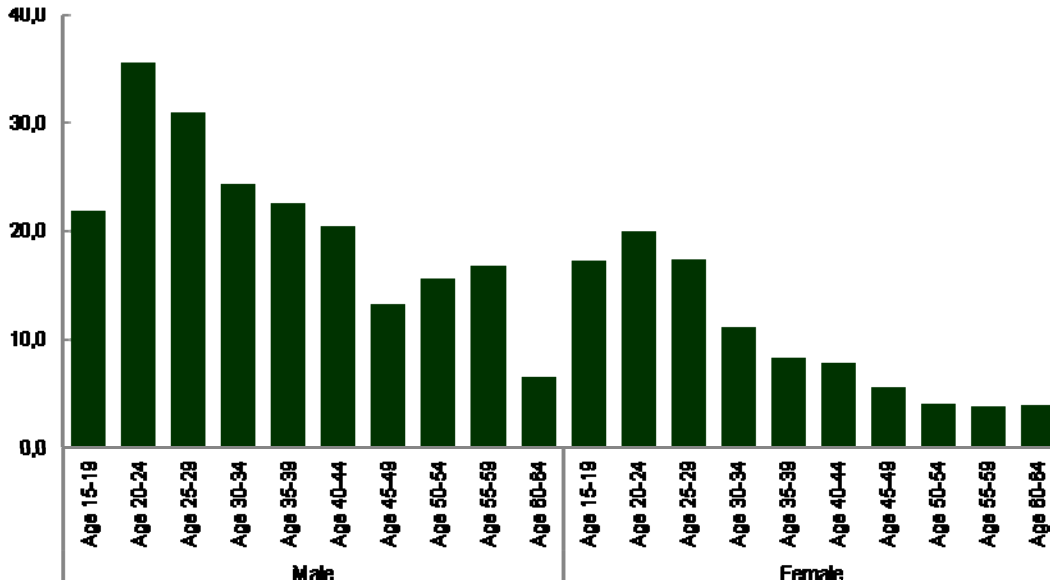
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Regarding binge drinking (5 or more drinks in males and 4 or more drinks in females within a two-hour period), a prevalence quite similar to that noted for 2009 is found for the nationwide total. In 2011, 15.2% of the Spaniards within the 15-64 age range had taken part in binge drinking within the last 12 months, the percentage recorded for males (20.7% being higher, as is customary, for this type of intensive drinking than among females (9.5%). The male/female ratio, although not showing any very striking changes, does seem to be continuing a downward trend (2.7 in 2007, 2.4 in 2009 and 2.1 in 2011). Compared to 2009 (14.9%), the total nationwide figure shows a slight rise due to the one percentage point increase among the females (8.6% in 2009 and 9.5% in 2011).

In general, for all of the age groups and for both genders, the highest percentage of binge drinkers take part in binge drinking 1-5 days per month (84.1%), which could be identified with a sporadic weekend use pattern. Nevertheless, a small percentage (3.4%) is also noted which admits drinking 4/5 (female/male) alcoholic beverages within a two-hour interval on more than 19 days a month, which could be identified with an alcohol dependence pattern.

As is shown in Fig. 2.10, taking into account the overall age 15-64 population in general, broken down by genders and then by age groups, the percentage of males who have been involved in being drinking within the last 30 days shows the highest figures for the 20-24 age group (35.6%), just as is the case of the females (19.9%), although with a 15.7 higher percentage among the males, comparing the 15-19 age group to the 20-24 age group, is substantially less in the case of the females, a difference of +13.8 percentage points being reported in the group of males and of +2.7 percentage points in the group of females. In any case, the prevalence of binge drinking is found to be less among females for all age ranges.

Fig. 2.10. Prevalence of binge drinking within the last 30 days, by gender and age, among the age 15-64 population (percentages). Spain 2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

If binge drinking among those individuals who had drunk alcoholic beverages within the last 12 months is analyzed instead of using the overall age 15-64 population as a reference, the figure totals 24.5% (28.5% in males and 18.6% in females), thus meaning that 1 out of every 4 individuals who have drunk alcoholic beverages within the last 12 months have done so by binge drinking. In this case, the male/female ratio drops down to 1.5.

Lastly, regarding what is referred to as “at-risk drinkers” males who drink on the average of 50 cc or more of pure alcohol per day or females who drink on the average of 30 cc or more of pure alcohol per day), the 2011 Household Survey on Alcohol and Drugs in Spain (EDADES 2011) shows a prevalence of 4.1% (4.5% in males and 3.5% in females) among Spain’s age 15-64 population (Table 2.16), which is slightly lower than the figure recorded in 2009 (4.4%). Taking into account the different age ranges, the 15-24, 25-34 and 45-54 age ranges show a similar prevalence (4.3%). Similarly, it is a reported fact that there are more at-risk female drinkers than males among the 15-24 age group (Table 2.17).

Table 2.16. Prevalence of at-risk drinkers among the age 15-64 population, by genders and ages (percentages). Spain, 2011

	15-24	25-34	35-44	45-54	55-64	Males	Females
Prevalence of at-risk drinkers	4.3	4.3	3.6	4.3	4.2	4.5	3.5

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Table 2.17. Prevalence of at-risk drinkers among the age 15-64 population, by genders and ages (percentages). Spain, 2011

	15-24		25-34		35-44		45-54		55-64	
	M	F	M	F	M	F	M	F	M	F
Prevalence of at-risk drinkers	4.2	4.4	4.5	4.1	4.4	2.2	5.1	3.1	4.2	4.2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

To summarize, the 2011 Household Survey on Alcohol and Drugs in Spain can be said to record a slightly downward trend in alcoholic beverage use among Spain’s overall age 15-64 population.

The highest prevalences of use are still those of the males, for all the time periods and also for the three types of intensive drinking patterns studies (alcohol poisoning, binge drinking and at-risk drinkers). These three at-risk patterns also show slight decreases compared to the levels recorded in 2009. Apparently, the rise in the prevalences among females for different indicators (intensive and non-intensive) which had been being found in the latest editions of the survey have been discreetly curbed.

Alcoholic beverage use continues to be concentrated on weekends, although a discreet rise in consumption on workdays is noted, which could be related to the trend which young people have had over the past few years of starting the weekend early, on Thursday. The beverage of choice for the greatest number of individuals is beer, both on workdays and on weekends, followed by wine. Even so, an increase is noted in mixed drink consumption on both workdays and weekends.

Cannabis

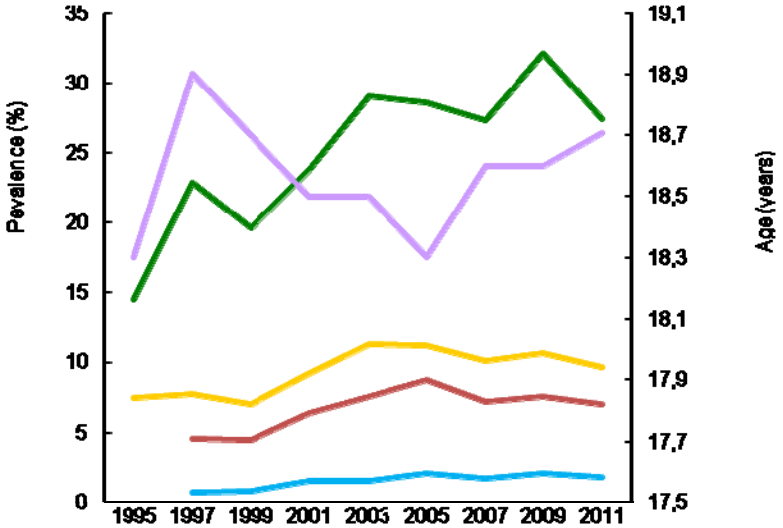
Cannabis continues to be the illicit drug most used among the age 15-64 population legally residing in Spain, despite a slight detected in the three time-related indicators (sometime in their lives, within the last 12 months and within the last 30 days), having a bearing on the stabilization which had been noted over the last few years. This drop is of greater significance in experimental use, the only indicator which has risen considerably in the immediately prior edition and which had reach the highest levels since 1995, thus returning to the “sometime in one’s life” use data for 2007. (Fig. 2.11).

In 2011, a total of 27.4% of the Spaniards within the 15-64 age range stated having used this substance at least once in their lifetime. This prevalences underwent an upward turn in 2009 (up to 32.1%), as a result of which the current figure means a drop in the use rate of 4.7 percentage points compared to the immediately previous measurement, thus returns to 2007 levels. Focusing on cannabis use within the last 12 months, the resulting prevalences is 9.6%, meaning 35% of the individuals who had used cannabis sometime in their lives, a percentage in keeping with that which had been found to exist in previous periods. Please note that the prevalence level for the last 12 months means a one-point drop compared to the immediately previous measurement, being the lowest since 2003 (the years in which maximums were recorded in this regard, with 11.3%).

Analysing the results for use within the last 30 days, the resulting percentage of users is 7.0% of the population studies, meaning 73% of those who used this substance within the last 12 months and 25.5% of those who had used it at some time in their lives. In terms of prevalence, there is a 0.6-point difference compared to 2009, meaning the lowest figure since 2003.

As regards daily cannabis use focusing on the last 30 days, a 1.7% prevalence is found to exist, without any substantial changes have occurred in this regard compared to previous years. Thus, it is found that one out of every four individuals who have used cannabis within the last 12 months, do so daily (24.3%). Furthermore, the age of onset of cannabis use is 18.7 years of age, thus following the past trend and thus being the illicit drug which is first used at the earliest age. (Fig. 2.11).

Fig. 2.11. Trend of the prevalence of cannabis use and average age of onset of use among Spain's age 15-64 population (percentages). Spain, 1995-2011.



	1995	1997	1999	2001	2003	2005	2007	2009	2011
Sometime in their lives	14,5	22,9	19 6	23,8	29	28,6	27,3	32,1	27,4
Within the last 12 months	7,5	7,7	7	9,2	11,3	11,2	10,1	10,6	9,6
Within the last 30 days		4,6	4,5	6,4	7,6	8,7	7,2	7,6	7
Within the last 30 days		0,7	0,8	1,5	1,5	2	1,7	2	1,7
Average of onset of use	18,3	18,9	18 7	18,5	18,5	18,3	18,6	18,6	18,7

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

In reference to cannabis use within the last 12 months, by the ages and genders of the individuals surveyed, it is seen how, for both genders, use progressively drops off as the individuals grow older. In any event, this is a use more widespread among males, independently of the age range, although the greatest differences between genders in percentage terms show up in the 15-64 age range (27.6% vs 13.5%) and in the 25-34 age range (20.5% vs. 8.5%). (Fig. 2.12)

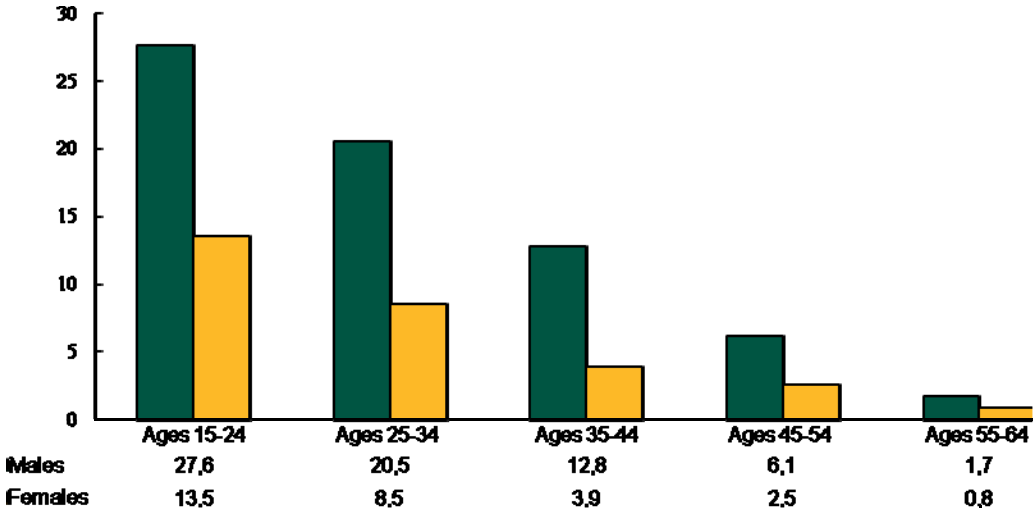
Apart from the above, for 2009, the most important developments in use within the last 12 months show up in the youngest segment with a decrease in use. The females within the 15-24 age range showed a 4.1 percentage point decrease (17.6% in 2009 vs. 13.5% in 2011) and, to a lesser degree, males by 2.3 points (29.9% in 2009 vs. 27.6% in 2011). On the contrary, an increase was found in cannabis use in the segment of males within the 35-44 age range, whose rate rose by two percentage points (10.8% in 2009 vs. 12.8% in 2011).

Focusing on cannabis use within the last 30 days, it is also the group of males within the 15-24 age range (20.0%) and within the 25-34 age range (16.2%) where the most frequent use takes place (Fig. 2.13). Similarly, as they grow older, the percentage of individuals who use cannabis within the last 30 days decreases. In this regard, it is among the first two age groups studied (15-24 age range and 25-34 age range) where the greatest differences in the prevalences of males and females are found to exist.

The differences between genders have remained the same year after year in favour of the females, whose prevalence figures are significantly lower than those of the males. Nevertheless, just as an overall downward trend or stabilization in use is found for all age groups of the males (except for the 35-44 age group), an increase in prevalence is found in all age groups for the females (except for the 15-24 age group), which comes to back the idea of the young females being prone to use cannabis to a greater degree. (Figs. 2.14 and 2.15).

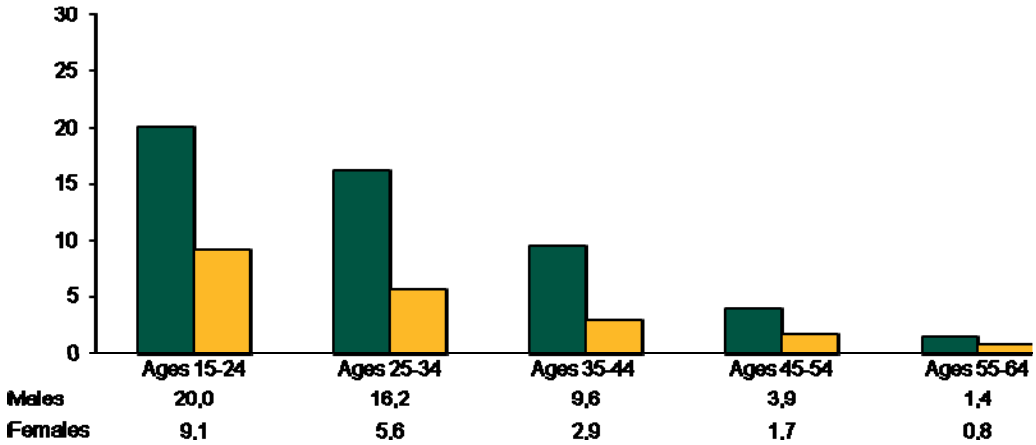
The most outstanding development in cannabis use within the last 30 days as compared to 2009 also takes place among the young individuals. Cannabis use among the youngest females is less widespread than in 2009 (dropping from 12.1% to 9.1%) and likewise for the males, although showing less of a drop (from 22.1% to 20.0%). On the contrary, cannabis use among males within the 35-44 age range rose from 7.3% in 2009 to 9.6% in 2011. (Figs. 2.14 and 2.15)

Fig. 2.12. Prevalence of cannabis use within the last 12 months among Spain's age 15-64 population, by age groups and genders (percentages). Spain, 2011.



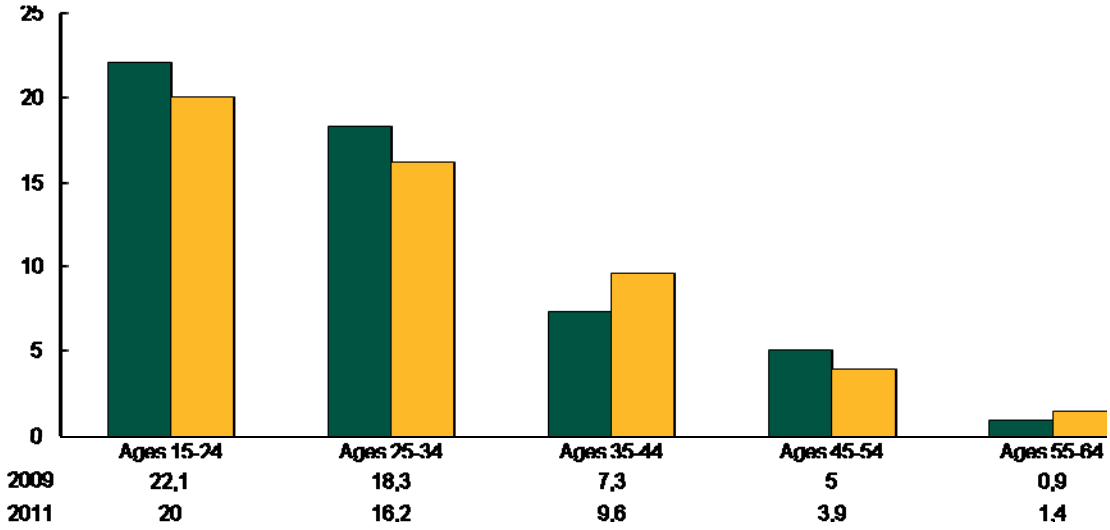
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Fig. 2.13. Prevalence of cannabis use within the last 30 days among Spain's age 15-64 population, by age groups and genders (percentages). Spain, 2011.



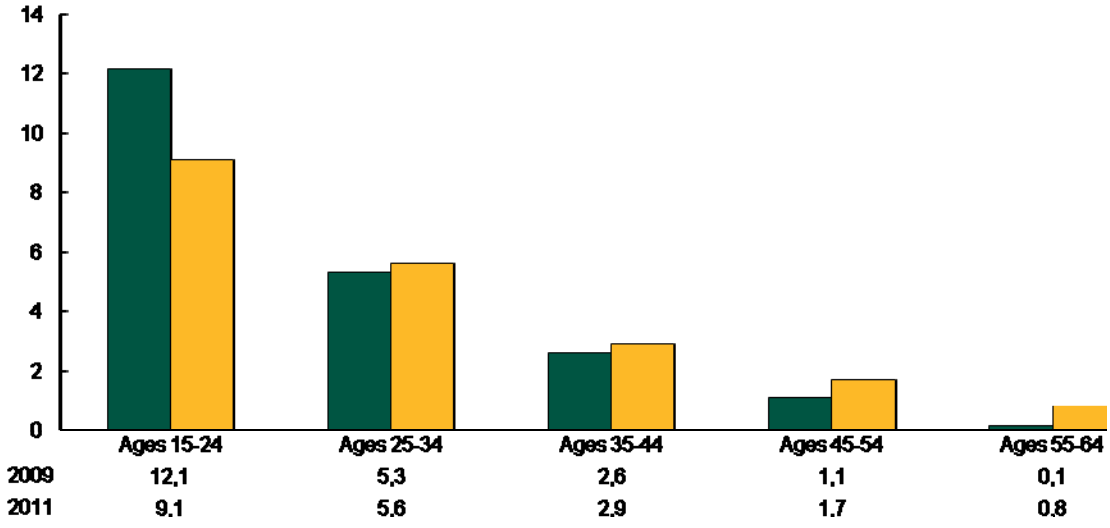
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Fig. 2.14. Prevalence of cannabis use within the last 30 days among Spain's age 15-64 population, by age groups (percentages). Spain, 2009-2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Fig. 2.15. Prevalence of cannabis use within the last 30 days among Spain's age 15-64 female population, by age groups (percentages). Spain, 2009- 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

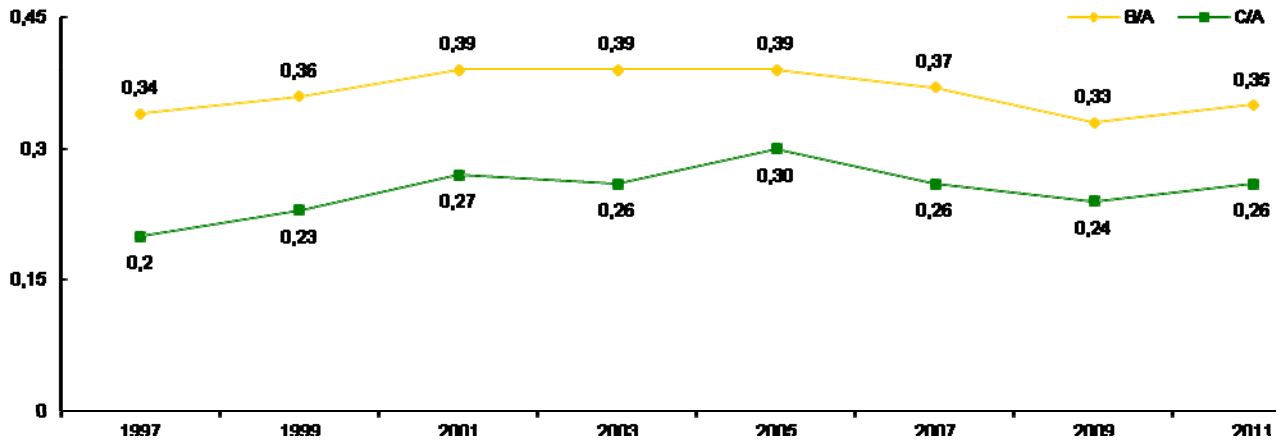
The continuity of use remains at 0.26 for the last 30 days, that is to say, one fourth of those who had used cannabis at some time in their lives continued use within the last 30 days, the same percentage as in 2009 and a few hundreds more for the continuity within the last 12 months, this figure being similar to that found in 1997. (Table 2.18 and Fig. 2.16).

Table 2.18. Prevalence and continuity in cannabis use among the age 15-64 population. Spain, 1995-2011.

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Prevalence sometime in their lives (%) (A)	14.5	22.9	19.6	23.8	29	28.6	27.3	32.1	27.4
Prevalence last 12 months (%) (B)	7.5	7.7	7	9.2	11.3	11.2	10.1	10.6	9.6
Prevalence last 30 days (%) (C)		4.6	4.5	6.4	7.6	8.7	7.1	7.6	7
B/A	0.52	0.34	0.36	0.39	0.39	0.39	0.37	0.33	0.35
C/A		0.2	0.23	0.27	0.26	0.3	0.26	0.24	0.26

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

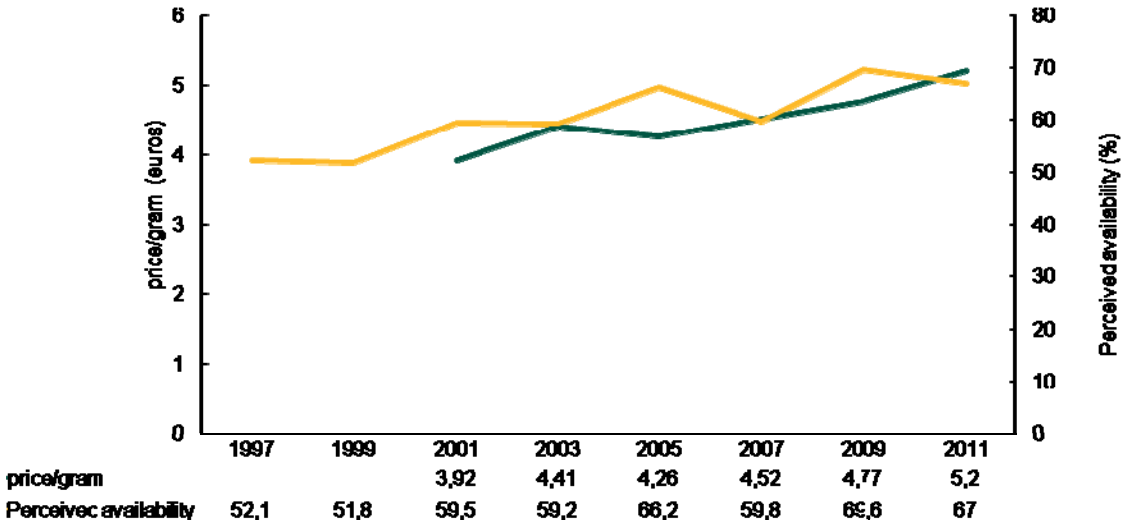
Fig. 2.16. Trend in the continuity of cannabis use among the age 15-64 population. Spain, 1997-2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Of interest is the reverse relationship existing between the perceived availability of cannabis and the price per gram of this same substance on the retail market in Spain. In 2001, 2005 and 2009, the years when the price was lowest, there was also a rise in availability, the opposite having occurred in 2003, 2007 and 2011, when the availability dropped in view of the rise in price, even though it not be particularly significant (Fig. 2.17).

Fig. 2.17. Trend of perceived availability of cannabis (easy / very easy to get within 24 hours) and the price per gram of cannabis (euros). Spain, 1997-2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

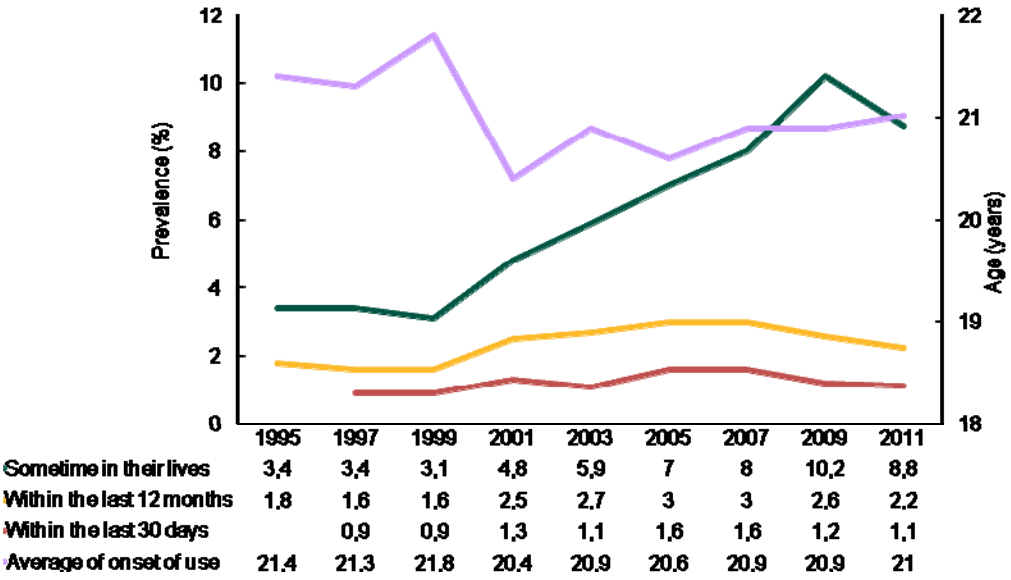
Cocaine

Among the illicit psychoactive substances, cocaine in general (powder and/or base) is the substance showing the second highest prevalence of use in Spain, after cannabis, among the individuals within the 15-64 age range.

Powder cocaine has an 8.8% prevalence for the sometime in their lives indicator, being the form and type most used of all. Nevertheless, in 2011, a break was found to exist with the upward trend which had been taking place for the past ten years and which had reached its peak level in 2009, with a 10.2% prevalence among the population surveyed and showing a higher degree of growth than in previous years (with a 2.2 percentage point increase compared to the year before). In any case, this reduction is not as yet important enough to return to the levels of 2007 (8.0%) nor to the previous years.

Continuing with powder cocaine use, the “within the last 12 months” time-related indicator consolidated, in 2011, the downward trend which had begun in 2007 (which a maximum prevalence of 3.0% was reached) to the 2.2% level currently noted. The same is true for the “within the last 30 days”time frame. In this case, 2005 and 2007 marked maximums (1.6%), whilst in 2011, the prevalence level was half a percentage point lower (1.1%), although the greatest drop in this regard occurred in 2009, from 1.6% to 1.2%). (Fig. 2.18).

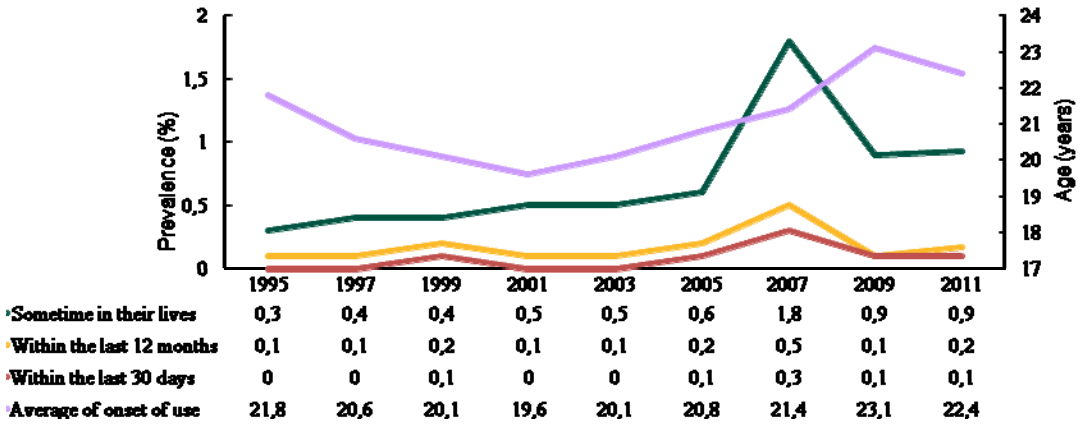
Fig. 2.18. Trend in the prevalence of powder cocaine use and average age of onset of powder cocaine use within Spain's age 15-64 population (percentages). Spain, 1995-2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

For base cocaine (crack), prevalence levels are similar to those of 2009, the year which marked a turnaround in the rise which had been being seen and which reached its highest peak in 2007 (1.8% for some time in their lives; 0,5% within the last 12 months and 0.3% within the last 30 days). In 2011, it was found that the number of individuals who had used base cocaine sometime in their lives had decreased to half compared to 2007, although this reduction must continue in order to achieve the levels recorded for the years showing the lowest prevalence in this series. Similarly, it must be stressed that, in 2011, the percentages found for use within the last 12 months (0.2%) and within the last 30 days (0.1%) are among the lowest figures. (Fig. 2.19).

Fig. 2.19. Trend of the prevalence of base cocaine and average age of onset of base cocaine use among Spain's age 15-64 population (percentages). Spain, 1995-2011

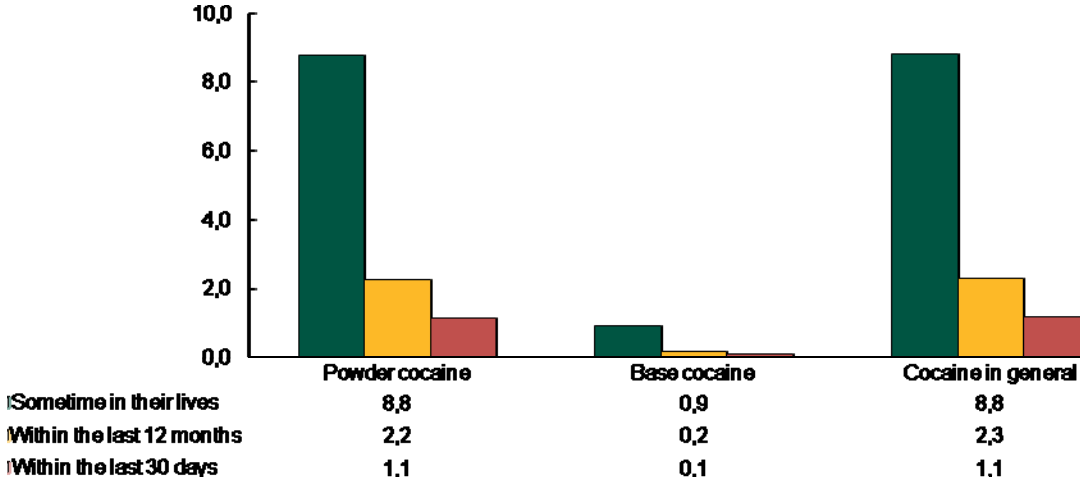


SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

The average age of onset of use of powder cocaine is at 21 years of age according to the age reported for previous years. Onset of base cocaine use is later (22.4 years of age), although 2011 is the first year in the last ten years that the age of onset has dropped compared to the immediately previous measurement (23.1 years recorded in 2009). (Figs. 2.18 and 2.19).

Generally speaking, special mention must be made of the fact that the decrease having occurred in cocaine use in general is mainly at expense of powder cocaine use, which is the cocaine used to the greatest extent (Fig. 2.20), as the use of base cocaine is spread residually.

Fig. 2.20. Prevalence of cocaine use according the format (base or powder) among Spain's age 15-64 population (percentages). Spain, 2011

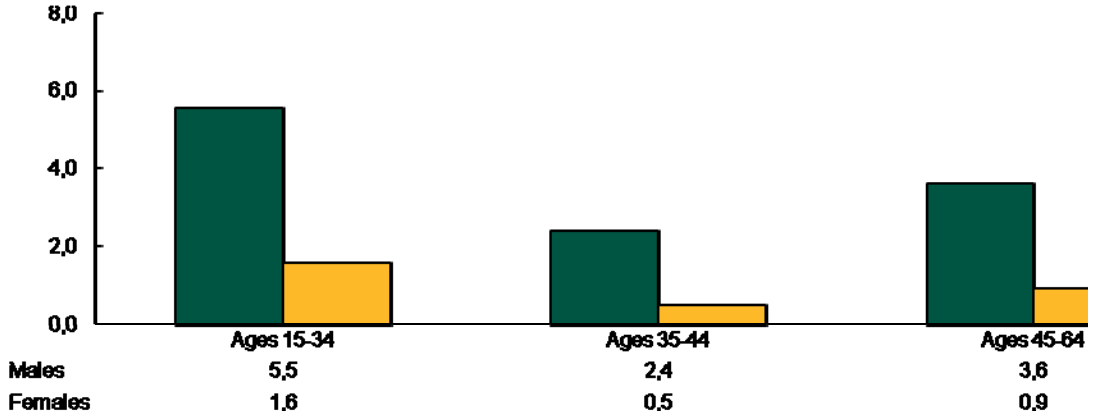


SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

By analysing cocaine use "within the last 12 months" by genders, cocaine use is found to be a habit more widespread among males (3.6%) than among females (0.9%), this being a situation which has remained unchanged throughout all editions of this survey. Nevertheless, it is important to point out that the drop which occurred in the prevalences of use of this substance is the result mainly of a decline in use on the part of the males (Figs. 2.21 and 2.22).

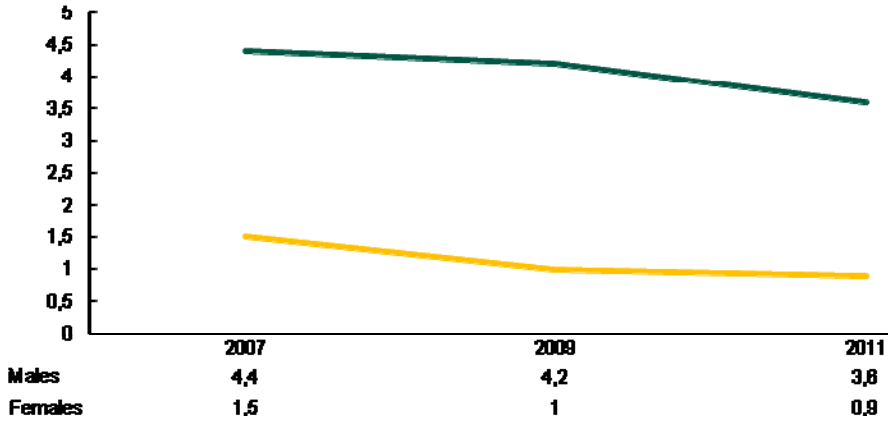
In the case of the males, this substance is more widespread among those within the 25-34 age range (5.9%), whilst in the case of the females, it is those within the 15-24 age range (1.9%) which use this substance the most (Fig. 2.23). The ratio between males and females is 3.6 males for each female involved in this type of use, but if the evaluation is made focusing on the age 25-34 population, this ratio amounts to 4.5 males for each female.

Fig. 2.21. Prevalence of cocaine use in general (base and powder within the last 12 months, by age groups and genders (percentages). Spain, 2011



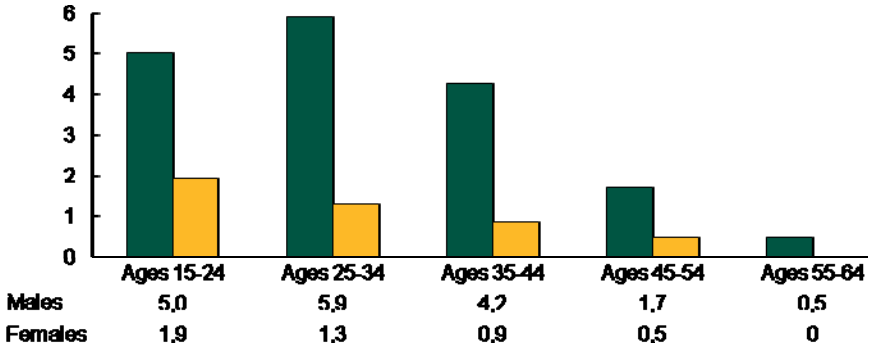
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Fig. 2.22. Trend in the prevalence of powder cocaine use within the last 12 months among the age 15-64 population, by genders. Spain 2007-2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

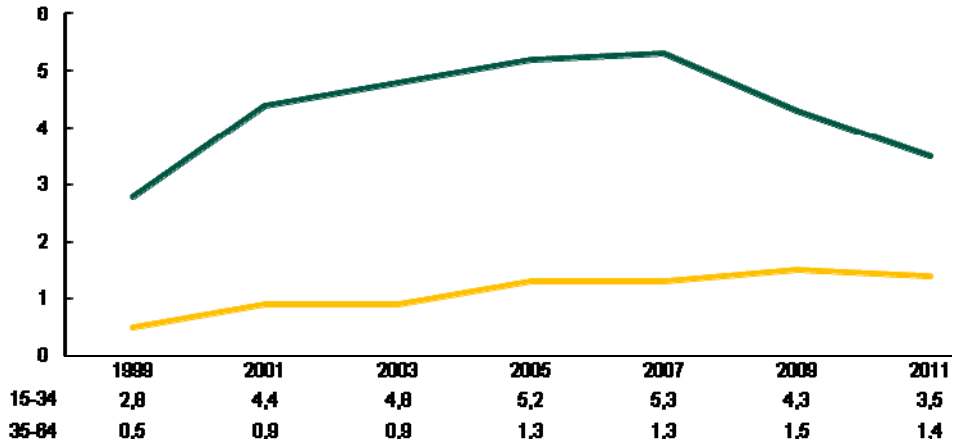
Fig. 2.23. Prevalence of cocaine use in general (base and powder) within the last 12 months, by age groups and genders (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

By age groups, it is the youngest age group, both males and females alike, that uses cocaine the most, with markedly significant prevalences. Although a marked drop in the prevalence of use within the last 12 months has been noted as of 2007 among the age 15-34 population, dropping from 5.3% in 2007 to 3.5% in 2011, with levels of use nearing that of 1999 (2.8%). (Fig. 2.24).

Fig. 2.24. Trend in the prevalence of powder cocaine use within the last 12 months among the age 15-64 population, by age groups. Spain 1999-2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

There is not any great degree of continuity in cocaine use. In 2011, around one fourth of those who had tried this drug sometime in their lives had used it within the last 12 months, and approximately one seventh had used it within the last 30 days. Continuity in use has been found (Table 2.19) to have dropped noticeably over the past few years, although, in 2011, a stabilization has been found to exist for both indicators in comparison to 2009, breaking with the downward trend which began in 2003.

Table 2.19. Prevalence and continuity in powder cocaine use among the age 15-64 population. Spain, 1997-2011

	1997	1999	2001	2003	2005	2007	2009	2011
Prevalence sometime in their lives (%) (A)	3.4	3.1	4.8	5.9	7	8	10.2	8.8
Prevalence last 12 months (%) (B)	1.6	1.6	2.5	2.7	3	3	2.6	2.2
Prevalence last 30 days (%) (C)	0.9	0.9	1.3	1.1	1.6	1.6	1.2	1.1
B/A	0.47	0.52	0.52	0.46	0.43	0.37	0.26	0.26
C/A	0.29	0.27	0.19	0.23	0.2	0.15	0.13	0.13

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Table 2.20 shows there to be a larger number of single people (70.9%) who use cocaine both in powder as well as in base form than married or separated/divorced or widowed people (29.1%), the percentage of individuals who are married (53.3%) however being much greater among those who do not use cocaine, compared to the 37.6% of single people.

Table 2.20. Spread by marital status of those people who have or have not used cocaine (powder and/or base) within the last 12 months among the age 15-64 population, by genders (percentages). Spain 2011

	Have used cocaine (powder and/or base) within the last 12 months				Have not used cocaine (powder and/or base) within the last 12 months			
	Total number of individuals who have used cocaine (powder and/or base) within the last 12 months (Absolute number)	**Single**	**Married**	**Separated/ divorced/ widowed**	**Total number of individuals who have not used cocaine (powder and/or base) within the last 12 months (Absolute number)**	**Single**	**Married**	**Separated/ divorced/ widowed**
Male	583,747	71.9	18.1	10	15,637,389	41.9	51.1	7
Female	142,067	67	18.2	14.8	15,709,687	33.4	55.4	11.2
TOTAL	**725,814**	**70.9**	**18.2**	**10.9**	**31,347,076**	**37.6**	**53.3**	**9.1**

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

One item of data worthy of special mention is that, among those individuals who use cocaine, a total of 86.2% consider themselves to be in good or very good health, compared to the 84.9% of the individuals who do not use cocaine and who consider themselves to be in very good or good health (Table 2.21). This may be due to cocaine being used to the greatest extent among the younger and therefore generally healthier population, although it must not be overlooked that, in 2010, cocaine was the leading cause of care provided in the emergency services for drug use in Spain.

Table 2.21. Spread of the subjective perception of their own health among those individuals who have or have not used cocaine in general (powder and/or base) within the last 12 months among the age 15-64 population, by genders and age groups (percentages). Spain 2011

	Have used cocaine (powder and/or base) within the last 12 months				Have not used cocaine (powder and/or base) within the last 12 months			
	Total number of individuals who have used cocaine (powder and/or base) within the last 12 months (Absolute number)	Very good or good	Fair	Poor or very poor	Total number of individuals who have not used cocaine (powder and/or base) within the last 12 months (Absolute number)	Very good or good	Fair	Poor or very poor
GENDER								
Male	583,747	86.9	11.5	1.6	15,637,389	86.5	11.5	2
Female	142,067	83.2	15.8	1.1	15,709,687	83.3	14.3	2.4
AGE								
15-24	171,362	88.3	11.2	0.6	4,707,799	95.7	4.1	0.3
25-34	267,510	91.8	7.6	0.5	7,063,291	93.2	6.1	0.6
35-44	204,560	81	16	3	7,671,166	88.7	9.5	1.8
45-54	69,245	75.6	20.8	3.6	6,353,719	80.8	16.2	3
55-64	13,137	79.3	20.7	0	5,551,102	64.7	29.7	5.6
15-34	438,873	90.4	9	0.5	11,771,090	94.2	5.3	0.5
35-64	286,942	79.6	17.4	3	19,575,986	79.3	17.4	3.2
15-17	13,371	96.4	3.6	0	1,059,431	97.7	2.1	0.2
18-64	712,443	86	12.5	1.5	30,287,646	84.5	13.2	2.3
TOTAL	**725,814**	**86.2**	**12.3**	**1.5**	**31,347,076**	**84.9**	**12.9**	**2.2**

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

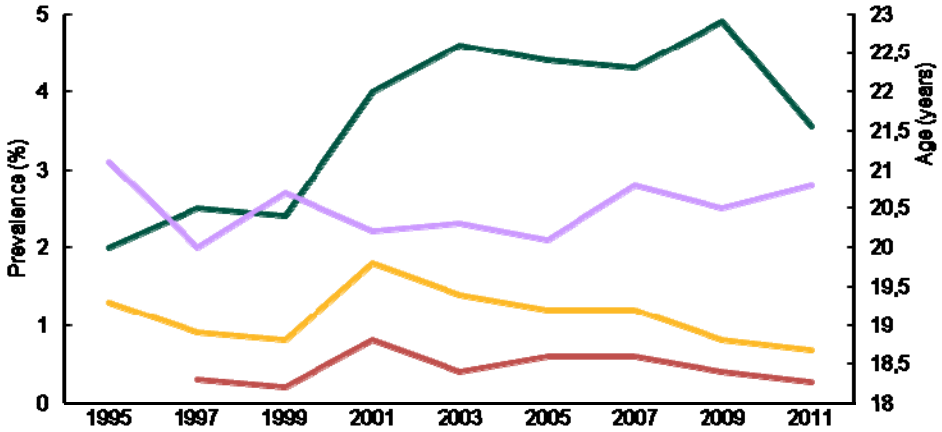
Ecstasy

Among the illicit psychoactive substances, ecstasy is ranked next in importance after cannabis and cocaine in Spain. In 2011, an overall drop has been reported in the use of ecstasy for the three customary time-related indicators (by 3.6% among sometime in their lives population, by 0.7% for the last 12 months and by 0.3% within the last 30 days). (Fig. 2.25).

This decline is sharper in experimental use, which is particularly significant, given that ecstasy is used mainly this way and additionally taking into account that, in 2009, the "sometime in their lives" use took an upward turn and showed the highest degree of prevalence of the entire historical series (4.9%). This percentage has dropped by 1.3 percentage points in 2011 down to the lowest level for the last ten years. However, regarding ecstasy use within the last 12 months and within the last 30 days, the prevalences show minimal declines, remaining at levels nearing those found in 2009, which, in this case, had already undergone a decrease compared to 2007.

Similarly, the average age of onset of use is at 20.8 years of age (20.5 in 2009), which is a positive albeit not a major change.

Fig. 2.25. Trend in the prevalence of ecstasy use and average age of onset of ecstasy use among Spain's age 15-64 population (percentages). Spain, 1995-2011



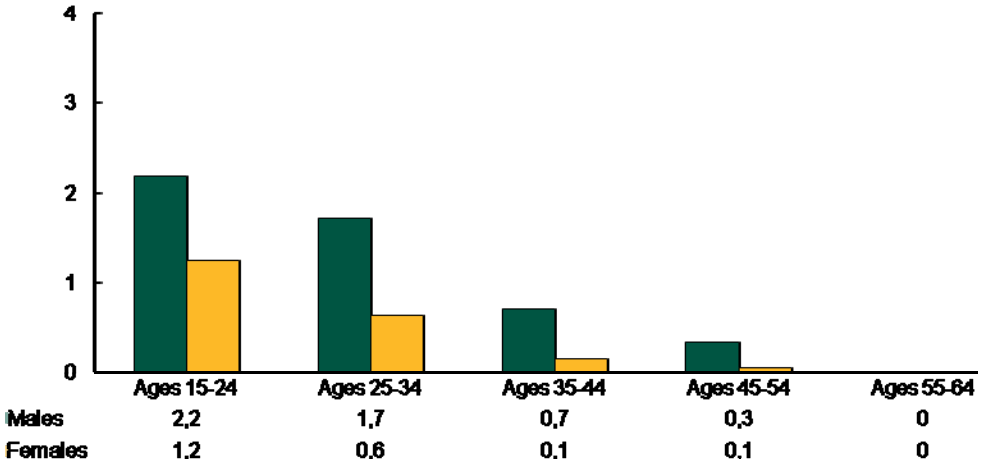
	1995	1997	1999	2001	2003	2005	2007	2009	2011
Sometime in their lives	2	2,5	2,4	4	4,6	4,4	4,3	4,9	3,6
Within the last 12 months	1,3	0,9	0,8	1,8	1,4	1,2	1,2	0,8	0,7
Within the last 30 days		0,3	0,2	0,8	0,4	0,6	0,6	0,4	0,3
Average of onset of use	21,1	20	20,7	20,2	20,3	20,1	20,8	20,5	20,8

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

By genders, as is true for all of the other illicit substances, ecstasy was used "within the last 12 months" more among males within the 15-24 age range than among the females (2.2% vs. 1.2%, respectively). (Fig. 2.26)

Compared to 2009, the most noteworthy downward trend as regards ecstasy use within the last 12 months is that noted for the males within the 15-24 age range (-1.2 percentage points compared to 2009) and within the 25-34 age range (-0.6 points)

Fig. 2.26. Prevalence of ecstasy use within the last 12 months, by age groups and genders (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Amphetamines

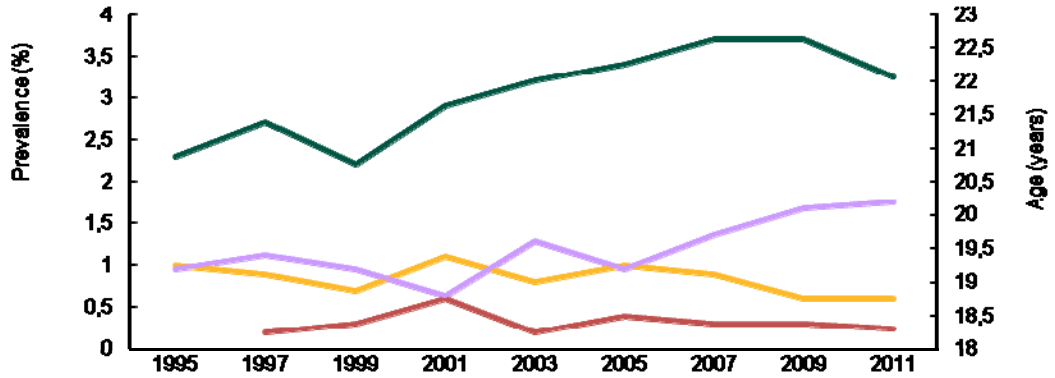
Amphetamines are substances also known as speed, ampeds, uppers, methamphetamines, ice or glass. They are used mainly experimentally, a prevalence of use with a growing trend for this modality having been noted now for more than ten years, which, although not remarkably high, is indeed steady, stabilizing in 2009 and dropping off for the first time in 2011 (from 3.7% to 3.3%, respectively). It will be necessary to take a look at further editions to see whether or not this downward trend takes hold (Fig. 2.27).

For “within the last 12 months” and “within the last 30 days”, the same prevalence levels as in 2009 are found (0.6% and 0.3%, respectively). Focusing likewise on “within the last 12 months”, the segment of males within the 15-24 age range is noted as being that in which this drug is most popular (1.8%), dropping to 1.4% when the 25-34 age range is taken into consideration. Among the females, this type of use is less widespread, thus for the youngest range, a prevalence of 1.0% and 0.4% are found for the 25-34 age group. (Fig. 2.28).

The main change in the prevalences of use compared to the year before in this study occurs in the case of males within the 15-24 age group, as the percentage of users of this type is 1.1 percentage points lower than in 2009.

Lastly, also worthy of note is that the age of onset of use is remaining relatively stable at around 20 years of age.

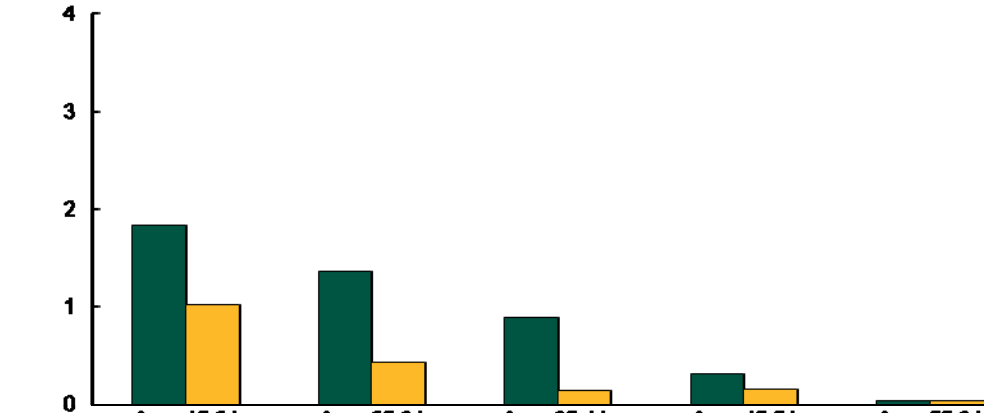
Fig. 2.27. Trend in the prevalence of amphetamine use and average age of onset of use among Spain's age 15-64 population (percentages). Spain, 1995-2011



	1995	1997	1999	2001	2003	2005	2007	2009	2011
Sometime in their lives	2,3	2,7	2,2	2,9	3,2	3,4	3,7	3,7	3,3
Within the last 12 months	1	0,9	0,7	1,1	0,8	1	0,9	0,6	0,6
Within the last 30 days		0,2	0,3	0,6	0,2	0,4	0,3	0,3	0,3
Average of onset of use	19,2	19,4	19,2	18,8	19,6	19,2	19,7	20,1	20,2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Fig. 2.28. Prevalence of use of amphetamines within the last 12 months, by age groups and genders (percentages). Spain, 2011



	Ages 15-24	Ages 25-34	Ages 35-44	Ages 45-54	Ages 55-64
Males	1,8	1,4	0,9	0,3	0
Females	1.0	0.4	0.1	0.2	0

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Tranquilizers and/or sleeping pills (hypnosedatives)

For discussing hypnosedatives, a distinction must be made between hypnosedatives in general, on one hand, and non-prescription hypnosedatives on the other. Hypnosedatives include medicines such as: lexatin, orphidal, noctamid, trankimazin, rohipnol, tranxilium, diazepam, valium, zolpidem, narcotics, benzos, benxodiazepines, barbituates, etc. .. and do not include medicinal plant type medicines, such as: valeriana, passionflower, antihistamines such as dormidin. It must be said that when reference is made to hypnosedatives in general, both prescription and non-prescription hypnosedatives are included. Non-prescription medicines are understood as being non-prescription medicines which are recommended by a physician for another person in the family and not the person surveyed, who takes them from time to time, may have continued taking them without checking with their physician or those medicines which the person surveyed has obtained by means other than a medical prescription.

Apart from the above, mention must also be made of the fact that it is not possible to extract the same historical depth from the data as for other substances, given that the use of this type of drugs began being recorded for the first time in 2005.

Hypnosedatives (prescription or non-prescription)

The data provided concerning hypnosedative use in general are the result of taking into account tranquilizers (which are for the purpose of calming nervousness or anxiety) and/or sleeping pills (sleeping aids). Similarly, it must be said that for classifying these substances as tranquilizers or as sleeping pills, their intended effect is taken into account, no record thus having been made as to the pharmacological group of the substances reported. Therefore, the case may have arisen in which those surveyed have reported using sleeping pills by referring to them as tranquilizers and vice versa.

A total of 19.5% of Spain's age 15-64 population reported in 2011 having used hypnosedatives at some time in their lives (Fig. 2.29). This prevalence marks a growth compared to 2009 by 6.1 percentage points, it also being found in 2011 that more than twice the number of people had taken hypnosedatives as in the first year a measurement was taken, in 2002, when a 8.7% prevalence was recorded. Focusing specifically on tranquilizer use, the population-based prevalence is 17.1% (+6.1 points compared to 2009), whilst for the case of sleeping pills, the prevalence is 7.9% (+1.6 points compared to 2009.).

Table 2.22. Evolution of the prevalences in the use of prescription or non-prescription hypnosedatives among Spain's age 15-64 population. Spain, 2005-2011

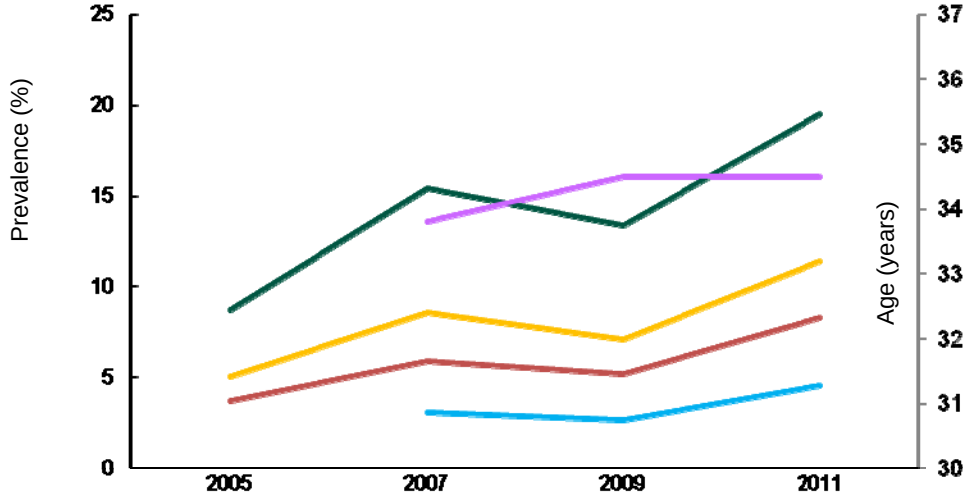
	2005	2007	2009	2011
Sometime in their lives	8.7	15.4	13.4	19.5
Within the last 12 months	5.1	8.6	7.1	11.4
Within the last 30 days	3.7	5.9	5.2	8.3
Daily	-	3.1	2.7	4.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

When asked about hypnosedative use within the last twelve months, 11.4% of the population studied stated having taken hypnosedatives. Here, once again, this marks a considerable growth compared to 2009. In this case, a 4.3 percentage point rise, and this percentage has also more than doubled compared to the percentage recorded in 2005 (Table 2.22).

Based on this data from last year, cannabis is no longer the third most widespread psychoactive substance in Spain after alcohol and tobacco for this time period, tranquilizers (9.8%) showing a greater relative importance than sleeping pills (4.4%) and a greater amount of growth (+4.3 percentage points compared to the +0.8 percentage points by which sleeping pills have grown).

Fig. 2.29. Evolution of the prevalence of prescription and non-prescription hypnosedative use and average age of onset of use of prescription and non-prescription hypnosedatives among Spain's age 15-64 population (percentages). Spain, 2005-2011



	2005	2007	2009	2011
Sometime in their lives	8,7	15,4	13,4	19,5
Within the last 12 months	5,1	8,6	7,1	11,4
Within the last 30 days	3,7	5,9	5,2	8,3
Daily within the last 30 days		3,1	2,7	4,6
Average of onset of use		33,8	34,5	34,5

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Focusing specifically on the "within the last 30 days" when recording the use of these substances renders a prevalence of 8.3%, which means a growth of 3.1 percentage points compared to 2009. By distinguishing between tranquilizers and sleeping pills, the prevalences are respectively 6.9% and 3.4%, therefore inferring that for all of the time periods included, the prevalence of tranquilizers approximately doubles that of sleeping pills.

Apart from the above, focusing on more intensive use, daily use within the last 30 days, there is a growth of 1.9 percentage points compared to 2009, totalling a 4.6% prevalence.

Worthy of note is the fact that although 2011 showed a remarkable rise in hypnosedative use for all of the time periods studied, 2009 marked a declilne in this rise regarding the trend found for previous years (Fig. 2.29). Generally speaking, hypnosedative use is also that which shows the greatest growth of all of the psychoactive substances studied, which, save certain specific cases from time to time, were showing prevalence figures lower than those recorded in 2009.

Focusing on hypnosedative use by genders, hypnosedatives are found to be the substances most widespread among the females, such that one out of every four females has taken hypnosedatives at some time in their lives (25.4% of the females). However, the prevalence of use among the males is substantially lower, 13.7%. Focusing similarly on both tranquilizers and sleeping pills, the prevalence for the females practically doubles that of the males for both types of substances (Table 2.23).

Table 2.23. Prevalences of prescription or non-prescription hypnosedative use, by genders and ages (percentages). Spain, 2011

		Ages 15 - 64			Ages 15 - 34			Ages 35 - 64		
		Overall	Males	Females	Overall	Males	Females	Overall	Males	Females
Prescription or non-prescription hypnosedatives	Sometime	19.5	13.7	25.4	12.1	8.9	15.4	24.1	16.7	31.5
	Last 12 months	11.4	7.6	15.3	6.3	4.8	7.9	14.5	9.3	19.8
	Last 30 days	8.3	5.2	11.4	3.4	2.6	4.2	11.3	6.9	15.7
Prescription or non-prescription tranquilizers	Sometime	17.1	11.9	22.3	10.7	7.8	13.8	21	14.5	27.5
	Last 12 months	9.8	6.4	13.2	5.5	4.1	7.1	12.4	7.9	16.9
	Last 30 days	6.9	4.4	9.6	2.8	2.1	3.6	9.5	5.8	13.2
Prescription or non-prescription sleeping pills	Sometime	7.9	5.5	10.2	3.9	3.3	4.6	10.3	6.9	13.6
	Last 12 months	4.4	3.1	5.9	2	1.7	2.4	5.9	3.9	8
	Last 30 days	3.4	2.1	4.7	1.3	1	1.5	4.7	2.9	6.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Analysing hypnosedative use within the last 12 months, the difference between genders is relatively similar to that found for the "sometime in their lives" use, given that twice the number of females as males have used them within the last 12 months (with prevalences of 7.6% for the males and 15.3% for the females). It is also not possible to say that the growth in population-wide use stems mostly from the higher prevalence of one single gender, given that the rise occurred in both genders.

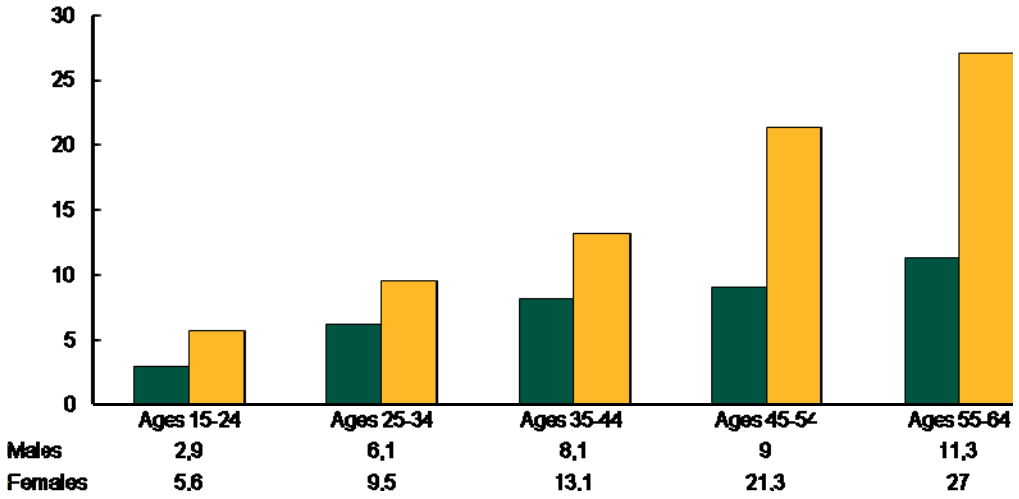
In the case of hypnosedative use "within the last 30 days", the results are similar to the previously detailed: use among the females is twice that of the males (with prevalences of 11.4% and 5.2%, respectively), and a 4.4 percentage point rise has also take place for the females and a 2-point rise for the males in the prevalences as compared to 2009.

The older the individuals, the more prevalent hypnosedative use becomes. Analysing hypnosedative used by age in a more detailed manner, by gender, some higher prevalences are found among the individuals within the 55-64 age range, reaching levels as high as 27% in the

case of the females and 11.3% for the males, taking into account the period within the last 12 months immediately prior to conducting the survey (Fig. 2.30).

Lastly, the average age of onset of hypnosedative use remains stable at 34.5 years of age and therefore continues to be the psychoactive substances which is used for the first time at an older age.

Fig. 2.30. Prevalence of prescription and non-prescription hypnosedative use within the last 12 months, by age groups and genders (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Non-prescription hypnosedatives

Given that the figures regarding hypnosedatives in general are including prescription and non-prescription hypnosedatives, the non-prescription hypnosedatives will also show lower prevalences than hypnosedatives in general.

Focusing on the “sometime in their lives” use of these substances, a 2.4% prevalence of use is found. Likewise, this is a substance more widespread among the females (2.6%), the difference in comparison to the males (2.1%) however not being as great as that which was found for hypnosedatives in general.

Non-prescription hypnosedative use within the last 12 months is spread throughout 1.2% of the population. The growth previously found to exist in hypnosedatives in general is not a result of the non-prescription hypnosedatives, because they have shown a lower prevalence in 2011 than in 2009 (0.7 percentage points). Even the figure found for this year marks a return to a minimum level (with regard to the historical series) which was recorded in 2005. By distinguishing between non-prescription tranquilizers and sleeping pills, 0,9% and 0.6% prevalences are found, respectively, entailing a decrease compared to 2009 of 0.7 and 0.5 percentage points respectively. The differences between males and females for the non-prescription hypnosedatives are quite small, additionally given the lower prevalence revealed on breaking down this data by genders (1.1% in the case of the males and 1.2% in that of the females). Both males and females show higher prevalences for the tranquilizers (0.9% and 1.0%, respectively) than for sleeping pills (0.5% and 0.7%) (Table 2.25).

Table 2.24. Trend over the course of time of the prevalences of non-prescription hypnosedative use among Spain's age 15-64 population. Spain, 2003-2011

	2003	2005	2007	2009	2011
Within the last 12 months	3.1	1.2	1.3	1.9	1.2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Table 2.25. Prevalences of non-prescription hypnosedative use within the last 12 months, by gender and age (percentages). Spain, 2011

	Ages 15 – 64			Ages 15 – 34			Ages 35 – 64		
	Overall	Males	Females	Overall	Males	Females	Overall	Males	Females
Hypnosedatives (non-prescription)	1.2	1.1	1.2	1.2	1.3	1.1	1.2	1	1.3
Tranquilizers (non-prescription)	0.9	0.9	1	1	1.1	0.8	0.9	0.8	1
Sleeping pills (non-prescription)	0.6	0.5	0.7	0.5	0.5	0.5	0.7	0.6	0.8

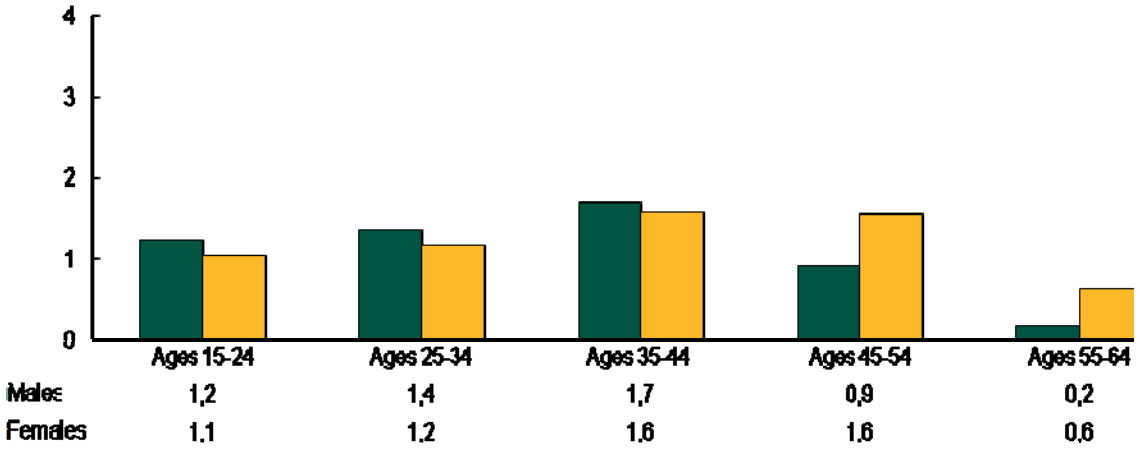
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Taking into account the age and gender of those surveyed, the females with the 35-64 age range are found to be the ones using non-prescription hypnosedatives to a greater extent than the younger 15-34 age group (1.3% vs. 1.1%), whilst there is a higher prevalence for these substances in those within the 15-34 age group (1.3% vs. 1.0%) than those within the 35-64 age group (Table 2.25).

Breaking down the ages to a greater extent, the use of this type of substances is found to be more widespread among the individuals within the 35-44 age range for both males and females (1.7% vs.1.6%, respectively), although this level remains the same in the following segment for the 45-54 age group. The prevalence of non-prescription hypnosedative use among males up to 44 years of age is slightly higher than that of the females (Fig. 2.31).

The average age of onset of non-prescription hypnosedative use is at 27.8 years of age, meaning nearly 7 years earlier than the average age recorded for hypnosedatives in general (prescription and non-prescription).

Fig. 2.31 Prevalence of non-prescription hypnosedative use within the last 12 months, by age groups and genders (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

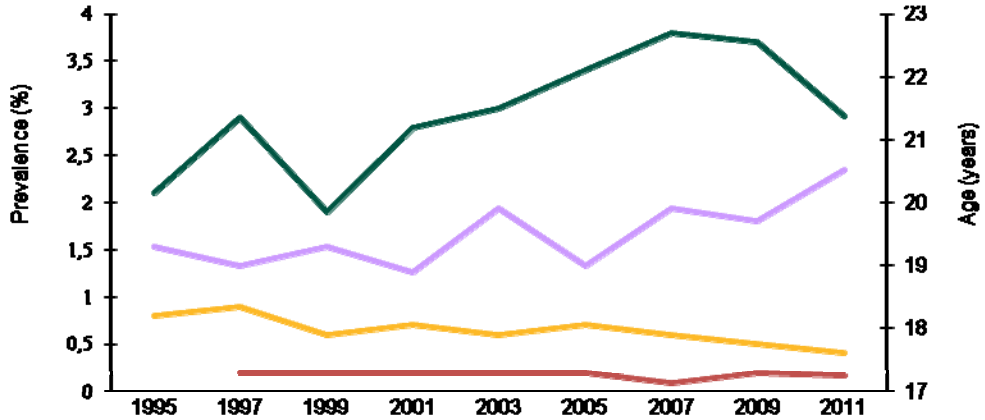
Hallucinogens

A total of 2.9% of Spain's age 15-64 population has used hallucinogens sometime in their lives, 0.4% having done so within the last 12 months and 0.2% within the last 30 days. Considering the importance of experimental use in the pattern of use of this group of substances, it is interesting to note the eight tenth's decline found to exist in the "sometime in their lives" time indicator, dropping below 3% for the first time within the last ten years. This decline, albeit small, is consolidated for the "within the last 12 months" use, reaching the lowest figure for the entire series, the "within the last 30 days" use remaining stable (Fig. 2.32).

The average age of onset of use of these substances is at 20.5 years of age, slightly later than in earlier editions of this survey, in which the age of onset was under 20 years of age.

The prevalence for "within the last 12 months" is greater among the males (0.6%) than among the females (0.2%). The segment with the highest prevalence is found to be that of the males within the 15-24 age range (1.8%), whilst for this same age, the females show a 0.8% prevalence, which is somewhat less than half. (Fig. 2.33).

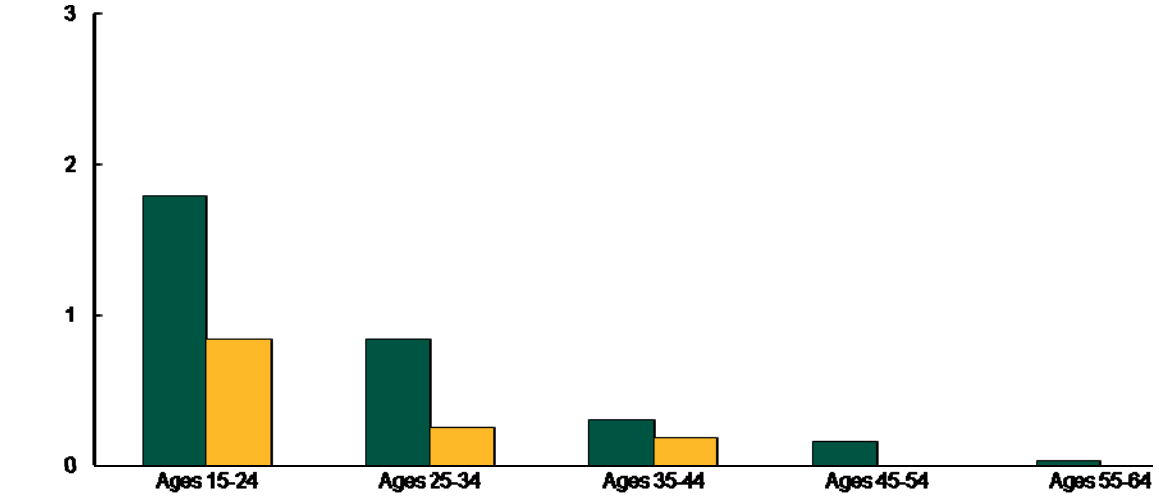
Fig. 2.32. Trend of the prevalence of hallucinogen use and average age of onset of hallucinogen use among Spain's age 15-64 population (percentages). Spain, 1995-2011



	1995	1997	1999	2001	2003	2005	2007	2009	2011
Sometime in their lives	2,1	2,9	1,9	2,8	3	3,4	3,8	3,7	2,9
Within the last 12 months	0,8	0,9	0,6	0,7	0,6	0,7	0,6	0,5	0,4
Within the last 30 days		0,2	0,2	0,2	0,2	0,2	0,1	0,2	0,2
Average of onset of use	19,3	19	19,3	18,9	19,9	19	19,9	19,7	20,5

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Fig. 2.33. Prevalence of hallucinogen use within the last 12 months, by age groups and gender (percentages). Spain, 2011



	Ages 15-24	Ages 25-34	Ages 35-44	Ages 45-54	Ages 55-64
Males	1,8	0,8	0,3	0,2	0
Females	0,8	0,3	0,2	0	0

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

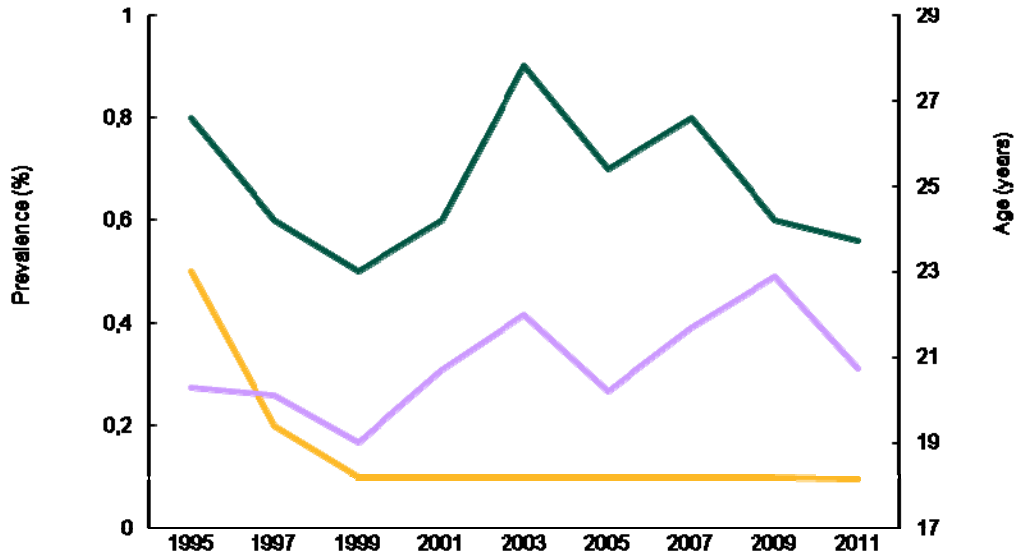
Other psychoactive drugs

The use of volatile inhalants and heroin is less widespread among Spain's resident population than for all of the other psychoactive substances. Their "sometime in their lives" prevalences are not even a full percentage point (0.8% vs. 0.6%, respectively), and for "within the last 12 months" both are at 0.1%. But these low prevalences are, on the other hand, a stumbling block for appropriately measuring the patterns of use for these drugs based on the population-wide surveys, given that the problem users, who are particularly significant among heroin addicts, are not sufficiently represented in this type of measurements.

The average of onset of volatile inhalant use is at 19.7 years of age, whilst the average age of onset of heroin use is one year later. The small number of those surveyed who state using these substances poses the need of taking the average ages of onset of use with all due precaution, given that the size of the survey may have a bearing on the figures for these ages, which would justify the variations seen in the historical series (Fig. 2.34).

Special note may be made of the growth, albeit slight, in the prevalences of volatile inhalant use as compared to 2009, the year in which these prevalences had dropped, whilst in the case of heroin, the prevalences have been remaining constant since 2007. (Fig. 2.35).

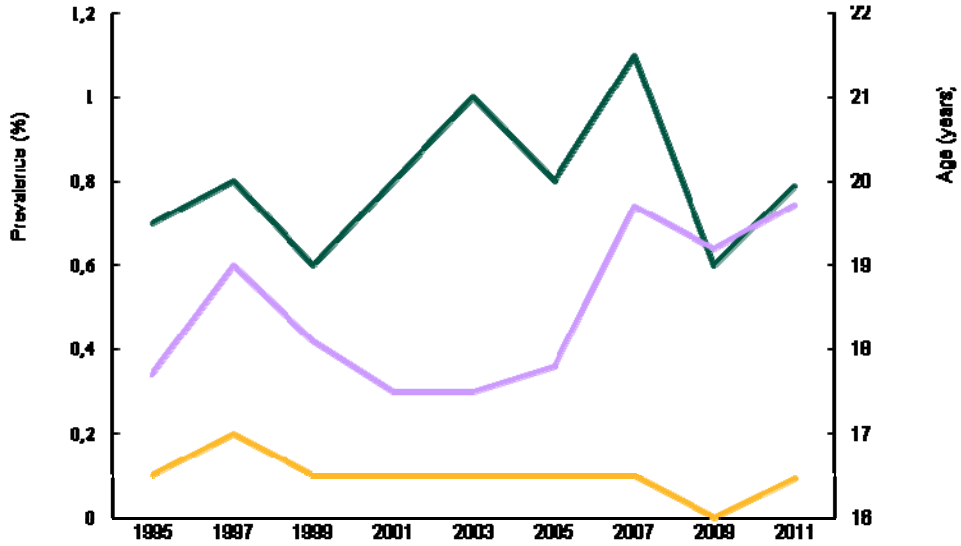
Fig. 2.34. Trend in the prevalence of heroin use and average age of onset of heroin use among Spain's age 15-64 population (percentages). Spain, 1995-2011.



	1995	1997	1999	2001	2003	2005	2007	2009	2011
Sometime in their lives	0,8	0,6	0,5	0,6	0,9	0,7	0,8	0,6	0,6
Within the last 12 months	0,5	0,2	0,1	0,1	0,1	0,1	0,1	0,1	0,1
Average of onset of use	20,3	20,1	19	20,7	22	20,2	21,7	22,9	20,7

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Fig. 2.35. Trend in the prevalence of volatile inhalant use and average age of onset of the use of volatile inhalants among Spain's age 15-64 population (percentages). Spain, 1995-2011



	1995	1997	1999	2001	2003	2005	2007	2009	2011
Sometime in their lives	0,7	0,9	0,8	0,9	1	0,3	1,1	0,8	0,9
Within the last 12 months	0,1	0,2	0,1	0,1	0,1	0,1	0,1	0	0,1
Average of onset of use	17,7	19	18,1	17,5	17,5	17,8	19,7	19,2	19,7

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Emerging drugs

This section reviews the results achieved from adding a module into the 2011 Household Survey on Alcohol and Drugs in Spain (EDADES) questionnaire aimed at ascertaining different aspects of a group of psychoactive substances known as emerging drugs, either due to their having made their way onto the market recently or because, although being substances known and used for a longer length of time, their use has been taken up again and reinvented by the overall population as a whole or by certain groups of the population. The substances included are: ketamine, spice, piperazines, mephedrone, nexus, methamphetamine, magic mushrooms, research chemicals, legal highs, salvia divinorum and anabolic steroids.

The 2010 Household Survey on Alcohol and Drugs in Spain (EDADES) conducted on secondary school students included a similar module for the first time, affording the possibility of initially approximating the emerging drug phenomenon in Spain among the youngest population (14-18 age range) (See the 2011 Spanish National Report). The results provided in following show the time-related trend of the prevalence of use among the youngest users and to determine, at least a broad-scale overview of the overall magnitude of the uses and whether or not any differences exist according to genders and age groups among the adult population. Information is also provided on the perception of risk and of the degree of availability related to these substances on the part of those surveyed and also regarding the actual ways of accessing these substances among those individuals who have used them.

Taken overall, in 2011, a total of 3.6% of Spain's age 15-64 population had used emerging drugs sometime in their lives, a total 0.9% having used them sometime within the last 12 months and 0.4% within the last 30 days immediately prior to being surveyed. For all of the time-related indicators and all age groups, the use thereof was more widespread among the males than among the females. The breakdown by ages showed, for the "sometime in their lives" time segment, a

higher prevalence figure in the 19-34 age group (6.6%), which, on the other hand, is not surprising taking into account that a large part of the emerging drug used are anticipated to be used by young users in leisure environments or private spaces with the intention of experimenting with new psychoactive substances or which, without being illicit, mimic the effects of others which are indeed illicit, access to which is therefore more restricted. Regarding the "within the last 30 days" time period, the 19-34 age group shows a prevalence similar to that of the group of young people within the 15-18 age group (1.7% and 1.8%, respectively), whist focusing on the "within the last 30 days" time period, the use is once again more widespread among these individuals in the 19-34 age groups (0.8%) (Table 2.26).

Table 2.26. Prevalence of emerging drug use among Spain's age 15-64 population, by gender and age (percentages). Spain, 2011

	15-18			19-34			35-64			15-64		
	Over all	**M**	**F**	**Over all**	**M**	**F**	**Over all**	**M**	**F**	**Over all**	**M**	**F**
Sometime in their lives	2.4	3.5	1.3	6.6	9.5	3.6	2.1	3.3	0.9	3.6	5.4	1.8
Within the last 12 months	1.8	2.4	1.2	1.7	2.6	0.8	0.3	0.5	0.1	0.9	1.3	0.4
Within the last 30 days	0.4	0.6	0.2	0.8	1.2	0.3	0.2	0.3	0.1	0.4	0.6	0.2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

By substances, focusing on the "sometime in their lives" use, the highest prevalences of use among the age 15-64 population were found for the magic mushrooms (2.4%), followed by ketamine (1%), salvia divinorum (0.9%), spice (0.8%) and methamphetamine (0.8%). The rest of the substances show a similar spread as far as the substances are concerned, but with very low prevalence figures, thus confirming the sporadic, experimental nature of the use of these substances among the general population (Table 2.27).

Table 2.27. Prevalences of use of emerging drugs among Spain's age 15-64 population (percentages). Spain, 2011

	Sometime in their lives	Within the last 12 months	Within the last 30 days
Ketamine	1	0.2	0
Spice	0.8	0.1	0.1
Piperazines	0.1	0	0
Mephedrone	0.1	0	0
Nexus	0.2	0	0
Methamphetamine	0.8	0.2	0.1
Magic mushrooms	2.4	0.4	0.1
Research chemicals	0.1	0	0
Legal highs	0.1	0	0
Salvia divinorum	0.9	0.2	0.1
Anabolic steroids	0.3	0.1	0.1

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).

Nevertheless, due to the characteristics proper of the phenomenon of using "new drugs" or emerging drugs, which seems to have spread and been publicized mainly by way of the internet, social networks, etc., it is worthwhile for a more detailed study to be conducted regarding those population groups which, in principle, could be more prone to adopting new substances or new uses.

Thus, Table 2.28 clearly shows how the highest percentage of those using magic mushrooms, ketamine, spice, methamphetamine, salvia divinorum and anabolic steroids falls within the 25-34 age group, whilst the highest percentages of use of mephedrone, piperazines, legal highs and research chemicals are found among the age 14-18 teenage population. Both groups show a similar prevalence of use for the case of nexus. In this regard, one striking fact is that the emerging drugs showing the highest prevalence of use among the 25-34 age group are precisely the newest ones, with the exception of spice (synthetic cannabis derivatives) and salvia divinorum, given that these are substances like ketamine, magic mushrooms, methamphetamine or anabolic steroids which have been around for decades and the use and popularity of which have varied over the course of time. However, it is the young population (14-18 age group) showin the greatest degree of penetration of the drugs which have most recently come onto the real and also virtual market (mephedrone, piperazines, research chemicals or legal highs). Table 2.29 includes the data for the prevalences of use "within the last 12 months".

Table 2.28. Prevalences of use of emerging drugs (sometime in their lives) among age 14-18 students and in the general age 15-64 population (percentages). Spain, 2010 y 2011

	2010	2011							
Sometime in their lives	**14-18**	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	**15-34**	**35-64**	**15-64**
Ketamine	1.1	1.4	2	1	0.4	0	1.8	0.5	1
Spice	1.1	1	1.4	0.9	0.4	0.1	1.2	0.5	0.8
Piperazines	0.4	0.1	0.2	0.2	0	0	0.1	0.1	0.1
Mephedrone	0.4	0.3	0.2	0.2	0	0	0.3	0.1	0.1
Nexus	0.5	0.2	0.5	0.1	0	0	0.4	0.1	0.2
Methamphetamine	0.8	0.9	1.2	1	0.3	0.1	1.1	0.5	0.8
Magic mushrooms	2.1	3.3	4.9	2.1	1	0.1	4.3	1.2	2.4
Research chemicals	0.4	0.1	0.2	0	0	0	0.1	0	0.1
Legal highs	0.7	0	0.2	0.1	0.1	0	0.1	0.1	0.1
Salvia divinorum	---*	1.1	1.8	0.8	0.3	0.1	1.5	0.5	0.9
Anabolic steroids	---*	0.3	0.6	0.4	0	0.1	0.4	0.2	0.3

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011) and National Survey on Drug Use Among Age 14-18 Secondary School Students (ESTUDES 2010).
*ESTUDES 2010 did not include question on the use of Salvia divinorum or anabolic steroids.

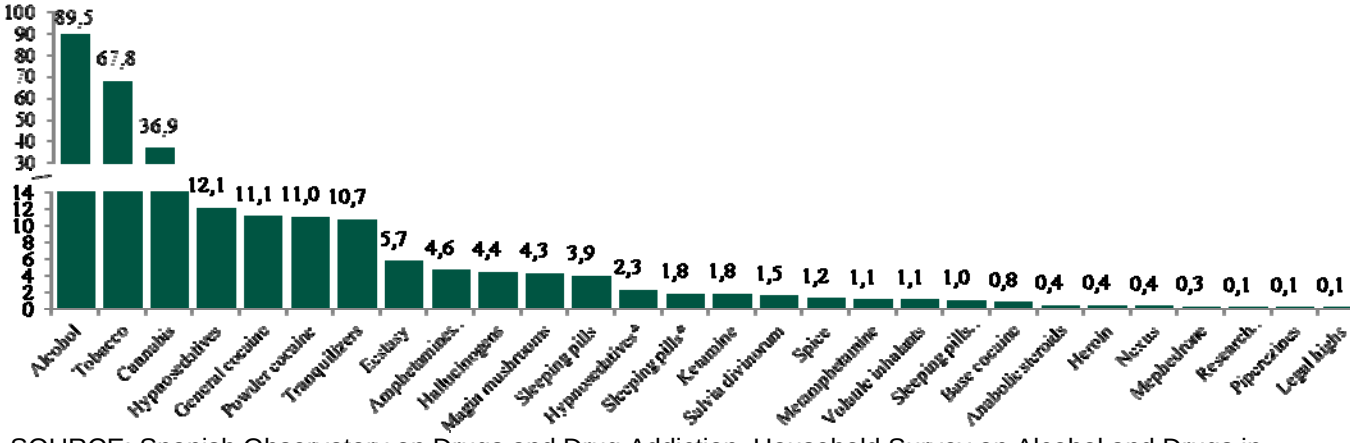
Table 2.29. Prevalences of use of emerging drugs (within the last 12 months) in students within the 14-18 age group and in the overall age 15-64 population (percentages). Spain, 2010 y 2011

	2010	2011							
Sometime	**14-18**	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	**15-34**	**35-64**	**15-64**
Ketamine	0.8	0.5	0.3	0.1	0	0	0.4	0	0.2
Spice	0.8	0.4	0.3	0.1	0	0	0.3	0	0.1
Piperazines	0.3	0.1	0	0	0	0	0	0	0
Mephedrone	0.3	0.2	0.1	0	0	0	0.1	0	0
Nexus	0.3	0	0.1	0	0	0	0.1	0	0
Methamphetamine	0.6	0.3	0.3	0.1	0.1	0	0.3	0.1	0.2
Magic mushrooms	1.6	1.1	0.8	0.2	0	0	1	0.1	0.4
Research chemicals	0.3	0	0.1	0	0	0	0	0	0
Legal highs	0.6	0	0	0.1	0	0	0	0	0
Salvia divinorum	---*	0.4	0.2	0.2	0.2	0.1	0.3	0.1	0.2
Anabolic steroids	---*	0.1	0.1	0.1	0	0.1	0.1	0.1	0.1

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011) and National Survey on Drug Use Among Age 14-18 Secondary School Students (ESTUDES 2010).
*ESTUDES 2010 did not include questions on the use of Salvia divinorum or anabolic steroids.

Despite the fact that, for the time being the prevalences of use of emerging drugs are not showing such high figures in Spain as those recorded in some other EU countries, Australia, etc., and that the difficulty of finding evidence of or ruling out the involvement thereof in poisonings and deaths having prevented any social alarm, it is interesting to note the magnitude of the uses consumptions of some of these substances within the context of all of the rest of the psychoactive substances to which attention has conventionally been being given.

Fig. 2.36. Prevalence of drug use "sometime in their lives" among Spain's age 15-34 population (percentages). Spain 2011.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
*Non-prescription

For most of the emerging drugs studied, one out of every two individuals surveyed states never having heard anything about them. Those most well-known among the general population would be the anabolic steroids and magic mushrooms. On the other hand, taking all of the emerging drugs as a whole, a total of 32.3% of those surveyed had never heard anything about any emerging drug of those mentioned, as is shown in Table 2.30. This Table details the spread, by genders and ages, of those who state being aware of the existence of one or more of the emerging drugs about which they have been asked and of those who are familiar with none. Thus, it is shown that the complete lack of knowledge of the emerging drugs is standard among the females and in the older age groups, whilst those within the 25-34 age group show the highest degree of knowledge in terms of the reputations of these drugs (78%), followed by the youngest segment (15-24 age group) (76.9%).

Table 2.30. Spread, by gender and age, of Spain's age 15-64 population who state being aware of the existence of one or more of the emerging drugs about which they were asked in the survey. Spain, 2011

	GENDER		AGE					TOTAL
	Male	Female	15 - 24	25 - 34	35 - 44	45 - 54	55 - 64	
Has heard about at least one emerging drug	71.9	63.5	76.9	78.0	70.5	62.9	47.6	67.7
Has never heard anything about any emerging drug	28.1	36.5	23.1	22.0	29.5	37.1	52.4	32.3

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

Taking into account solely those individuals who say they know the emerging drugs about which they are asked in the survey, more than 95% of them agree on associating many or quite a few problems with the sporadic use of these drugs (for each one of the substances studied), although this percentage is somewhat smaller in the case of the substances most well-known among the population (magic mushrooms (92%) and anabolic steroids (92.9%) and in the case of salvia divinorum (93.3%) (Table 2.31).

The perception of the risk associated to sporadic use is greater among the females than among the males, for all of the emerging drugs studies, the greatest differences between the two genders also being noted in the case of magic mushrooms and anabolic steroids.

Regarding the age, it is found that, the older those surveyed, the greater the perception of risk among the population. Nevertheless, the perception of risk is above 90% for all of these substances and age ranges, magic mushrooms being the only substances for which the percentage is not so high in the case of the young people (87.6% in the 15-24 age group and 89.9% in the 25-34 age group). (Table 2.31).

Table 2.31. Perceived risk in view of different emerging drug use-related behaviours (percentage of age 15-64 population who believe that each use behaviour can cause many or quite a few problems)*, by gender and age. Spain, 2011

	GENDER		AGE					TOTAL
Sometime	**Male**	**Female**	**15-24**	**25-34**	**35-44**	**45-54**	**55-64**	
Ketamine	94.4	96.5	93.9	94.4	95.8	96.6	97.2	95.4
Spice	94.3	96.7	93	94.6	96.2	96.4	97.5	95.4
Piperazines	95.5	97.2	95.1	95.5	96.5	96.8	98.3	96.3
Mephedrone	95.6	97.3	95.2	95.5	96.9	96.8	98.3	96.4
Nexus	95.4	97.2	94.5	95.4	96.9	96.9	97.7	96.2
Methamphetamine	94.5	97.2	94.1	95.1	96	96.8	97.4	95.7
Magic mushrooms	90.1	94.3	87.6	89.9	93	95.8	96.5	92
Research chemicals	95.7	97.4	95.4	95.7	96.9	97.1	97.7	96.5
Legal highs	95.4	97.4	95.3	95.2	96.8	97	98	96.3
Salvia divinorum	92	94.9	91.2	91.5	94.6	94.6	95.8	93.3
Anabolic steroids	91.5	94.5	90.5	91.9	93.8	93.3	95.9	92.9

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
Ruling out those cases marking “Don’t know this substance” or who have answered “Don’t know/No answer”.

Regarding the perceived degree of availability, in other words, how readily obtainable within 24 hours those surveyed believe each one of the substances studied to be, data taken from those who state knowing these substances is provided. Depending on the substances, 37.7% - 59.5% of those surveyed were not at all familiar with them, and around 13.5% did not answer, this entailing that, depending on the type of substance, 53.4% - 72% of those surveyed did not provide an answer regarding the perceived degree of availability.

Among those who did give an answer, anabolic steroids are the substance considered to be readily available by the largest percentage of the population (48.8%), given that approximately one out of every two people who is familiar with this substance believes that they can obtain it easily or very easily within 24 hours. The same is true among the 43.9% who know spice and among the 43.7% who know magic mushrooms. The remaining substances studied show figures which are also above 40% (Table 2.32).

Focusing specifically on the age of the individuals surveyed, the older the person surveyed, the lesser the degree of perceived availability. In the 15-24 age group, the magic mushrooms and anabolic steroids are the substances considered to be readily/very readily available by a larger percentage of young people (one out of every two believe that they could obtain them easily/very easily within 24 hours). In the 25-34 age group, anabolic steroids (55.2%) and spice (49%) are the substances they perceive as being readily /very readily available by a higher percentage (Table 2.32).

Table 2.32. Perceived degree of availability of emerging drugs (relatively easily / very easily obtainable within 24 hours) among the age 15-64 population, by gender and age (percentages)*. Spain 2011

	GENDER		AGE					TOTAL
	Males	Females	15-24	25-34	35-44	45-54	55-64	
Ketamine	43.0	39.2	45.8	45.5	42.0	36.1	28.4	41.4
Spice	45.3	42.2	49.0	49.0	44.0	38.4	30.9	43.9
Piperazines	42.8	39.2	45.5	45.0	42.8	36.5	29.2	41.2
Mephedrone	42.2	38.7	45.6	44.7	41.5	36.2	28.6	40.7
Nexus	42.2	39.3	45.1	44.8	42.1	36.3	29.9	40.9
Methamphetamine	43.4	38.6	46.5	45.4	41.5	36.3	29.2	41.3
Magic mushrooms	46.4	40.3	50.2	47.9	42.8	37.8	30.9	43.7
Research chemicals	42.7	39.3	45.9	44.9	42.1	37.5	28.5	41.2
Legal highs	42.5	39.1	45.8	45.2	42.2	36.4	28.2	41.0
Salvia divinorum	44.8	40.7	48.4	47.7	43.7	36.9	31.1	43.0
Anabolic steroids	51.7	45.2	54.4	55.2	48.7	41.8	35.2	48.8

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011)
* Ruling out those cases marking “Don’t know this substance” or who have answered “Don’t know/No answer”.

The greater or lesser degrees to which the risk associated with using a certain substance and the perception as to the greater or lesser degree to which the substance in question is readily available (perceived availability) are usually related to the prevalence of use directly for the case of perceived risk and inversely in the case of the readiness of availability. Thus, it is somewhat logical that greater percentages of users are recorded among those who perceived the use of a substance as being less dangerous than those who perceive it as being very dangerous. Similarly, generally speaking, a higher percentage of users are usually found among those who believe a substance to the readily available than among those who recognize a greater deal of difficulty for obtaining that substance in particular. Nevertheless, this is not always the case, given that sometimes the existence of a high perception of risk does not mean use being avoided (i.e. active smokers who perceive a high degree of risk, etc.) on which different factors may have a bearing, such as the age, existing regulations regarding the substance in question the degree of social acceptance of the use of such a substance, the association of the substance in question with certain social characteristics (high social standing, marginality, etc.).

Table 2.33. Perceived risk in view of different emerging drug use behaviours (percentage of the age 15-64 population who believes that each behaviour can cause many or quite a few health problems) by users and non-users of the different emerging drugs. Spain, 2011

	Has never used this substance		Has used this substance sometime	
	%	Cases	%	Cases
Ketamine	95.9	10,189	68.2	187
Spice	95.9	8,890	69.9	135
Piperazines	96.3	7,896	85.4	19
Mephedrone	96.5	7,972	66.5	25
Nexus	96.3	7,773	59.9	26
Methamphetamine	96.1	10,296	71.8	148
Magic mushrooms	93.9	10,282	51.5	324
Research chemicals	96.5	7,578	50.6	10
Legal highs	96.3	7,511	66.2	9
Salvia divinorum	94.4	7,828	43.7	91
Anabolic steroids	93.0	11,626	60.7	40

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011)
* Ruling out those cases marking “Don’t know this substance” or who have answered “Don’t know/No answer”.

Table 2.33 shows how those using each one of the substances analysed show a lesser degree of perception of risk than those who do not use the substance in question, some major differences also existing depending on the substance in question. It must be taken into account that the sub-sample of users is quite small, but it is clearly patent how more than half of those using magic mushrooms do not consider this substance to be dangerous.

Ways of obtaining these substances

On analysing the different ways in which those using emerging drugs (one or more substances) have managed to gain access to them, the way found to be used by its highest percentage is through a friend or acquaintance (55%), followed, to a much lesser degree, by obtaining them through dealers and bars or discotheques (13.2% in both cases), the smart-shops/head shops (6.1%) and festivals (5.4%) (Table 2.34).

Worthy of special mention is the Internet being used as a way of accessing emerging drugs, given that this way has played a fundamental role in the rest of the European Union countries in broadcasting the information on many of these substances, especially those which have most recently made their way onto the market (spice, mephedrone, legal highs, research chemicals..) and has also made it possible to obtain them easily through webpages offering quite affordable prices and minimal personal identification requirements for consumers. It also must not be overlooked that the Internet is, for the young population, a regularly-used tool which makes possible and expands upon their recreational options almost effortlessly. However, in Spain, this does not seem to have been the case. Table 2.34 shows that solely 1.4% of those to state who had accessed/bought any of the emerging drugs as having done so via the Internet. A total of 0.9% thereof obtained these drugs through webpages, 0,4% via the social networks and 0.1% through forums. It is at least surprising to find that the Internet is of such relatively little importance in acquiring these substances, but this route must be monitored so as to prevent it from becoming an "easy" port of entry for certain substances, as is the case in other countries.

Table 2.34. Ways of obtaining emerging drugs among those who have acquired them sometime, among the age 15-64 population (percentages). Spain 2011

	Where did you get these drugs?
On the net: webpages	0.9
On the net: social networks	0.4
On the net: forums	0.1
A friend or acquaintance	55
Through a dealer	13.2
At a discotheque or bar	13.2
At a specialized shop (smart shop or head shop)	6.1
At a festival	5.4
Others	5.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011
*Nota: Note: Ruling out the cases of "I have never acquired this type of drugs" and distributing the response based on 100%

Information channels

Half of the population surveyed stated not having received any information about these drugs. Among those who had indeed received information, the most prevalent ways are the mass media (30% of the individuals surveyed had received information this way) and through friends, acquaintances or fellow workers (14.2%). When those surveyed were asked about the ways they would like to receive information on these substances, 34.5% are not interested in receiving information on this subject. Among those who would like to receive information, the option mentioned by most is the mass media (39.4%), followed by socio-sanitary professionals (18.6%). It is precisely through the socio-sanitary professionals that the greatest gap occurs between the percentage of individuals who would like to be provided with information this way and the percentage who are provided, in fact, with this information through these professionals.

Table 2.35. Main information channels through which the age 15-64 population has been provided with information about new drugs and through which they would like to be provided with better, more objective information on the use of new drugs, the effects and the problems associated with these drugs and their ways of use. Spain 2011

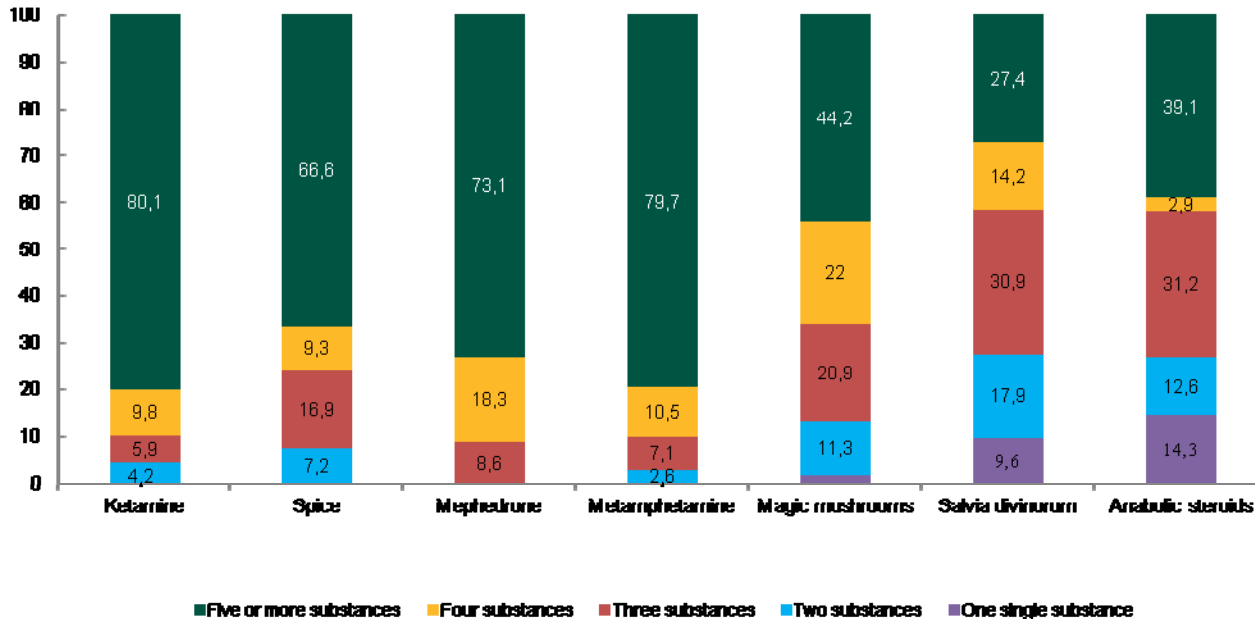
	Channels through which you have been provided with information	Channels through which you would like to be provided with information
On the net: webpages	6.1	14.2
On the net: social networks	2.4	9.2
On the net: forums	1.3	5.0
Parents/ family members	5.2	6.2
A friend, acquaintance or fellow worker	14.2	5.1
Socio-sanitary professionals (physicians, nurses, social workers)	4.0	18.6
Teachers/professors	6.7	14.4
Talks or courses on this subject	5.8	16.4
Official agencies (ministries, government departments…)	2.6	11.8
Books and/or pamphlets	6.8	14.6
The media (press, TV or radio)	30.0	39.4
The police	1.2	5.0
People who have dealt with them	6.6	8.0
Others	1.4	0.7
I have not been provided with any information on these drugs	50.8	-
I am not interested in this type of information	-	34.5
No answer	1.8	3.8

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

Use of other drugs

The Household Survey on Alcohol and Drugs in Spain (EDADES 2011) results reveal the vast majority of emerging drug users (60%-90%) to have used at least five different psychoactive substances during their lives. An excepcion in this regard are those using ketamine (92.3%) and those who use methamphetamines (92.1%). At the opposite end of the scale are the salvia divinorum users, a total of 61.6% of whom had used five psychoactive substances during their lives. Figure 2.37 shows the prevalence of use of other substances within the last 12 months among those who have used emerging drugs within the last 12 months.

Fig. 2.37. Number of substances used sometime in their lives by those using each one of the emerging substances within the last 12 months (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011)

On analysing the uses of other substances among those using the emerging drugs, using the "within the last 12 months" time reference, it is found that, generally speaking, they are users of other illicit drugs, because despite the fact that around 90% use tobacco and alcohol, the vast majority uses more than three drugs within the same period, which entails the use of other illicit drugs.

All of the above leads to the conclusion that those who use the substances included in the emerging drug category are, for the most part, poly-users of multiple drugs, although it is not possible to determine the time span between one and another, or if they are used all at the same time. Anyway, independently of the effects of the emerging drug used and how often it is used, it can be said, generally speaking, that having used some emerging drug within the last 12 months makes the user in question an at-risk user, solely due to the high prevalence of poly-use associated with the same.

Studying the association of the different drugs (licit and illicit) for those using emerging drugs (Table 2.36) within the last 12 months, alcohol, tobacco and cannabis is found to be used by all.

Table 2.36. Percentage of those using other drugs within the last 12 months among the individuals within the age 15-64 population who have used ketamine, spice, piperazines, mephedrone, nexus, methamphetamine, magic mushrooms, research chemicals, legal highs, salvia divinorum or anabolic steroids within the same period (percentages). Spain, 2011

	Ketamine	Spice	Piperazines	Mephedrone	Nexus	Methamphetamine	Magic mushrooms	Research chemicals	Legal highs	Salvia divinorum	Anabolic steroids
Alcohol	100	100	100	100	100	99.2	97.1	100	100	100	100
Tobacco	97.2	85.2	79	100	100	88.2	87.9	79	100	81.4	82
Volatile inhalants	12.4	7.4	55.3	19.2	0	12.8	5.6	26.5	0	4.7	0
Amphetamines/speed	61.8	48.5	79	73.1	68.5	71.4	32.6	87.7	71	22.6	20.1
Hallucinogens	46.6	25.9	55.3	67.6	54.4	37.4	45.8	47.6	10.7	18.1	5
Heroin	9.2	11.4	0	10.4	0	9.7	0	0	0	0	18.6
Tranquilizers	34.2	13.5	38.8	9	58.8	27.3	17.3	26.5	12.6	15.2	44.3
Sleeping pills	22.2	13.3	0	0	34.7	17.2	7.6	21.1	12.6	4	25.7
Hypnosedatives	34.8	14.5	38.8	9	58.8	27.3	19.2	47.6	12.6	15.2	45.2
Cannabis	94.1	90.8	100	100	100	84.3	84.9	100	100	73.3	55.5
Ecstasy	67.5	49.8	55.3	66.5	92.6	61.2	36	87.7	71	19	20.9
Powder cocaine	79.9	67.1	79	69.4	79.9	74.1	48.2	66.5	71	32.9	34
Base cocaine	13.2	20.3	0	0	0	15.3	3.9	21	0	3.7	19.1
General cocaine	79.9	71.6	79	69.4	79.9	74.1	48.2	66.5	71	32.9	34

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

Similarly, cocaine (in general) is the fourth-ranked substance most used by all of those profiles with the exception of those who use research chemicals, given that, in this case, the prevalence of amphetamines and ecstasy is greater than that of cocaine.

Certain associations of substances are also found to exist among those who use the different emerging drugs. Thus, hallucinogens show a higher prevalence among those who use piperazines as does nexus than among those who use other emerging drugs. Ecstasy is more widespread among those who use nexus, research chemicals and legal highs. The prevalence of amphetamines/speed stands out among those using piperazines, mephedrone, methamphetamines, research chemicals and legal highs.

Responses to the new emerging drugs

The drug phenomenon is undoubtedly changing both in our country and in the rest of the world, with new drugs and new patterns of use arising. Being aware of this situation, efforts are being made through the Government Delegation for the National Plan on Drugs to address this process. Within this context is the effort being made to adapt the Information Systems in order to obtain data on the new drugs, as has been done in the 2010 student survey or in the 2011 survey conducted on the general population detailed hereinabove.

Another action gotten under way is that of the "emerging drugs1" report being published by the Government Delegation for the National Plan on Drugs' clinical commission of experts. Therein, a practical manual is provided for professionals, serving as a compendium of the current knowledge on the emerging drugs and their effects on human health, providing updated information on the situation of the use of these substances in Spain and reviewing some related legal and social aspects.

One field in which work is also being done is that of promoting and further bolstering the Spanish Early Warning System,2,3 in place within the frameworks of European Union Council resolution 2005/587/JAI, which requires that each European Union member nation avail of a national system for sharing information and a system for gathering data on new substances so as to furnish the European Monitoring Centre for Drugs and Drug Addiction and Europol with reports and thus fulfil the objectives of said resolution.

In this regard, a meeting was held in March 2012 with all of the agents involved in the system, and a virtual, two-way communications network is currently being maintained with all those involved every time it is necessary to report an alert. This system is comprised of different Central Government Ministries, the Autonomous Community Administration and Non-Governmental Organizations, as well as other entities. The Government Delegation for the National Plan on Drugs coordinates this network, keeps in touch with the European Monitoring Centre for Drugs and Drug Addiction, notifies the new substances detected and prepares those reports which are necessary.

Injecting drugs

The prevalences found by way of this study show that 0.4% of the age 15-64 population has injected heroin, cocaine or other illicit drugs sometime in their lives (0.6% of the males and 0.2% of the females). Focusing on the results by the ages of those interviewed, those individuals who are within the 35-44 age group are found to be those showing the highest prevalence (0.8%) (Table 2.37).

Table 2.37. Prevalence of use of heroin, cocaine or other illicit drugs by injection sometime in their lives, by age groups and gender (percentages). Spain, 2011

	Total	Males	Females	Ages 15 -24	Ages 25-34	Ages 35-44	Ages 45 – 54	Ages 55-64
Prevalence of use of heroin, cocaine or other illicit drugs by injecting	0.4	0.6	0.2	0.1	0.3	0.8	0.5	0.2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

Poly-drug use

Poly-drug use refers to the use of two or more either licit or illicit psychoactive substances within a specific time period. Taking into account this aspect and focusing specifically on the last 12 months immediately prior to the survey, it has been recorded in 2011 that 48.1% of the population using psychoactive substances (within the 15-64 age group) has entailed poly-use within the last 12 months Therefore, it is found that approximately one half of the populations using psychoactive substances uses exclusively a specific type of drugs, whilst the other half uses at least two different types of substances. The use of two substances is the most prevalent habit among the population involved in poly-use, with a prevalence of 34.7% (Table 2.38).

Focusing specifically on the last 30 days immediately prior to this survey having been conducted, the percentage of people using psychoactive substances who are involved in poly-use totals 42.9%; totalling 33.2% if specifically focusing on the use of two different substances within the last 30 days. Similarly, regarding the most extreme poly-use habits, it is noted that 2.2% of the user population has used four substances within the last 12 months (1.3% of the user population in the case of focusing specifically on the last 30 days, and 1.2% at least five substances (0.6% for the period "within the last 30 days").

Table 2.38. Prevalence in the use of one or more psychoactive substances (licit or illicit) (percentages). Spain, 2011.

	Within the last 12 months	Within the last 30 days
One single substance	51.9	57.1
Two substances	34.7	33.2
Three substances	10	7.8
Four substances	2.2	1.3
Five or more substances	1.2	0.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011)

Looking at both the intensity of the poly-use and the substances used within the last 12 months (Table 2.39), alcohol is found to be present in practically all of the types of poly-use. The use of tobacco is also a constant in poly-use, mainly insomuch as there being a larger number of substances involved. Cannabis is starting to show a major prevalence now in the poly—use of three substances (62.6%). Lastly, special note must be made of the growth which tranquilizers and sleeping pills have undergone in this regard. Among those individuals who have used two psychoactive substances, the prevalence of tranquilizers has risen from the 6.3% recorded in 2009 to the 14.5% in 2011, and in the case of sleeping pills, from the 3.7% in 2009 to the 6.4% found in 2011. Similarly, among those individuals suing three substances within the last 12 months, the prevalence of tranquilizers has grown from the 22.3% in 2009 to the 30.5% in 2011, whilst that of sleeping pills remains constant.

Table 2.39. Prevalence of poly-use of two or more psychoactive substances by substance used within the last 12 months (column percentages). Spain, 2011

Substances used	Two substances	Three substances	Four substances	Five or more substances
Alcohol	95.3	99	98.7	99.8
Tobacco	82.8	97.1	96.6	98.3
Cannabis	5	62.6	95.1	95.1
Ecstasy	0	0.8	5.7	50.7
Tranquilizers	14.5	30.5	36.4	43.2
Sleeping pills	6.4	14.6	16.1	23.8
Powder cocaine	0.2	4	54.1	82.3
Base cocaine	0	0	3.1	10
Amphetamines/Speed	0	0.5	4.5	49
Hallucinogens	0	0.3	3.3	31.9
Heroin	0	0	0.5	8.6
Volatile inhalants	0	0	0.6	7.8

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011)

Table 2.40, related to the last 12 months of use, includes the prevalences for those who use one single substance from among all the rest of the substances studied. Thus, it can be seen to what degree some psychoactive substances are associated with or connected to others. For example, one of the associations worthy of note is that of the individuals who have used cannabis within the last 12 months, 19.2% had also used cocaine (general). However, 81.5% of those who used cocaine, used cannabis and almost 20% of them used hypnosedatives and/or ecstasy (19.3% and 19.6%, respectively). In conclusion concerning this level, on reviewing the poly-use with hypnosedatives, it is found that this substance is used by 18.2% of the individuals who have used ecstasy, by the 24.9% who have used hallucinogens or by the 28.1% of the amphetamine/speed users.

The general trend found is that a broader-ranging use of any type of substance is recorded when analysing a residual illicit drug (volatile inhalants, heroin, speed…) than others more socially approved (alcohol, tobacco...).

Table 2.40. Percentage of users of other drugs among the individuals with the 15-64 age group who have used alcohol, tobacco, cannabis, ecstasy, tranquilizers, sleeping pills, hypnosedatives, powder cocaine, base cocaine, cocaine in general (powder and/or base), amphetamines, hallucinogens, heroin or volatile inhalants within the last 12 months (column percentages). Spain, 2011

	Alcohol	Tobacco	Cannabis	Ecstasy	Tranquilizers	Sleeping pills	Hypnosedatives	Powder cocaine	Base cocaine	General cocaine	Amphetamines/speed	Hallucinogens	Heroin	Volatile inhalants
Alcohol	-	84.7	94.4	97.2	70.9	71	71.5	98.1	90.4	98.2	97.6	97.7	94.5	100
Tobacco	44.5	-	84	87.7	46.8	49.8	46.4	88	93.8	87.8	90.8	92.7	100	94.7
Volatile inhalants	0.1	0.2	0.9	5.1	0.4	0.1	0.3	2.4	5.7	2.3	7.9	11.1	6.5	-
Amphetamines/ speed	0.8	1.4	5	51.4	1.4	2	1.5	18.2	20.9	18	100	52.6	37.1	51.3
Hallucinogens	0.5	0.9	3.7	29.7	0.9	1.1	0.9	10	10.3	9.9	35.4	-	24.7	48.9
Heroin	0.1	0.2	0.9	3.5	0.7	1	0.6	2.4	17.8	2.4	5.9	5.8	-	6.8
Tranquilizers	9	11.4	12.4	16.3	-	64.6	86.2	17.4	45	17.5	23.1	22.5	69.6	43.1
Sleeping pills	4.1	5.5	5.8	9.8	29.2	-	39.2	10.9	35.7	10.8	14.7	12.3	46.5	6.2
Hypnosedatives	10.6	13.2	13.6	18.2	100	100	-	19.2	47.5	19.3	28.1	24.9	73.8	43.1
Cannabis	11.9	20.2	-	84.7	12.2	12.6	11.5	81.5	94	81.5	79.4	88.2	90.3	94.7
Ecstasy	0.9	1.5	6	-	1.1	1.5	1.1	19.6	29.5	19.6	57.9	49.7	24.7	39.2
Powder cocaine	2.9	4.9	19	64.2	3.9	5.4	3.7	-	84.3	98.9	68.7	55.1	56.7	57.3
Base cocaine	0.2	0.4	1.6	7.1	0.7	1.3	0.7	6.2	-	7.2	5.7	4.1	30.4	10.1
General cocaine	2.9	5	19.2	65	4	5.4	3.8	100	100	-	68.7	55.1	56.7	57.3

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

If analysing the poly-use phenomenon according to the age of the users, the younger-aged 15-17 age group is found to be involved in less poly-use than those age 18 or older (39.2% vs. 48.3%). It seems logical to think that the older-aged individuals have greater buying power, a greater degree of social activity and a greater degree of personal autonomy (later time to return home, etc.) and this increases the opportunities and possibilities of suing one or more psychoactive substances (Table 2.41). Within the group of the older-aged individuals, it is the 25-34 age groups who are involved in the greatest degree of poly-use (52.7%).

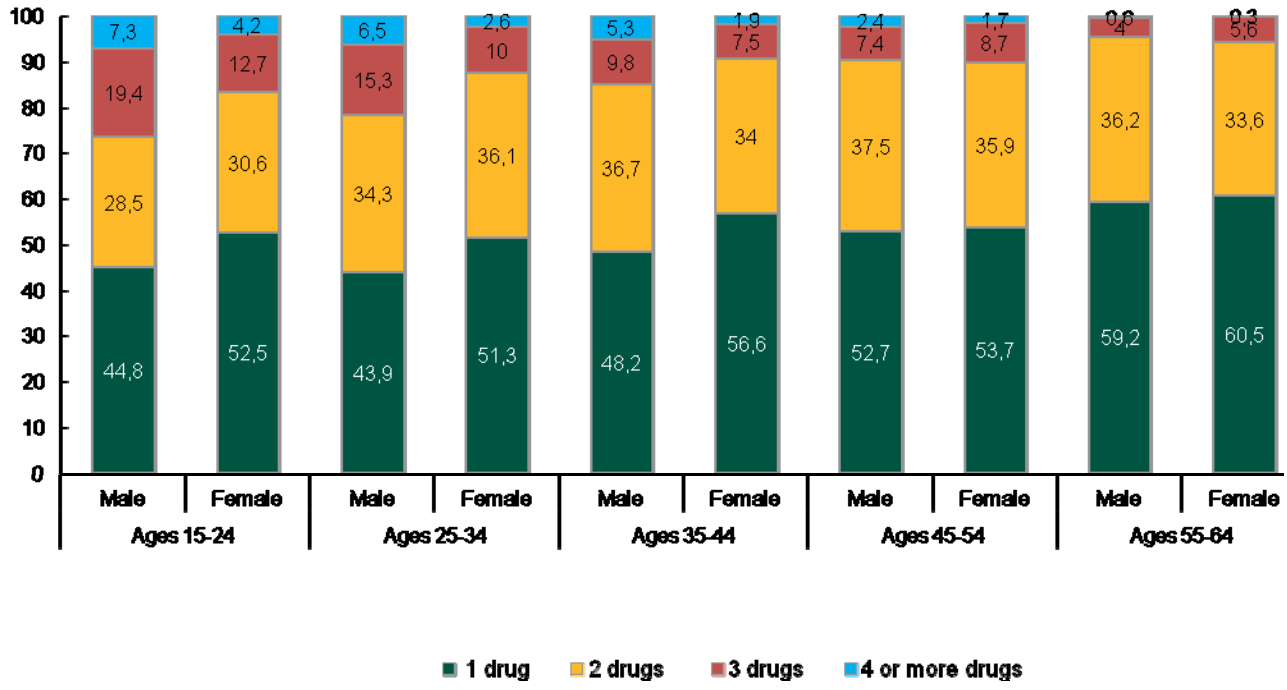
Table 2.41. Spread of the number of psychoactive substances (licit and illicit) used within the last 12 months among the users in terms of their ages (percentages). Spain, 2011

	15-17	18-64	15-24	25-34	35-44	45-54	55-64
One single substance	60.8	51.7	48.5	47.3	52	53.2	59.8
Two substances	22.2	35	29.5	35.1	35.4	36.7	35
Three substances	14.3	9.9	16.2	12.9	8.8	8.1	4.8
Four substances	1.5	2.3	3.4	3	2.6	1.5	0.4
Five or more substances	1.3	1.2	2.4	1.7	1.1	0.6	0.1

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

There are few differences in gender-related terms (Fig 2.38), arising mainly among the youngest population groups. As of age 45, there are practically no differences at all between the two genders.

Fig. 2.38. Prevalences of poly-use within the last 12 months by age groups and genders (percentages). Spain 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).

Regarding the marital status of those individuals who have used 2 or more psychoactive substances within the last 12 months in Spain, the singles are the ones involved in the greatest amount of poly-use (51.8%) as compared to the married, separated, divorced or widowed individuals (Table 2.42). This is possibly quite closely related to the age of these users and to the responsibilities which are usually associated to marital status, children and economic responsibilities, which involve less time and greater economic availability for being involved in poly-use.

Table 2.42. Spread, by marital status, of those individuals who have used 2 or more psychoactive substances (poly-use*), not including tobacco, within the last 12 months among the age 15-64 population, by gender (percentages). Spain 2011

	Have been involved in poly-use within the last 12 months				**Have not been involved in poly-use within the last 12 months**			
	Total no. involved in poly-use within the last 12 months (absolute no.)	**Single**	**Married**	**Separated / divorced /widowed**	**Total no. Not involved in poly-use within the last 12 months (absolute no.)**	**Single**	**Married**	**Separated / divorced / widowed**
Total GENDER	**5,276,156**	**51.8**	**36.3**	**11.9**	**26,806,602**	**35.8**	**55.6**	**8.6**
Males	2,955,656	60.5	31.4	8.1	13,271,176	39.1	54	6.9
Females	2,320,500	40.8	42.5	16.7	13,535,426	32.5	57.2	10.3

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
*Poly-use= concomitant use of 2 or more of these substances: alcohol, prescription or non-prescription hypnosedatives, cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin or volatile inhalants.
Note: Those cases which have provided no answer as to the use of the drug in question have not been taken into account.

Regarding educational levels and poly-use, after reviewing the results (Table 2.43), no difference can be said to exist between the educational level of those who are involved in poly-use and those who are not involved in poly-use.

Table 2.43. Spread, by highest educational level completed of those individuals who have used 2 or more psychoactive substances (poly-use*), not including tobacco, within the last 12 months among the age 15-64 population, by gender and age groups (percentages). Spain 2011

	Have been involved in poly-use within the last 12 months				Have not been involved in poly-use within the last 12 months			
	Total no. involved in poly-use within the last 12 months (absolute no.)	No schooling /Elementary school	Secon dary school	College	Total no. not involved in poly-use within the last 12 months (absolute no.)	No schooling/ Elementary school	Secon dary school	College
Total GENDER	**5,276,156**	**19.4**	**64**	**16.6**	**26,806,602**	**20.4**	**61.6**	**18.1**
Males	2,955,656	19.2	65.2	15.6	13,271,176	20.7	62.5	16.8
Females	2,320,500	19.6	62.4	18	13,535,426	20	60.6	19.3
AGE								
15-24	1,104,513	16.5	74.9	8.6	3,774,648	14.8	76.6	8.6
25-34	1,433,827	11.9	64.8	23.4	5,899,852	8.9	66.9	24.2
35-44	1,164,703	16	65.9	18.1	6,711,731	12.5	64.6	22.8
45-54	883,571	23.5	60.4	16.1	5,545,673	22.2	59.9	17.9
55-64	689,542	40.2	46	13.8	4,874,697	47.3	41.2	11.5
15-34	2,538,339	13.9	69.2	16.9	9,674,501	11.2	70.7	18.1
35-64	2,737,817	24.5	59.1	16.4	17,132,101	25.5	56.4	18
15-17	147,065	35.4	64.6	0	925,737	30.9	69.1	0
18-64	5,129,091	18.9	64	17.1	25,880,865	20	61.3	18.7

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
Poly-use= concomitant use of 2 or more of these substances: alcohol, prescription or non-prescription hypnosedatives, cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin or volatile inhalants.
Note: Those cases which have provided no answer as to the use of the drug in question have not been taken into account.

Those individuals who have been involved in poly-use within the last 12 months have a more negative subjective opinion of their health than those who are not involved in poly-use (3.8% of those who are involved in poly-use believe their health to be poor or very poor, compared to the 1.9% who consider their health to be poor or very poor of those who are not involved in poly-use) within the last 12 months have experienced more than two injuries in a higher percentage than those who are not involved in poly-use. (Tables 2.44 and 2.45).

Table 2.44. Spread of the subjective opinion of the health of those individuals who have used 2 or more psychoactive substances (poly-use*), not including tobacco, within the last 12 months among the age 15-64 population, by gender (percentages). Spain 2011

	Ha been involved in poly-use within the last 12 months				Has not be involved in poly-use within the last 12 months			
	Total no. involved in poly-use within the last 12 months (absolute no.)	Very good or good	Fair	Poor or very poor	Total no. not involved in poly-use within the last 12 months (absolute no.)	Very good or good	Fair	Poor or very poor
Total GENDER	**5,276,156**	**79.4**	**16.8**	**3.8**	**26,806,602**	**86**	**12.1**	**1.9**
Males	2,955,656	85.1	12	3	13,271,176	86.9	11.4	1.8
Females	2,320,500	72.1	23.0	4.9	13,535,426	85.2	12.8	2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
Poly-use= concomitant use of 2 or more of these substances: alcohol, prescription or non-prescription hypnosedatives, cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin or volatile inhalants.
Note: Those cases which have provided no answer as to the use of the drug in question have not been taken into account.

Table 2.45. Spread of the number of times having sustained wounds, injuries or acute physical trauma having forced them to undergo medical care within the last 12 months among those individuals who have used 2 or more psychoactive substances (poly-use*), not including tobacco, within the same period among the age 15-64 population, by gender and age groups (percentages). Spain 2011

	Have been involved in poly-use within the last 12 months					Have not been involved in poly-use within the last 12 months				
	Total no. involved in poly-use within the last 12 months (absolute no.)	Never had any injuries	Has had injury once	Has had injuries twice	Has had injuries more than twice	Total no. not involved in poly-use within the last 12 months (absolute no.)	Never had any injuries	Has had injury once	Has had injuries twice	Has had injuries more than twice
Total GENDER	**5,276,156**	**80.4**	**13.1**	**3.6**	**2.9**	**26,806,602**	**88.7**	**8.3**	**1.5**	**1.5**
Males	2,955,656	81.7	12.7	3.3	2.3	13,271,176	88.2	8.7	1.8	1.3
Females	2,320,500	78.9	13.5	4	3.6	13,535,426	89.2	7.9	1.3	1.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
*Poly-use= concomitant use of 2 or more of these substances: alcohol, prescription or non-prescription hypnosedatives, cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin or volatile inhalants.
Note: Those cases which have provided no answer as to the use of the drug in question have not been taken into account.

Lastly, it is important to point out according to Table 2.46 that some individuals who have been involved in poly-use within the last 12 months live to a greater extent with their parents or by themselves than those who are not involved in poly-use.

Table 2.46. Spread of the type of living situation of the individuals who have used 2 or more psychoactive substances (poly-use*), not including tobacco, within the last 12 months among the age 15-64 population, by gender and age groups (percentages). Spain 2011

	Has been involved in poly-use within the last 12 months					Has not been involved in poly-use within the last 12 months				
	Total no. involved in poly-use within the last 12 months (absolute no.)	Lives alone / shares apt.	Lives with parents	Lives with partner and/or children	All others	Total no. involved in poly-use within the last 12 months (absolute no.)	Lives alone /shares at.	Lives with parents	Lives with partner and/or children	All others
Total GENDER	**5,276,156**	**15.7**	**31.1**	**49.3**	**3.8**	**26,806,602**	**10.4**	**23.8**	**63.7**	**2.1**
Males	2,955,656	18.3	37.0	40.6	4.1	13,271,176	12.5	25.1	60.2	2.1
Females	2,320,500	12.5	23.5	60.5	3.5	13,535,426	8.4	22.4	67.1	2.2
AGE										
15-24	1,104,513	7.4	77.5	10.5	4.6	3,774,648	4.4	81.1	10.8	3.7
25-34	1,433,827	17.5	35.0	42.4	5.1	5,899,852	11.0	30.2	55.9	2.8

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
* Poly-use= concomitant use of 2 or more of these substances: alcohol, prescription or non-prescription hypnosedatives, cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin or volatile inhalants.
Note: Those cases which have provided no answer as to the use of the drug in question have not been taken into account.

Perception of risk regarding the different drug-use related behaviours

The risk which the population perceives regarding the use of different drugs might be construed as a factor safeguarding against the use thereof and especially against the initial onset of use.

As already in previous years, the thought is still entertained by most (more than 94% of the population) that the use of heroin, cocaine and ecstasy can cause many or quite a few problems regardless of the frequency of use. However, when asked about the fact of trying ecstasy or cocaine once or twice in one's life, there is a greater tolerance to the risk involved. Thus, in these cases, the perception drops to 78.2% of the population in the case of ecstasy and to 76.5% in that of cocaine (Table. 2.47).

On the contrary, the perceived risk for the case of drinking 5/6 beers or mixed drinks on the weekend continues to be the lowest of all, given that approximately half of the population does not

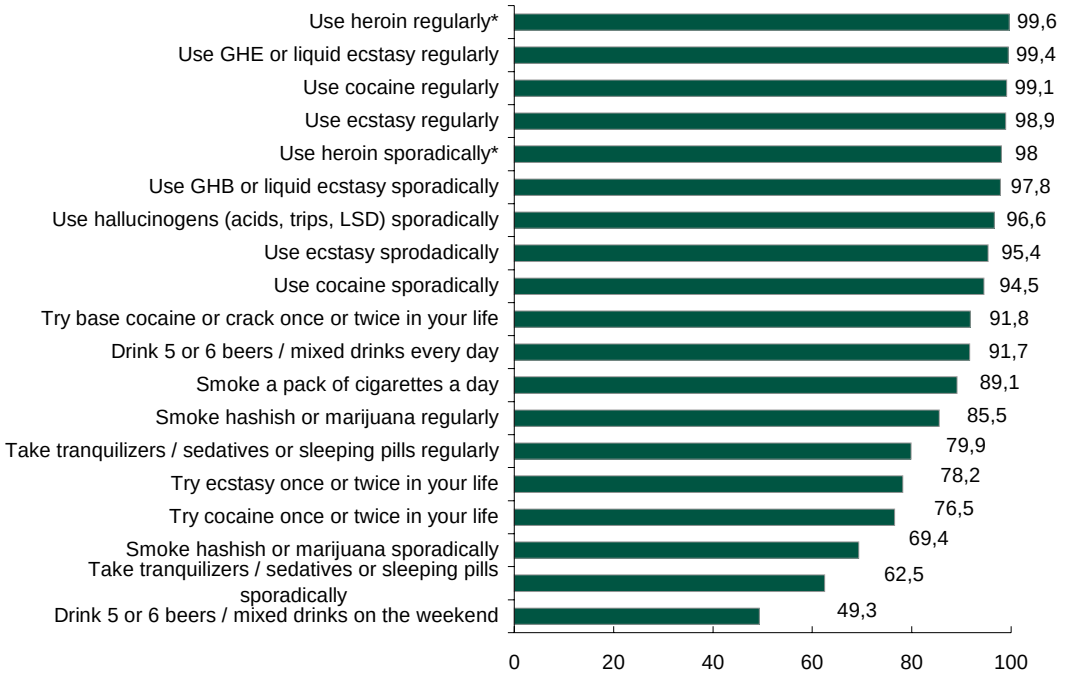
think that this can entail many or quite a few problems (Fig. 2.39). Nevertheless, the perceived risk for this consumption has risen compared to 2009 by 4.3 percentage points, thus reaching the highest figure for the entire historical series.

Regarding tranquilizers (the substances showing the greatest amount of growth of all in 2011 among the age 15-64 population), it is noted that the risk resulting from taking tranquilizers once or twice a month is the second lowest, after drinking 5/6 beers or mixed drinks on the weekend. In this regard, 62.5% of the population surveyed associates this type of use with the possibility of having quite a few or many problems whilst if the intensity of use is once a week or more often, the perceived risk totals 79.9% of the population (Table 2.47).

The most notable change compared to the immediately previous measurement is for the use of cannabis once a month or less, the perception of which rose by 6.7 percentage points compared to 2009, having reached the highest figure since 2001, and 3.9 points for weekly use, also reaching the highest level for the ten-year period.

Apart from the above, as of 1997 smoking a pack of cigarettes a day being considered as an at-risk habit has been growing among citizen up to 2011, the year in which this trend has been found to come to a standstill, although this attitude is now found among practically 90% of Spain's resident population.

Fig. 2.39. Percentage of Spain's age 15-64 population who think that each use-related behaviour can cause quite a few / many problems (percentages)*. Spain, 2011



* "regularly" means once a week or more often; "sporadically" is once a month or less often
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

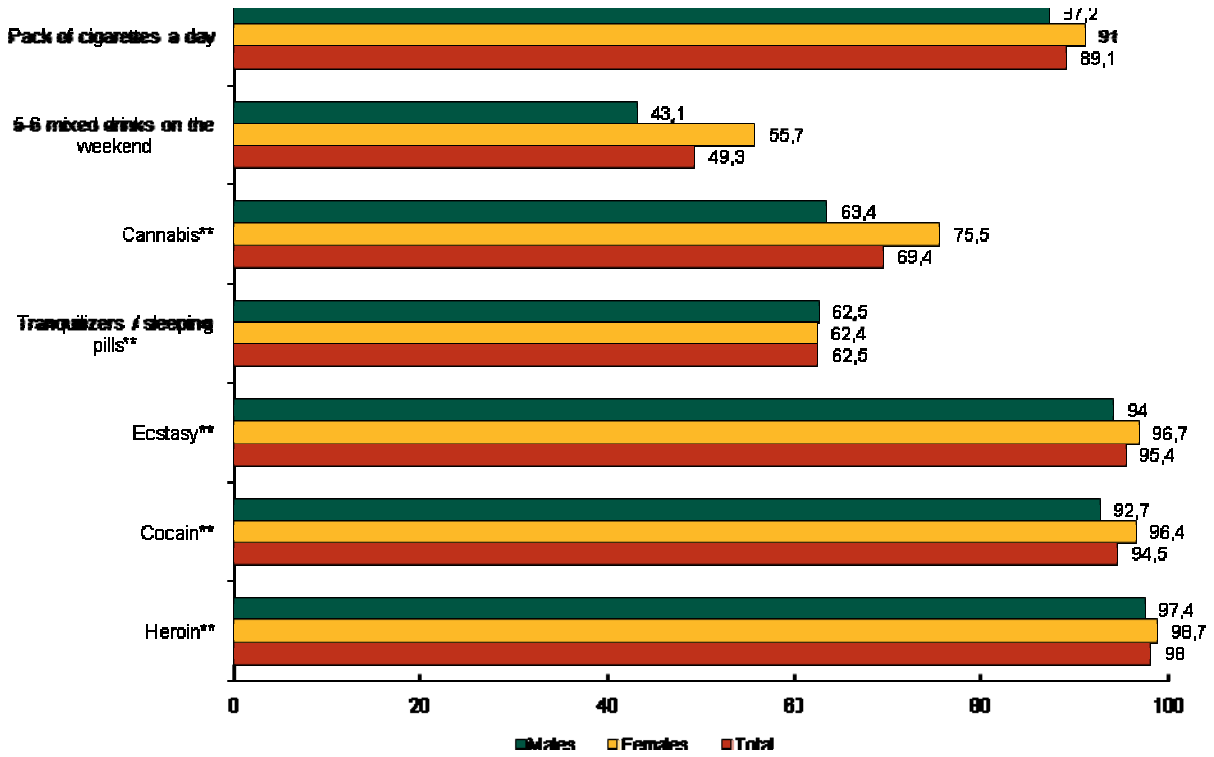
Table 2.47. Trend in the perceived risk regarding different drug use-related behaviours (percentage of the age 15-64 population who think each type of behaviour can cause many or quite a few problems)*. Spain, 1997-2011

	1997	1999	2001	2003	2005	2007	2009	2011	Difference 2011-2009	Difference 2011-1997
Use heroin once a week or more	99.4	99.6	98.8	99.3	99.3	99.4	99.4	99.6	0.2	0.2
Use heroin once a month or less	97.6	98.5	96.7	97.4	97.9	98.7	97.5	98	0.5	0.4
Use cocaine once a week or more	98.5	99.2	97.9	98.5	98.7	98.9	99	99.1	0.1	0.6
Use cocaine once a month or less	93.5	95.4	93.3	93.1	95	95.8	94.6	94.5	-0.1	1.0
Try cocaine once or twice in your life	-	-	-	-	-	-	77.4	76.5	-0.9	-
Use ecstasy once a week or more	98.6	98.9	97.8	98.3	98.7	98.3	98.3	98.9	0.6	0.3
Use ecstasy once a month or less	92.5	94.6	92.6	92.6	94.4	95.8	94.4	95.4	1.0	2.9
Try ecstasy once or twice in your life	-	-	-	-	-	-	76.7	78.2	1.5	-
Use hallucinogens once a week or more	99.1	99.4	98.5	99.1	99.2	-	-	-	-	-
Use hallucinogens once a month or less	96	97.4	95.5	96.3	97.1	97.4	96.1	96.6	0.5	0.6
Use tranquil./sleeping pills once a week or more	81.4	86.8	84.8	85.4	81.8	79.7	79.7	79.9	0.2	-1.5
Use tranquil/sleeping pills once a month or less	60.4	70.1	66.7	65.3	62.3	62.2	60.1	62.5	2.4	2.1
Use cannabis once a week or more	84	87.6	83.1	79.2	80.8	83	81.6	85.5	3.9	1.5
Use cannabis once a month or less	68.9	74.8	67.9	62	64.2	68.5	62.7	69.4	6.7	0.5
Try base cocaine once or twice in your life	-	-	-	-	-	-	95.7	91.8	-3.9	-
Drink5-6 beers/mixed drinks a day	89.2	90.7	86.1	83.3	87.3	89.2	91.4	91.7	0.3	2.5
Drink 5-6 beers/mixed drinks on the weekend	45.6	49.2	44.2	41.8	43.6	46.6	45	49.3	4.3	3.7
Smoke a pack of cigarettes a day	79.7	82.4	83.6	84.6	87.1	87.1	89.4	89.1	-0.3	9.4
Use GHB or liquid ecstasy once a week or more	-	-	-	-	-	-	-	99.4	-	-
Use GHB or liquid ecstasy once a month or less	-	-	-	-	-	-	-	97.8	-	-

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).
* Valid percentages calculated based on the cases providing information, ruling out the “Don’t know/ No answer” cases.

Generally speaking, the perception of risk is greater among the females than among the males for all of the psychoactive substances and for all frequencies of use. The one exception is when it comes to tranquilizers/sleeping pills, substances used more prevalently among the females. In this case, the ratio between genders is similar when associating a certain risk to the sporadic use of these substances (Fig. 2.40).

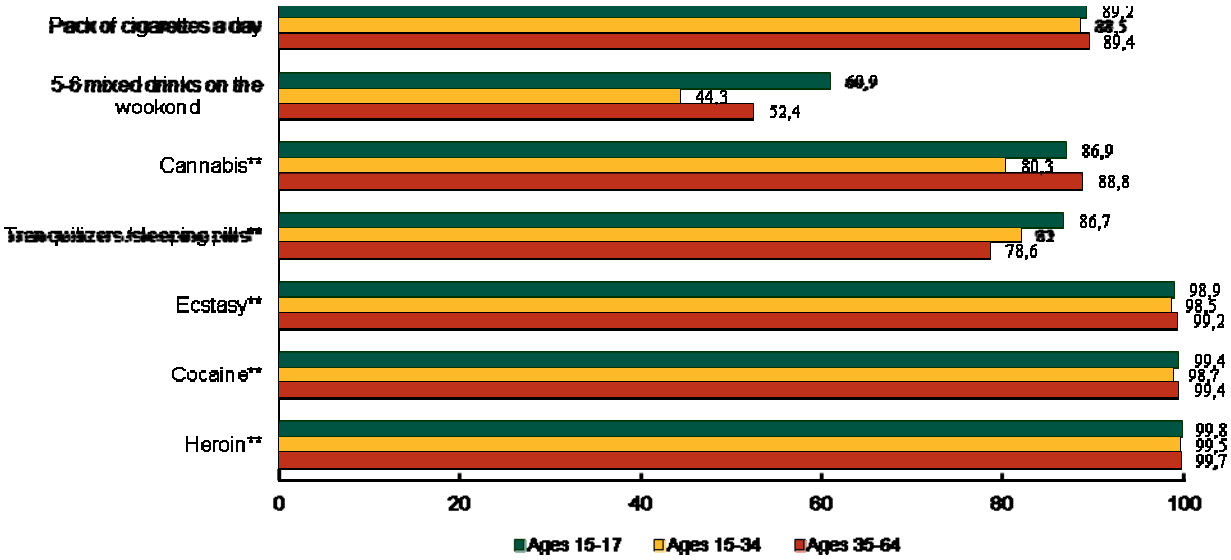
Fig. 2.40. Perception of risk associated to the use of psychoactive substances (Percentage of age 15-64 population who think that each use behaviour can cause many or quite a few problems*, by gender (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.
** Once a month or less

In terms of age, there is a major degree of unanimity when evaluating the risk of regular use of heroin, cocaine, ecstasy and smoking a pack of cigarettes a day. However, in regard to the use of cannabis and drinking 5/6 mixed drinks on the weekend, the 15-34 age group shows a greater deal of tolerance to the risk than the youngest segment (15-17 age group) and the oldest age group (35-64 age group). On the other hand, taking tranquilizers regularly is considered to be a risk progressively less as progressively older agent segments are questioned (Fig. 2.41).

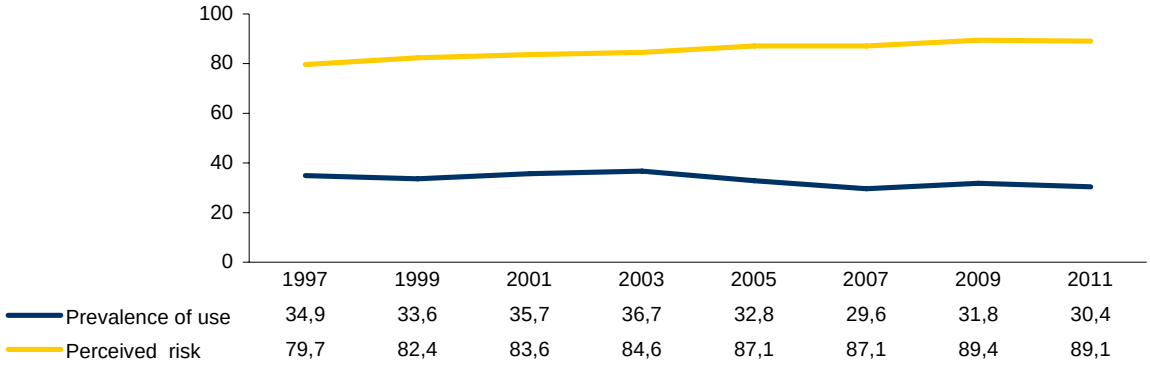
Fig. 2.41. Perception of the risk associated with the use of psychoactive substances. Percentage of age 15-64 population who think that each use-related behaviour can cause many quite a few problems*, by age groups (percentages). Spain, 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.
** Once a week or less

Fig. 2.42 clearly shows how, as the perception of risk of smoking a pack of cigarettes a day reduces the prevalence of use, with which the perception of risk regarding the use of different drugs could be interpreted as a factor safeguarding against the use.

Fig. 2.42. Trend in the prevalence of smoking a pack of cigarettes daily within the last 30 days and perceived risk regarding daily cigarette smoking (percentage of age 15-64 population who think that each use-related behaviour can cause many or quite a few problems)*. Spain, 1997-2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997- 2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

Perceived degree of drug availability

When the population is asked "How difficult do you think it would be for you to obtain a certain drug within a 24-hour period?", cannabis reveals itself to be the most readily-obtainable drug, such that 67% of the population believes that it is easy or very easy for them to acquire cannabis within 24 hours. On the contrary, the drug thought to be the hardest to obtain is liquid ecstasy, followed by heroin, although heroin shows degrees of perceived availability similar to those of ecstasy and hallucinogens (around 45%).

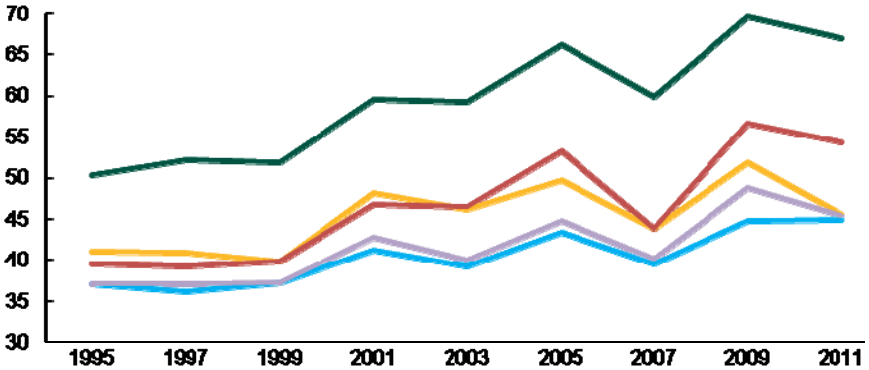
With the exception of heroin, 2009 showed the greatest degrees of perceived availability of all those on record to date for all the substances. In 2011, this perception is not so widespread, worthy of special note being the decline in this regard concerning ecstasy (-6.3 percentage points). Within the 1995-2011 period, the perception of availability has risen for all of the substances studied, a greater degree of growth having been noted in this regard for the case of cannabis (by 16.7 percentage points) and cocaine (by 14.9 percentage points) (Table 2.48 and Fig. 2.43).

Table 2.48. Trend in the perceived degree of availability of illicit psychoactive drugs (acquiring them easily or very easily within 24 hours), among the age 15-64 population (percentages)*. Spain, 1995-2011

	1995	1997	1999	2001	2003	2005	2007	2009	2011	Difference 2009-2011	Difference 1995-2011
Cannabis	50.3	52.1	51.8	59.5	59.2	66.2	59.8	69.6	67	-3	16.7
Ecstasy	41.1	40.9	39.9	48.2	46.1	49.7	43.8	51.9	45.6	-6.3	4.5
Cocaine	39.5	39.2	39.9	46.7	46.5	53.3	43.8	56.7	54.4	-2.3	14.9
Heroin	37	36.2	37.2	41.2	39.2	43.4	39.5	44.7	44.9	0.2	7.9
Hallucinogens (LSD)	37.1	37	37.2	42.7	40	44.8	40.2	48.7	45.4	-3.3	8.3
GHB or liquid ecstasy	-	-	-	-	-	-	-	-	41.8	-	-

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).*
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

Fig. 2.43 Trend in the perceived degree of availability of illicit psychoactive drugs (acquiring them within 24 hours is relatively easy /very easy)*, among the age 15-64 population (percentages). Spain, 1995-2011



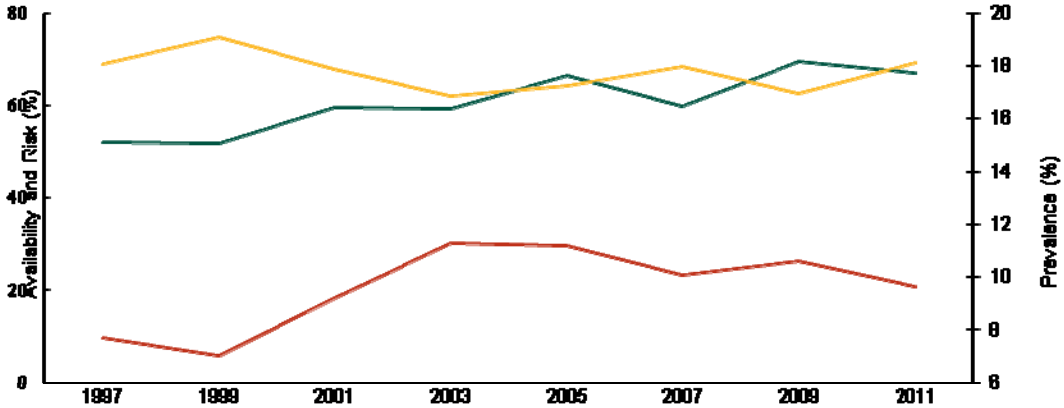
	1995	1997	1999	2001	2003	2005	2007	2009	2011
Cannabis	50,3	52 1	51,8	59,5	59,2	66,2	59,8	69,6	67
Ecstasy	41,1	40 9	39,9	48,2	46,1	49,7	43,8	51,9	45,6
Cocaine	39,5	39 2	39,9	46,7	46,5	53,3	43,8	56,7	54,4
Heroin	37	36 2	37,2	41,2	39,2	43,4	39,5	44,7	44,9
Hallucinogens (LSD)	37,1	37	37,2	42,7	40	44,8	40,2	48,7	45,4

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995- 2011)

In following, the trends are provided for the prevalences of use, perceived associated risk and degree of availability for sporadic use within the last 12 months of cannabis, powder cocaine and ecstasy.

Focusing specifically on cannabis, the prevalence of use and perceived degree of availability have dropped, whilst the perceived associated risk has risen. For cocaine, the use and perceived degree of availability dropped slightly, whilst the feeling of risk regarding sporadic cocaine use remains stable, insomuch as it has been showing levels nearing 95% since previous years. The same holds true for ecstasy, the perceived risk regarding which has hardly changes, given that practically the entire population associates risk with sporadic use of ecstasy. Likewise, this substance is perceived to be less readily available whilst ecstasy use has stabilized without totalling a full percentage point among the general population (Figs. 2.43 – 2.48).

Fig. 2.44. Trend in the prevalence of cannabis use within the last 12 months, perceived degree of availability (obtain cannabis within 24 hours easily/very easily)* and perceived risk regarding sporadic use (once a month or less, percentage of age 15-64 population who think that each use-related behaviour can cause many or quite a few problems)*. Spain, 1997-2011

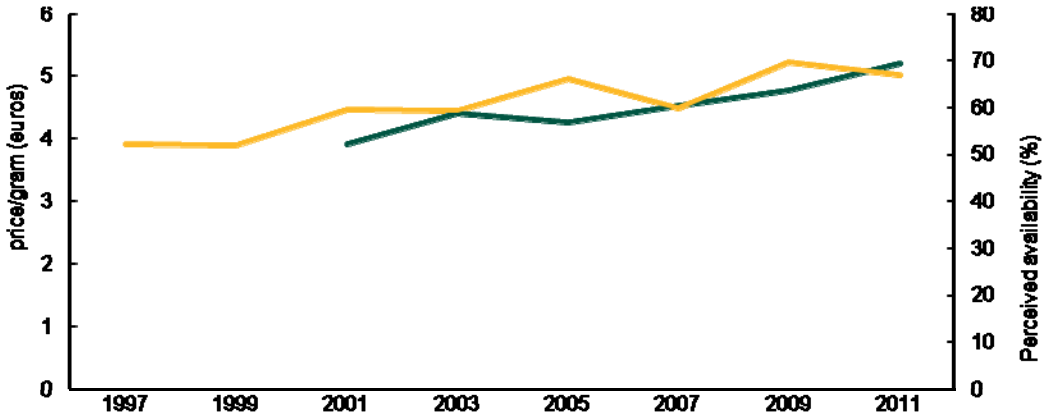


	1997	1999	2001	2003	2005	2007	2009	2011
Availability	52,1	51,8	59,5	59,2	66,4	59,8	69,6	67,0
Risk	68,9	74,8	67,9	62	64,2	68,5	62,7	69,4
Prevalence of use	7.7	7	9.2	11.3	11.2	10.1	10.6	9.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

Particularly of interest is the reverse relationship which exists between the perceived degree of availability of cannabis and the per gram price of cannabis on the retail market. In 2001, 2005 and 2009, the fact of the price being lower is in keeping with the greater degree of availability and, on the contrary, in 2003, 2007 and 2011, the availability drops in view of the rise in price, although said rise not be particularly high (Fig. 2.45).

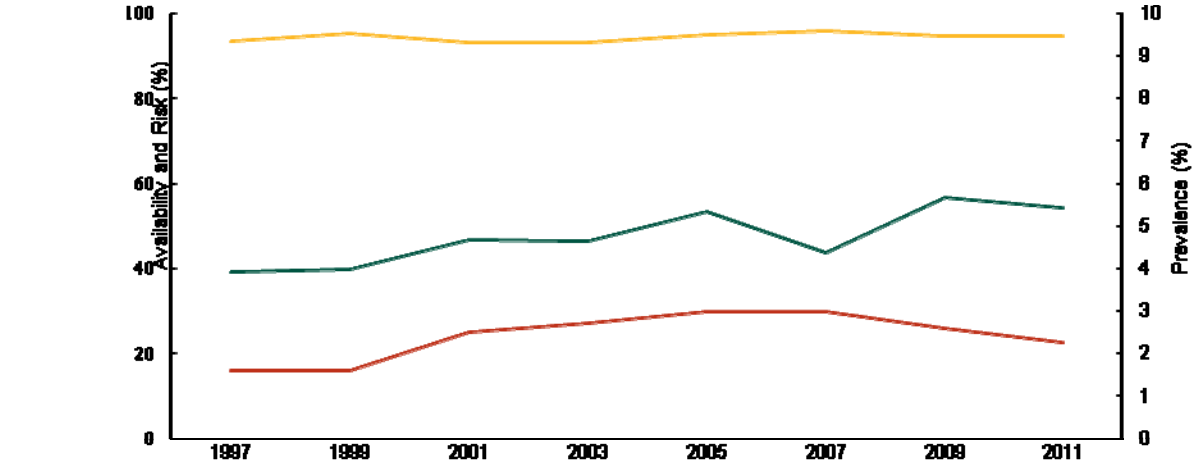
Fig. 2.45. Trend in the perceived degree of availability of cannabis (obtaining cannabis within 24 hours is easy / very easy) the per gram price of cannabis (euros). Spain, 1997-2011



	1997	1999	2001	2003	2005	2007	2009	2011
price/gram (euros)			3,92	4,41	4,26	4,52	4,77	5,2
perceived availability	52,1	51,8	59,5	59,2	66,2	59,8	69,6	67

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).

Fig. 2.46. Trend in the prevalence of cocaine use within the last 12 months, perceived degree of availability (obtaining cocaine within 24 hours is easy/very easy)* and perception of the risk regarding sporadic use (once a month or less, percentage of age 15-64 population who think that each behaviour can cause many or quite a few problems)*. Spain, 1997-2011

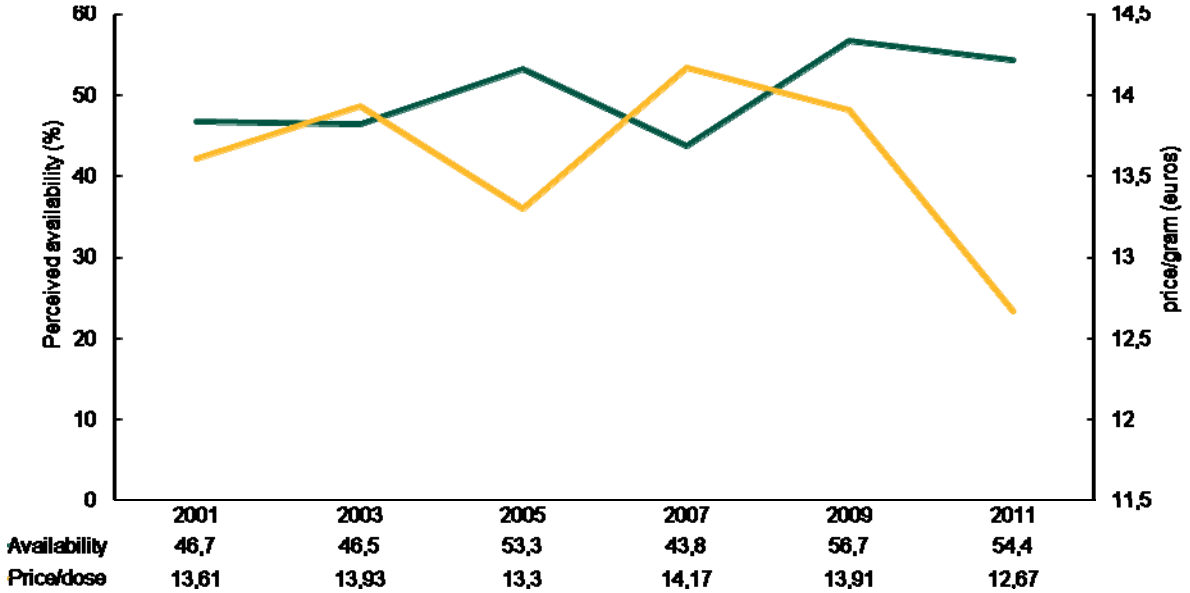


	1997	1999	2001	2003	2005	2007	2009	2011
Availability	39,2	39,9	46,7	46,5	53,3	43,8	56,7	54,4
Risk	93,5	95,4	93,3	93,1	95	95,8	94,8	94,5
Prevalence of use	1,6	1,6	2,5	2,7	3	3	2,6	2,3

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997- 2011).
* Valid percentages calculated based on the cases providing information, ruling out the “Don’t know/ No answer” cases.

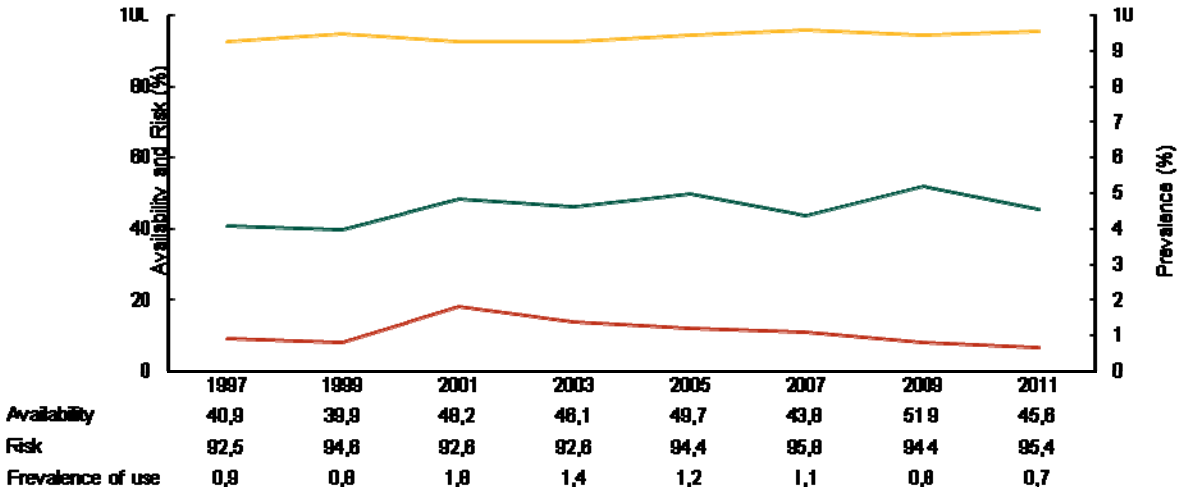
Taking into account the information furnished by the National Intelligence Centre Against Organized Crime (CICO) in Spain concerning the cocaine market in our country, the highest price per dose hikes occurred in 2005 and 2007, based on which a major drop has been recorded, the lowest price since 2001 having been reached in 2011. If this data is related to the degree of availability perceived by those surveyed on the surveys conducted for the respective years, a foreseeable reverse relationship is found to exist, that is to say, the lower the price, the greater the degree of accessibility, the more readily available the drug is perceived as being. (Fig. 2.47).

Fig. 2.47 Trend in the perceived degree of availability (obtaining cocaine within 24 hours is easy or very easy) and per-dose price of cocaine. Spain, 2001-2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2001-2011).

Fig. 2.48. Trend in the prevalence of use of ecstasy within the last 12 months, perceived degree of availability (obtaining ecstasy within 24 hours is easy/very easy)* and perception of the risk of sporadic use (once a month or less, percentage of age 15-64 population who think that each use-related behaviour can cause many or quite a few problems)*. Spain, 1997-2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).
* Valid percentages calculated based on the cases providing information, ruling out the “Don’t know/ No answer” cases.

Perception of the importance of the drug use problem and visibility of some problem use-related phenomena and the drug supply

In 2011, 40% of Spain's age 15-64 population stated the illicit drug problem to be "a highly important problem" where they lived. This perception has dropped considerably among the population compared to 2009, when 48.9% of citizens pointed out illicit drugs as a highly important problem in the close vicinity where they lived. On the contrary, 27.5% of the population surveyed believes that the problem of illicit drugs is "unimportant", the highest figure recorded in this regard in the time-related series since 1997 (Table 2.49).

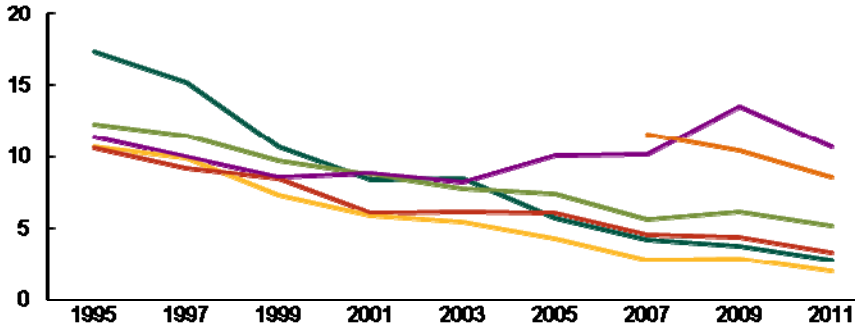
Table 2.49. Trend of the importance which the age 15-64 population places on the illicit drug problem where they live (percentages)*. Spain, 1997-2011

	1997	1999	2001	2003	2005	2007	2009	2011	Difference 2009- 2011
Unimportant	19.6	22.3	19.1	20.9	14.8	20.5	20.4	27.5	7.1
Somewhat important	28.1	32.1	34.3	34.3	27.9	29.7	30.7	32.5	1.8
Highly important	46.4	37.3	39.3	36.3	52	49.8	48.9	40	-8.9

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1997-2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

This change tallies with a lesser degree of visibility in the surrounding environment of some situations related to the use of illegal drugs (Fig. 2.49). The most high-visibility situations of all for citizens in the living environment in their close vicinity are, as for previous years, the drug pushers (10.7%) and people sniffing drugs (8.6%), these likewise being those situations which have undergone the greatest percentage point drop in visibility (-2.8 and -1.8, respectively) compared to 2009. On the contrary, the least visible situations are individuals injecting drugs and needles and syringes lying on the ground. As of years ago, the number of citizens who encounter these situations often or very often has progressively declined, having dropped in 2011 down to 2.1% and 2.9%, respectively (Table 2.50).

Fig. 2.49. Trend in the degree of visibility in the surrounding environment of some situations related to illicit drug use (percentage of age 15-64 population who encounter each situation often or very often where they live)*. Spain, 1995-2011



	1995	1997	1999	2001	2003	2005	2007	2009	2011
Needles and syringes lying on ground	17,3	15,2	10,7	8,4	8,5	5,7	4,2	3,8	2,9
Individuals injecting drugs	10,7	9,9	7,3	5,9	5,5	4,3	2,8	2,9	2,1
Individuals smoking heroin	10,6	9,2	8,5	6,1	6,2	6,1	4,6	4,4	3,3
Drugged individuals lying on ground	12,3	11,5	9,7	8,7	7,8	7,4	5,6	6,2	5,2
Pushers selling drugs	11,4	10	8,6	8,8	8,2	10,1	10,2	13,5	10,7
Individuals sniffing drugs							11,6	10,4	8,6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

Table 2.50. Trend of the visibility in the surrounding environment of some situations related to the use of illicit drugs (percentage of the age 15-64 population who encounter each situation often or very often where they live)*. Spain, 1995-2011

	1995	1997	1999	2001	2003	2005	2007	2009	2011	Difference 2001-2011
Needles and syringes lying on ground	17.3	15.2	10.7	8.4	8.5	5.7	4.2	3.8	2.9	-5.5
Individuals injecting drugs	10.7	9.9	7.3	5.9	5.5	4.3	2.8	2.9	2.1	-3.8
Individuals smoking heroin	10.6	9.2	8.5	6.1	6.2	6.1	4.6	4.4	3.3	-2.8
Drugged individuals lying on ground	12.3	11.5	9.7	8.7	7.8	7.4	5.6	6.2	5.2	-3.5
Pushers selling drugs	11.4	10	8.6	8.8	8.2	10.1	10.2	13.5	10.7	1.9
Individuals sniffing drugs	-	-	-	-	-	-	11.6	10.4	8.6	-

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).
* Valid percentages calculated based on the cases providing information, ruling out the "Don't know/ No answer" cases.

Also worthy of note is that the degree of visibility of the different situations studied has continued, generally speaking, a noticeable upward trend from the historic record to which it is related. The

year 2011 marks minimum levels with regard to the percentage of people who encounter illegal drug use-related situations often where they live, thus, far from stabilizing, the downward trend which had been being noted in this regard is continuing. The one exception to this trend lies in the drug pushers, their degree of visibility having risen as of 2003, having reached a top level of 13.5% in 2009 (Fig. 2.49).

Evaluation of the importance of the actions aimed at providing a solution to the problem of illicit drugs

As in previous years, the measure aimed at providing a solution to the drug problem which scored highest is the education provided at schools (backed by 91.8% of the population). The second most highly-supported measure is voluntary drug user treatment (84.9%), followed by police and Customs supervision (84.2%) (Table 2.51 and Fig. 2.50).

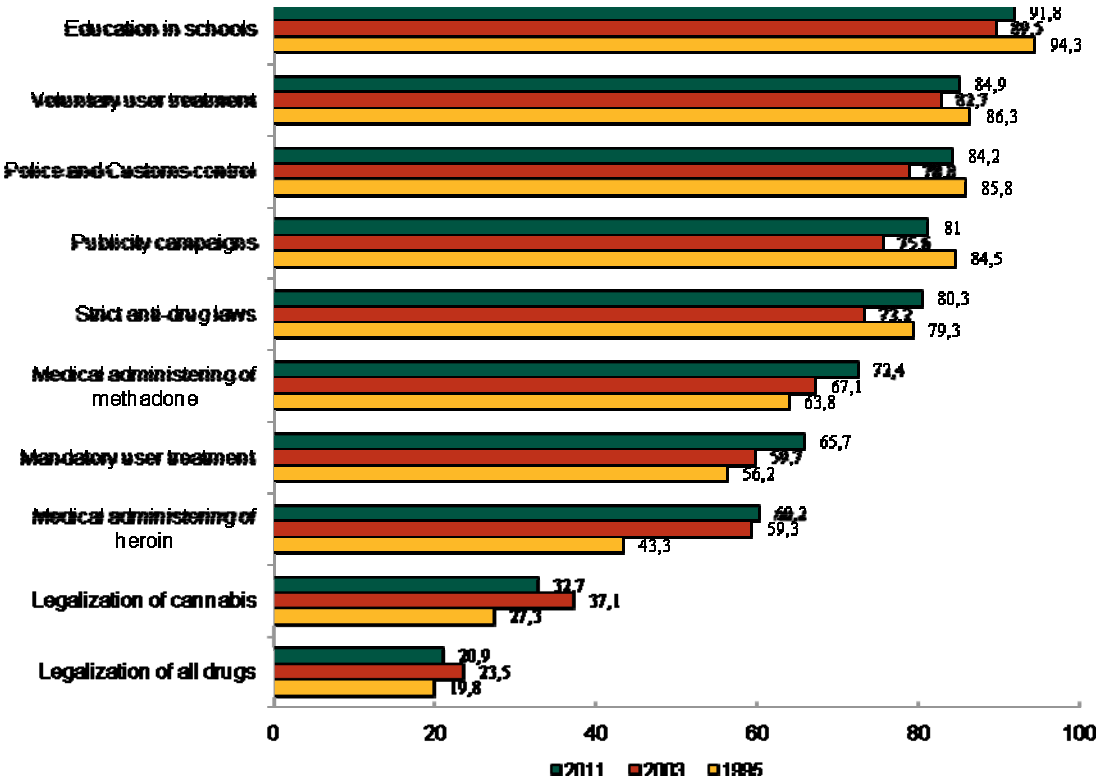
On the contrary, the measures which are considered to be least effective are those regarding legalization. The legalization of all drugs shows a 20.9% support, meaning a 5.3 percentage point rise compared to 2009, although still far from the level encountered ten years ago (27.1%). Support of the legalization of cannabis has been growing since 2007, up to 32.7% of the population found to support cannabis legalization in the last measurement taken. Similarly, the degree of support is not as high as ten years ago (38.5%).
Similarly, other measures considered to be effective by more than 80% of the citizens are the publicity campaigns (81.0%) and the strict anti-drug laws (80.3%). Hence, the measures considered most highly effective by citizens are the informative measures, voluntary treatment, police control and legal restriction.

Table 2.51. Trend in the assessment of different actions for providing a solution to the problem of drugs among the age 15-64 population (percentages)*. Spain, 1995-2011

	1995	1997	1999	2001	2003	2005	2007	2009	2011
Education in schools	94,3	93,1	91,8	89,4	89,5	88,8	90,6	90,4	91,8
Voluntary user treatment	86,3	87,1	84,8	81,6	82,7	82,4	83,2	85,1	84,9
Police and Customs inspections	85,8	83,7	82,1	80,5	78,8	79,8	83,3	84,7	84,2
Publicity campaigns	84,5	81,5	79,8	77,6	75,6	77,7	79,1	77,7	81
Strict anti-drug laws	79,3	77	76,9	75,5	73,2	75,3	77,9	80,6	80,3
Medical administering of methadone	63,8	62,9	67,5	66,6	67,1	68,4	66,8	65,8	72,4
Mandatory user treatment	56,2	57,2	57,9	62,8	59,7	58,2	56,3	57,2	65,7
Medical administering of heroin	43,3	47,5	53,9	58,2	59,3	59,9	52,8	48,9	60,2
Legalization of cannabis	27,3	30,2	33,3	38,5	37,1	35,2	23,4	29,6	32,7
Legalization of all drugs	19,8	21,5	24,6	27,1	23,5	21,4	16,6	15,6	20,9

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).
* Valid percentages calculated based on the cases providing information, ruling out the “Don’t know/ No answer” cases.

Fig. 2.50. Trend in the support of different measures for providing a solution to the drug problem among the age 15-64 population (percentages)*. Spain, 1995-2011

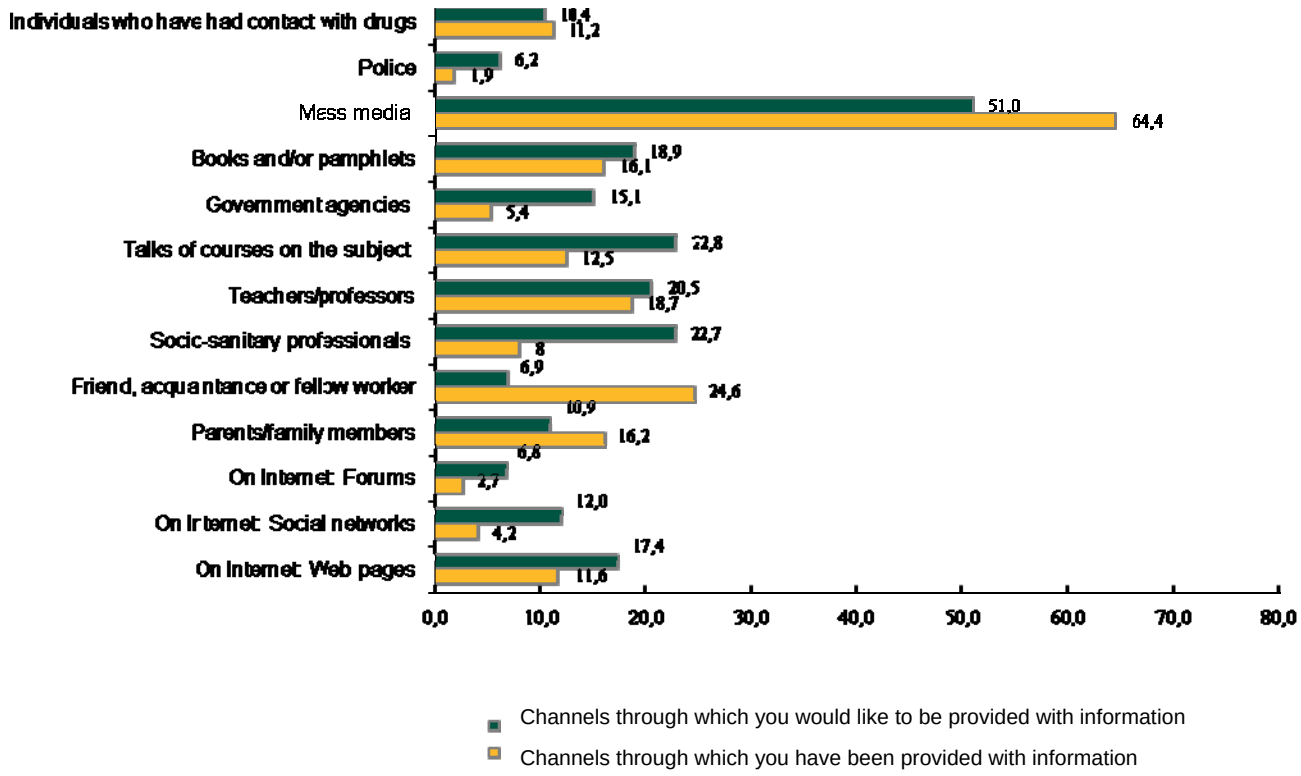


SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 1995-2011).
* Valid percentages calculated based on the cases providing information, ruling out the “Don’t know/ No answer” cases.

Information on drugs

In 2011, two questions were added for the first time concerning the main channels through which citizens are provided with information on drugs and the main channels through which they would like to be provided with this information. The results obtained are provided in Fig. 2.51.

Fig. 2.51. Main information channels through which the age 15-64 population had been provided with information concerning drugs and channels through which they would like to be provided with information on drugs, their effects and the associated problems. Spain 2011



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Household Survey on Alcohol and Drugs in Spain (EDADES 2011)

The channels through which a larger percentage of Spain's resident population is provided with information are the mass media (64.4%), a friend, acquaintance or fellow worker (24.6%), teachers / professors (18.7%) and Internet, taking into account that the Internet includes forums, social networks and webpages, these three types of Internet access adding up to 18.5% (Fig. 2.51).

However, the channels through which these individuals have been provided with less information on drugs are the police (1.9%), official agencies (5.4%) and health care professions (8%). It is important to stop and think about this, given that, taking a look at the channels through which the individuals would like to be provided with information on drugs, a total 51% prefer the mass media, 36.2% the internet and approximately one fifth of the population would prefer being provided with information through the health care professionals or being offered talks or courses or through teachers /professors, which can mean more personalized assistance and a greater deal of involvement on the part of all of the socio-sanitary agents in drug-related prevention.

Another aspect to be taken into account is the difference between those who have been provided with information via internet and those who would like to be provided with information through this channel, a 17.7% difference being found. This is a major difference, revealing the great need for creating internet contents which will meet this great need of providing drug-related information, especially of creating high-quality webpages informing on drugs.

3.2. ENVIRONMENTAL PREVENTION

Alcohol and tobacco policies

In the case of **tobacco**, some major advances have been made in Spain over the last few years thanks mainly to smoke-free spaces being regulated by Law 42/2010 of December 30th, further expanding upon the prohibition of smoking to include all enclosed public spaces and certain open spaces. Tobacco prices are remaining relatively stable in the case of the most expensive brands (4.25€) and are rising in that of the cheapest brands (3.10€ to 3.75€).

Throughout almost the entire country, the legal drinking age 18, with the exception of Asturias, where it is 16 years of age. Numerous regulatory measures have been passed in regard to outdoor binge drinking in different municipalities, prohibiting drinking in outdoor public areas.

Another model which has started being implemented over the past few years is that of working in cooperation with the **leisure industry** to promote **responsible service** and healthy leisure. In Spain, some Autonomous Communities have unrolled their own programs, such as the "Q de Nit" program in Catalonia; the Government Delegation for the National Plan on Drugs availing of a Responsible Service program in collaboration with the recreation industry. Others, such as the Autonomous Community of Castile and Leon, are promoting collaboration with the hotel and catering trade by means of signing a protocol for collaborating with the Provincial Association of hotel and catering trade enterprises; activities being carried out within this framework for training professionals from this sector and other types of actions such as informing and raising awareness among establishments which sell alcohol, promoting alternative transportation and instructing young people and social mediators for preventing alcohol abuse.

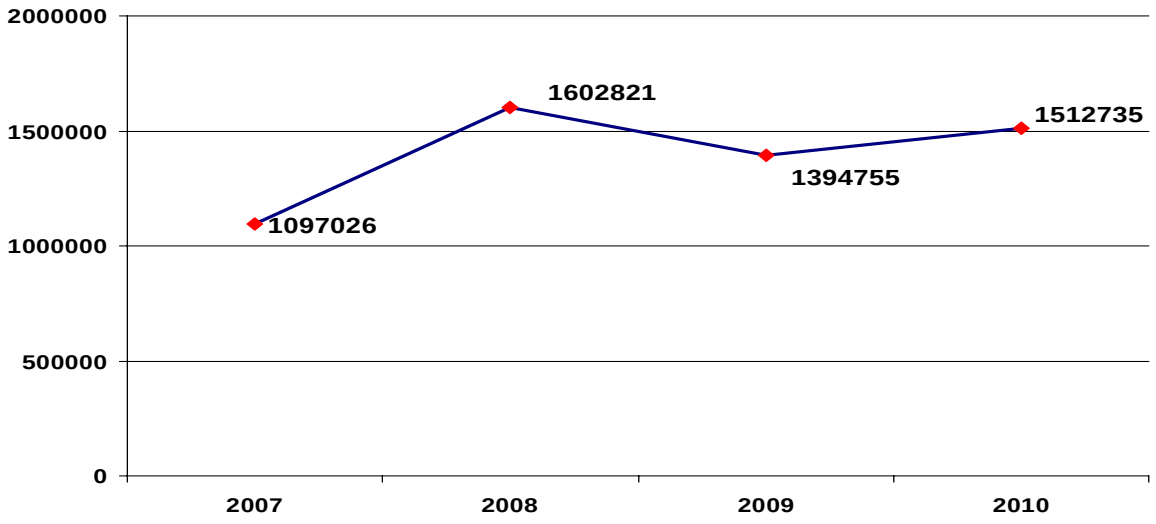
Regarding the drinking and driving legislation, the limits in Spain are **0.5 gram blood-alcohol concentration** (or 0.25 milligrams in breath test) for most drivers and **0.3 (0.15 in breath test) for professionals and novice drivers.**

3.3. UNIVERSAL PREVENTION

SCHOOL

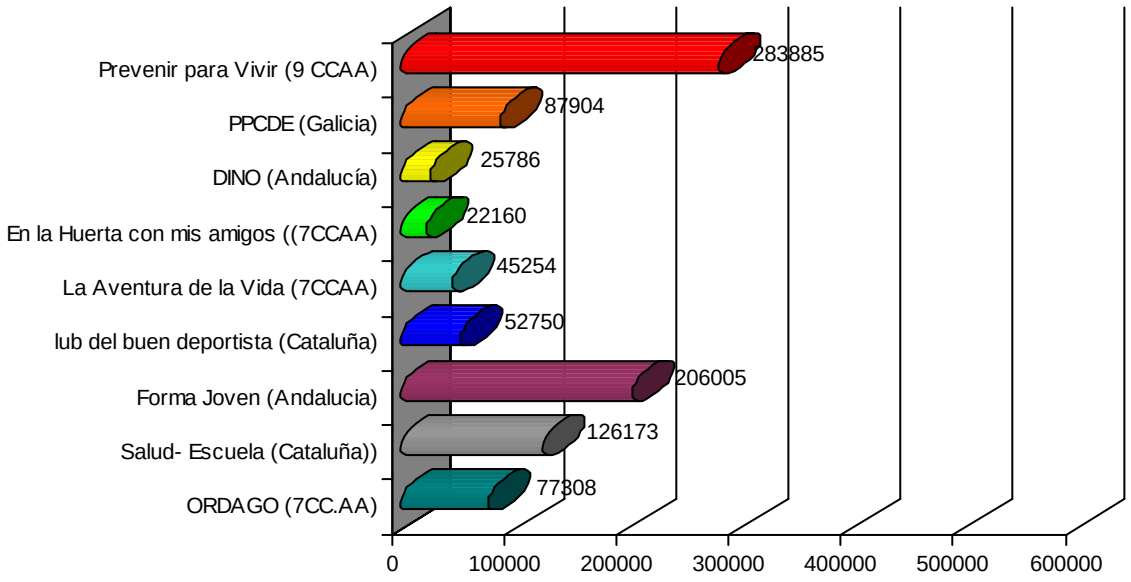
Three types of activities are carried out targeting the students at the school level. Firstly, **structured prevention programs,** generally entailing multiple components combining drug-related information with working on their attitudes toward drugs, the standard consumption-related beliefs and the skills for successfully dealing with refusing drugs when offered. Programs of this type are carried out based on an interactive methodology and involved 5-20 hours of work in the classroom. Generally speaking, they required specific training on the part of the professionals who implement these programs, who are usually the school's own faculty members and are furnished with handbooks for their implementation. Most of these type of programs are offered for Elementary School and Secondary-School-Leaving Certificate-level students. Somewhat over 35% of all students nationwide take part in these programs, with some variations compared to previous years, given that, in 2009, there was a major drop in the **number of students**, which was recouped in 2010, having increased from 1,394,755 students in 2009 to **1,512,735** in 2010.

Fig. 3.1. Number of students taking part in structured school student prevention programs, 2007-2010



Despite the wide variety of structured school prevention programs (more than 100 different programs in Spain), they are some which are significantly widespread, because in addition to having major degrees of coverage, they are implemented in different Autonomous Communities. This is the case of the Help Foundation Against Drug Addiction's "Preventing for Living" Program, which is being implemented in 8 Autonomous Communities, or the EDEX Foundation's "*Órdago*" ["Ultimatum: Meeting the Drug Challenge"] and "La Aventura de la Vida" ["The Adventure of Living"] programs, which are also quite widespread.

Fig. 3.2. School programmes most widespread in Spain, 2009



The number of **schools** taking part in this type of programs underwent a significant increase compared to previous years, totalling more than **11,000** schools in 2010. However, the number of

teachers trained in prevention in these programs remains at **67,000**, meaning a slight decline compared to 2009.

Fig. 3.3. Number of schools participating in prevention programs, 2007-2010

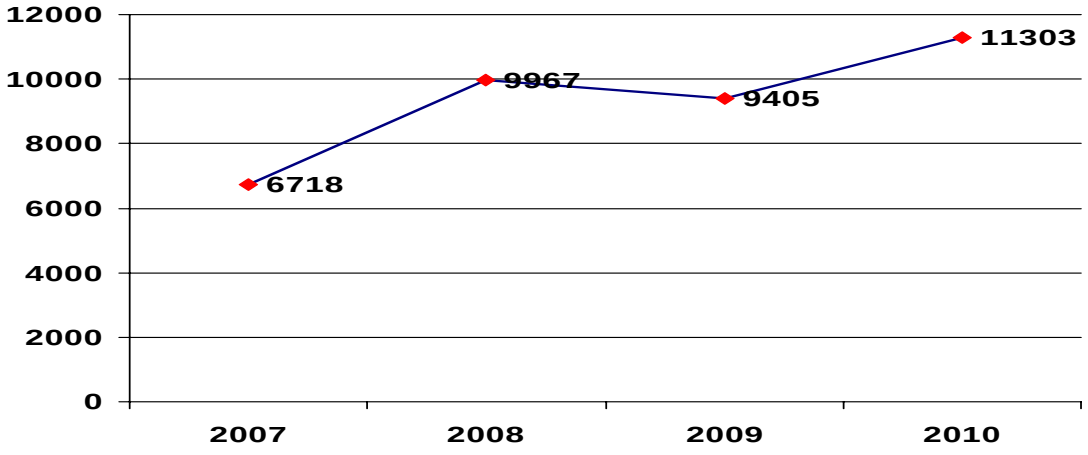
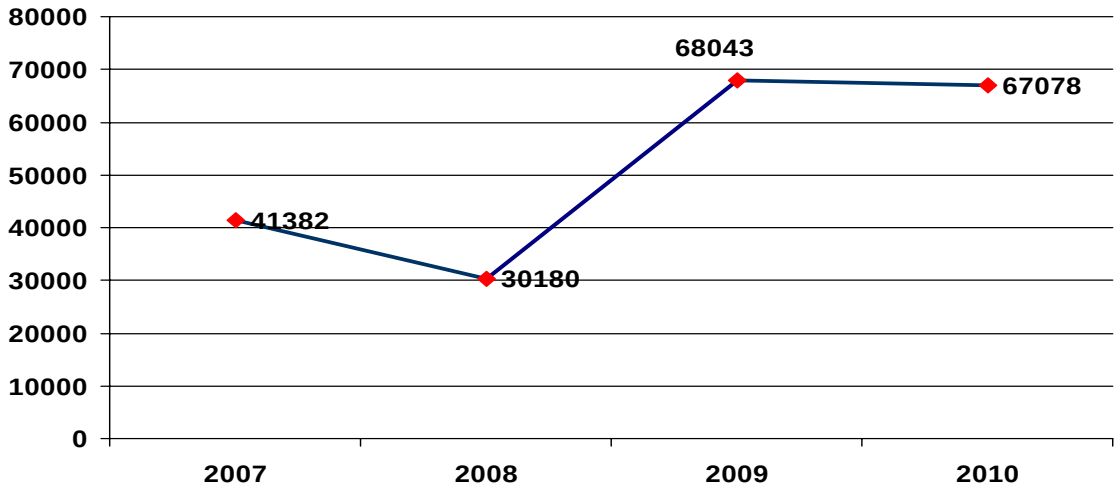


Fig. 3.4. Number of teachers trained in prevention, 2007-2010



Secondly, **specific activities** are occasionally carried out from time to time at schools, being held in many cases on international drug-free days (including tobacco and alcohol). There has been a major increase in the number of students who have taken part in this type of activities, having risen from 435,499 in 2009 to **995,739** in 2010. These activities are usually focused on providing information and heightening awareness.

In one case or another, such as that of the Autonomous Community of Castile and Leon, the activities offered during school hours are rounded out with **extracurricular preventive activities offered after school hours** through programmes such as the "*Te apuntas*" ["Join In"], "*Vivir el momento*" ["Live the Present"], "*Escuelas Deportivas*" [Sports Schools] and *Nexus* programs, in which 137 schools from this Autonomous Community have taken part.

In addition to the schools, interventions have begun at **universities** with programs for providing information and heightening awareness regarding the risks of alcohol abuse and the use of other

drugs. Many of these programs encourage the participation of previously-trained university students for conveying health promotion and drug use prevention messages. Progressively more Autonomous Communities are carrying out this type of programs. In Andalusia, working agreements have been signed with the public Universities of seven provinces for implementing programs including different research and educational activities. Another example is that of the Autonomous Community of Murcia's *Universan@s* program, which avails of several services, such as the online counselling and information service or the personalized psychological assistance program for more problematical cases. Special mention must also be made of the case of the Autonomous Community of Castile and Leon, which has collaborated with 4 public universities in this community within the framework of a Working Agreement, in addition to which they are also carrying out mediator training measures held at student dormitory facilities. Also worthy of note is the case of the Autonomous Community of Valencia, with its "*En plenas Facultades*" ["Full Faculties"] program implemented at 3 Universities in this Autonomous Community.

FAMILY

According to information from the Autonomous Communities Plans on Drugs, a total of **219,260 parents have taken part in family prevention programs**, meaning the upward trend having been noted over the past few years is continuing, although this figure continues to be much lower than might be hoped, mainly because, precisely as is pointed out in the research, it is the family programs which have shown themselves to achieve a greater deal of preventiveness. In most cases, the format employed is that of the Parents' Schools. The components which are usually included are, in addition to the drug-related information, the development of educating skills and setting clear-cut rules regarding the use of alcohol and drugs. In some Autonomous Communities are offering distance on-line courses such Cantabria, with the "*En Familia*" ["Among Family"] course or that of the Autonomous Community of Castile and Leon, which takes part in the Help Foundation's online program for families. One of the conventional problems in the field of endeavour is that of keeping the parents in the preventive programs. In this regard, special mention may be made of the case of Castile and Leon, with its "*Moneo*" program, where 88% of the parents fully completed the program.

In addition to these parent-oriented programs, one must also have the **active involvement of parents in the prevention programs at schools**, either by way of specific parent-focused modules or by way of including activities for the home as part of the aforesaid school programs.

COMMUNITY

At the community level, most of the prevention-oriented actions at the community level target groups in particularly vulnerable situations, either families or the minors in the families or minors in general through alternative leisure-time programs. Both one and the other have already been discussed in the respective sections. But special mention must be made of some actions of particular interest under this heading, one of which is the "*Penelope"* Program carried out in Galicia, which is a comprehensive program focused specifically on females, hence being of importance, given that there are few preventive work experiences with a gender perspective. In 2010, this program has worked with as many as 23,497 females. Another of the more interesting initiatives under this heading is that of the "Community Alliances" unrolled in the Autonomous Community of Castile and Leon Plan on Drugs, which consists of raising the awareness of different sectors of the community and getting them actively involved for preventing minors from drinking alcohol. Some Autonomous Communities organize community prevention through specific facilities which coordinate the actions within one same territory, such as, for example the Autonomous Communities of Valencia (UPCCAS) and Aragon, with their community prevention centres offering their services to schools, companies and families.

PROGRAMS AT LEISURE ESTABLISHMENTS

The number of participants in **alternative leisure** programs continues declining. In 2010, a total of **404,692 minors and youths** took part in this type of programs, meaning 100,000 fewer participants than the year before. In general, these are universal prevention programs, although they are offered in some cases for groups at risk of social exclusion, such as, for example, in Extremadura, where a Prevention program is carried out by way of encouraging sports for groups in at-risk situations. Most of these activities are short in length, being offered on weekends or during vacations, but there are also more intensive, more continuous programs, such as is the case of the Autonomous Community of Castile-La Mancha's "*Alcazul* "program, in which 225 municipalities take part; Andalusia's "*Ciudades ante las Drogas*" ["Cities Combatting Drugs"] program, in which 407 municipalities in this Autonomous Community are taking part; or the Autonomous Community of Murcia's *"Búrlalas"* ["Handle Them"] program, an alternative leisure program backed by a prevention campaign. In addition to the above, the Autonomous Communities of Madrid and Ceuta have Mobile Units for promoting alternative leisure.

Apart from the above, the Government Delegation subsidized 62 programs from as many municipalities in 2010 for carrying out healthy activities as alternatives to using toxic substances during youth leisure time for preventing drug dependences totalling the amount of 3,820,000 euros allocated from the Fund of Assets Seized for Illicit Drug Traffic and Other Related-Offenses. Similarly, within the framework of the Working Agreement signed by the Spanish Federation of Municipalities and Provinces and the Government Delegation for the National Plan on Drugs, the Announcement of the IV Call for Contributions Related to Best Practices in Drug Dependence

3.4. SELECTIVE PREVENTION IN AT-RISKS GROUPS AND SETTINGS

The work done by the Autonomic Plans on Drugs is focused mainly on two groups: minors and families in a situation of vulnerability, and the programs are usually carried out at the school level or at the community level.

At schools, work is done with selective school programs at standardized schools consisting of identifying schools for taking preferential action (Basque Country) or in specific classrooms of schools where drug use problems are detected (Galicia). In the Rioja Autonomous Community, for example, there is a system for detecting and referring school students at risk which is rounded out with the training of the principals of these schools. In Navarre, work is done with 101 schools at which tasks are carried out to support school students who have problems.

Some Autonomous Communities implement selective programs at Social Guarantee or similar centres. For example, the Autonomous Community of Castile and Leon carries out interventions with the "*Galilei"* program, which is an adaptation of the "*Odisea"* program promoted by the Government Delegation for the National Plan on Drugs, which has become consolidated as a major line of action in this Community, which has also enriched it with the successive evaluations which have been conducted thereon. This program is also implemented in its original version in the Basque Country.

Programs are implemented at Reform and Protection Centres in Autonomous Communities such as the Balearic Islands or Melilla, where work is done with unaccompanied underage minors who are placed in these centres.

At the community level, nearly all of the Autonomous Communities implement Education programs out in the street. One example is the Autonomous Community of Castile La Mancha's *"Risk Antenna*" program. Some work with minors who have been sentenced for possessing or using drugs in public, such as is the case of the Basque Country, Melilla, Extremadura with its "*Pandora"* program and Galicia with its "*Alternative"* program.

As regards families, some Autonomous Communities are working with structured, indicated, selective prevention programs, such as is the case of Castile and Leon, which has several programs at this level of intervention: "*Alfil*" (for children of alcoholics); "*Dédalo", "Brújula"* or the Family Empowerment Program, the latter of these three being an adaption to Spain's population of the U.S. SFP program and has been evaluated in this Autonomous Community; or the case of the Rioja Autonomous Community, where the *"Protego"* program is being implemented. In other cases, less structured interventions are implemented for informing, counselling and treating families with problems, in many cases in collaboration with the Social Services, such as, for example, in Navarre, where an indicated, selective prevention program is implemented, in which nearly 700 families have taken part; or in Madrid, which has a specific indicated, selective prevention services. Special mention must be made, due to its newness, of the selective prevention program carried out with mothers at the Los Rosales prison facility in Ceuta.

3.6. NATIONAL AND LOCAL MEDIA CAMPAIGNS

Focus on big campaigns, state message and costs

As in previous years, the Government Delegation got under way, with the collaboration of the Ramón Rubial Foundation, the Campaign for preventing drug trafficking while travelling to foreign countries. This Campaign cost 20,000 €.

A total of three Autonomous Community campaigns have also been funded, amounting to a total of 60,000 €, meaning a major budget cut compared to the year before for this type of activity (192,000€ in 2009).

In September 2011, a Manifesto against drug use by minors was presented for the purpose of achieving a national agreement for prevention. This manifesto was signed by representatives from the alcohol industry and by NGOs from this sector, emphasizing information, education and self-regulation measures on the part of the industry.

OTHER LEVELS OF INTERVENTION

- **At the health care level,** some Autonomous Communities work especially with the health care sector by promoting the training of this sector's professionals and their active involvement in endeavours focused on early detection and prevention of drug dependence. The Rioja Autonomous Community, for example, promotes the training of primary care professionals and brief interventions concerning tobacco and alcohol. The Autonomous Community of Castile-La Mancha has been collaborating for years with the Scientific Societies for the prevention of the smoking habit at schools and at the community level. The Autonomous Community of Madrid has a specific program for these professionals: the "*Actúa"* [Take Action] program. In Asturias, work is being done through the community nursing "*Niño San"* [Healthy Child] program, into which early detection and early intervention contents have been added. Lastly, in Murcia, the "*Argos-Murcia"* program has been consolidated, based on an intervention promoted by the Government Delegation for the National Plan on Drugs in 2006 in collaboration with SEMFYC for encouraging the health care sector taking part in preventive work. In addition to the general component, revolving around the training of health care professionals for taking action at the school and community levels, a specific component has been developed for pregnant women, known as "*Argos-Nato"*.

- **At the working place level**, the measures are carried out through the occupational health services in coordination with the trade union and employers' organizations and revolve around heightening the awareness of workers regarding the risks and harm associated with drug use

and the training of professionals, although they are now starting to carry out more advanced measures by means of preparing prevention plans at the companies. For example, within the framework of its *"Mano a Mano"* [Hand-in-Hand] program, which provides companies with materials and advisory, the Rioja Autonomous Community has started up a line of collaboration with the municipal governments for preparing global intervention plans at local companies. In 2010, three municipal governments were taking part in this initiative. In the Autonomous Community of Castile-La Mancha, this is a preferential field of action, with measures for heightening awareness, training and providing counselling in collaboration with trade unions and employers. In the Autonomous Community of Castile and Leon, work is being done with 50 companies through their occupational risk prevention services for preparing plans for action. The Autonomous Community of Asturias is also carrying out similar activities in addition to including research projects in this field.

4. PROBLEM DRUG USE

4.1. INTRODUCTION

Prevalence and estimates of incidence of problem drug use

No clear consensus exists as to the requirements the use of a drug must meet in order to be considered problem drug use. The use of psychoactive substances can give rise to problems not only for those who use them, but also for others who do not use them. Similarly, the problems may be of widely-varying types: physical, psychological or social and, lastly, the form, frequency and route of administration involved, the user's social environment and the characteristics of the user proper will be fundamental to being able to determine whether or not the uses in question are cases of problem drug use.

Nevertheless, the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) defines problem use as "*injecting drug use or the long-duration/regular use of opioids, cocaine and/or amphetamines*". This also includes regular or long-duration use of prescription opioids, such as is the case of methadone or others, but does not include the sporadic use thereof or the use of other drugs such as cannabis or ecstasy. Nevertheless, this definition is currently in the process of undergoing a revision for the purpose of adapting it to the changes found to have taken place over the past few years in the area of the European Union with regard to the substances and patterns of use.

Knowing the prevalence and incidence of problem use is useful for designing and evaluating health programs. For this purpose, in addition to the surveys, indicators of drugs problems are also used based, generally on the drug users for whom care is provided through the different types of services available for those using psychoactive substances.

Although quite a few methodological limitations exist with regard to being able to obtain direct information on problem drug use based on population-based surveys, some countries have recently shown a certain degree of interest in including specific scales for measuring problem use of the different psychoactive substances in drug use-related surveys conducted on both the general population as well as on students.

Being able to avail of simple tools for distinguishing between problem drug use and those cases which are not considered problem use and which also afford the possibility of drawing a comparison among different populations at the international level must obviously be considered a true breakthrough. Nevertheless, the psychometrics, translation, adaptation to each individual country and type of population etc. are determining factors when evaluating the use of scales on the surveys.

As will be discussed at a further point in this document, Spain has introduced and evaluated different scales aimed at measuring problem cannabis use on the ESTUDES survey (2006, 2008 and 2010) and does not rule out the possibility of introducing other scales once validated and adapted to the use of other substances or population groups.

4.2. PREVALENCE AND INCIDENCE ESTIMATES OF PDU

Indirect estimates of problem drug users

Problem heroin use

The estimates of problem use indicate that the total number of problem heroin users (prevalence) peaked in Spain in the early 1990's with more than 150,000 heroin users, as of which time these numbers began to decline.

Due to the small number of heroin users found in the samples, it is practically impossible to obtain reliable estimates directly from the population-based surveys as to the percentage of users who have started treatment for this substance and to be able to apply the in-treatment multiplier method. However, previously, in the 2007 Household Survey on Alcohol and Drugs in Spain (EDADES), the nominative method, a variation on the in-treatment multiplier method, was employed.

To date, problem heroin users have therefore been being estimated by using the multiplier figures found in the 2007 Household Survey on Alcohol and Drugs in Spain (EDADES) and by applying this multiplier to the data available regarding treatment in Spain (indicator of admissions to treatment, users who have undergone treatment at outpatient centres and number of users in treatment with opiate maintenance) for the years 2006, 2007, 2008 and 2009.

In 2011, the Household Survey on Alcohol and Drugs in Spain (EDADES) once again included the questions necessary so as to be able to apply the nominative method, thus making it possible to update the in-treatment multiplier. For this purpose, those surveyed were asked whether they knew any heroin users, and for each one of the heroin users they knew, those surveyed were to indicate if they knew whether or not those in question had started treatment for dependence on this drug within the last 12 months.

Thus, valid answers were obtained on 1427 reported users, a total of 643 (45%) of whom had started treatment for dependence according to those surveyed. By applying this multiplier to the 17,325 “individuals admitted to treatment for heroin in 2010”, the figure of 38,500 problem heroin users is calculated.

However, this figure may not be in keeping with the true situation and may be underestimated. This is due to the fact, on one hand, of heroin users in treatment being more visible than those undergoing treatment for other drugs, for which reason it is therefore probable that those surveyed have overestimated the percentage of the heroin users they stated as having “started treatment for heroin dependence within the last 12 months”. On the other hand, it is highly likely that those surveyed may have confused “starting treatment for heroin within the last 12 months” (which is the question they were being asked) with “being in treatment for heroin within the last twelve months” – although they had started treatment previously, which would also render a higher percentage of “started treatment for heroin within the last twelve months (45%) among the individuals mentioned by those surveyed than would actually be true if those surveyed were to report strictly those who “started treatment for heroin within the last twelve months”.

This is the reason why, instead of taking the population of “individuals admitted to treatment for heroin in 2010 – started within the last 12 months” (TDI) as a reference, it has been decided to take the population of heroin users who have undergone treatment for heroin – regardless of whether or not started within the last 12 months – at the outpatient centres for drug dependence treatment as the reference. In 2010, a total of 93,732 illicit drug users were treated at outpatient centres throughout Spain. If the same spread as recorded in the treatment demand indicator (“admitted to treatment within the last 12 months”) for heroin for that same year (2010) is assumed for this group, we would find 93,732 x 32.4% = 30,369 individuals who had been in treatment for heroin in 2010 and, by applying the multiplier (30,369 x 100/45), an estimate of 67,487 problem heroin users in the population would be calculated.

Lastly, it must not be overlooked that the previous estimates (38,500 and 67,487) would be, generally speaking, those heroin users who are not in treatment with opioid maintenance (OMT), as these are recorded separately. In 2010, according to the data furnished by the Autonomous Communities, there were 81,022 in OMT. It is known that a none too negligible percentage (around 40%) of the users on OMT additionally use heroin, as a result of which 81,022 x 40% = 32,408 could also be considered problem users.

Thus, the sum of the aforementioned (32,408) and the estimates previously calculated in parallel (38,500 based on the TDI and 67,487 based on the total number of individuals treated for drug use at outpatient centres) makes it possible to establish a range within which the final estimate of problem users in Spain in 2010 (70,908 and 99,895 individuals) would fall. These figures mark an approximate 3.7% average increase compared to the figures estimated for 2009 included in the 2011 Spanish National Report (68,056-96,624 individuals).

There is no clear-cut consensus among the experts as to whether those heroin users who are undergoing treatment, regardless of whether or not they are undergoing maintenance treatment, must continue being considered "problem users". The inclusion and exclusion-related criteria being used by the different countries to estimating the number of problem drug users vary greatly and are based on widely differing reasons.

Table 4.1. Estimates of the number of problem heroin users. Spain 2009-2010

	Method	2009	2010
Problem heroin use	Estimate 1: TDI (multiplier) + OMT*	68,056	70,908
	Estimate 2 : Outpatient treatment (multiplier) + OMT*	96,624	99,895
	TOTAL	68,056 - 96,624	70,908 - 99,895

* OMT: Opioid Maintenance Treatment.
SOURCE: Prepared by the Spanish Observatory on Drugs and Drug Addiction. Treatment Demand Indicator (TDI) 2009 and 2010. Household Survey on Alcohol and Drugs (EDADES) 2011. 2010 and 2011 Annual Report by the Government Delegation for the National Plan on Drugs (in press). Government Delegation for the National Plan on Drugs.

Injecting drug use

Concerning the estimated number of injecting drug users, valid answers of 1551 named injecting users were obtained in the 2011 Household Survey on Alcohol and Drugs (EDADES), a total of 741 (48%)of whom had started treatment for drug abuse or dependence according to those surveyed, which, applied to the 3,549 injecting users (injection within the 12 months immediately prior to being admitted to treatment) who were admitted to treatment in Spain in 2010 led to an estimate of 7,393 (3,549/0.48) recent injecting drug users in 2010 who would not be in OMT.

To estimate the number of injecting users who were patients in OMT in 2010, it is assumed, as in previous years, that 40% of this population has used heroin within the last 12 months and that 17% thereof have been injecting drug users. Thus, the estimate would be of at least (81,022 patients in OMT in 2010 x 40% who have used heroin within the last 12 months = 32,408 and 32,408 x 17% injecting = 5,509).

Hence, based on the treatment indicator data and on the estimated number of injecting users among those patients in OMT, estimates would be found of **12,902 (**7,393 + 5,509**) recent (within the last 12 months) injecting drug users, meaning a 8.1% decline in the estimated number of injecting drug users in comparison to the figures estimated for 2009, mainly at the expense of a decline in the number of injecting users admitted for treatment in 2010.**

One must bear in mind that, in the 2011 Spanish National Report, a review was conducted of the relative importance the injecting route has among those admitted to treatment for heroin use in general and among the group of those considered "older" (long-duration users older than 39 years of age) in particular, it was deemed appropriate to assume an injecting use among those undergoing OMT treatment similar to that which is found both among all of those admitted to treatment for heroin and among the "older" group, which was 17% in 2009 and remained unchanged in 2010. The percentage employed previously had been 40%, which is not in keeping with the decline in injecting use among heroin users recorded over the past few years.

However, when, instead of using the number of injecting users admitted to treatment, the estimated number of injecting users who had undergone some treatment for drug abuse or dependence in 2009 was used (6,186 individuals, calculated based on the number of drug users for whom care was provided in 2010 = 93,732, multiplied by 6.6%, which is the percentage of those admitted for treatment – for any drug- in 2010 who had injected drugs within the last 12 months), **an estimate was calculated of** 12,888 (6,186/0.48 = 12,888). Lastly, on adding the estimated number of injecting users among those undergoing OMT, the figure of **18,397** (12,888 + 5,509) **recent injecting users** is calculated.

Therefore, the estimated figure of recent injecting users (within the last 12 months) would fall within the range of 12,902 – 18,397 individuals.

Table 4.2. Estimates of the number of injecting drug users. Spain 2009-2010

	Method	**2009**	**2010**
Injecting drug use	Estimate 1: TDI (multiplier) +OMT*	14 042	12 902
	Estimate 2 : Outpatient treatment (multiplier) + OMT*	23 056	18 397
	TOTAL	14 042 – 23 056	12 902 – 18 397

* OMT: Opioid Maintenance Treatment.
SOURCE: Prepared by the Spanish Observatory on Drugs and Drug Addiction. Treatment Demand Indicator (TDI) 2009 and 2010. Household Survey on Alcohol and Drugs (EDADES) 2011. 2010 and 2011 Annual Report by the Government Delegation for the National Plan on Drugs (in press). Government Delegation for the National Plan on Drugs.

4.4. INTENSIVE, FREQUENT, LONG-TERM AND OTHER PROBLEMATIC FORMS OF USE

Prevalence estimates of intensive, frequent long-term and other problematic forms of use, not included in PDU definition

Problem cocaine use

Regarding cocaine, the 2011 Household Survey on Alcohol and Drugs (EDADES) obtained valid answers on 495 named users, a total of 29 (2.45%) of whom had started treatment for cocaine abuse or dependence with the last 12 months according to those surveyed, which, applied to the 22,131 individuals admitted for treatment for cocaine abuse or dependence in Spain in 2010, leads to a very high figure for problem cocaine users of 903,306 (22,131/0.0245), which might overestimate the actual number. The reason probably lies in the fact that, in the case of cocaine, there is a lengthy time lapse between the start of use and the start of treatment, as a result of which it would not be correct to apply the 2.45% annual treatment rate to the 2010 cocaine users.

However, different estimates can be made by the direct method based on the 2011 Household Survey of Alcohol and Drugs (EDADES) (direct extrapolation of the prevalence of use figures), rendering lower figures which, although may be underestimated due to a certain degree of concealment of the more intensive uses, can be considered at least as a minimum.

It is complicated to decide what criteria to use for considering a pattern of cocaine use to be a case of problem use solely by virtue of the characteristics thereof, given that it is well known that very different types of combinations among the intensity of use at each given time, the frequency with which used, the age at which used, the other psychoactive substances with which cocaine is combined and the different underlying disorders of those who use cocaine can cause problems for cocaine users.

As a starting point, within the context of the information available in the 2011 Household Survey on Alcohol and Drugs (EDADES), a problem user is considered as being that user who states having used cocaine on 30 days or more within the last 12 months and/or on 10 days or more within the last 30 days. In 2011, according to the Household Survey on Alcohol and Drugs (EDADES), there were a total of 121,130 cocaine users[1] in Spain who had used cocaine on 30 days or more within the last 12 months and 48,561 who had used cocaine on 10 days or more within the last 30 days, a total of 45,608 of whom who met the requirements (use on 30 days or more within the last 12 months and us on 10 days or more within the last 30 days) may be ruled out for the sake of avoiding repetitions,. The estimated number would then total 124,083 problem cocaine users.

Some thought was also given to the possibility of adjusting this figure by taking into consideration the highest and lowest number of years since each cocaine user had started using cocaine, but the Household Survey on Alcohol and Drugs (EDADES) does not include information affording the possibility of assuming that the users who have actually used cocaine continuously throughout this time period, this variable thus having not turned out to be useful nor having been included in the calculation of the estimate.

In addition to the length of continuous use, from the Public Health standpoint, it also seems important to take into consideration the cases of use at very young ages. Thus, a parallel estimate was made, considering problem users as being all those 20 years of age or younger (approximate age by which the CNS has fully matured) who had used cocaine on 10 days or more within the last 12 months and at least on 1-3 days within the last 30 days, having totalled 12,181 in number on the Household Survey of Alcohol and Drugs (EDADES), representing 16.7% of the cocaine users (12 months) in this age range.

[1] For this estimate, “cocaine” is considered to be both cocaine hydrochloride (powder cocaine) and base cocaine (crack).

To these numbers, it would be necessary to add those users over 20 years of age who used cocaine on 30 days or more within the last 12 months and/or on 10 days or more within the last 30 days (118,356 individuals), theoretically assuming that those who, as a result of being chronologically old enough, had reached psychophysical maturity, would be less susceptible than the youngest individuals to be harmed as a result of using cocaine, for equal amounts used. According to this hypothesis, in 2011, 130,537 (12,181 + 118,356) would be recorded.

Hence, according to the method employed for these estimates, the number of problem cocaine users could be said to fall within the range of 124,083 – 130,537 individuals. This means an approximate 6% decline in comparison to 2009, which might be explained by the downward trend in the prevalence of cocaine use within the last 12 months and within the last 30 days found in the Household Survey on Alcohol and Drugs (EDADES) for the 2009-2011 period. Nevertheless, despite this fact, an estimated number is found for users on 10 days or more within the last 30 days which is higher than the number found in 2009, which would mean that, despite the fact that the trend in the prevalences of overall use may indicated an improvement in the situation generally speaking, it must not be inferred from this that problem use is behaving in the same way.

Considering the limitations of the methods employed for making prevalence-related estimates and the numerous assumptions which must be made, the results of the previous years must be taken and used with a great deal of precaution.

Table 4.3**.** Estimates of the number of problem cocaine users. Spain 2009 -2010

	Method	**2009**	**2010**
Problem cocaine use	Estimate 1: use >/= 30 days within the last 12 months and/or >/= 10 days within the last 30 days. Age 15 - 64 population.	130,409	124,083
	Estimate 2 : use >/= 10 days within the last 12 months and at least 1-3 days within the last 30 days among age 15-20 population. + use >/= 30 days within the last 12 months and/or >/= 10 days within the last 30 days in age > 20 population	140,525	130,537
	TOTAL	130,409 - 124,083	140,525 - 130,537

SOURCE: Prepared by the Spanish Observatory on Drugs and Drug Addiction. 2009 and 2011 Household Survey on Alcohol and Drugs (EDADES). Government Delegation for the National Plan on Drugs.

Problem cannabis users

Over the past few years, increasingly greater importance has been being placed on the possible implications of cannabis use for Public Health due both to the widespread degree to which cannabis is used among Spain's population and also due to the rise recorded in the demand for treatment for cannabis abuse or dependence.

The vast majority of cannabis users are experimental or sporadic users. However, in a considerable percentage of cases, the pattern of use of cannabis heightens the risk of experiencing effects on their own health, developing dependence or achieving poorer academic or work-related performance, etc.[2,3,4,5,6,7].

This type of uses pose a short and medium-range challenge in terms of providing services and Public Health, it therefore being advisable to attempt to identify its characteristics and the population groups most vulnerable to its possible effects and consequences.

It is therefore necessary to introduce methods making it possible to distinguish problem cannabis use from that which is not a problem. Currently, no consensus has been reached as to a definition making it possible to clearly distinguish between these two types of use, although it be obvious that "problem use" makes reference to that which gives rise to problems for the itself user or for third parties, be they of the physical, psychological or social type or which favour at-risk behaviours which may put the life or health of the user or of others in jeopardy.

For this purpose, as part of a project in collaboration with the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction), a number of scales have been being included since 2006 in the successive editions of the National Survey on Drug Use Among Secondary School Students (ESTUDES) aimed at evaluating the problem cannabis use and dependence.

Several different scales being included at the same time in some of the ESTUDES Survey editions (SDS-*Severity of Dependence Scale*, DSM-IV-*American Psychiatric Association* y CAST-*Cannabis Abuse Screening Test,* en 2006 *y* SDS-*Severity of Dependence Scale*, M-CIDI- *Munich Composite International Diagnostic Interview* y CAST- *Cannabis Abuse Screening Test* en 2010) better serve methodological interest aimed at evaluating the suitability and usefulness of the scales for measuring problem cannabis use than estimating the prevalence of this type of use. Nevertheless, the results detailed herein are those obtained by the CAST scale, given that this was the scale which, from the psychometric standpoint, gave the soundest results compared to all of the other scales evaluated, in addition to the inclusion thereof in the ESTUDES Survey in 2006, 2008 and 2010 affording the possibility of determining a time-related trend.

In addition to the above, the CAST scale was also chosen to be included in the ESPAD Survey (*European School Survey Project on Alcohol and Other Drugs*), thus enabling, although with precaution, a certain degree of comparison at the international level.

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[2] Hall W,.Solowij N. Adverse effects of Cannabis. Lancet 1998;352:1611-6.
[3] Laumon B, Gadegbeku B, Martin JL, Biecheler MB. Cannabis intoxication and fatal road crashes in France: population based case-control study. BMJ 2005; 331: 1371.
[4] Macleod J, Oakes R, Copello A, Crome I, Egger M, Hickman M et al. Psychological and social sequelae of Cannabis and other illicit drug use by young people: A systematic review of longitudinal, general population studies. Lancet 2004; 363: 1579-88.
[5] Moore TH, Zammit S, Lingford-Hughes A, Barnes TR, Jones PB, Burke M et al. Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review. Lancet 2007; 370: 319-28.
[6] Zammit S, Moore TH, Lingford-Hughes A, Barnes TR, Jones PB, Burke M et al. Effects of Cannabis use on outcomes of psychotic disorders: Systematic review. Br. J. Psychiatry 2008; 193: 357-63.
[7] Aldington S, Williams M, Nowitz M, Weatherall M, Pritchard A, McNaughton A et al. Effects of Cannabis on pulmonary structure, function and symptoms. Thorax 2007; 62: 1058-63.

The CAST scale was prepared in France by *François Beck* and *Stephane Legleye*. The objective was to avail of a tool for measuring problem Cannabis use which would include items related to dependence, abuse – as defined in the DSM-IV- and other use-related problems. The CAST[8] scale is comprised of 6 items, each having 5 categories of answers which are scored in a set manner.

Table 4.4. CAST Scale

1. Have you ever smoked cannabis before midday?
0 = Never; 0 = Rarely; 0 = From time to time; 1 = Fairly often; 1 = Very often

2. Have you ever smoked cannabis when you were alone?
0 = Never; 0 = Rarely; 0 = From time to time; 1 = Fairly often; 1 = Very often

3. Have you ever had memory problems when you smoked cannabis?
0 = Never; 0 = Rarely; 0 = From time to time; 1 = Fairly often; 1 = Very often

4. Have friends or family members of yours told you that you ought to reduce your cannabis use?
0 = Never; 0 = Rarely; 0 = From time to time; 1 = Fairly often; 1 = Very often

5. Have you ever tried to reduce or quit your cannabis use without succeeding?
0 = Never; 0 = Rarely; 0 = From time to time; 1 = Fairly often; 1 = Very often

6. Have you ever had problems because of your cannabis use (argument, fight, accident, poor performance at school, etc.)?
Which of the above?: /……../
0 = Never; 0 = Rarely; 0 = From time to time; 1 = Fairly often; 1 = Very often

Source: Modified and translated into Spanish. Original by F. Beck and S. Legleye (2003).

The CAST scale scoring and cut-off points used (2 and 4) make it possible to distinguish among three different groups of cannabis users:

1. Score of 0-1: Non-problem users
2. Score of 2-3: Users at low risk of having problems.
3. Score of 4 or above: Users at high risk of having problems

Table 4.5. Prevalence of problem cannabis use. Estimate of the number of problem cannabis users among Spain's age 14-18 population. Spain, 2006, 2008 and 2010.

	ESTUDES 2006	ESTUDES 2008	ESTUDES 2010
Prevalence % of problem cannabis sue	3.3	3.7	4.6
Estimated number users (absolute figures)*	73,534	81,080	100,340

* Estimate calculated based on the age 14-18 population in 2006, 2008 and 2010.
SOURCE: Prepared by the Spanish Observatory on Drugs and Drug Addiction. National Survey on Drug Use Among Secondary School Students (ESTUDES) 2006, 2008 y 2010. Government Delegation for the National Plan on Drugs.

[8]Legleye S. et al. J Subst Use 2007, 12(4), 233-242

As shown in Table 4.5 above, in 2010, a total of 4.6% of Spain's students within the 14-18 age range might be involved in a use of drugs which may cause them some type of problem. The prevalence of problem use, calculated by means of the CAST scale, reveals an upward trend in Spain within the 2006-2010 time period, despite a slight decline in cannabis use having been record for the same period.

The upward trend revealed by the results of the CAST scale fits in with the rise recorded in the number of individuals admitted for treatment due to cannabis among minors within the past few years. Hence, the percentage of individuals admitted for treatment among minors related to cannabis was 69.2% in 2005, 72.4% in 2006, 78.4% in 2007, 83.8% in 2008, 84.4% in 2009 and 89.5% in 2010.

The analysis of the CAST scale on the 2007 ESPAD survey (students ages 15-16 from different European countries) resulted in a 2% problem cannabis use prevalence figure (similar to that recorded in Spain in 2006), using cut-off points similar to those used in the case of Spain. However, even though these are the cut-off points which are used as standard practice, studies have now been published pointing out certain advantages being involved in using lower cut-off points when the CAST scale is used as a screening method for the general population. Hence, the 2011 ESPAD survey recorded a 5% prevalence of problem use when a >2 cut-off point was used.

5. DRUG-RELATED TREATMENT: TREATMENT DEMAND AND TREATMENT AVAILABILITY

5.1. INTRODUCTION

Drug related treatment system is based on the Spanish territorial division in Autonomous Communities and Cities. Each Autonomous Community or City has three levels of care at the treatment network.

5.2. GENERAL DESCRIPTION, AVAILABILITY AND QUALITY ASSURANCE

5.2.1. Strategy / policy and 5.2.2. Treatment systems

First of all, special mention may be made of the approval of the National Strategy on Drugs 2009-2016 by the Council of Ministers on January 23, 2009. This Strategy is configured as a framework of reference for all of the Public Administrations and social organisations.

The Strategy's objectives include:

- Guaranteeing quality care adapted to the needs of all those persons directly or indirectly affected by drug use.

- Reducing or limiting the harm caused to the health of the persons who use drugs and, in general, the undesirable social and health-related effects related to drug use.

To promote the Strategy being carried out, the Government Delegation for the National Plan on Drugs urged the preparation of a Plan for Action for the 2009-2012 period. Some of the actions included in this Plan which may be mentioned are:

- To standardize the healthcare provided for drug-dependent individuals based on scientific evidence by means of the preparation of protocols, guides and catalogues of interventions.

- To reduce or limit the harm cause to the health of drug users and, in general, the undesirable social and health-related effects associated with drug use.

- To foster the expansion and accessibility to the drug substitute treatment programmes and urge the use of other therapies of proven effectiveness based on evidence in those users who are not benefitting from the conventional treatment options.

- To strengthen specific harm-reducing programmes being carried out to prevent health problems, such as acute poisonings and overdoses.

In Spain, the planning, organisation and coordination of the drug-related measures which are carried out within their respective autonomous territories fall to the 17 Autonomous Communities and to the 2 Autonomous Cities of Ceuta and Melilla through of the respective Autonomous Plans on Drugs.

Thus, the Autonomous Communities and Autonomous Cities proper are the ones evaluating the status of the trend in drug use within each one of their territorial scopes, as well as the implementation of the pertinent measures in the different areas of intervention in regard to this matter (prevention, the dispensing of care and social reintegration, training, research, etc.). The implementation of the resources allocated to providing care for drug-dependent individuals also comes under their authority.

In this regard, it must be mentioned that they are also the ones who set the criteria for admission to the treatment centres, the profiles which the patients must meet, the length of the time they are to remain in the different treatment modalities, etc. In short, they are responsible for the care benefits provided to drug users.

Special mention must also be made, as has been mentioned in other reports, as to the Autonomous Communities and Autonomous Cities being the ones determining both the criteria as well as the tools for monitoring and evaluating the effectiveness of the treatments which are carried out in the care programmes and services.

The care networks have duly accredited general, specialized and specific centres and services for providing drug dependence care which are public or private and publicly-funded.

In general, there is what may be referred to as a first level which is the gateway into the system. The resources thereof are the most accessible and those placing the fewest demands on drug-dependent individuals of all those comprising the care-providing network. The main missions of this level are that of detecting, recruiting, motivating and referring drug-dependent individuals to the specialized services to start treatment and the care of the basic social and healthcare-related needs of drug-dependent individuals and their families.

The resources comprising part of this level generally pertain to two well-defined categories: general resources at the Primary Healthcare Level and specific resources for providing care for drug dependencies with programmes entailing a differing degree of demand. The harm-reduction resources, involving a low degree of demand, may also refer to other more specialized care levels.

The second level of the treatment circuit is the core around which a good part of the process of providing care for drug-dependent individuals by way of interdisciplinary outpatient teams revolves, these teams being in charge of designing and carrying out individualized plans for specialized treatment. The outpatient drug dependence care centres are integrated into this level. Access may be direct or by referral from the first level or second level resources.

This second level also integrates the centres providing care for alcoholic patients.

In some Autonomous Communities, these second-level drug dependence care programmes are integrated into the Mental Health Teams.

Lastly, mention may be made of a third level comprised of specific resources with a high level of specialization for drug dependence in a residential treatment setting. All of the facilities comprising this level are accessed by referral from centres or services which have specialized treatment duties.

Included here are the hospital detoxification units (HDUs), the therapeutic communities for drug-dependent individuals and the specific programmes for providing care for dual diagnosis patients.

The description of these programmes and centres as well as the data related thereto is all provided in Chapter 7 of this document.

5.3. ACCESS TO TREATMENT

5.3.1. Characteristics of treated clients (TDI data included)

This section is devoted to summarizing the working protocol of the "indicator of individuals admitted to treatment for abuse or dependence of psychoactive substances", the latest version of which dates from 2003. In said protocol, certain operating criteria are set out for the inclusion and exclusion of episodes, criteria for selecting the centres to take part in the notification process, definitions and criteria for classifying the different variables, as well as details on the tools and the circuit for collecting and reporting the information and on the coverage of this indicator.

The treatment admissions indicator is a record including individualized data on admissions to outpatient treatment for psychoactive substance abuse or dependence throughout Spain and has been in existence since 1987. This record comprises part of a wider-ranging information sub-system developed within the framework of the National Plan on Drugs in collaboration with the Autonomous Communities, which also includes the drug-related hospital emergencies indicator and the acute drug reaction-related deaths indicator. This information sub-system, which was originally called the State Information System on Drug Addiction (SEIT) and which, after having gone by different names, came into being for the purpose of monitoring the trends and characteristics of problem psychoactive drug use, especially the use of those drugs, such as opioids and cocaine, which usually cause problems more often and are difficult to explore with other means.

The treatment demand indicator, in its current version (Protocol 2003), is defined as the number of individuals admitted for outpatient treatment for abuse or dependence for each one of the psychoactive substances listed in an annex to the protocol in an Autonomous Community for a given year. If an individual is admitted to treatment more than once within one same year within the same Autonomous Community, solely the first admission will be taken into account for that year, ruling out, at the Autonomous Community level, the repeated episodes with the aid of a personal identification number (PIN) comprised of the first two letters of the individual's two surnames, the date and province of birth and the gender. The value of the indicator at the nationwide level is determined by means of adding together the number of admissions for treatment recorded in each one of the Autonomous Communities, but since the PINs are not reported at the national level, the repeated episodes of admission for one same individual during one same year in two or more different Autonomous Communities cannot be distinguished. Although the available information indicates that this situation is infrequent, it may give rise to a minor overestimation of the indicator at the nationwide level.

Treatment is considered as being any intervention carried out by qualified professional for eliminating psychoactive substance abuse or dependence or reducing its intensity. Those treatments in which the patient does not stay overnight at the centre or those carried out in prison drug dependence treatment services are considered outpatient treatments. One must bear in mind that, in addition to outpatient treatments, some notifying centres may provide inpatient treatments or combined modalities. However, for the purposes of this indicator, solely the outpatient treatments are notified. The criteria for diagnosing dependence and abuse are those which are employed by the professionals who process the admission for treatment, although this must be aimed at applying that of the two main international classifications in effect (DSM-IV or ICD-10).

Any of the following situations are notified as <u>episodes of admission for treatment</u>:

1) Admission to treatment at a centre for the first time, considering this situation to arise the first time that care is provided for a patient at a certain notifying centre and a clinical (medical, social and psychological) record is initiated for the individual in question in the presence of a qualified professional (physician, psychologist, professional nurse, social worker, etc.) for the purpose of initiating a treatment process of psychoactive substance abuse or dependence, although this treatment not be the first the user in question is

undergoing within the network of centres which notify this indicator. The admissions to treatment are notified regarding of its modality, including the treatments with opioid replacement substances, both if its objective is detoxification or maintenance. In the case of the treatments with replacements, the drug which is to be used therapeutically in the maintenance program (i.e. methadone) is not considered to be the main drug, but rather the substance the abuse of or dependence on gave rise to the first treatment (generally heroin). Progressing from a maintenance program with replacements to a "drug-free" program directly without any lapse of time in between is considered as one single treatment.

2) Readmission for treatment at one same centre, considering "readmission" to be an admission to treatment of an individual who had already previous undergone one or more treatments at the same centre and had ended the same by treatment release, expulsion or dropout. The criteria of treatment release, expulsion and dropout. (6 months without the patient contacting the centre) are described in the indicator protocol.

3) Continuing a treatment already started, for reasons of emergency or for other reasons, at services which do not notify the indicator, such as hospitals, health centres or social work centres and who then later come to a notifying centre to continue the treatment.

4) Admission to treatment of individuals affected by a legal or administrative situation (conditional suspension of sentence, release from prison to serve out their sentence at a treatment facility, treatment in lieu of an administrative penalty or treatment of an individual in grade three prison regime).

The following are not notified as admissions for treatment:

1) The mere contacts made in person or by phone to request information or treatment or the demands which are place on the waiting list.

2) The contacts for the sole purpose of requesting social benefits or aids.

3) The treatment for the sole purpose of treating the organic complications related to drug use such as the treatment of an overdose, a withdrawal syndrome or an infection.

4) The interventions consisting exclusively of exchanging needles and syringes or other injecting material, handing out condoms or providing advice as to techniques of safe drug use and safe sex.

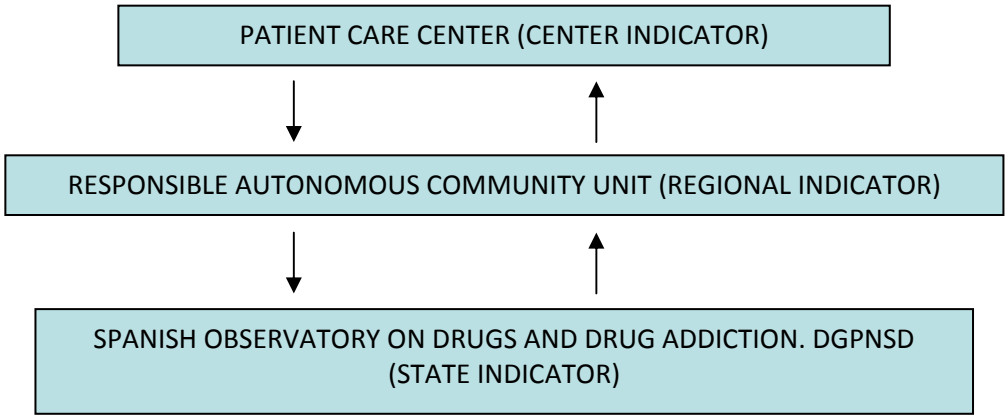
5) The treatments involving overnight stays in hospital units, psychiatric hospitals, therapeutic communities, residences, etc.

Although it would be desirable for all of the facilities which can potentially provide treatments for psychoactive substance abuse or dependence in Spain to be notified, it is very difficult and costly to include all of them (primary health care centres, hospitals, private clinics, etc.). This is the reason why, in practice, the public or subsidized or officially arranged private programs, services or centres which provide outpatient treatment for psychoactive substance abuse or dependence are included. They may be specific drug dependence centres, mental health centres or services which are already integrated into general health centres, hospitals or another type of centres), prison drug dependence treatment programs, centres which provide complex treatments including an outpatient phase or mobile units which provide treatments with opioid replacements which are manned by physicians and nurses. Generally speaking, those centres which provide treatment only on an inpatient basis (hospital detoxification units, therapeutic communities, some psychiatric hospitals or services) are not included as notifying centres, because most of the dependent individuals for whom care is provided at these centres are considered to have been referred from notifying outpatient centres.

The coverage of the Treatment Indicator with regard to the public or subsidized private centres which provide outpatient treatments for drug abuse or dependence has been practically one hundred per cent since the indicator was put into practice and, taking into account the characteristics of the health system in Spain, it is difficult for a major part of treatments for psychoactive drugs to be provided at exclusively private centres, although the percentage may be higher in the case of cocaine and cannabis than in the case of the opioids.

Regarding the circuit for collecting and reporting information, the treatment centres select the episodes of admission for treatment and notify them as an individualized record to the autonomous community units in both hardcopy and computer format. The autonomous community units then validate and refine the data, extracting those cases which are to be sent to the national unit by filtering out the episodes repeated within one same year. The information is sent in the form of an aggregate electronic file. The information is received at the central unit, the file structure, which is not always the same, is adjusted, the data is once again validated and refined and the information is tabulated and analysed (Fig. 5.1.).

Figure 5.1**.** Information Circuit. Treatment Indicator. Spain



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD)

There is an indicator computer program which is used by most of the Autonomous Communities which makes it possible to save the data with a number of logic and range controls, to filter out the repeated episodes and to export the data in a suitable format for sending it on to the state unit.

To properly interpret the indicator data, one must take into account that, although its basic elements have remained stable throughout its years of existence and statistics comparable over the course of time can be prepared, the indicator has indeed undergone three modifications since 1987. Up to 1990, solely information on opioids and cocaine was collected. Besides, it was not possible to know neither whether the person admitted for treatment had been treated previously for the same main drug (the drug giving rise to the treatment) nor if it was the first treatment in their lifetime, nor what the main route was for administering the drug in question. Therefore, certain changes were made in 1991 to provide a solution to the two latter solutions, others having entered into effect in 1996 consisting mainly of collecting information on the admissions due to any psychoactive substance (not including tobacco) and not solely for opioids or cocaine, and including variables for the first time for ascertaining the highest educational level completed, the main employment situation within the 30 days immediately prior to the treatment, the length of time since the last having injected a psychoactive substance and the HIV-related serological status. Lastly, a new methodological protocol entered into effect in 2003 for the treatment admissions indicator, prepared for the purpose of adapting it to the European TDI (Treatment Demand Indicator)

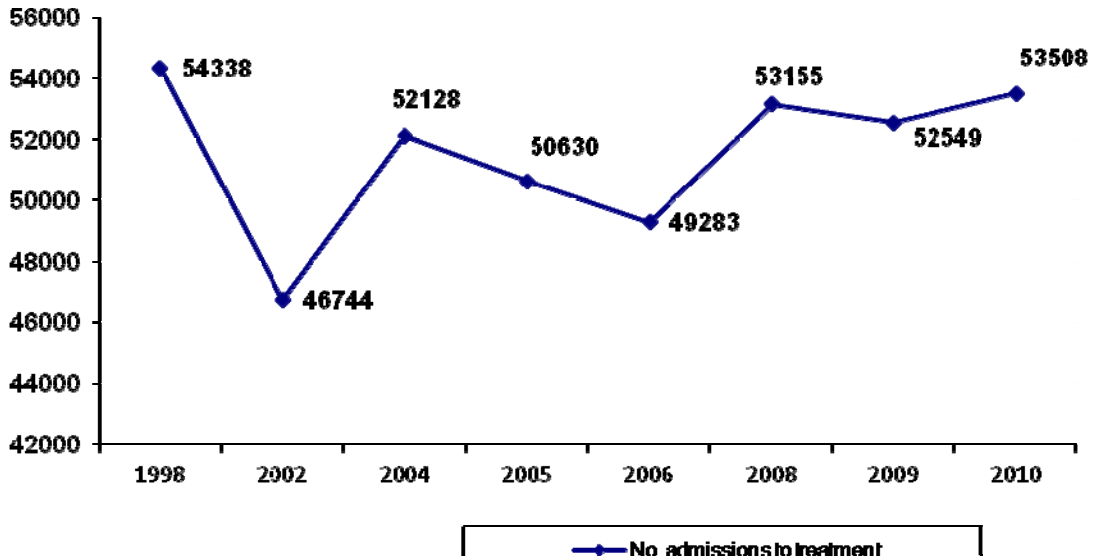
standard promoted by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) and for correcting some glitches previously detected.

Results

In 2010, a total of 53,508 admissions were recorded in Spain for treatment for psychoactive substance abuse or dependence (not including alcohol or tobacco). Within the 1998-2002 period, the number of admissions for treatment declined, from 54,338 in 1998 (the year in which the largest number of admissions were recorded) down to 46,744 in 2002. However, within the 2002-2004 period, a rise occurred, totalling up to 52,128 admissions in 2004, which then declined again in 2005 (50,630) and 2006 (49,283). As of 2006, a new rise has taken place, bringing the number of admissions for treatment up to figures nearing those of 1998.

The decline within the 1998-2002 period might have been due to the effect of the methadone maintenance programs which meant that many heroin users ceased rotating through the treatment services. The rise within the 2002-2004 period and from 2006 to 2008 could be explained by the rise in the number of admissions for treatment for cocaine and cannabis (Fig. 5.2).

Fig. 5.2. Trend in the admissions for treatment. Treatment Indicator. Spain, 1998-2010

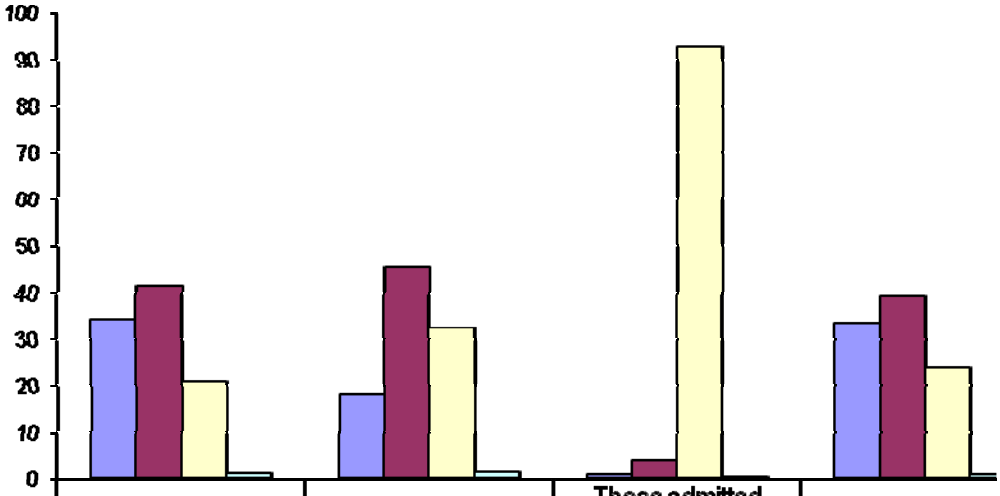


SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD)

The profile of the admissions for treatment have undergone some noticeable changes over the course of time, the low levels of admissions for heroin currently remaining stable and a rise being noted in the number of admissions for cocaine and cannabis.

Regarding the relative importance of each drug in 2010 within the total number of admissions for treatment for psychoactive substance abuse or dependence, Figure 5.3 shows cocaine to be the illicit drug having been the cause of the largest number of admissions for treatment (41.4% of all), followed by opiates (34.3%) and cannabis (21%). Focusing solely on the data for those individuals admitted for the first time in their lives (first admissions), there are even greater differences in favour of cocaine. In this case, cocaine is the drug having been the cause of more first admissions (45.3%), followed by cannabis (32.3%) and opiates (18.2%) (Fig. 5.3)

Fig. 5.3. Percentage of individuals treated for psychoactive substance abuse or dependence in Spain, 2010



	All admissions	Admitted first time in their lives	Those admitted under 18 years of age*	Born outside Spain
Opiates	34,3	18,2	0,9	33,5
Cocaine	41,4	45,3	3,7	39,3
Cannabis	21	32,3	92,7	23,8
Other stimulants **	1,2	1,5	0,3	0,8

All admissions	53,508	26,805	2,114	3,797

* All of the cases admitted for treatment under 18 years of age
** Other stimulants: amphetamines, ecstasy...)
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

As has been the case over previous years, cannabis use is responsible for the majority (92.7%) of the admissions for treatment among individuals under 18 years of age.

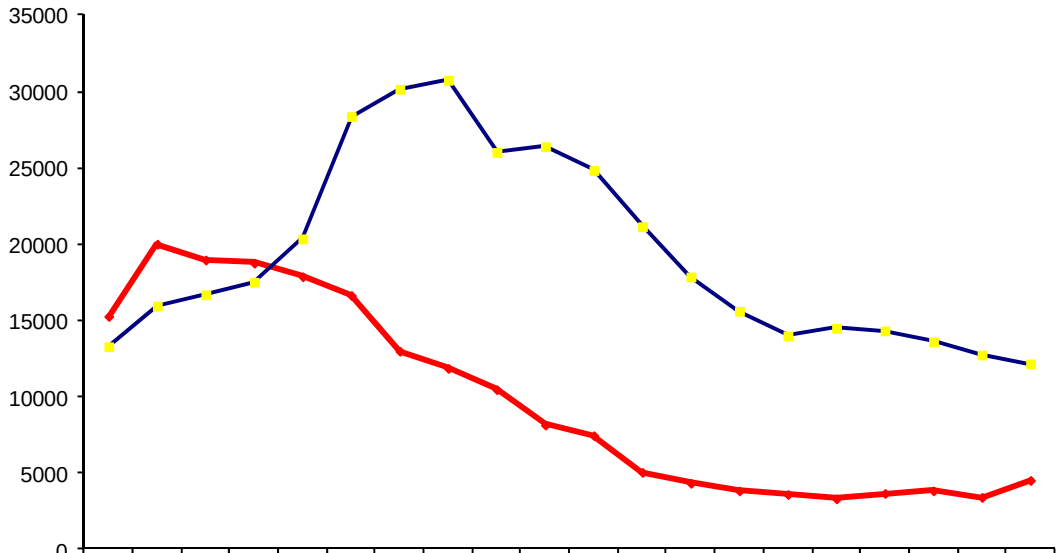
For those individuals born outside Spain, cocaine was consolidated in 2010 as the substance for which there are the largest number of treatment demands (39.3%), followed in second place by opiates (33.5%) as those having given rise to the greatest demand for care.

HEROIN

A total of 17,325 individuals were admitted for treatment for heroin use in 2010, meaning a 6% decline in comparison to 2008 (18,407), totalling 34.3% of all admissions for treatment, showing stability compared to 2008 (34.6%).

This decline can be explained mainly due to the smaller number of individuals admitted for treatment who had already been treated previously, a total of 12,166 individuals, marking the lowest figure since 1991. However, the number of first admissions for heroin treatment increases similarly to 2003 figures.

Fig. 5.4. Trend in the number of individuals treated for heroin abuse or dependence in Spain, 1991-2010



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
First treatments	15277	20017	18977	18770	17878	16647	12993	11867	10473	8151	7461	5051	4337	3836	3604	3318	3672	3840	3412	4526
Had prior treatment	13296	15956	16703	17526	20369	28382	30173	30756	26031	26412	24844	21162	17867	15617	14005	14502	14331	13616	12750	12166

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

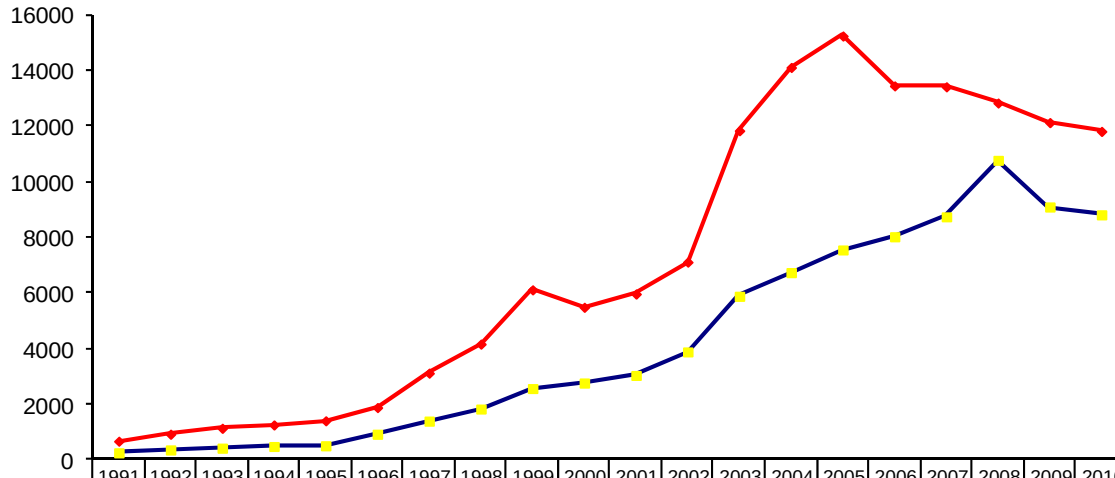
COCAINE

A total of 22,131 individuals were admitted for treatment for cocaine use in 2010, meaning a 4.5% decline in comparison to 2009 (23,132) and totalling 41.4% of all admissions recorded for that same year.

The number of individuals admitted for the first time for treatment for cocaine increased progressively from 1991 to 2005, having risen from 681 in 1991 to 7,125 in 2002 and then 15,258 in 2005, the year in which the highest figure was recorded, tallying with the higher prevalences for regular use (within last 12 months) and recent use (within last 30 days) found in the Household Survey on Alcohol and Drugs (EDADES) conducted on the age 15-64 population. However, from 2005 to 2010, the number of first admissions for treatment for cocaine underwent a decline from 15,258 in 2005 to 11,827 in 2010, somehow revealing this being indicative of a stabilization first (2007) and then the decline recently recorded in the 2009 Household Survey on Alcohol and Drugs (EDADES) (See Chapter 2 of this report).

Apart from the above, the number of individuals admitted for cocaine abuse or dependence who had undergone prior treatment for cocaine peaked in 2008, the year marking the all-time largest number. In 2009, the decline began and continued in 2010.

Fig. 5.5. Trend in the number of individuals treated for cocaine abuse or dependence in Spain, 1991-2010



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
First treatments	681	932	1146	1265	1415	1892	3129	4174	6126	5499	5977	7125	11851	14126	15258	13463	13429	12847	12142	11827
Had prior treatment	262	367	431	491	516	932	1402	1838	2576	2773	3046	3893	5893	6747	7562	8036	8753	10786	9107	8824

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

CANNABIS

A total of 11,210 individuals were admitted for treatment for cannabis use in 2010, meaning a 15% rise in comparison to the number recorded in 2009 (9,503) and totalling 21% of all admissions for treatment for drug use for that same year.

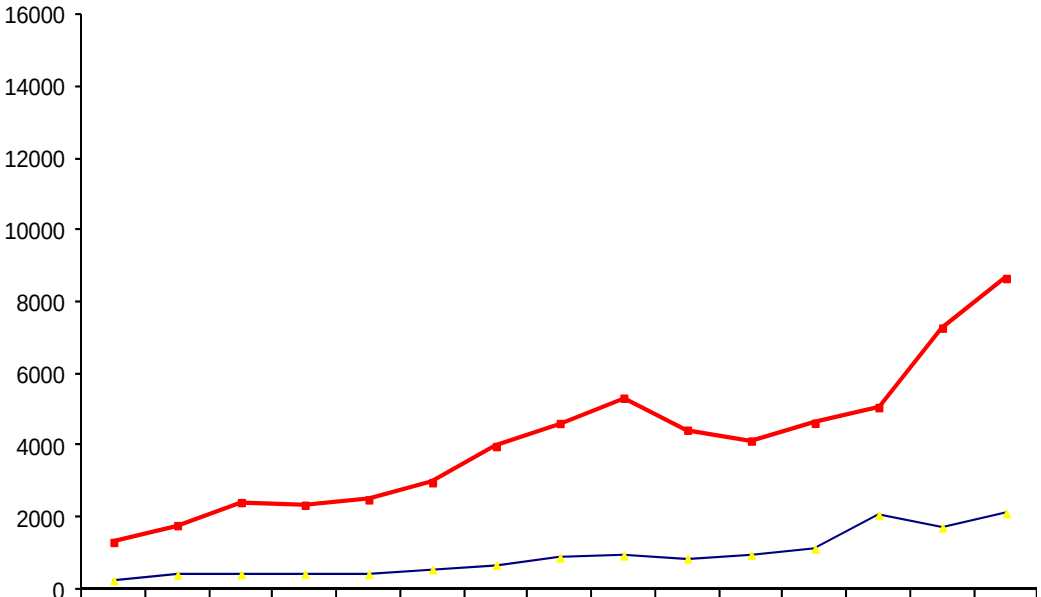
As shown in Fig. 5.6, the number of individuals admitted to treatment for cannabis use showed an upward trend, which has been quite pronounced over the past few years. In fact, cannabis has gone from totalling 10.9% of all admissions for treatment in 2005 to totalling 21% of all admissions in 2010.

This larger number is the direct result of the increase in the number of individuals who have demanded treatment for the first time, as is shown in Fig. 5.6.

This is perfectly compatible with the aforementioned fact of the large percentage of minors who are demanding treatment for cannabis use. A total of 92.7% of all of the individuals under 18 years of age who underwent treatment for drug use in 2010 in our country did so for problems related to cannabis use, meaning an 8.9 point rise in comparison to the percentage of minors treated for this drug in 2008 (83.8%).

This upward trend is taking place within the current context of prevalences of cannabis use both among the general population and among secondary school students, taking into account that cannabis is the illicit drug used the most by both of these populations in Spain.

Fig. 5.6. Number of individuals admitted for treatment for cannabis abuse or dependence (absolute numbers). Spain, 1996-2010.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
First treatments	1300	1768	2412	2335	2487	2966	3972	4613	5319	4426	4125	4619	5058	7273	8653
Had prior treatment	230	387	407	418	408	540	665	871	928	844	941	1114	2055	1705	2105

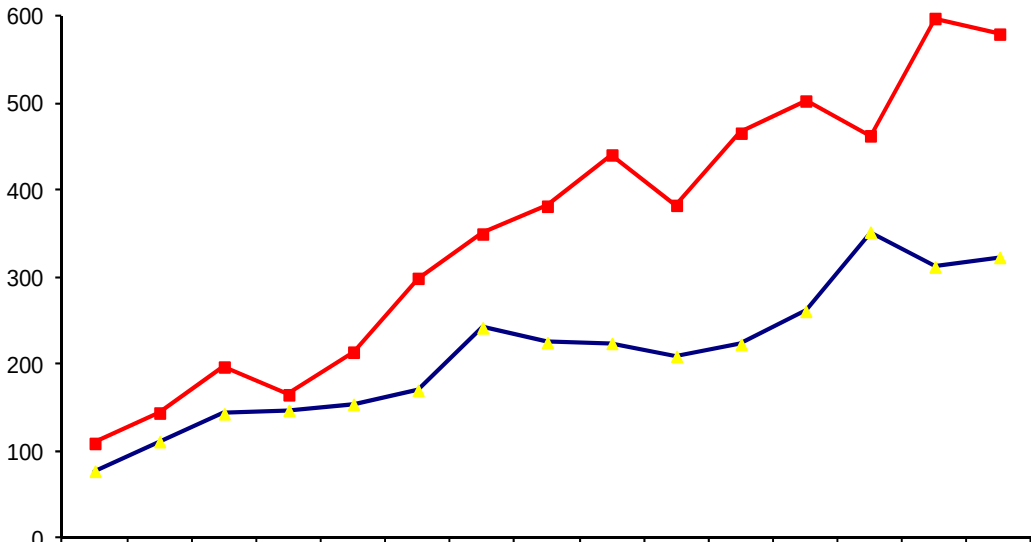
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

HYPNOSEDATIVES

A total of 944 individuals were admitted for treatment for hypnosedative use. In 2010, this being a figure similar to that of 2009 and totalling 1.8% of all of the admissions for treatment for drug use recorded in 2010.

The number of individuals admitted for treatment for hypnosedatives (tranquilizers, sedatives or sleeping pills) has been showing a clear-cut upward trend since the start of the series, with some slight occasional rises and drops.

Fig. 5.7. Number of individuals admitted for treatment for hypnosedative abuse or dependence (absolute numbers). Spain, 1996-2010.

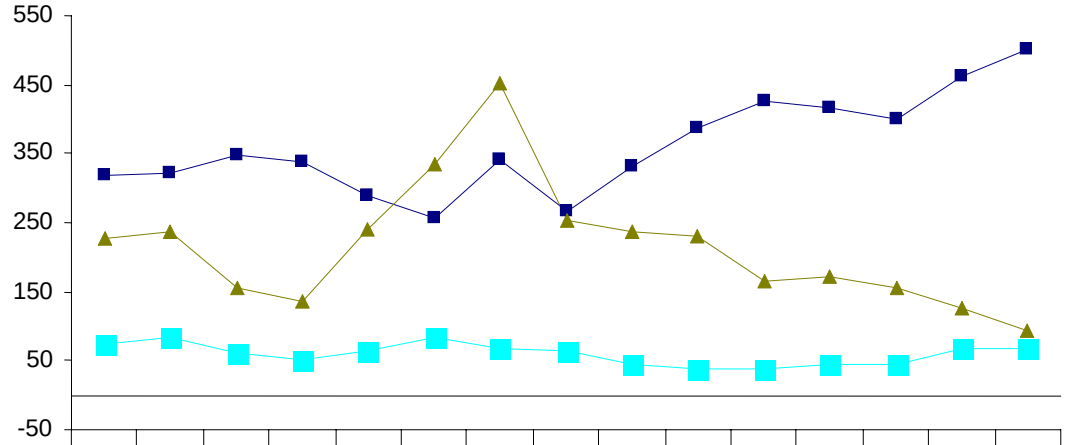


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
First treatments	109	144	197	165	214	299	350	382	441	383	466	503	463	598	580
Had prior treatment	77	111	143	147	154	170	242	225	224	209	223	261	352	312	323

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

OTHER DRUGS

Fig. 5.8. Trend in the number of individuals treated for amphetamine, ecstasy or hallucinogen use. Spain, 1996-2010.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Amphetamines	319	323	347	339	288	255	342	266	330	386	426	415	400	461	501
Ectasy	226	237	154	135	240	335	452	254	236	229	165	172	155	127	93
Hallucinogens	74	85	62	50	64	83	68	63	44	39	37	43	43	69	66

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

The rest of the drugs continue to be seen to only a very small degree in the treatment services. In fact, the stimulants other than cocaine (amphetamines, ecstasy and others) total only 1.2% of all admissions for all the drugs in 2010. Comparing these figures to those found for cocaine, heroin and cannabis, these drugs are found to have only a minimal impact on the specific drug dependence treatment services in Spain.

As shown in Fig. 5.8, the evolution over the course of time shows a downward trend which has continued over the past few years regarding the number of individuals treated for ecstasy use, the least number of admissions for treatment since data began being collected having taken place in 2010. The opposite is true for amphetamines, given that the largest number of admissions for this substance were recorded in 2010. Hallucinogens have been remaining relatively stable in this indicator since the data thereon first began being collected in 1996.

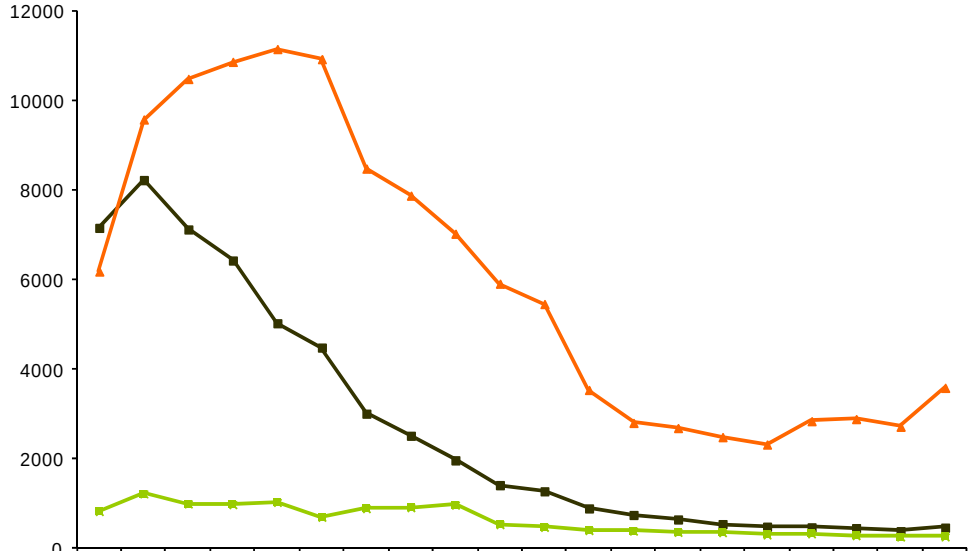
Administration route predominantly used for the main drug used among those admitted for treatment

In 2010, the predominant route for administering the main drug among all of those admitted for treatment for heroin use (within the 30 days immediately prior to having started treatment) was the inhaled or smoked route, totalling 72.2%, followed by injection (15.8%) and the intranasal or sniffed route (5.4%).

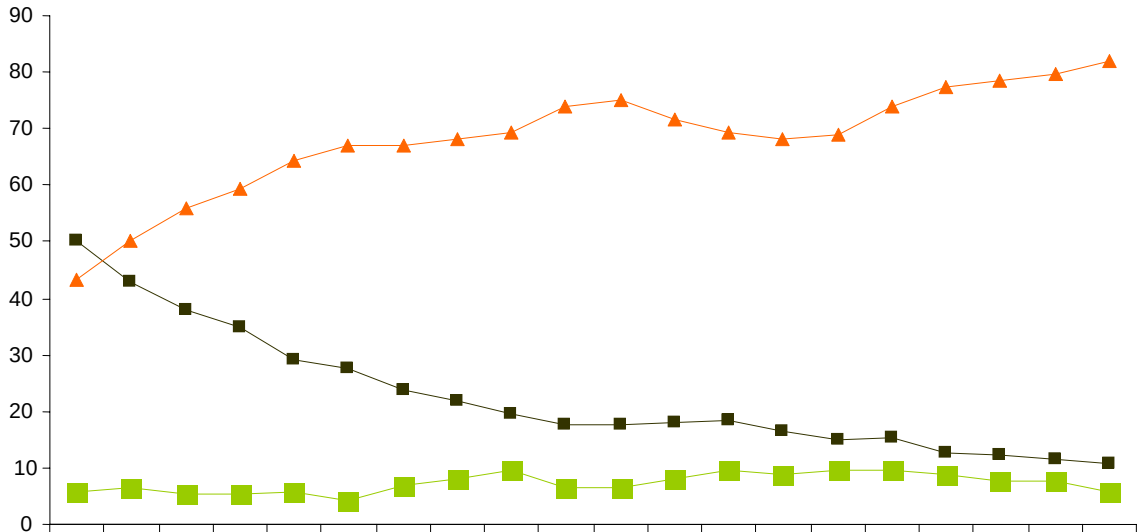
Regarding the 1980's, when, regardless of the use of other routes, the use of the injected route as the main route for administering heroin was practically universal among heroin users, a radical change has taken place in the predominant route of administration, the route predominantly used currently being inhaling or smoking.

Thus, the number of individuals admitted for treatment for the first time in their lives for heroin abuse or dependence using the injecting route most often or as the main or preferred route of administration dropped from 8,232 in 1992 (the year in which the highest number was recorded) to 465 in 2010, and although this might seem to be solely a matter of the effect of the decline in the absolute number of those individuals admitted for treatment for the first time for heroin use, this change is confirmed on noting how the percentage these individuals total within the number of all those admitted for heroin dropped from 42.9% in 1992 to 15.1% in 2005 and down to 10.6% in 2010 (Fig. 5.9).

Fig. 5.9. Spread of the individuals treated for the first time ever for heroin abuse or dependence, according to the main route of heroin administration (absolute numbers and percentages). Spain, 1991-2010.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Injected	7164	8232	7129	6435	5033	4488	3011	2518	1969	1414	1276	894	748	648	544	486	470	455	386	465
Inhaled	6188	9585	10493	10873	11161	10934	8487	7884	7033	5917	5461	3540	2805	2690	2487	2320	2842	2891	2719	3589
Sniffed	822	1219	995	978	1028	696	887	910	968	532	471	399	386	358	350	303	327	285	256	258



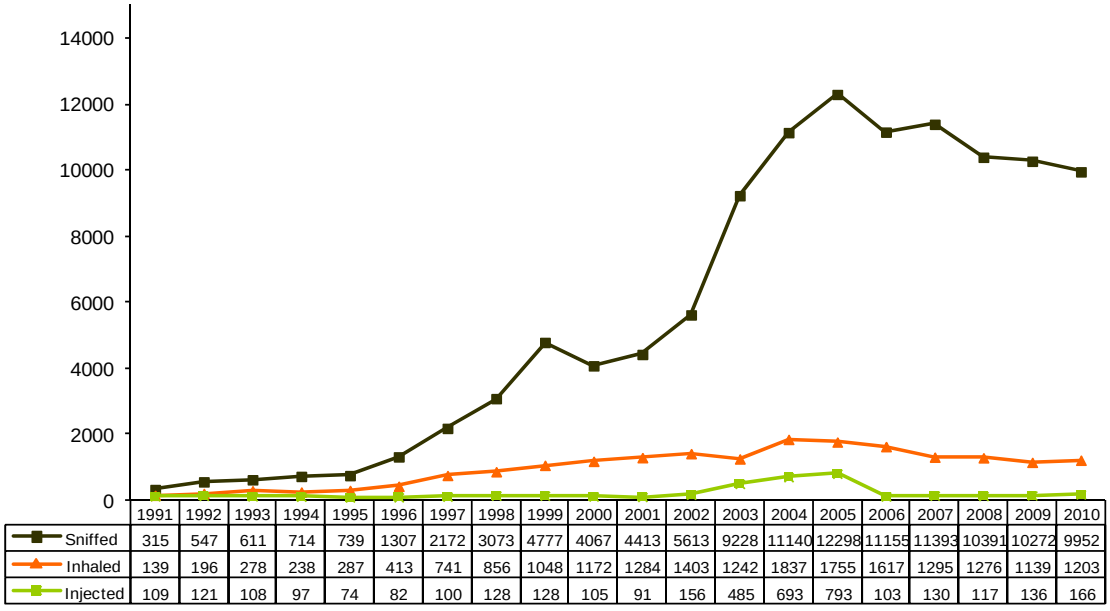
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Injected	50,3	42,9	38,1	35	29,1	27,5	23,8	21,8	19,4	17,7	17,5	18,1	18,5	16,4	15,1	15,5	12,8	12,4	11,3	10,6
Inhaled	43,4	50	56,1	59,2	64,5	67	67,2	68,3	69,3	74,1	74,9	71,8	69,3	68	69	73,8	77,4	78,5	79,7	82
Sniffed	5,8	6,4	5,3	5,3	5,9	4,3	7	7,9	9,5	6,7	6,5	8,1	9,5	9	9,7	9,6	8,9	7,7	7,5	5,9

Note: The estimates of the number of individuals treated for heroin for all of Spain as a whole, according to the main route of administration, have been calculated by multiplying the number of individuals treated for heroin throughout all of Spain by the percentage of those admitted for each route of administration (this being a percentage which was not available for all of the Autonomous Communities for some of the years within the period studied.
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

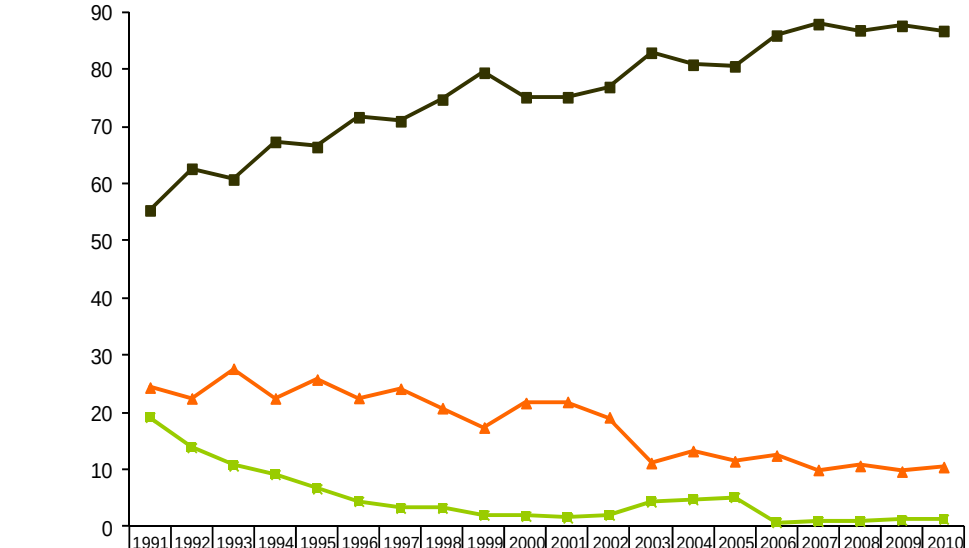
In 2010, the predominant route of administration among all those admitted for treatment for cocaine hydrochloride is the intranasal or sniffed route (83%) followed by the inhaled or smoked

route (12.6%) and the injected route (2.3%). Use of the injecting route has been declining since 1991 among those admitted for the very first time for cocaine use, having shown some relatively stable prevalences of use as of 2006. Regarding the number of individuals admitted for treatment for the first time for cocaine use, the main route of administration continues to be mostly the intranasal or sniffed route, followed by the inhaled and the injected routes, although to a considerably lesser degree (Fig. 5.10).

Fig. 5.10. Number of individuals admitted for treatment for the very first time in their lives for cocaine abuse or dependence, according to the main route of cocaine administration (absolute numbers and percentages). Spain, 1991-2010.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Sniffed	315	547	611	714	739	1307	2172	3073	4777	4067	4413	5613	9228	11140	12298	11155	11393	10391	10272	9952
Inhaled	139	196	278	238	287	413	741	856	1048	1172	1284	1403	1242	1837	1755	1617	1295	1276	1139	1203
Injected	109	121	108	97	74	82	100	128	128	105	91	156	485	693	793	103	130	117	136	166

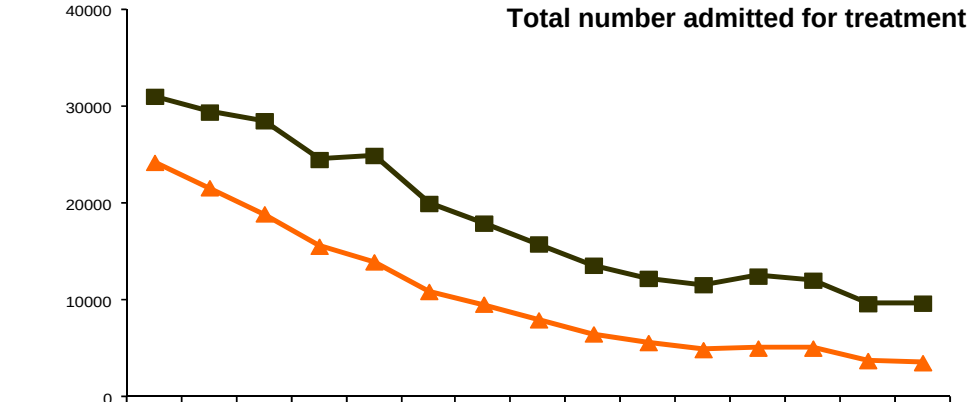


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Sniffed	55,4	62,7	60,8	67,4	66,5	71,7	71	74,8	79,5	75,2	75,2	77	83	80,9	80,6	86	88	86,9	87,7	86,8
Inhaled	24,4	22,5	27,7	22,5	25,8	22,6	24,2	20,8	17,4	21,7	21,9	19,2	11,2	13,3	11,5	12,5	10	10,7	9,7	10,5
Injected	19,2	13,9	10,7	9,2	6,7	4,5	3,3	3,3	2,1	1,9	1,6	2,1	4,4	4,8	5,2	0,8	1	1	1,2	1,4

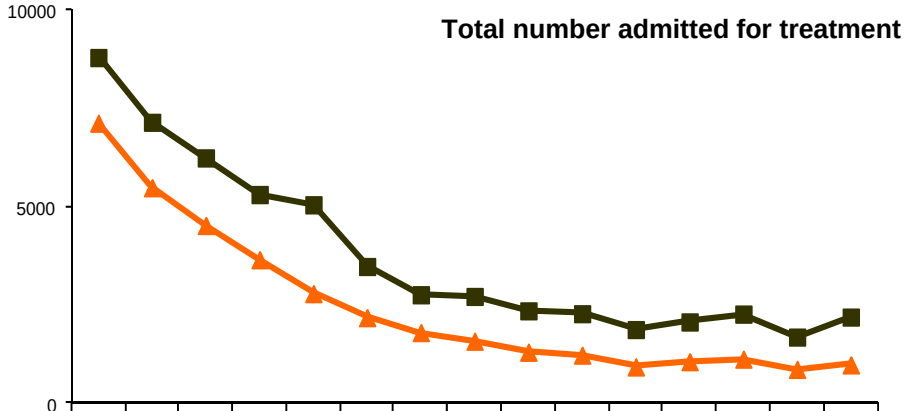
Note: The estimates of the number of individuals treated for cocaine for all of Spain as a whole, according to the main route of administration, have been calculated by multiplying the number of individuals treated for cocaine throughout all of Spain by the percentage of those admitted for each route of administration (Percentage not available for all of the Autonomous Communities for some of the years within the period studied). SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

On reviewing the injecting users admitted for treatment (Fig. 5.11), the number of those admitted for any psychoactive drug for the very first time in their lives who had injected at some time in their lives dropped from 8,801 in 1996 to 2,196 in 2009. The number of those who had injected within the last 12 months dropped from 7,132 in 1996 to 979 in 2010. In general, a downward trend is found to exist and to have apparently stabilized over the past few years.

Fig. 5.11. Trend in the number of injecting users admitted for treatment for drug abuse or dependence in Spain. 1996-2010.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Injection some time in their lives	31046	29419	28527	24520	24941	19988	17950	15806	13605	12252	11601	12487	12066	9637	9697
Injection within the last 12 months immediately prior to admission	24224	21605	18910	15562	13955	10898	9583	7966	6516	5620	4892	5055	5050	3763	3549



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Injection some time in their lives	8801	7154	6247	5315	5055	3483	2765	2722	2356	2283	1879	2073	2271	1687	2196
Injection within the last 12 months immediately prior to admission	7132	5488	4526	3655	2793	2181	1801	1583	1303	1228	928	1060	1124	866	979

Note: The estimates of the number of injecting users admitted for treatment for all of Spain as a whole were calculated by multiplying the number of individuals admitted for treatment for all Spain by the percentage of those admitted who had injected drugs at some time in their lives or within the last 12 months immediately prior to admission (Percentage not available for all of the Autonomous Communities for some of the years within the period studied).

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

As in previous years, the majority of the patients admitted for treatment for illicit drug abuse or dependence were males, totalling 85.1% of all those admitted. Also as in other years, the presence of females is greater in the hypnosedatives than in the rest of the drugs, although there still continues to be a greater number of males admitted for all of these substances.

The average age of those admitted for treatment was 33.4 years of age for all of the admissions as a whole (for both genders alike), being the same as in 2008 and 2009 and averaging 30.5 years of age for the first admissions. A total of 7.3% of all those admitted were born outside Spain, although mention may be made of the fact that a higher percentage of females born outside Spain (8.2%) were provided with treatment than the percentage of the males born outside Spain (7.2%).

The average age of the individuals admitted varies depending on the main drug involved. Hence, the average age of the individuals admitted for heroin was 38.4 years of age; for hypnosedatives, 38 years of age; for cocaine, 33.3 years of age and for cannabis, 25 years of age.

The educational levels of the patients admitted for treatment have improved slightly over the course of time but still continue to show some significant variations depending on the main drug for which these patients are admitted for treatment. In 2010, most of the patients admitted for heroin treatment (53.2%) had completed solely an elementary-level education, whilst 53.2% of those admitted for treatment for cocaine and 49.2% of those admitted for treatment for cannabis had completed their secondary education. Regarding their employment situation, the percentage of those gainfully employed among those treated for cocaine (42.7%) was much higher than the percentage of those gainfully employed among those treated for heroin (21.1%), and even being the case of quite a much younger population, the percentage of those gainfully employed among those treated for cannabis (23.6%) was higher than the percentage of those gainfully employed among those treated for heroin.

In Spain, the large majority (86.3%) of the patients admitted for treatment for illicit drugs live in family households (houses, flats or apartments). In 2010, a total of 8.5% of the individuals admitted to treatment were living in institutions, and 2.6% were in a precarious or unstable (homeless) living situation. The most frequent living modality is with their original families (with their parents) or with their own families (spouse and/or children). Some major differences are also noted in the living situation models and the types of accommodations depending on the main drug for which admitted for treatment. In 2010, living in an institution or having a precarious or unstable living situation was much more frequent among those admitted for treatment for heroin (18.8%) than among those admitted for cannabis (6.2%) or cocaine (7.6%), the opposite being true for the percentage of patients who were living with their original family or their own family.

Regarding the service or the source having referred the patients for treatment, nearly half (46.9%) of the patients started treatment on their own initiative or were encouraged to do so by their parents or friends, although the public health system referred approximately one third (27.7%) of those admitted for treatment.

The poly-drug use pattern is firmly established among those admitted for treatment. The majority (64.2%) of those admitted in 2010 had used other drugs different than that which had given rise to the treatment (secondary drugs) within the last 30 days immediately prior to the admission. Solely 35.8% had used only the drug for which they were admitted for treatment. A total 35.7% reported using one single drug, 20.4% using two drugs, 6.4% admitting using 3 drugs and 1.7% more than three drugs. Among those admitted for heroin, the secondary drugs reported most often were cocaine and cannabis, and among those admitted for cocaine, alcohol and cannabis.

In 2010, nearly half (52.1%) of those admitted for treatment for psychoactive drugs in Spain were undergoing treatment for the first time for the same main drug, this being a percentage which was much lower among those admitted for heroin (27.1%) than among those admitted for cocaine (57.1%), cannabis (80.4%), amphetamines (63.9%) or ecstasy (71%).

Table 5.1. Socio-demographic characteristics of those admitted for treatment for psychoactive substance abuse or dependence, according to whether or not having previously treatment and by genders. Spain, 2010.

	Total	Prior treatment[1]		Gender[1]	
		Yes	No	Males	Females
No. Cases	53,508	24,611	26,805	45,309	7,915
Treated for first time for main drug (%)	52.1			51.8	54.3
Average age (years)	33.4	36.5	30.5	33.3	33.8
Females (%)	14.9	14.2	15.5		
Highest educational level completed (%)					
No schooling	1.4	1.6	1.2	1.4	1.4
Elementary school	45.8	46.3	45.4	46.8	39.7
Secondary school	48.1	48.2	48.1	47.6	51.4
College	4.2	3.5	4.8	3.7	6.7
Other	0.5	0.5	0.5	0.5	0.8
Main employment situation (%)					
Working	31.0	28.0	33.5	31.8	26.3
Unemployed, has never worked	5.7	5.4	5.8	5.3	7.3
Unemployed, has worked	40.8	44.7	37.5	41.3	37.8
Others	22.6	21.8	23.2	21.6	28.6
Born outside Spain (%)	7.3	5.9	8.7	7.2	8.2
Main source having referred to treatment (%)					
Other drug dependence treatment services	12.2	16.8	8.1	11.6	15.6
General practitioners, primary care physicians	9.5	6.5	11.9	9.2	11.1
Hospitals or other health services	6.0	7.3	4.8	5.6	8.2
Social services	4.9	3.3	6.2	4.4	7.8
Prisons, minors detention centres	8.1	9.6	6.9	8.5	6.1
Legal or police services	8.4	5.1	11.2	8.9	5.5
Companies or employers	1.6	1.7	1.6	1.7	1.1
Family members or friends	13.2	8.4	17.2	13.4	.0
Own initiative	33.7	39.1	29.2	34.2	42.3
Others	2.5	2.0	2.8	2.5	2.3
Longest living situation within the last 30 days prior to admission for treatment (%)					
Alone	12.8	15.1	10.8	13.0	11.2
Only with spouse/partner	10.6	10.7	10.5	9.6	16.0
Only with children	5.8	5.7	5.9	4.9	11.0
With spouse/partner and children	15.2	14.7	15.6	15.1	15.6
With parents or original family	40.8	36.2	44.8	42.5	30.8
With friends	3.0	3.0	3.0	2.8	4.0
Others	11.9	14.6	9.5	12.0	11.5
Main living accommodations within the last 30 days prior to admission for treatment (%)					
Houses, flats, apartments	86.3	82.0	90.3	86.0	88.0
Prisons, juvenile detention centres	6.4	7.7	5.2	7.0	3.2
Other institutions	2.1	2.9	1.4	2.0	2.6
Boarding houses, hotels, hostels	0.5	0.7	0.4	0.5	0.7
Unstable/precarious accommodations	2.6	3.5	1.8	2.5	3.3
Other places	2.0	3.1	1.0	2.0	2.2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs (DGPNSD). Treatment Demand Indicator.

6. HEALTH CORRELATES AND CONSEQUENCES

6.1. INTRODUCTION

In this chapter, updated data on Drug-related Infectious Diseases", "Drug-related Emergencies" and "Drug-related Deaths" are included. Each section includes detailed information on the methodology used to collect data, sources of information and achieved results at national level from the analysis of the last year with available information as well as previous years in order to analyze and evaluate trends.

6.2. DRUG-RELATED INFECTIOUS DISEASES

Over the past 20 years, AIDS and HIV infections have been one of the main health problems associated with the use of drugs in Spain, HIV infections associated with injecting drug users however having declined for the time being. Apart from the above, the infections by way of hepatitis virus infections secondary to injecting drug use must be kept in mind.

HIV/AIDS

Data is available in Spain from different sources of information which, all combined as a whole, aid toward understanding the trends regarding how this phenomenon is evolving as well as the current situation. A summary is provided in following as to the methodology and the findings by way of some of the main systems comprising HIV epidemiologic surveillance in Spain.

1. Population information systems: These systems comprise the Information System on Newly-Diagnosed Cases of HIV Infection and the National AIDS Registry.

> 1.1 The Information System of Newly-Diagnosed Cases of HIV Infection collects information on the newly-diagnosed cases of HIV made among the population as a whole and provides the closest available estimate of HIV incidence. For the latest available year (2010) this System was covering 71% of Spain's population, it being anticipated for it to be covering 100% of the population in 2012.
> 1.2. The AIDS Registry collects information on the AIDS cases diagnosed in Spain, this Registry covering 100% of Spain's population. AIDS incidence is an indicator as to how the advanced states of HIV infection are evolving among the population.

2. Sentinel Networks collect information on certain population groups which are of particular interest for the purpose of monitoring the evolution of the HIV epidemic. In Spain, there are two large-scale networks of this type: The EPI-HIV study and the Working Group on Sexually-Transmitted Infections (STIs)

> 2.1. The EPI-HIV study includes 19 HIV/STI diagnosis centres and provides information concerning conducting the HIV test, HIV prevalence and incidence among the individuals who come to these centres, it therefore being possible for the results thereof to be extrapolated to this type of population.
> 2.2. The Working Group on STIs is comprised of a network of 15 specifically STI centres and collects clinical-epidemiological information on patients diagnosed with different STIs. As in the case above, the results are can be extrapolated solely to the population from which the data is taken.

3. In-Hospital Survey of Patients with HIV/AIDS. This is a prevalence-day survey which has been being conducted as of 1996 in which data is collected on patients who are being provided with care (outpatient or in-hospital) at the hospitals participating on a specific day for the purpose of describing their characteristics and monitoring their evolution.

4. Indicator of Admissions to Treatment for Drug Abuse of Dependence: This is the only one of the information systems detailed herein which is specifically for drug users. This System collects data on the number and characteristics of the individuals admitted to outpatient treatment for abuse of or dependence on different psychoactive substances, the variables collected including some HIV7AIDS-related variables.

The aspects of greatest interest within this context are presented in following, although full and detailed information is available at:

- The Spanish Ministry of Health, Social Services and Equality's epidemiologic surveillance website:
http://www.msssi.gob.es/ciudadanos/enfLesiones/enfTransmisibles/sida/vigilancia/

- Spain's National Epidemiology Centre website:
http://www.isciii.es/ISCIII/es/contenidos/fd-servicios-cientifico-tecnicos/fd-vigilancias-alertas/fd-enfermedades/sida.shtml

- Spanish Observatory on Drugs and Drug Addiction, National Plan on Drugs:
http://www.pnsd.msc.es/Categoria2/observa/home.htm

1.1. Information System on Newly-Diagnosed HIV Cases[9,10]

Objectives

This information system serves the main purpose of contributing to HIV epidemiology surveillance, specifically seeking to quantify the newly-diagnosed cases of HIV infection and their evolution over the course of time and to describe the epidemiological characteristics of the individuals recently diagnosed as infected by HIV.

Methodology

- Study period: This information has been being collected annually since 2003.

- Geographic scope and population: The number of Autonomous Communities reporting has risen since this data first began being collected. In 2010, a total of 17 of the 19 Autonomous Communities reported, being the equivalent of 32,530,190 inhabitants (71% of Spain's population).

Main results

A total of 17,183 new HIV cases were notified within the 2003-2010 period. The annual rates of newly-diagnosed cases per million inhabitants ranges from 96.4 in 2003 to 90.0 in 2009 and 88.5 in 2010.

Situation by transmission categories (2010): Transmission among males who have sexual relationships with males was the most frequent (46.1%), followed by heterosexual transmission, which totalled 33.1%, and that of injecting drug users, which amounted to 5.9% (Fig. 6.2).

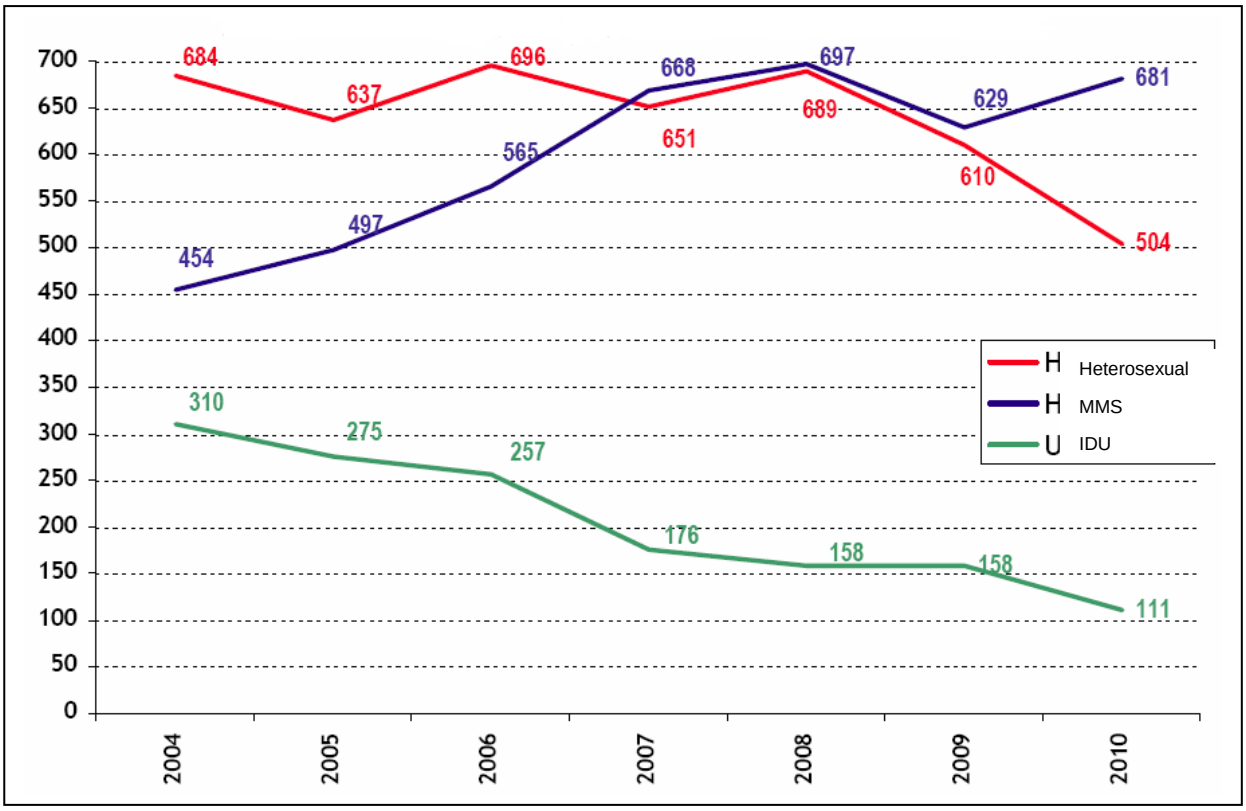
[9]. HIV/AIDS Epidemiologic Surveillance in Spain. Autonomous Community Epidemiologic Surveillance. National Epidemiology Center. November 2011. Available at:
http://www.msssi.gob.es/ciudadanos/enfLesiones/enfTransmisibles/sida/vigilancia/InformeVIHSida_Junio_2011.pdf

[10] HIV/AIDS Epidemiologic Surveillance in Spain. Autonomous Community Epidemiologic Surveillance. National Epidemiology Center. November 2011. Selected graphics. June 2011. Available at:
http://www.msssi.gob.es/ciudadanos/enfLesiones/enfTransmisibles/sida/vigilancia/SeleccionGraficos_Junio2011.pdf

Therefore, 79.0% of the newly-diagnosed HIV cases for 2010 were sexually-transmitted. Breaking the transmission categories down by gender, among males, homosexual transmission totals 56.0% of the newly-diagnosed HIV cases and heterosexual transmission, 23.0%. Among females, the vast majority entail heterosexual transmission, totalling 80% of the newly-diagnosed cases (Fig. 6.3).

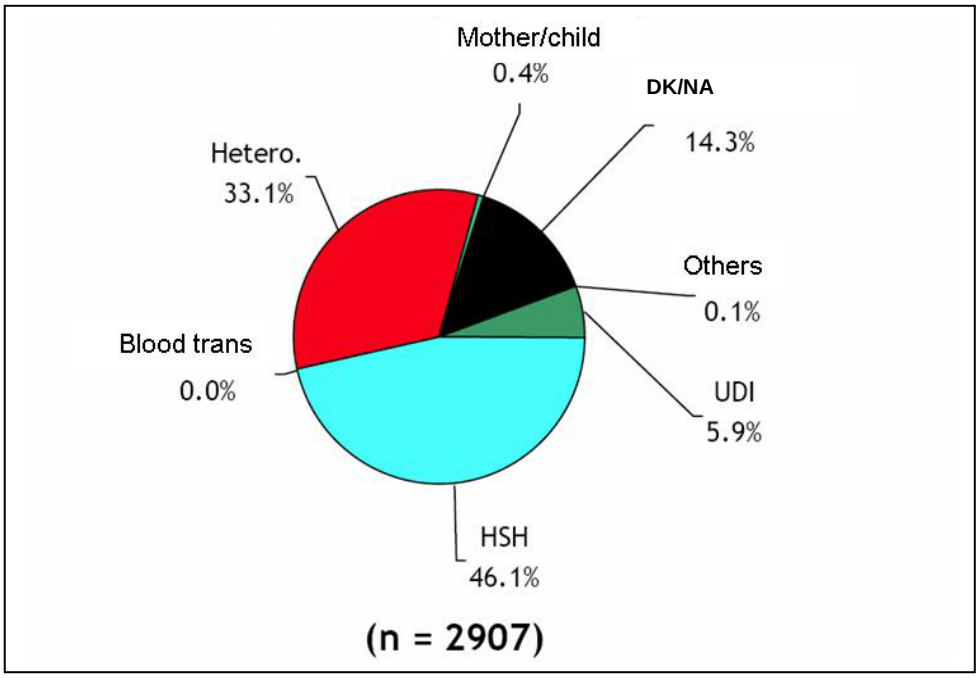
Time Trend (2004-2010 Period): The trend in the rates of newly-diagnosed HIV cases vary depending on the mechanism of transmission: Among injecting drug users, the downward trend is continuing regarding the number of newly-diagnosed HIV cases (18.9 / million inhabitants in 2004 compared to 6.7 /million inhabitants in 2010), whilst the rates are tending to stabilize in the case of heterosexual transmission and are clearly rising in homosexual transmission among males. Fig. 6.1 shows the trend over the course of time of the newly-diagnosed cases of HIV, by transmission categories.

Fig. 6.1. Newly-diagnosed HIV cases, by transmission category. Spain* 2004-2009



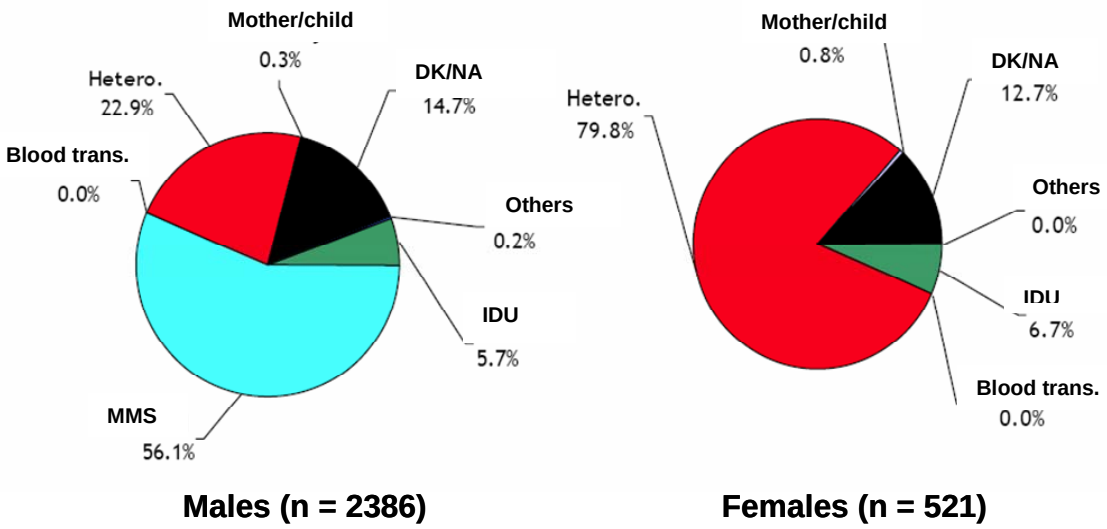
Balearic Islands, Canary Islands, Catalonia, Ceuta, Extremadura, Galicia, La Rioja, Navarre and Basque Country
MMS: Male-to-Male Sexual Contact.
IDU: Injecting Drug Use
SOURCE: Information System on Newly-Diagnosed HIV Cases. Ministry of Health, Social Services and Equality. Ministry of Economy and Competitiveness.

Fig. 6.2. Newly-diagnosed HIV cases, by transmission category. Spain* 2010



* Aragon, Asturias, Balearic Islands, Canary Islands, Cantabria, Castile-La Mancha, Castile and Leon, Catalonia, Ceuta, Extremadura, Galicia, La Rioja, Madrid, Melilla, Murcia, Navarre and Basque Country.
MMS: Male-to-Male Sexual Contact.
IDU: Injecting Drug Use
SOURCE: Information System on Newly-Diagnosed HIV Cases. Ministry of Health, Social Services and Equality. Ministry of Economy and Competitiveness.

Fig. 6.3. Newly-diagnosed HIV cases, by transmission category and gender. Spain* 2010.



* Aragón, Asturias, Balearic Islands, Canary Islands, Cantabria, Castile-La Mancha, Castile and Leon, Catalonia, Ceuta, Extremadura, Galicia, La Rioja, Madrid, Melilla, Murcia, Navarre and Basque Country.
MMS: Male-to-Male Sexual Contact.
IDU: Injecting Drug Use
SOURCE: Information System on Newly-Diagnosed HIV Cases. Ministry of Health, Social Services and Equality. Ministry of Economy and Competitiveness.

1.2. National AIDS Registry

There is a National AIDS Registry in Spain which collects information on the newly-diagnosed AIDS cases at the nationwide level. This Registry has data from 1981 to the present and provides us with useful information as to the evolution of this disease and the transmission mechanism.

Main results

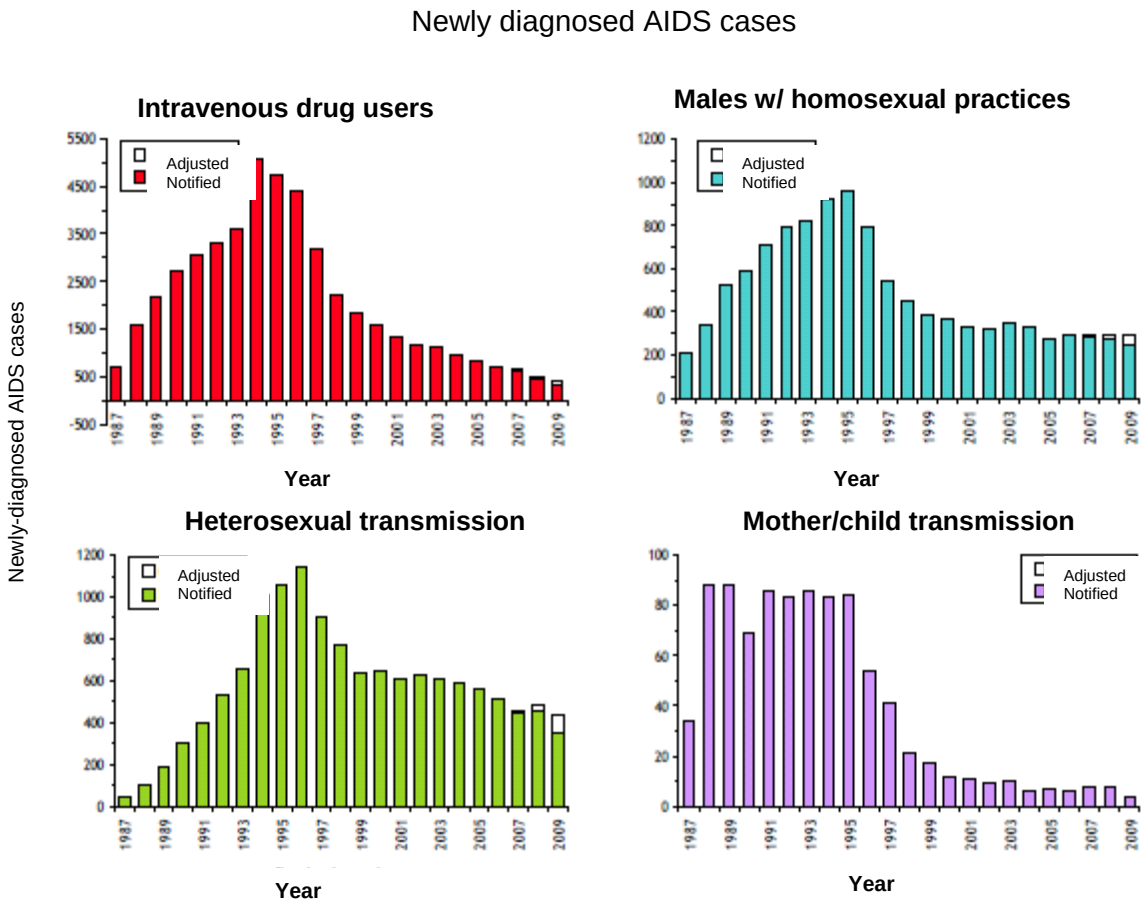
According to the National Epidemiology Centre, a total of 80,827 AIDS cases had been notified from 1981 up to June 30, 2011.

Current situation: In 2010 (at June 30, 2011), a total of 930 cases had been notified, its being estimated that, after making adjustments as a result of delayed notification, that a total of 1,162 cases were diagnosed in 2010. A total of 77% of these newly-diagnosed cases were males. The median age was age 42, being somewhat older among the males than among the females. A total of 28% of those who were diagnosed with AIDS in 2010 contracted the infection as a result of sharing injecting material for injecting drug use. A total of 33% contracted the infection as a result of unprotected heterosexual relations. The transmission secondary to male-to-male sexual contact totals 26% of all cases and 34% if only male cases are considered.

Time trend: The diagnosis of AIDS cases, which peaked in the 1990's, has been showing a downward trend since that time, totalling 83% since 1996 (the year prior to HAART becoming widely-available) up to 2010. In 2009, the number of cases declined by 16% among males and by 18% among females. As far as the transmission mechanism is concerned, the percentage of AIDS cases which can be attributed to injecting drug use has declined over the past few years following the peak recorded in 1990 (69.6%) whilst the percentage of cases in the sexual transmission category has risen. In 2009, there was a 26% drop in the percentage of ADIS cases diagnosed among injecting drug users. This decline may be due to several factors which have had a bearing on the course of this epidemic in recent years, one of the most noteworthy being the high degree of availability of methadone maintenance treatments and the decline in the use of the injecting route of administration for heroin use. There was a 20% decline in the number of cases involving heterosexual transmission in 2009 and a 1% decline in the cases involving male-to-male sexual contact.

Fig. 6.4 shows the trend over the course of time for the 1986-2009 period for newly-diagnosed AIDS cases in relation to the HIV transmission-related risk factor. The first graph features the decline in the number of AIDS cases as of 1995.

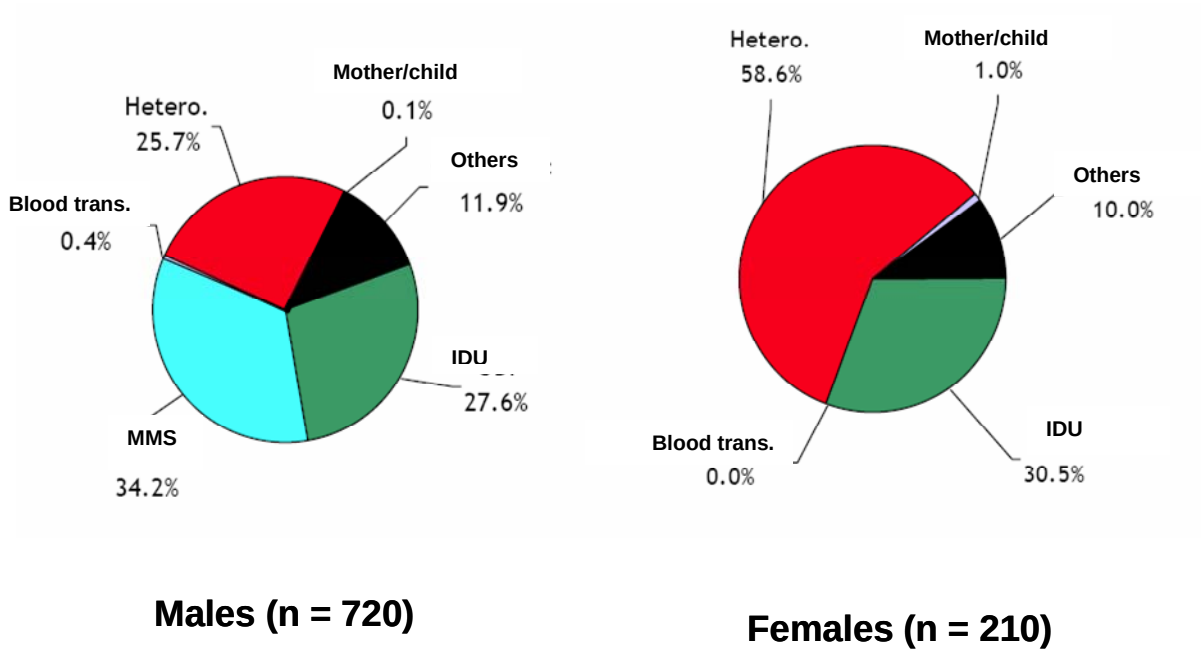
Fig. 6.4. Newly-diagnosed AIDS cases, by associated risk factor. Spain. 1986-2009



* AIDS cases adjusted due to delayed notification. June 30, 2010 update.
SOURCE: Information System on Newly-Diagnosed HIV Cases. Ministry of Health, Social Services and Equality. Ministry of Economy and Competitiveness.

Fig. 6.5 shows the newly-diagnosed AIDS cases in relation to the HIV transmission-related risk factor (Spain 2010), in which the sexual route patently plays a leading role, the heterosexual route being predominant among the females and the homosexual route predominant among the males.

Fig. 6.5. AIDS cases diagnosed in Spain in 2010, by transmission categories. Newly diagnosed HIV cases by transmission category and gender. Spain, (June, 30, 2011)



MMS: Male-to-Male Sexual Contact.
IDU: Injecting Drug Use
SOURCE: Information System on Newly-Diagnosed HIV Cases. Ministry of Health, Social Services and Equality. Ministry of Economy and Competitiveness.

2.1. HIV Prevalence Study. EPI-HIV[11]

Objectives

- Describe the characteristics of those individuals who took the HIV test and of those who were diagnosed with HIV infection at any of the HIV diagnosis centres comprising the network for this study within the 2000-2010 period.
- Describe the HIV prevalence among those individuals who took the test in the network of HIV diagnosis centres in terms of the at-risk exposures, gender, age and region of origin.

Methodology

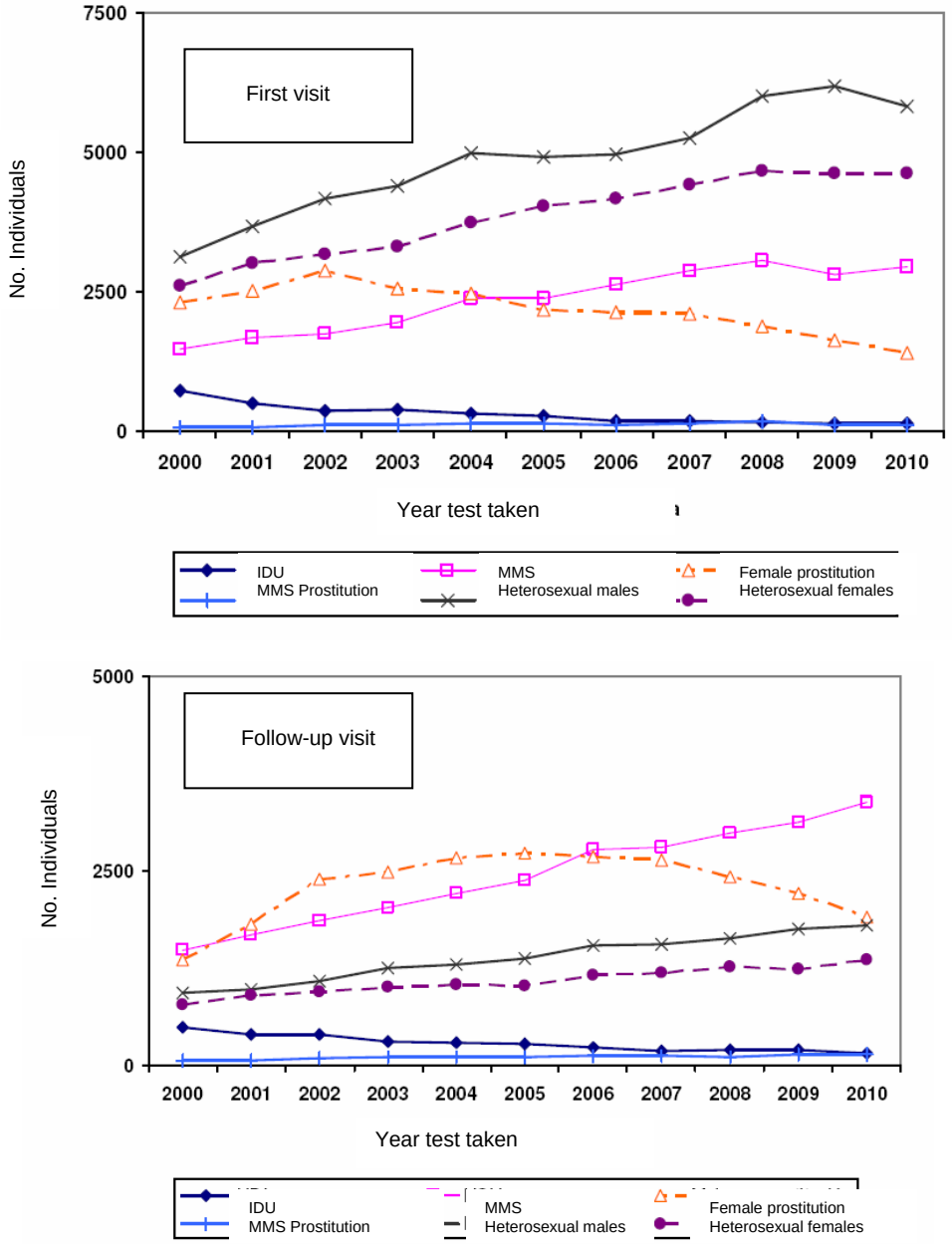
- Design: Longitudinal descriptive study
- Period: 2000-2010
- Scope: 20 HIV diagnosis centres
- Inclusion criteria: Individuals who voluntarily took the HIV test within the study period at any of the participating centres. Only confirmed results were considered.
- Estimated prevalence. The HIV infection prevalence was calculated as the number of individuals diagnosed divided by the total number of those analysed.

[11] EPI-HIV Group. Prospective study of HIV prevalence among individuals seen at the HIV/STI centres, 2000-2010. Madrid: National Epidemiology Centre, 2012. Available at: http://www.msssi.gob.es/ciudadanos/enfLesiones/enfTransmisibles/sida/vigilancia/InformeEPI_VIH2000_2010.pdf

Main results

Characteristics of the individuals who took the HIV test: A total of 243,695 HIV assays were conducted at the participating centres within the 2000-2010 period. A total of 64% of these assays were conducted on individuals who were coming into the centre for their first visit, all others having been conducted on individuals who had already taken the HIV test at the same centre at previous times. By HIV transmission mechanisms, the largest percentage of demands for testing on a first visit was among heterosexual males, who also showed a clear upward trend, having risen from 28.6% (2000) to 37.7% (2010). Concerning the injecting drug users, worthy of note is the demand for testing both on the first visit as well as on follow-up visits having declined over the course of the period in question (Fig. 6.6).

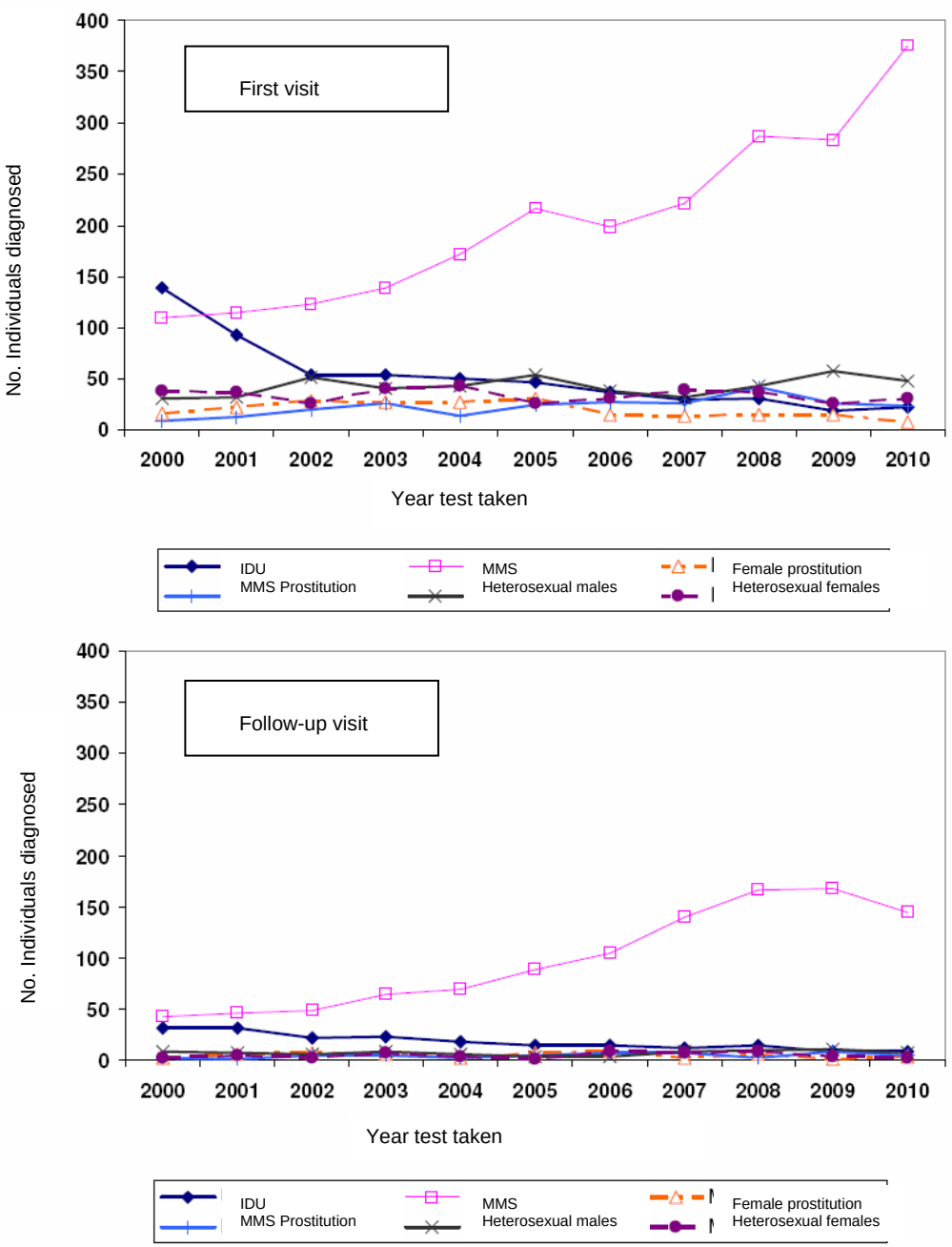
Fig. 6.6. Number of individuals who took the HIV test, by year in which the test was taken, type of visit and transmission mechanism. 2000-2010.



SOURCE: EPI-HIV Group. Prospective study of HIV prevalence among individuals seen at the HIV/STI centres, 2000-2010. Madrid: National Epidemiology Centre, 2012
MMS: Male-to-Male Sexual Contact.
IDU: Injecting Drug Use

Description of the individuals diagnosed with HIV infection: In all, a total of 5,732 cases of HIV infection were diagnosed within the period in question. On first visits, the greatest number were diagnosed among males who had male-to-male sexual contact and the injecting drug users, but within the 2000-2010 period, the number of cases diagnosed among the former rose from 109 (31.6%) to 376 (73.6%), having decline among the latter from 139 (40.3%) to 22 (4.3%). The trend is similar for the follow-up visits (Fig. 6.7).

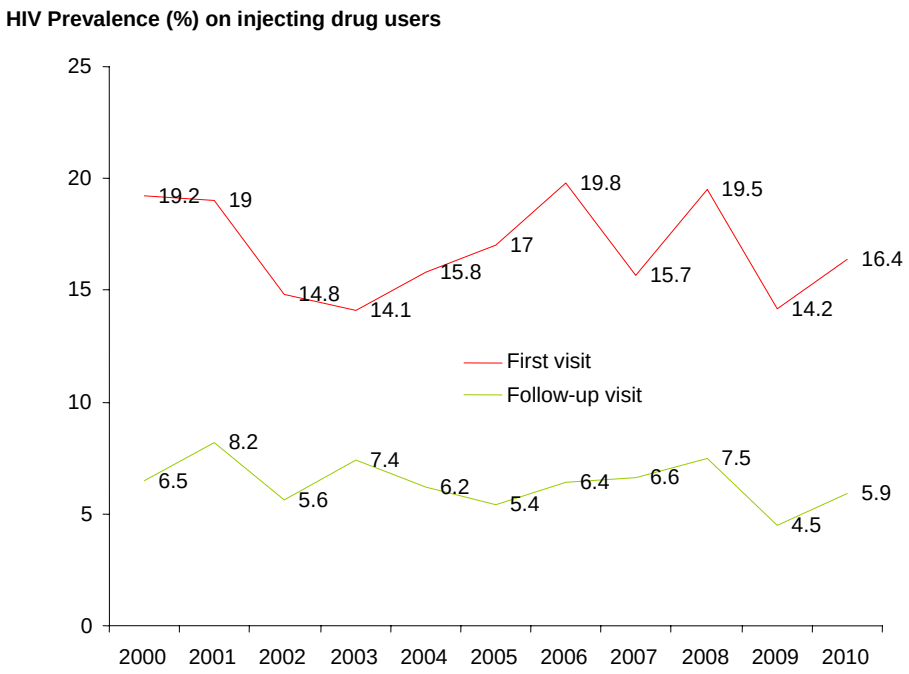
Fig. 6.7. Individuals diagnosed with HIV infection, by year of first test, type of visit and transmission mechanism



Source: EPI-HIV Group. Prospective study of HIV prevalence among individuals seen at the HIV/STI centres, 2000-2010. Madrid: National Epidemiology Centre, 2012
MMS: Male-to-Male Sexual Contact.
IDU: Injecting Drug Use

Description of the HIV prevalence: Throughout the period under study, the overall HIV infection on first visits was 2.7%, being 1.8% higher than that found on the follow-up visits. Focusing specifically on injecting drug users, on first visits, this groups shows the broadest prevalence, the time trend showing a decline within the 2000-2003 period (from 19.2% down to 14.1%), following by a stabilization within the 2004-2010 period. On the follow-up visits, the prevalence figures for the injecting users ranged from the 6.5% recorded in 2000 to the 5.9% recorded in 2010 without showing any clear-cut trend (Fig. 6.8).

Fig. 6.8. Prevalence (%) of HIV in IDUs/exIDUs, by year test taken and first or follow-up visits. 2000-2010



SOURCE: Graph plotted by the Spanish Monitoring Centre for Drugs and Drug Addictions on the basis of the data from the EPI-HIV Group. Prospective study of HIV prevalence among individuals seen at the HIV/STI centres, 2000-2010. Madrid: National Epidemiology Centre, 2012

In-hospital HIV/AIDS Survey[12]

The last edition of this survey was conducted in June 2011, a summary being provided in following as to the Methodology and results for that year, as well as the trend throughout the 2000-2011 period.

Objectives

- Describe the clinical and socio-demographic characteristics of the individuals infected with HIV/AIDS for whom care was provided by the hospital services and their evolution over the course of time.
- Estimate the prevalence of at-risk HIV-related behaviours for the population studied.

[12] In-Hospital Survey of HIV/AIDS Patients. 2011 Results. Analysis of the 2000-2011 Trend. Office of the Secretary for the National Plan on AIDS. National Epidemiology Centre. Madrid, April 2012. Available at: http://www.msssi.gob.es/ciudadanos/enfLesiones/enfTransmisibles/sida/vigilancia/InformeEncuestaHospitalaria2011.pdf

- Estimate the prevalence of the patients undergoing antiretroviral treatment and define their characteristics.

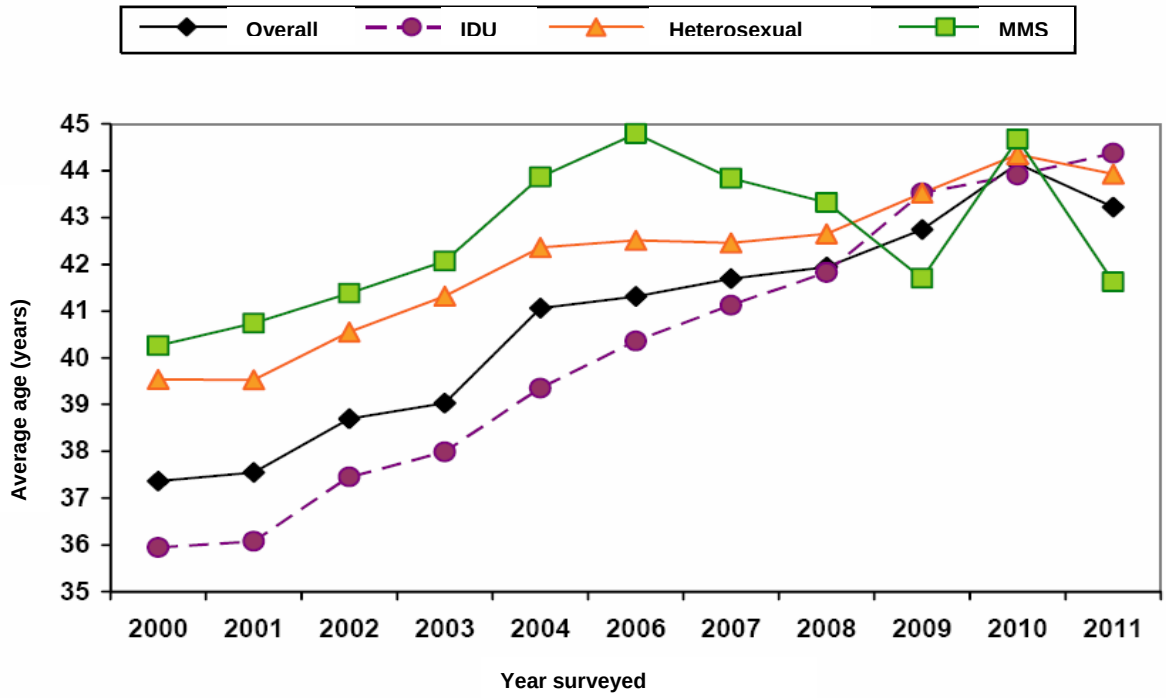
Methodology

- Type of study: Cross-sectional, descriptive, observational study conducted on a previously-scheduled date.
- Study population: Patients diagnosed with HIV in contact with the National Health System.
- Scope: Network of National Health System hospitals in the Autonomous Communities voluntarily taking part in the study. Period: 2000-2011.
- Inclusion criteria: Patients diagnosed with HIV who are hospitalized, on an outpatient or day hospital appointment on the day the survey is conducted.
- Data collection: Questionnaire completed by the physician responsible for the patient in question.

Main results

Overall, the clinical situation has improved to a major degree on extending the antiretroviral treatments, a continuing trend toward improvement having been noted over the past 11 years. An increase is noted in the number of patients of other countries, the majority of whom contracts HIV as a result of heterosexual practices. The patients for whom care was provided in the hospitals were mainly males of progressively older ages, this being something which is being found in all of the transmission categories with the exception of the males who have male-to-male sexual contact (Fig. 6.9).

Fig. 6.9. Trend in the average age of the patients by transmission categories and years surveyed, 2000-2011

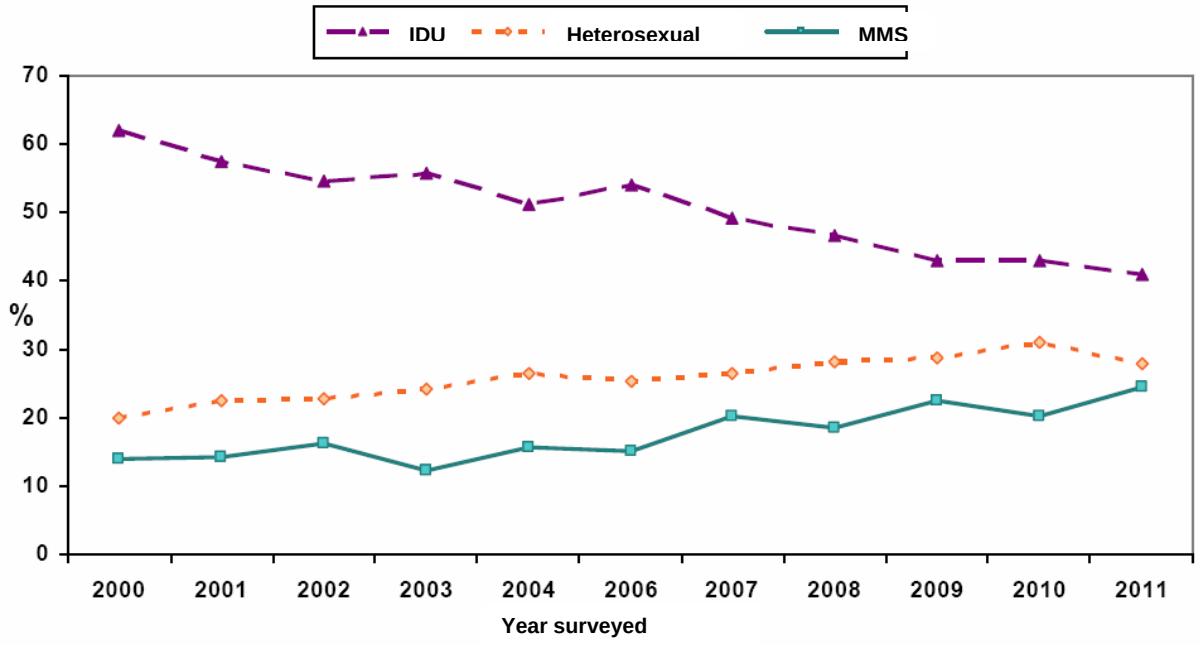


IDU: Injecting Drug Users.
MMS: Male-to-male Sexual Contact
Source: In-Hospital Survey of HIV/AIDS Patients. 2011 Results. Analysis of the 2000-2011 Trend. Office of the Secretary for the National Plan on AIDS. National Epidemiology Centre. Madrid, April 2012.

Focusing specifically on the mechanism of transmission, for the 2000-2011 period, injecting drug use (4,683, 51%) and heterosexual transmission (2,318, 26%) showed the largest percentages. However, some significant variations arose over the course of time, one of the most outstanding of which was the progressive decline in the number of patients who contracted this infection as a result of being Injecting Drug Users, this number having dropped form 62% in 2000 to 41% in 2011 and then to 28% in 2011. The percentage of cases attributed to male-to-male sexual contact also rose from 14% in 2000 to 25% in 2011. In 2011, the majority are infected by way of sexual relations.

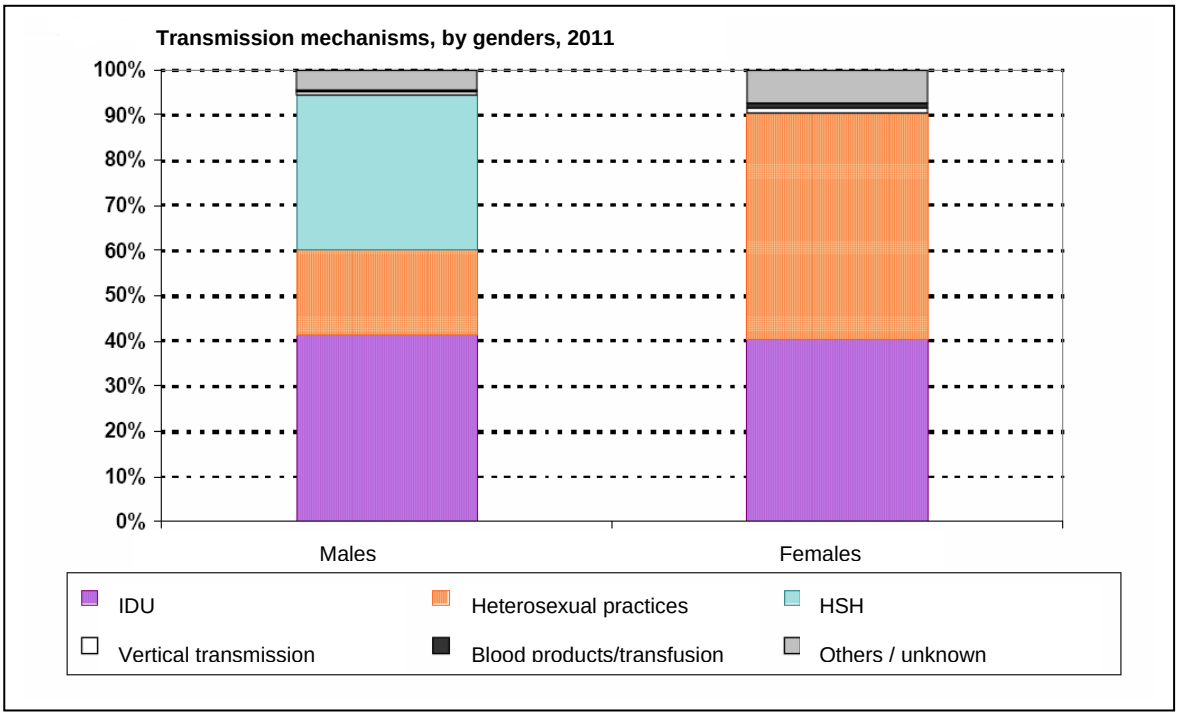
Two Figures are provided in following showing the trend in cases from 2000 to 2011 regarding the mechanism of transmission (%) (Fig. 6.10) and the breakdown of cases by transmission mechanisms and genders in 2011 (Fig. 6.11).

Fig. 6.10. Breakdown of cases by transmission mechanisms(%). Spain 2000-2011.



IDU: Injecting Drug Users.
MMS: Male-to-male Sexual Contact
Source: In-Hospital Survey of HIV/AIDS Patients. 2011 Results. Analysis of the 2000-2011 Trend. Office of the Secretary for the National Plan on AIDS. National Epidemiology Centre.

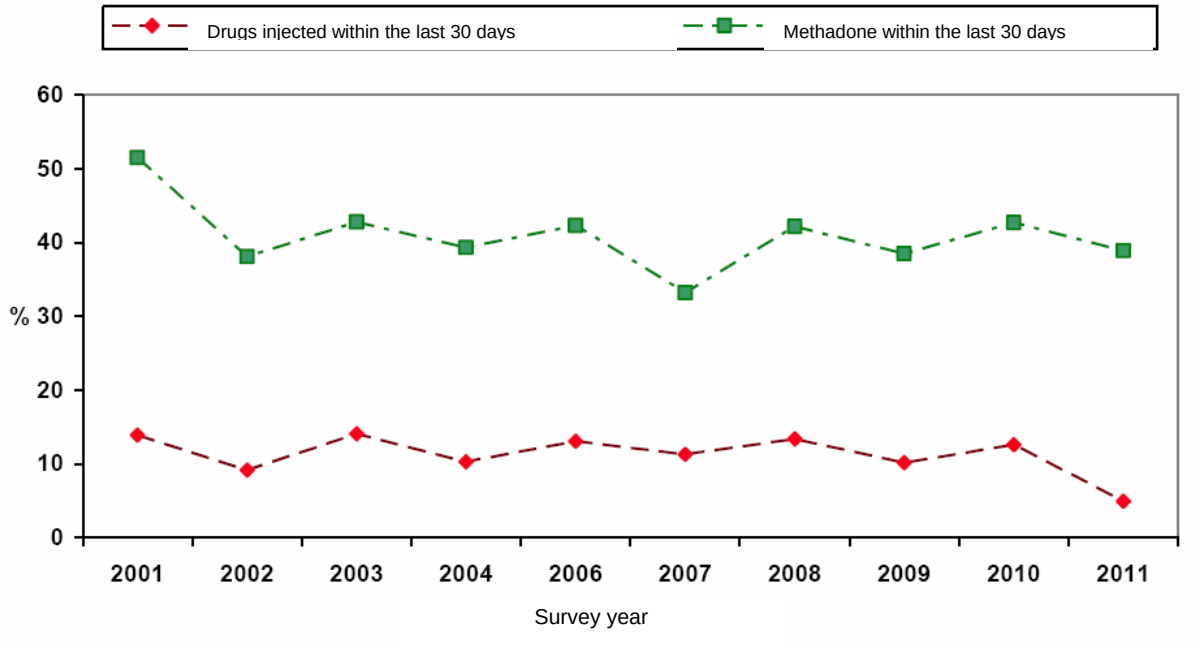
Fig. 6.11. Breakdown of cases by transmission mechanisms and genders. Spain 2011.



IDU: Injecting Drug Users.
MMS: Male-to-male Sexual Contact
Source: In-Hospital Survey of HIV/AIDS Patients. 2011 Results. Analysis of the 2000-2011 Trend. Office of the Secretary for the National Plan on AIDS. National Epidemiology Centre.

In 2011, a total of 332 infected patients infected as a result of sharing injecting material were surveyed, a total of 5% of whom reported having injected drugs within the last 30 days, this being the lowest percentage for the entire period, and 37% of the total number underwent methadone treatment. A significant decline was noted in the percentage of this group of patients who reported maintaining their habit of use within the last 30 days within the 2001-2011 period, that of those undergoing treatment with methadone remaining stable (Fig. 6.12)

Fig. 6.12. IDU/ex-IDU patients (%) who injected illicit d or underwent methadone treatment within the last 30 days immediately prior to the survey, 2001-2011



Source: In-Hospital Survey of HIV/AIDS Patients. 2011 Results. Analysis of the 2000-2011 Trend. Office of the Secretary for the National Plan on AIDS. National Epidemiology Centre.

4. Indicator of admission to treatment for drug abuse or dependence[13]

Objectives

This indicator is for the purpose of ascertaining the number of individuals admitted to outpatient treatment for different psychoactive substance abuse or dependence. The information which is collected by way of this indicator is useful for obtaining information on the infections among users.

Methodology

Coverage:
This indicator's coverage is nationwide. In 2010, a total of 53,508 admissions to treatment were notified from Spain's 19 Autonomous Communities. This indicator has been functioning systematically as of 1987.

Treatment indicator information collection mechanism:
The treatment centres collect the information on a record sheet which they send to the Autonomous Communities, which send in the information grouped at the State level. For the notification of cases, the public or subsidized or officially arranged centres, services or programs which provide outpatient treatments for psychoactive substance abuse or dependence are included. These may be specific drug dependence centres, mental health centres or services which provide outpatient drug dependence treatment (whether independent centres, centres integrated into general health centres, hospitals or another type of centres), prison drug dependence treatment programs, centres providing complex treatments including an outpatient

[13] Periodical Spanish Monitoring Centre for Drugs reports. Available at: http://www.pnsd.msc.es/Categoria2/observa/oed/home.htm

phase, or mobile units which provide opioid replacement treatments which are manned by physicians and nurses.

Variables:
The data collection sheet is comprised of 23 variables, some of which have several sections. The information collected includes:

- Enrolment information (Clinical record number, data admitted for treatment, centre identification number).

- Socio-demographic information (gender, date of birth, city/town, province and country of birth, nationality, employment status, educational level, living situation within the last 30 days, place where has lived).

- Health and drug use-related information (source of referral for treatment, main drug for which admitted for treatment, frequency of use of the main drug, year of onset of use of the main drug, prior treatment for the same drug, most frequent route of administration, other drugs, etc. Information is also collected on the HIV-related serological status and it is planned to start collecting information on hepatitis B and C.

Treatment indicator inclusion and exclusion criteria:
The cases meeting any of the following requirements are included:

(a) First-time admission to a centre for treatment
(b) Readmission for treatment to the same centre
(c) Continuing a treatment started, for reasons of emergency or for other reasons, at services which do not notify the indicator, such as hospitals, health centres or social welfare centres and who later come in to a notifying centre to continue treatment.
(d) Admission to a treatment affected by a judicial or administrative situation.

Those cases which are of any of the following characteristics are not notified as admissions for treatment:

(a) Mere contacts in person or by telephone for requesting information or treatment or the demands which are placed on the waiting list.
(b) The contacts for the sole purpose of requesting social assistance or benefits.
(c) The treatments for the sole purpose of treating the organic complications related to drug use.
(d) The interventions consisting exclusively of exchanging needles and syringes or other injecting material, handing out condoms or providing counselling con safe sex and drug use.
(e) The treatments involving overnight stays at hospitals, psychiatric hospitals, therapeutic communities, residence facilities, etc.

Main results

Some results prepared by the Spanish Monitoring Centre for Drugs based on the information from this indicator are provided in following.

Table 6.1 shows information on those admitted for treatment in 2010, classified by the main drug for which they were admitted, detailing whether or not they were injecting users as well as the route of administration used most often and the HIV-related serological status. Note is made of the major differences existing in injecting and in HIV depending on the substance for which they are admitted for treatment. The highest prevalence of injecting use and testing HIV-positive exist among the opioids.

Table 6.1. Individuals admitted for treatment: Serological status and route of administration of main drug. Spain 2010.

	Opioids	Heroin	Methadone	Other opioids	Cocaine	CLH Cocaine	Base cocaine	Other stimulants	Amphetamines	MDMA and derivatives	Hypnosedatives	Benzodiaze-pines	Hallucinogens	Volatile inhalants	Cannabis
No. cases	18,374	17,325	645	404	22,131	21,505	626	654	517	98	944	875	69	72	11,210
Age onset of use of main drug (yrs.)	21.7	21.4	28.9	25.6	20.9	20.8	22.7	20.2	20.1	19.2	27.3	26.9	19.3	16.3	15.8
Route of administration used most often for main drug within last 30 days (%)															
Oral	5.3	1.2	91.0	42.3	1.5	1.5	.3	36.7	26.3	85.3	97.6	97.5	41.8	1.5	2.4
Smoked /inhaled	72.2	75.6	5.5	34.1	14.6	12.6	83.9	6.0	5.5	4.2	1.1	1.2	4.5	47.1	96.5
Intranasal	5.4	5.5	1.3	6.9	81.0	83.0	13.7	56.1	67.6	8.4	0.5	0.5	47.8	42.6	.6
Injecting	15.8	16.4	1.8	14.0	2.3	2.3	0.7	0.8	0.6	0.0	0.2	0.2	6.0	0.0	0.0
Others	1.3	1.3	0.5	2.7	0.6	0.6	1.5	.5	.0	2.1	0.5	0.6	0.0	8.8	0.4
Injected drugs sometime in their lives	42.0	42.2	41.1	34.7	6.6	6.5	11.0	4.4	4.1	4.1	9.0	9.1	4.3	2.8	3.5
Injected drugs within the last 12 months	14.7	15.0	8.1	12.9	3.0	3.0	3.0	2.6	2.1	2.0	3.9	4.1	0.0	0.0	0.9
HIV-related serological status (%)															
Positive	14.4	14.3	17.4	11.9	1.8	1.8	2.9	1.5	1.4	2.0	3.9	4.1	0.0	0.0	0.9
Negative (analysis within last 6 months)	24.3	24.5	19.1	24.0	25.1	25.3	16.3	19.7	19.0	24.5	17.3	17.5	21.7	11.1	13.7
Negative (no date of analysis)	24.7	25.0	22.9	14.6	19.5	19.3	26.5	19.4	20.3	15.3	19.1	19.4	21.7	12.5	12.9
No analysis or unknown result	36.7	36.2	40.6	49.5	53.6	53.6	54.3	59.3	59.4	58.2	59.7	59.0	56.5	76.4	72.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Ministry of Health, Social Services and Equality. Treatment Demand Indicator.

Table 6.2 provides some items of data concerning the knowledge of the HIV-related serological status and prevalence among the injecting users admitted for treatment for psychoactive drug abuse or dependence in Spain in 2010, taking into account the ages and genders and whether they had injected sometime in their lives or within the last 12 months immediately prior to being admitted.

In short, a total of 9,697 individuals who had injected sometime in their lives and 3,549 individuals who had injected within the last 12 months immediately prior to being admitted were admitted for treatment in 2010. Among the former, 74.7% knew their serological status, 70.1% of the latter knowing their status.

Focusing specifically on those who had injected within the last 12 months, a slightly higher percentage of the females were found to be aware of their serological status (71.4%) in comparison to the males (70.2%). The difference is greater in regard to age, it being found that the older the age, the greater the knowledge. Hence, 40.6% of those under 25 years of age are aware of their serological status, compared to 76.8% of those over 34 years of age. It is also advisable to point out the difference between whether or not they have undergone prior treatment, a total of 77.6% of the injecting users who had undergone prior treatment being aware of their serological status, compared to the 52.6% of the injecting users who were coming in for treatment for the very first time, this fact being justifiable as a result of it being standard practice for HIV serological testing to be conducted on all those admitted for treatment, although it would be advisable to continue working toward increasing this percentage.

Table 6.2. Prevalence of HIV infection among the injecting users admitted for treatment for psychoactive substance abuse or dependence (%). Spain, 2010

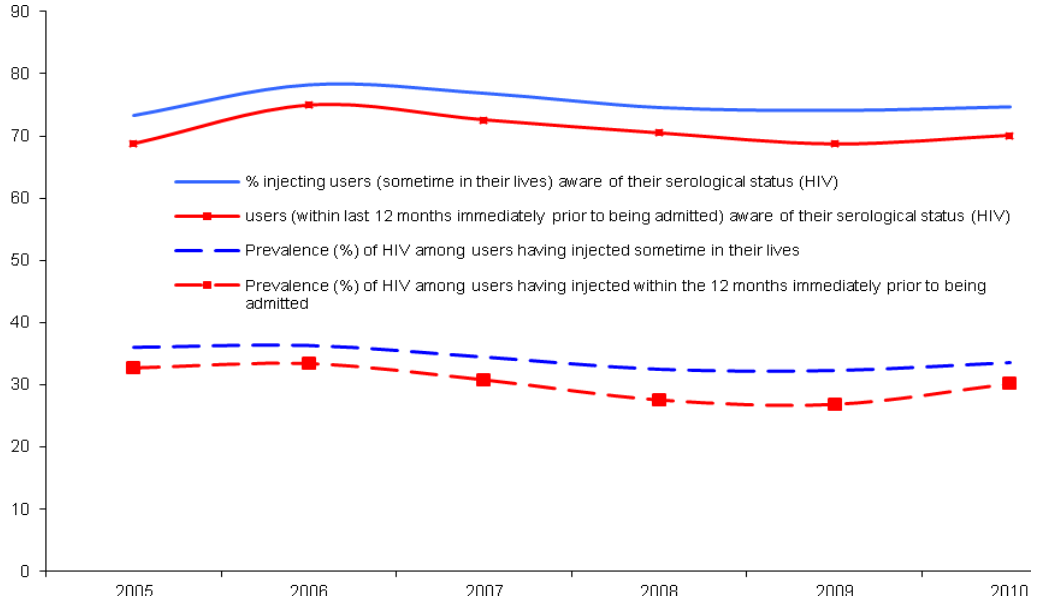
	Injection within the last 12 months immediately prior to being admitted			Injection sometime in their lives		
	Total	Prior treatment		Total	Prior treatment	
		Yes	No		Yes	No
Total number of injecting users	**3,549**	**2,490**	**979**	**9,697**	**7,316**	**2,196**
No. Injecting users aware of their HIC-related serological status	2,487	1,932	515	7,243	5,788	1,335
Prevalence of HIV infection (%)	30.2	32.9	18.4	33.6	34.9	26.7
Male injecting users (No.)	**3,027**	**2,156**	**805**	**8,246**	**6,220**	**1,866**
Aware of their HIV-related serological status (No.)	2,124	1,663	428	6,125	4,890	1,130
Prevalence of HIV infection (%)	29.8	32.4	18.7	32.8	33.9	27
Female injecting users (No.)	**500**	**319**	**170**	**1,404**	**1,061**	**322**
Aware of their HIV-related serological status (No.)	357	264	87	1,094	879	201
Prevalence of HIV infection (%)	31.7	36	17.2	38.4	40.7	25.4
Injecting users < age 25 (No.)	**303**	**116**	**175**	**401**	**169**	**218**
Aware of their HIV-related serological status (No.)	123	70	52	168	104	62
Prevalence of HIV infection (%)	8.1	7.1	7.7	7.7	5.8	9.7
Injecting users ages 25-34 (No.)	**1,055**	**628**	**403**	**2,047**	**1,368**	**639**
Aware of their HIV-related serological status (No.)	681	458	210	1,392	1,024	343
Prevalence of HIV infection (%)	14.8	17.9	7.6	16.2	18.2	9.6
Injecting users > age 34 (No.)	**2,189**	**1,744**	**401**	**7,241**	**5,771**	**1,339**
Aware of their HIV-related serological status (No.)	1,682	1,403	253	5,677	4,654	930
Prevalence of HIV infection (%)	38	39.1	29.6	38.7	39.3	34.2
Injecting user < 2 years using the main drug	**87**	**24**	**61**	**119**	**42**	**75**
Aware of their HIV-related serological status (No.)	45	14	31	68	24	44
Prevalence of HIV infection (%)	11.1	21.4	6.5	19.1	29.2	13.6
Injecting users using main drug for 2 years or more	**2,618**	**1,992**	**572**	**6,718**	**5,431**	**1,172**
Aware of their HIV-related serological status (No.)	2,038	1,620	389	5,407	4,479	853
Prevalence of HIV infection (%)	30	32.2	19.3	32.7	34.2	23.2
Injecting users using opiates[2]	**2,916**	**2,229**	**630**	**8,230**	**6,604**	**1,474**
Aware of their HIV-related serological status (No.)	2,193	1,760	397	6,388	5,275	1,003
Prevalence of HIV infection (%)	31.5	33.6	21.2	35.1	36	29.2
Injecting users not using opiates	**633**	**261**	**349**	**1,467**	**712**	**722**
Aware of their HIV-related serological status (No.)	294	172	118	855	513	332
Prevalence of HIV infection (%)	20.1	26.2	9.3	22.5	24.2	19.3

1. The prevalence figures are calculation on the basis of the number of cases entailing information on the HIV-related serological status and on the other variables which are crossed.
2. Both those admitted for treatment for opioid dependence and those admitted for other psychoactive drugs who have used opioids within the last 30 days immediately prior to being admitted are included.
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Ministry of Health, Social Services and Equality. Treatment Demand Indicator.

In regard to HIV prevalence, a total of 30.2% of those who had injected within the last 12 months were HIV-positive, a somewhat higher percentage being found among females (31.7%) than among males (29.8%). Clear-cut difference was also found by age (8.1% in those under age 25 and 38% in those over 34 years of age).

Fig. 6.13 and Table 6.3 provide the data for injecting users who are aware of their serological status and for HIV prevalence among those who had injected sometime in their lives and those who had injected within the last 12 months immediately prior to being admitted for treatment, the trend having been found to have remained stable as of 2005, showing a slight rise in prevalence and in the percentage of individuals aware of their serological status within the last 12 months.

Fig. 6.13. Prevalence of HIV and percentage of individuals aware of their serological status among those who injected within the last 12 months and at some time in their lives. Spain, 2005-2010.



SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Ministry of Health, Social Services and Equality. Treatment Demand Indicator.

Table 6.3. Prevalence of HIV, number of injecting users aware of their serological status (injected within the last 12 months and at some time in their lives). Spain, 2005-2010

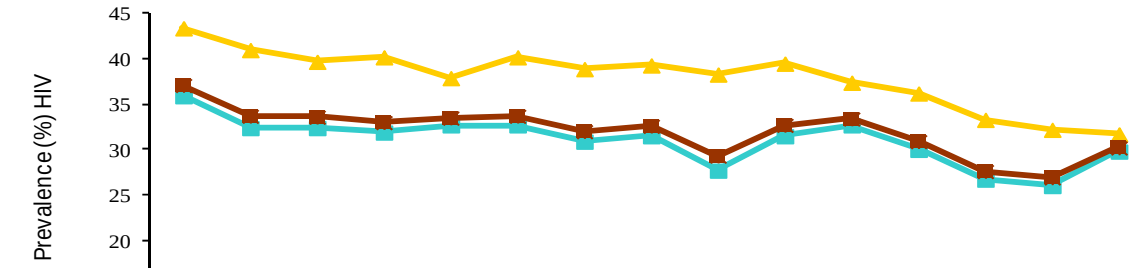
	2005	2006	2007	2008	2009	2010
Injected within the last 12 months immediately prior to having been admitted						
Total number of injecting users	4,358	4,892	4,575	4,546	3,763	3,549
No. Injecting users aware of their serological status (HIV)	2,996	3,665	3,319	3,203	2,585	2,487
Prevalence of HIV infection (%).	32 .7	33 .4	30 .8	27 .6	26 .9	30 .2
Injected sometime in their lives						
Total number of injecting users	9,533	11,601	11,249	10,895	9,637	9,697
No. Injecting users aware of their serological status (HIV)	6,991	9,068	8,643	8,126	7,143	7,243
Prevalence of HIV infection (%).	36 .1	36 .4	34 .5	32 .5	32 .3	33 .6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Ministry of Health, Social Services and Equality. Treatment Demand Indicator.

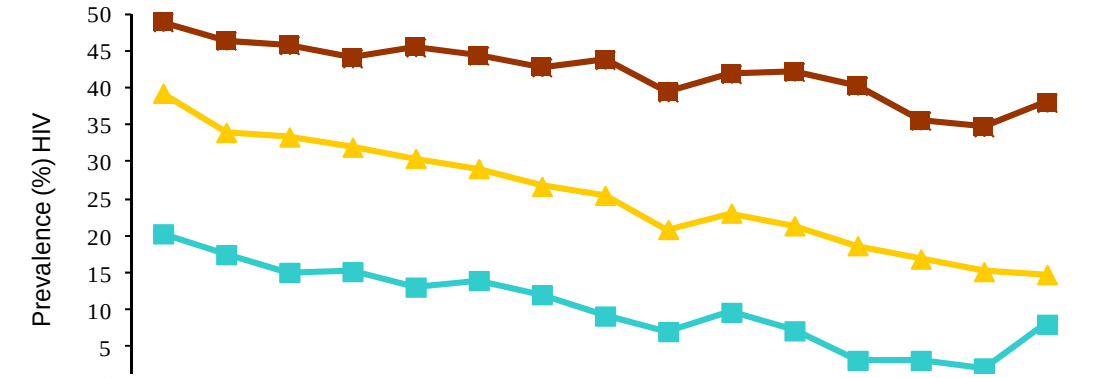
Fig. 6.14 provides the HIV prevalence-related data, by ages and genders, for those admitted for treatment who had injected drugs within the last 12 months who were aware of their serological status.

Generally speaking, a slight downward trend may be noted, although a slight rise is noted in 2010 among males, among those under age 25 and among those older than 34 years of age, which, although may be related to the rise in the number of individuals aware of their serological status, the size of the sample, given that there is a small number of injecting users under 25 years of age, which may result in few HIV-positive cases, is a large percentage. This is an aspect which will have to be monitored.

Fig. 6.14. Prevalence of HIV among those admitted to treatment who had injected drugs within the last 12 months and who were aware of their serological status, by genders and age groups. Spain, 1996-2010



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Male	35.9	32.4	32.4	31.9	32.7	32.7	30.9	31.5	27.7	31.5	32.7	30	26.7	26	29.8
Female	43.4	41	39.7	40.2	37.9	40.2	38.9	39.3	38.3	39.5	37.4	36.2	33.3	32.2	31.7
Total	37.1	33.7	33.6	33	33.5	33.7	32	32.6	29.3	32.7	33.4	30.9	27.6	26.9	30.2



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<25	20.3	17.5	15.1	15.2	13.1	14	12.1	9.2	7.1	9.7	7.2	3.2	3.2	2.2	8.1
25-34	39.3	34	33.4	32	30.5	29.1	26.7	25.5	20.9	23.1	21.4	18.7	16.9	15.2	14.8
>34	48.9	46.4	45.8	44	45.5	44.4	42.8	43.8	39.4	41.9	42.2	40.3	35.6	34.7	38

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Ministry of Health, Social Services and Equality. Treatment Demand Indicator.

VIRAL HEPATITIS

The Spanish Monitoring Centre for Drugs is working on systematically organizing the collection of data on hepatitis B and C among drug users, this information however not being available at present. Recourse must be taken to the specific studies in order to ascertain the prevalence of hepatitis B and C among drug users.

A systematic review was published in *The Lancet*[14] in August 2011 on the Hepatitis B and C epidemic among drug users, in which the latest available data in different countries, including Spain, was collected. A summary is provided of the main results presented in the aforementioned article.

The prevalence (in percentage form) of anti-HCV antibodies in injecting drug users (data for 1999-2011 and 2003) averages 79.6%, with a maximum of 85.9% and a minimum of 73.3%. The prevalence (in percentage form) of core HBc antibodies in injecting drug users (2003 data) averages 22.5%, the prevalence (in percentage form) of Hepatitis B surface antigen HAsAg in injecting drug users (2006 data) averages 3.6%, with a minimum of 1.8% and a maximum of 5.3%).

It is advisable to point out that hepatitis B vaccinations are systematically provided in Spain and that, according to the latest available data from the Spanish Ministry of Health[15], the vaccination coverage (3 doses) was 79.4% among adolescents ages 11-14 in Spain in 2011.

6.3. OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

INDICATOR OF HOSPITAL EMERGENCIES AMONG PSYCHOACTIVE SUBSTANCE USERS

Monitoring the non-fatal consequence of psychoactive substance use can be complicated but provides information of interest for knowing the characteristics and trend in the use of drugs and is useful for taking the fitting measures. In Spain, one of the indicators used for this purpose is that of monitoring hospital emergencies among psychoactive substance users. A brief description is provided in following of the methodology and main results.

Methodology

Description
This indicator has been in use since 1987, and its objective is to monitor the characteristics of the hospital emergencies related to the non-medical or non-therapeutic use of psychoactive drugs in Spain.

Information collection mechanism
This information is gathered by the personnel responsible in each Autonomous Community by way of actively, systematically, thoroughly and retrospectively reviewing the emergency service medical records.

A single geographical area is selected and all of the hospitals located within that area (not including maternity units, children's hospitals and monographic hospitals) are monitored. Each Autonomous Community may decide whether this information is collected continuously or solely

[14] Global epidemiology of hepatitis B and hepatitis C in people who inject drugs: results of systematic reviews. The Lancet, Volume 378, Issue 9791, Pages 571 - 583, 13 August 2011
[15] http://www.msc.es/profesionales/saludPublica/prevPromocion/vacunaciones/coberturas.htm#octavo

one week per month chosen at random through the Spanish Monitoring Centre for Drugs. In 2010, the emergencies came from 15 Autonomous Communities (of a total of 19 ACs). For the most part of the areas monitored, the information collection process was confined to one week per month, but in others, such as in the city of Barcelona and on Ibiza Island, this information was collected continuously.

Data sheet

The data collection sheet is comprised of 20 variables, some of which have various sections. The information gathered includes: Enrolment information (clinical record number, hospital identification number, date admitted to emergency services), socio-demographic information (gender, date of birth, city/town and province of birth, nationality, patient's legal status), information on the emergency and use of drugs (ID-10 diagnosis, solution provided to the emergency, name of the drugs mentioned and route of administration and evidence – if any- of a relationship between use and emergency).

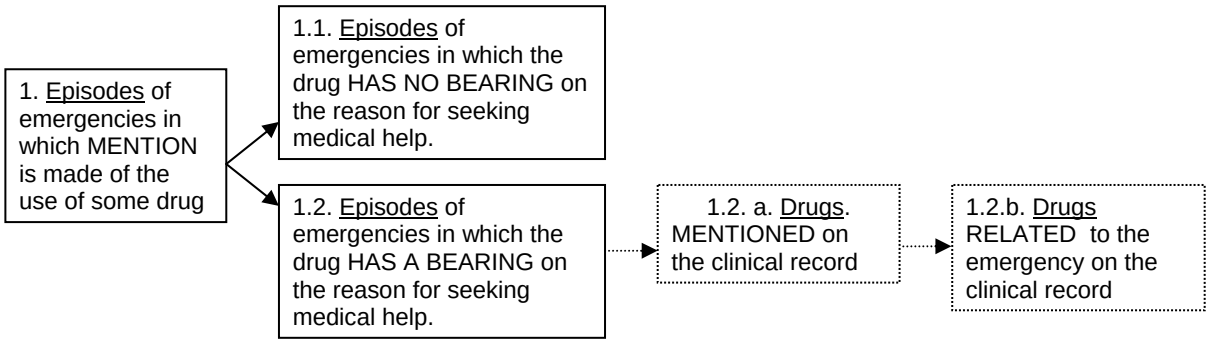
Inclusion and exclusion criteria

All episodes of hospital emergencies among individuals within the 15-64 age range in which mention is made on the clinical record of non-medical or non-therapeutic use of psychoactive drugs, independently of more than one thereof being involved for one same individual, are collected, Illicit drugs, opioids other than heroin or volatile inhalants are included, those episodes mentioning exclusively the use of alcohol, tobacco or xanthines being excluded.

Classification of the episodes and drugs (Fig. 6.15)

The episodes of emergencies in which the use of some drug is mentioned are classified into two groups: episodes in which the drugs are not related to the emergencies and episodes in which the drugs are related to the emergencies. The analysis revolves mainly around the latter of the two, an analysis being made, on one hand, of all the substances mentioned on the record and, on the other, solely those which are directly related to the emergency (selected from all those mentioned). A drug is considered to be directly related to the emergency when the clinical record includes statements made by the physician affording the possibility of related the emergency in question to the non-medical or non-therapeutic use thereof.

Fig. 6.15. Classification of the episodes of emergencies and the drugs in terms of its relationship with the non-medical or non-therapeutic use of drugs



1. Episodes in which it is stated on the clinical record that the patient has been involved, at some time in their life, in non-medical or non-therapeutic use of one or more drugs, whether or not these drugs have been the reason for seeking help through the emergency services.
   1.1. Episodes of emergencies in which the drug HAD NO BEARING on the reason for seeking medical help.
   1.2. Episodes of emergencies in which the drug HAS A BEARING on the reason for seeking medical help.
      1.2.a. Including those drugs which ARE MENTIONED in the clinical record, whether or not they are related to the emergency in question. This may a case of regular or sporadic use.
      1.2.b. Among the drugs mentioned, exclusively those substances which are directly related to the emergency in question are selected from among the drugs mentioned and are classified as RELATED.

Results

In 2010, data was collected on a total of 11,265 episodes of emergencies in which mention was made of the non-therapeutic or non-medical use of some substance. In a total of 49.9% (5,626) of these 11,265 episodes of emergencies, the drug had had a bearing on medical help being sought for the emergency in question, no evidence (statements made by the physician) having been found in the remaining 50.1% (5,639) affording the possibility of relating the emergency to the non-therapeutic use of any of these drugs.

The analysis made in following refers exclusively to those episodes of emergencies in which the use of drugs has a bearing on the reason for seeking medical help (5,626). First of all, the characteristics are presented for the episodes in 2010, then followed by those for the 1996-2010 trend.

General characteristics (2010) of the episodes of emergencies in which drugs had a bearing on the reason for seeking medical help among drug users

The general characteristics of the episodes of emergencies in 2010 indicate that: a higher percentage of males than females came to the emergency services for help for non-medical use of psychoactive substances. The final outcome of most of the emergencies directly related to drugs ended was a medical release (79.6%), there being a non-existent percentage of deaths. The percentage of individuals arrested among the emergencies related to drug use remained stable at around 5% over the last 5 years. The substances mentioned most often by the patients for whom care was provided, just as those most often related to the episodes of emergencies are, in this order: cocaine, alcohol and cannabis, a patent rise in the presence of cannabis having been noted. Heroin seems to have stabilized over the past few years, being related to less than 20% of the emergencies, although its trend must be monitored.

Table 6.4 shows the characteristics of the episodes of hospital emergencies broken down by genders in 2010, the latest available year.

Table 6.4. Characteristics of the episodes of hospital emergencies* among drug users, broken down by genders. Spain**, 2010.

	MALES	FEMALES	TOTAL
NUMBER OF EPISODES	4,115	1,480	5,626
AVERAGE AGE (years)	33.0	31.6	32.6
FEMALES (%)	-	-	26.5
ARRESTEES (%)	1.5	2.7	1.8
FINAL OUTCOME OF THE EMERGENCY (%)			
Medical release	79.3	80.5	79.6
Voluntary release	7.0	6.9	7.0
Admission to hospital	10.6	9.2	10.2
Death in emergency services	0.0	0.0	0.0
Transfer to a different centre	3.1	3.4	3.2

* Emergencies in which the drug has a bearing on the reason for seeking medical help
** Autonomous Communities notifying to the emergency indicator
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator

Table 6.5 shows the spread of mentioned and related substances among drug users. The top-ranked substances mentioned were cocaine (58.6%), alcohol (42.1%) and cannabis (39.3%). Concerning the related drugs, the leading drug was cocaine (49.4%), followed by cannabis (30.5%). By genders, males are found to mention heroin, cocaine, cannabis and alcohol to a greater degree, whilst the females show a higher percentage of hypnosedatives. No differences were found to exist between males and females regarding the percentage of mentions of amphetamines or volatile inhalants.

Table 6.5. Spread (%) of the substances mentioned and related in the episodes of hospital emergencies* among drug users, broken down by genders. Spain^, 2010.

PSYCHOACTIVE SUBSTANCES MENTIONED (%)[a]			
	MALES	**FEMALES**	**TOTAL**
Heroin	21.9	20.6	21.5
Other Opiates	12.6	12.8	12.6
Cocaine	59.6	55.3	58.5
Amphetamines	7.2	8.4	7.5
MDMA and Derivatives	3.7	4.2	3.9
Hypnosedatives	22.4	23.1	22.6
Cannabis	40.8	35.2	39.3
Hallucinogens	2.8	2.2	2.6
Volatile Substances	0.6	0.2	0.5
Alcohol	43.5	38.0	42.1
Other substances	2.9	4.9	3.4
RELATED PSYCHOACTIVE SUBSTANCES (%)[b]			
	MALES	**FEMALES**	**TOTAL**
Heroin	18.0	17.3	17.8
Other Opiates	6.7	7.0	6.7
Cocaine	50.0	47.7	49.4
Amphetamines	5.3	6.1	5.5
MDMA and Derivatives	2.8	3.1	2.9
Hypnosedatives	16.5	17.6	16.8
Cannabis	31.5	27.5	30.5
Hallucinogens	1.8	1.6	1.8
Volatile Substances	0.5	0.2	0.4
Alcohol	37.4	33.0	36.3
Other substances	5.0	1.9	4.2

* Emergencies in which the drug had a bearing on the reason for seeking medical help
^ Autonomous Communities notifying to the emergency indicator
a) Substances mentioned: Including the drugs which are mentioned on the record, whether or not related to the emergency (regular or sporadic use)
b) Related substances: The drugs related to the emergency in question (statements made by the physician are included on the clinical record making it possible to relate the emergency to the use) are selected from among the drugs mentioned.
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

Table 6.6 provides the characteristics of the episodes of hospital emergencies among drug users by type of substance mentioned or related.

The average age of the individuals for whom care was provided in 2010 was 32.6 years of age (the age being somewhat older among males than among females), showing the customary differences depending upon the substance having caused the emergency. Hence, the lowest average ages are found to be for the emergencies related to MDMA (27.1 years of age) and hallucinogens (27.9 years of age), the oldest ages being related to heroin (36.3 years of age) and other opiates (37.5 years of age). As far as the patient's juridical condition is concerned, a total 4.2% of the emergencies directly related to drugs in 2010 involved individuals who were arrested, a wide variety also having been found to exist with regard to the substance having given rise to the emergency in question.

Table 6.6. Characteristics of the episodes of hospital emergencies* among drug users, broken down by substances. Spain^, 2010.

	SUBSTANCES MENTIONED[1]										
	Heroin	Other opiates	Cocaine	Amphetamines	MDMA 6 deriv.	Hypno /Sleeping pills	Cannabis	Hallucinogens	Volatile substances	Alcohol	Others
NO. EPISODES RELATED TO EACH DRUG	1,210	708	3,295	421	217	1,269	2,211	147	27	2,368	195
AVERAGE AGE (years)	36.6	37.9	33.3	29.1	27.7	34.4	30.0	27.6	30.3	33.1	34.9
FEMALES (%)	25.3	26.8	25.0	29.7	28.7	27.1	23.7	22.4	11.1	23.9	37.3
ARRESTEES (%)	6.8	8.2	3.8	2.6	2.3	6.2	3.6	1.4	0.0	3.0	5.7
FINAL OUTCOME OF THE EMERGENCY (%)											
Medical release	75.5	75.9	79.4	79.9	79.6	72.6	80.4	75.5	91.7	78.6	61.8
Voluntary release	8.3	7.8	7.6	6.5	11.3	8.0	5.6	10.0	0.0	7.7	7.9
Hospital admission	12.4	13.8	9.8	10.8	7.0	14.5	10.8	10.9	8.3	10.7	21.5
Death in emergency services	0.0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Transfer to different centre	3.8	2.5	3.2	2.5	2.1	4.9	3.2	3.6	0.0	3.0	8.9
	RELATED SUBSTANCES[2]										
	Heroin	Other opiates	Cocaine	Amphetamines	MDMA & deriv.	Hypno/sleeping pills	Cannabis	Hallucinogens	Volatile substances	Alcohol	Others
NO. EPISODES RELATED TO EACH DRUG	967	367	2 691	297	158	911	1 657	95	23	1 973	98
AVERAGE AGE (years)	36.3	37.5	33.0	29.3	27.1	34.5	29.1	27.9	29.8	33.1	34.2
FEMALES (%)	25.8	27.4	25.5	29.6	28.7	27.8	23.9	24.2	13.0	24.1	40.2
ARRESTEES (%)	6.4	9.6	3.9	2.7	3.2	6.5	3.0	0.0	0.0	2.7	5.2
FINAL OUTCOME OF THE EMERGENCY (%)											
Medical release	75.2	78.6	79.8	80.4	80.0	74.0	81.6	79.7	100.0	78.7	63.8
Voluntary release	7.7	6.6	7.2	5.7	10.5	7.9	4.9	7.2	0.0	7.4	6.4
Hospital admission	13.5	11.4	9.9	10.6	6.7	12.8	10.5	11.6	0.0	10.6	19.1
Death in emergency services	0.0	0.0	0.1	0.4	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Transfer to different centre	3.7	3.3	3.2	2.9	2.9	5.2	3.0	1.4	0.0	3.3	10.6

* Emergencies in which the drug had a bearing on the reason for seeking medical help ^ Autonomous Communities notifying to the emergency indicator

a) Substances mentioned: Including the drugs which are mentioned on the record, whether or not related to the emergency (regular or sporadic use)

b) Related substances: The drugs related to the emergency in question (statements made by the physician are included on the clinical record making it possible to relate the emergency to the use) are selected from among the drugs mentioned. SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

Table 6.7 provides the data related to the route of administration. On interpreting this data, one must bear in mind that there are a major percentage of unknown values, as a result of which the results must be evaluated with all due precaution. In 2010, in the emergencies entailing a mention of heroin, the predominant route of administration was the injecting route (59.4%), following by the smoked (31.7%) and the intranasal or sniffed route (8%), the route of administration in the emergencies involving a mention of cocaine being the intranasal or sniffed route (62.1%), followed by the injected route (18.3%) and the smoked route (16.1%).

An improvement has been made in the classification of the route of administration for the episodes of emergencies in which “inhaled use” was mentioned. Up until 2003, these episodes were attributed to the smoked route, but the implementation of the new data collection protocol in 2003 made it possible to identify that most of these episodes have to do with the intranasal or sniffed route. This improvement in the classification in the case of cocaine marks a major change, because the route of administration found most often in emergencies is no longer pulmonary, changing over by far to intranasal, just as is also true for the treatment indicator. In the case of heroin, the relative importance of the injected route is much greater in emergencies than among those individuals admitted for treatment for intranasal or sniffed-route heroin abuse or dependence, revealing the greater risk of some acute problems, such as overdose, among injecting users.

The data on the administration route for all of the other psychoactive substances tally with what is known on the basis of other sources. In the case of ecstasy, hypnosedatives, amphetamines and hallucinogens, the route of administration is mostly oral. The use of opiates other than heroin is also generally orally, although approximately 3% of the cases involved injecting use. Cannabis is used predominantly smoked (96%), there however being a small percentage (3.6%) of individuals using cannabis orally.

Any comparison of the data related to the route of administration to the data for previous years must be avoided in principle due to the improvements made for classifying this variable and some incidences such as the incorporation of all of the episodes of emergencies on which information was included in the city of Barcelona as of 2004, which take on quite a major degree of relative importance in the whole and which, due to the characteristics of the population of Barcelona (mainly urban), adds a large number of cases of injecting use into the total.

Table 6.7. Route of administration of different drugs for the episodes of hospital emergencies* among drug users, broken down by drug mentioned or related drug. Spain^, 2010

	DRUGS MENTIONED (a)		DRUGS RELATED (b)	
	No.	%	No.	%
HEROIN				
Oral	4	0.6	7	1.2
Pulmonary or smoked	214	31.7	178	29.8
Intranasal or sniffed	54	8.0	45	7.5
Injected	401	59.4	366	61.2
Another route	2	0.3	2	0.3
OTHER OPIATES				
Oral	660	95.5	337	93.6
Pulmonary or smoked	8	1.2	7	1.9
Intranasal or sniffed	0	0.0	10	2.8
Injected	20	2.9	4	1.1
Another route	3	0.4	2	0.6
COCAÍNE				
Oral	47	3.3	53	4.3
Pulmonary or smoked	227	16.1	191	15.5
Intranasal or sniffed	875	62.1	785	63.8
Injected	257	18.3	201	16.3
Another route	2	0.1	1	0.1
AMPHETAMINES				
Oral	166	82.2	147	83.5
Pulmonary or smoked	8	4.0	6	3.4
Intranasal or sniffed	27	13.4	22	12.5
Injected	1	0.5	1	0.6
Another route	0	0.0	0	0.0
MDMA				
Oral	123	96.9	101	97.1
Pulmonary or smoked	1	0.8	1	1.0
Intranasal or sniffed	2	1.6	2	1.9
Injected	1	0.8	0	0.0
Another route	0	0.0	0	0.0
HYPNOSEDATIVES				
Oral	1 489	99.7	999	99.6
Pulmonary or smoked	2	0.1	1	0.1
Intranasal or sniffed	1	0.1	2	0.2
Injected	1	0.1	1	0.1
Another route	0	0.0	0	0.0
CANNABIS				
Oral	51	3.6	59	4.9
Pulmonary or smoked	1 378	96.0	1 131	94.6
Intranasal or sniffed	6	0.4	4	0.3
Injected	0	0.0	0	0.0
Another route	1	0.1	1	0.1
HALLUCINOGENS				
Oral	40	83.3	31	79.5
Pulmonary or smoked	4	8.3	4	10.3
Intranasal or sniffed	2	4.2	2	5.1
Injected	2	4.2	2	5.1
Another route	0	0.0	0	0.0

* Emergencies in which the drug had a bearing on the reason for seeking medical help
^ Autonomous Communities notifying to the emergency indicator
a) Substances mentioned: Including the drugs which are mentioned on the record, whether or not related to the emergency (regular or sporadic use)
b) Related substances: The drugs related to the emergency in question (statements made by the physician are included on the clinical record making it possible to relate the emergency to the use) are selected from among the drugs mentioned.
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

Trend (1996-2010) of the overall characteristics of the episodes of emergencies in which the drug had a bearing on the reason for seeking medical help among drug users

Focusing specifically on how the trends have evolved as of 1996 (Table 5), the percentage of females for whom care was provided in emergency services (related to the non-medical use of psychoactive substances) can be said to have shown a regular trend of 20%-30% of all the emergencies. Generally speaking, a trend is noted of a rise, for the time period studied, in the average age of the individuals for whom care was provided in emergencies, this figure having risen from an average of 27.8 years of age in 1996 to 32.6 years of age in 2010.

The legal status of the patients has progressively evolved, the highest percentage of arrestees having been found in 1997, the year as of which a decline began which reached its lowest point in 2006 (3.7%). Since then, there has been a stabilization at around 5% (4.4% in 2008, 5.2% in 2009 and 4.2% in 2010). The breakdown of the emergencies by the final outcome thereof has not varied greatly over the course of time, "medical release" being the most frequent, no major differences being noted either according to the drugs mentioned or genders.

Table 6.8. Characteristics of the episodes of hospital emergencies* among drug users. Spain^, 1996-2010.

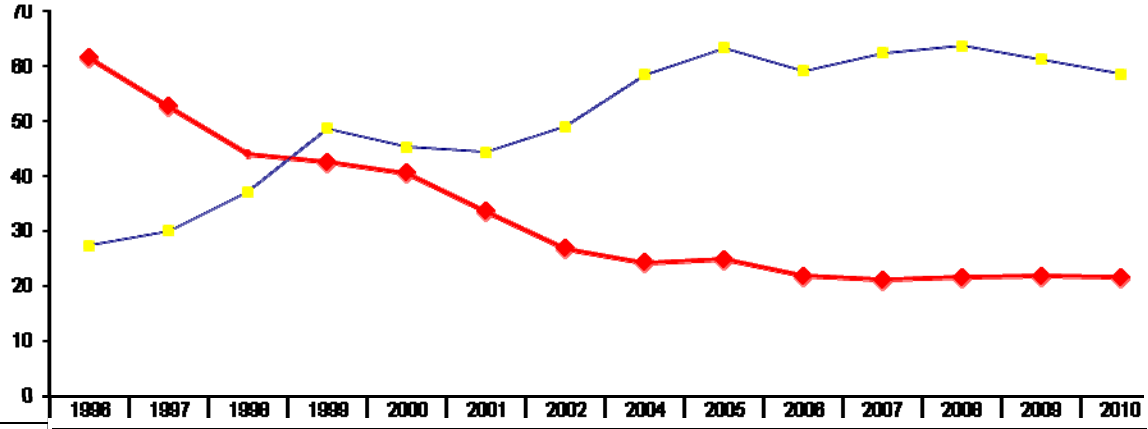
	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008	2009	2010
NUMBER OF EPISODES	2,585	1,932	2,099	2,141	2,328	2,145	2,673	5,828	7,089	7,042	7,822	6,431	5,567	5,626
AVERAGE AGE (YEARS)	27.8	28.1	29.1	29.4	30.3	29.8	29.8	31.0	30.7	31.6	32.0	32.4	32.7	32.6
GENDER (% females)	21.4%	20.8%	23.1%	23.5%	27.4%	27.1%	27.4%	28.0%	25.0%	26.1%	23.4%	22.7%	21.6%	26.3%
ARRESTEES (%)	14.4%	22.4%	11.7%	9.4%	6.4%	5.7%	5.2%	4.1%	4.9%	3.7%	3.8%	4.4%	5.2%	4.2%
FINAL OUTCOME OF THE EMERGENCY (%)														
Medical release	80.5%	82.0%	81.2%	80.9%	78.7%	79.1%	82.1%	81.4%	79.1%	76.2%	79.1%	80.0%	81.0%	79.6%
Voluntary release	7.0%	6.7%	8.8%	8.6%	8.5%	7.5%	7.4%	5.3%	6.7%	8.6%	7.8%	8.5%	8.2%	7.0%
Hospital admission	7.6%	7.2%	6.0%	6.5%	8.3%	7.8%	6.3%	8.0%	8.4%	8.8%	9.0%	7.8%	7.9%	10.2%
Death in emergency services	0.1%	0.1%	0.0%	0.2%	0.7%	0.2%	0.1%	0.0%	0.1%	0.1%	0.0%	0.1%	0.0%	0.0%
Transfer to a different centre	4.8%	4.1%	3.9%	3.9%	3.7%	5.4%	4.0%	5.3%	5.7%	6.3%	4.1%	3.7%	2.8%	3.2%

* Emergencies in which the drug had a bearing on the reason for seeking medical help
^ Autonomous Communities notifying to the emergency indicator
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

The way in which this trend has evolved over the course of time as shown in Table 6.9 reveals one same behaviour for the mentioned and the related substances.

Focusing specifically on the substances mentioned, a major decline is found to exist in the percentage of mentions of heroin, which seems to have stabilized over the past few years at around 21%. The mentions of cocaine show an opposite trend, the number of mentions having been rising since 1996 (27.4%) and having stabilized at around 60%-63%) as of 2005 (Fig. 6.16).

Fig. 6.16. Trend in the percentage of emergencies due to acute reactions following psychoactive substance use with mentions of heroin or cocaine (%). Spain, 1996-2010.



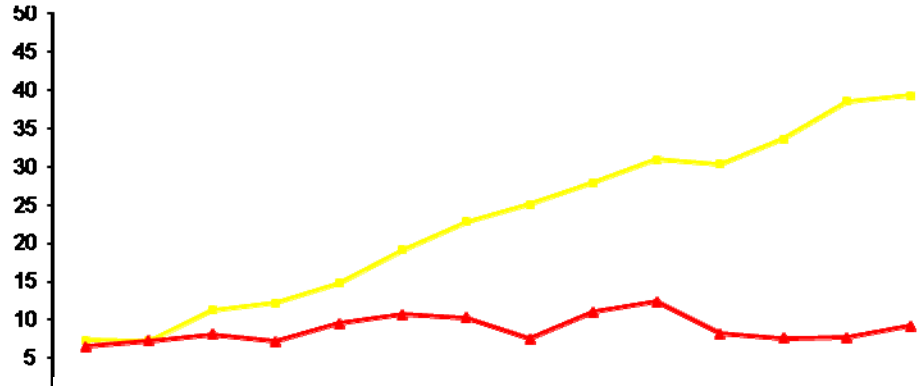
	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008	2009	2010
Heroin	61.5	52.6	43.9	42.5	40.5	33.5	26.8	24.2	24.8	21.8	21	21.5	21.8	21.5
Cocaine	27.4	30	37.2	48.7	45.3	44.4	49	58.5	63.4	59.2	62.4	63.7	61.3	58.6

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

The percentage of mentions of cannabis has risen considerably, having increased from 7.4% in 1996 to 39.3% in 2010. As holds true for all of the other indicators and trends noted in the national surveys, cannabis is present to a great degree in Spain, its presence having consolidated over recent years, now beginning to surpass all others in admissions to treatment and in emergencies.

The percentage of mentions of ecstasy, amphetamines and hallucinogens (combined) peaked in 2006 (12.4%), a decline having begun as of that time, a new slight upward move (9.2%) having been noted in 2010 mainly at the expense of amphetamines (Fig. 6.17).

Fig. 6.17. Trend in the percentage of emergencies due to an acute reaction after using psychoactive substances involving a mention of cannabis or ecstasy/amphetamines/hallucinogens (%). Spain, 1996-2010.



	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008	2009	2010
Cannabis	7.4	7.3	11.3	12.2	14.8	19.1	22.8	25.1	27.9	30.9	30.3	33.6	38.5	39.3
Ecstasy, amphetamines or hallucinogens	6.5	7.3	8.1	7.2	9.5	10.7	10.3	7.5	11	12.4	8.2	7.6	7.7	9.2

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

When analysed separately, the percentages of mentions of amphetamines has shown a slight upward trend over the 1996-2010 period, with some minor variations, remaining relatively stable at around 5% over the last four years and a rise having taken place in 2010, up to 7.5%. Ecstasy has shown some ups and downs over the years for which studied in emergencies, having risen as high as 7.2% in 2006 to then having started a downward trend, down to 3.9% in 2010. The percentage of mentions of hallucinogens remains at relatively low, stable levels at around 2%.

The trend in the percentage of mentions of hypnosedatives is hard to evaluate, especially as of 2002, due to the changes made regarding the data collection criteria among the different Autonomous Communities and the analysis of the information.

Table 6:9. Spread (%) of the substances mentioned and related in the episodes of hospital emergencies* among drug users. Spain^, 1996-2010.

	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008	2009	2010
PSYCHACTIVE SUBSTANCES MENTIONED (a)														
Heroin	61.4%	52.6%	43.8%	41.9%	40.5%	33.5%	26.8%	24.2%	24.8%	21.8%	21.0%	21.5%	21.8%	21.5%
Other Opiates	17.3%	26.2%	23.3%	23.4%	20.9%	21.9%	17.7%	14.0%	13.6%	13.7%	15.0%	14.7%	14.0%	12.6%
Cocaine	27.3%	29.9%	37.2%	48.1%	45.3%	44.4%	49.0%	58.5%	63.4%	59.2%	62.4%	63.7%	61.3%	58.6%
Amphetamines	3.1%	3.3%	3.4%	2.7%	2.6%	4.6%	3.8%	3.0%	4.8%	5.4%	4.8%	5.2%	5.6%	7.5%
MDMA & Derivatives	1.6%	2.7%	2.9%	3.1%	4.8%	5.2%	6.3%	4.2%	5.7%	7.2%	5.8%	5.0%	3.2%	3.9%
Hypnosedatives	25.7%	21.6%	26.1%	25.1%	30.6%	32.0%	34.1%	27.7%	24.6%	28.3%	23.5%	21.3%	20.8%	22.6%
Cannabis	7.4%	7.3%	11.3%	12.2%	14.8%	19.1%	22.8%	25.1%	27.9%	30.9%	30.3%	33.6%	38.5%	39.3%
Hallucinogens	2.7%	2.2%	2.9%	2.1%	2.9%	2.4%	1.4%	1.2%	2.0%	2.4%	2.3%	2.0%	3.2%	2.6%
Volatile substances	0.3%	0.1%	0.5%	0.1%	0.3%	0.9%	0.3%	0.7%	0.5%	0.4%	0.5%	0.5%	0.6%	0.5%
Alcohol	13.3%	15.8%	22.9%	22.0%	29.5%	33.8%	39.0%	36.3%	39.0%	42.9%	41.9%	44.6%	47.4%	42.1%
Other substances	5.1%	3.6%	6.0%	2.0%	0.8%	2.8%	4.5%	12.5%	4.7%	9.3%	10.5%	3.3%	2.7%	3.5%
RELATED PSYCHOACTIVE SUBSTANCES %) (b)														
Heroin	56.1%	50.9%	38.7%	33.0%	35.3%	29.2%	21.4%	17.5%	19.0%	16.9%	16.9%	17.2%	17.2%	17.8%
Other Opiates	13.5%	17.4%	16.8%	18.9%	18.0%	17.4%	13.1%	9.1%	8.3%	8.5%	8.1%	7.5%	7.7%	6.7%
Cocaine	19.9%	25.0%	31.6%	39.4%	40.9%	40.5%	44.7%	50.0%	55.5%	51.1%	53.8%	55.1%	51.1%	49.5%
Amphetamines	2.2%	2.9%	3.0%	9.8%	2.2%	4.2%	3.4%	2.3%	4.2%	4.7%	4.2%	4.4%	4.6%	5.5%
MDMA & Derivatives	1.3%	2.2%	2.2%	2.4%	4.5%	4.4%	5.3%	3.2%	4.7%	6.4%	5.0%	4.2%	2.4%	2.9%
Hypnosedatives	23.6%	18.9%	24.3%	23.8%	28.9%	29.2%	30.1%	22.3%	17.0%	21.0%	15.8%	15.6%	16.5%	16.7%
Cannabis	6.2%	6.6%	8.9%	9.3%	12.8%	16.9%	19.9%	19.3%	21.7%	23.9%	22.9%	24.7%	29.5%	30.5%
Hallucinogens	2.1%	1.8%	2.4%	1.7%	2.7%	1.9%	1.3%	0.8%	1.7%	1.7%	2.0%	1.6%	2.6%	1.7%
Volatile substances	0.2%	0.1%	0.3%	0.1%	0.3%	0.9%	0.2%	0.6%	0.5%	0.4%	0.5%	0.5%	0.5%	0.4%
Alcohol	12.4%	15.2%	22.2%	20.0%	26.8%	29.0%	35.4%	30.7%	32.3%	36.0%	35.7%	37.3%	40.2%	36.3%
Other substances	4.1%	3.2%	4.9%	1.3%	0.8%	1.6%	1.8%	8.7%	3.3%	4.9%	6.0%	1.8%	1.2%	1.8%

* Emergencies in which the drug had a bearing on the reason for seeking medical help
^ Autonomous Communities notifying to the emergency indicator
a) Substances mentioned: Including the drugs which are mentioned on the record, whether or not related to the emergency (regular or sporadic use)
b) Related substances: The drugs related to the emergency in question (statements made by the physician are included on the clinical record making it possible to relate the emergency to the use) are selected from among the drugs mentioned.
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Emergency Indicator.

In short, cocaine and cannabis are found to be present to a great degree in the emergencies related to psychoactive substance use. Heroin seems to have stabilized at around 20%, but the serious consequences associated with opiates in general and with heroin in particular make it necessary to keep a very close watch on these substances.

6.4. DRUG-RELATED DEATHS AND MORTALITY OF DRUG USERS

Psychoactive substance use-related mortality is important due to the fact that it is a reflection of the social and health-related impact of psychoactive substance use.

It is complicated to collect information on the deaths indirectly related to the use of psychoactive substances in the routine information systems with a wide-ranging geographical base because, in these cases, death is often the result of a complex interaction among several factors, one of which is drug use, the most important one being the most readily-identifiable, and because in some types of death (i.e. in accidents), the presence of these substances is not systematically investigated and, in other cases (i.e. cocaine infarction), drugs are not stated as the main cause of death, although they have been a determining factor in the death in question.

In order to find out the deaths secondary to drugs, there are currently two sources of information in Spain: on one hand, a Specific Death Registry due to acute reactions to drugs and, on the other, the General Death Registry. A description is provided in following of the methodology and the main results of each one thereof and the resulting estimate on combining the two.

1. SPECIFIC REGISTRY

1.1. Methodology

Description:
This is a specific Death registry serving the purpose of collecting information on deaths involving judicial intervention in which the direct, main cause of the death is an acute adverse reaction following intentional, non-medical use of psychoactive substances (exception alcohol and tobacco).

Coverage:
The population coverage at the geographical level has been increasing progressively. In 2010, a total of 14 of the 19 Autonomous Communities existing in Spain notified data, which would total approximately somewhat over half of Spain's population. The characteristics of the population of these Autonomous Communities can be considered representative of all of Spain as a whole. This indicator initially began functioning systematically in 1990, although partial information as of 1983 is available.

Mechanism for collecting information on the death indicator:
The primary source of information is from the Anatomical Forensic Institutes, Coroners, National Toxicology Institute and University Legal Medicine Departments which notify the data to their Autonomous Communities, said data then being sent thereby to the Spanish Government Delegation for the National Plan on Drugs' Spanish Monitoring Centre on Drugs database.

A detailed protocol is in place describing the variables to be included, the way in which they are to be included and the inclusion and exclusion criteria. A summary is provided in following of the most important aspects of this protocol.

Variables:
The data collection sheet is comprised of 26 variables, some of which have several sections. The information collected includes:

1. Enrolment information (number of the coroner's report or autopsy, toxicological report number, number of prior formalities, institution collecting the information, number of the court processing the case, city/town and province of the court in question).
2. Socio-demographic information (gender, date of birth, city/town and province of birth, nationality, city/town and province where resided, marital status, date of death, city/town and province of death)
3. Information concerning the body and drugs (provenance of the body, clinical criteria and signs from the autopsy indicative of an acute reaction due to drug use, forensic diagnosis of death, evidence of suicide, signs of venipuncture or anti-HIV antibodies).

Criteria for inclusion:
A case is selected and included in the registry if it meets any of the following four criteria for inclusion:

1. Evidence of recent use of psychoactive drugs. This evidence may be of several types:
   - Clinical evidence of acute intoxication by psychoactive substances immediately prior to the death which are recorded on some document (hospital report, clinical record, etc.).
   - Outer physical signs of recent administration of psychoactive drugs (recent venipunctures, presence of psychoactive substance residue in mouth, nasal passages, stomach, etc., solvent odour in hair on head, breath or clothes, etc.).
   - Presence of psychoactive substances or utensils for using the same at the place of death (needle /syringe or other injecting utensils, aluminium foil, pipe, empty pill bottle, glue can or aerosol sprays, lighter refills, plastic bags for inhaling, etc.).
   - Recent use (within the 7 days immediately prior to death) reported by family members or detected by the coroner in a recent legal medical expert opinion or care concerning the person now deceased.
2. Presence of positive toxicological analysis for some recordable substance.
3. Anatomopathological findings from autopsy indicative of death due to recent use of some psychoactive substance.
4. Existence of a forensic diagnosis of death due to an acute reaction to some psychoactive substance.

Criteria for exclusion:
According to the definition initially set out, the following types of deaths are excluded:

1. Deaths in which there is no judicial intervention or forensic study as to the causes with a written record of the results. However, toxicological analyses not being conducted is not a reason for exclusion, although the availability of the results of these analyses is highly advisable. Deaths not related to the use of psychoactive substances. However, the deaths caused by disorders which may have been worsened or complicated by the recent use of psychoactive substances are not excluded, provided that they meet the criteria for inclusion.

2. Deaths *indirectly* related to the use of recordable psychoactive substances, in other words, those in which the use of a psychoactive drugs has been a contributing factor but not the main or major cause of the death.

For this reason, the deaths due to the following causes are not included:

- Infectious diseases presumably acquired as a result of drug use (AIDS, endocarditis, hepatitis, septicaemia, tetanus, etc.).
- Homicides of any type, although the deceased were to be under the influence of psychoactive substances, were to be caused in the course of activities related to drug trafficking or drug use or the murderer were to employ psychoactive substances to cause the death.
- Accidents of any type (occupational, household, traffic, etc.) in individuals under the influence of psychoactive substances, except those deaths caused directly by acute intoxication or poisoning with these substances.

- Suicides (hanging, falling to one's death, drowning, shooting, etc.) On the other hand, the deaths caused directly by acute, self-inflicted poisoning or intoxication with psychoactive substances are included.
- Deaths due to inadvertent or unintentional exposure to or intake of psychoactive substances.
- Deaths due to adverse reactions to properly prescribed and administered psychoactive pharmaceutical products or medicines. The deaths due to an acute reaction to psychoactive substances in persons in methadone maintenance programs are included unless it can be demonstrated that all of the psychoactive drugs taken by the deceased have been properly prescribed and administered.
- Deaths due to a chronic disease related to drinking alcohol and deaths due exclusively to acute alcohol intoxication (drunkenness).

1.2. Results

The main results from the mining of the Specific Death Registry in Spain for the 1983-2010 period are provided in following:

General characteristics of those deceased due to an acute reaction following the use of psychoactive substances

Table 6.10 provides a summary of the general characteristics of those individuals who died due to an acute reaction after using psychoactive substances in Spain within the 2003-2010 period.

A total of 83.9% of the deceased were males, compared to the 16.1% who were females. This male predominance has been a constant trait since the very beginning of this series. The average age in 2010 was 39.8 years of age, an upward trend having been noted as of 2003. A total 24.8% were within the 40-44 age range, 26.5% being over 45 years of age. A total of 61% of the individuals on whom information was available were single. In 77.4% of the cases, evidence existed of recent use of some substance, 70.4% having shown no signs of veinpuncture. In most of the cases (90.3%), there was no evidence of suicide. In relation to other disorders, in 31.4%, the death was due to a previously-existing disorder which was worsened by the use of substances, and a total 34.4% were HIV-positive.

Taking into account the limitations of the estimate, the most frequent profile of death due to an acute reaction to psychoactive substances could be said to be that of a single male over 40 years of age having no previously-existing disorder who has recently used some substance and in whom there are no signs of suicide.

Table 6.10. General characteristics of those individuals who died due to an acute reaction following the use of psychoactive substances. Spain*, 2003-2010.

	2003	2004	2005	2006	2007	2008	2009	2010
Number of deaths	493	468	455	428	475	424	438	517
Gender (%)								
Males	85.3	83.9	86.3	84.3	87.4	85.6	84.5	83.9
Females	14.7	16.1	13.7	15.7	12.6	14.4	15.5	16.1
Average age (years)	35.3	37.0	36.1	37.2	38.2	38.1	38.3	39.8
Age group (years)								
15-19	0.8	1.3	1.4	0.9	0.6	1.9	0.7	0.4
20-24	6.7	4.1	6.2	4.2	4.3	6.1	6.4	2.5
25-29	14.6	11.9	11.2	12.9	9.7	10.6	8.0	7.9
30-34	22.6	20.5	20.0	18.0	17.6	16.3	17.4	12.4
35-39	28.2	27.9	28.9	23.8	24.1	22.2	18.9	25.5
40-44	16.9	19.2	20.7	21.3	22.2	19.8	24.9	24.8
>= 45	10.2	15.1	11.6	18.9	21.5	23.1	23.7	26.5
Marital status (%)								
Single	69.4	68.9	68.7	72.0	62.8	61.4	67.3	61.0
Married	19.0	15.6	16.4	12.2	19.1	16.8	15.4	21.6
Separated/Divorced	10.5	14.4	13.7	13.6	17.4	18.9	15.0	15.9
Widowed	1.0	1.1	1.1	2.2	0.7	2.9	2.3	1.5
Provenance of body (%)								
Home	54.5	55.2	58.1	52.3	60.6	60.0	61.9	64.3
Hotel-Boarding House	5.3	5.1	6.2	5.8	4.6	3.9	5.9	4.3
Street	18.5	17.4	13.5	20.1	13.1	15.8	11.8	14.0
Public establishment	1.8	1.3	2.5	4.8	2.4	1.7	2.8	2.6
Hospital	10.6	9.5	6.4	7.7	5.7	6.8	6.1	3.9
Prison	1.1	3.5	4.8	3.9	3.7	4.9	4.0	3.7
Other	8.2	8.1	8.5	5.3	9.8	7.0	7.3	7.1
Evidence of recent use (%)								
Yes	85.6	92.6	94.4	92.4	85.3	89.0	90.4	77.4
No	14.4	7.4	5.6	7.6	14.7	11.0	9.6	22.6
Evidence of suicide (%)								
Yes	12.1	8.8	5.7	10.8	8.8	9.0	8.5	9.7
No	87.9	91.2	94.3	89.2	91.2	91.0	91.5	90.3
Signs of recent venepuncture (%)								
Yes	53.3	43.0	51.7	40.6	35.2	35.4	39.2	29.6
No	46.7	57.0	48.3	59.4	64.8	64.6	60.8	70.4
Death caused by previously-existing disorder worsened by the use of psychoactive substances (%)								
Yes	35.4	32.6	35.5	28.6	20.4	26.6	30.9	31.4
No	64.6	67.4	64.5	71.4	79.6	73.4	69.1	68.6
HIV antibodies (%)								
Positive	42.7	40.6	42.8	36.9	37.4	40.7	41.1	34.4
Negative	57.3	59.4	57.2	63.1	62.6	59.3	58.9	65.6

* Autonomous Communities which notify to the death indicator (50% of Spain's population)
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Drug-Related Deaths Indicator
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Trends of the deaths due to an acute reaction following the use of psychoactive substances, according to the type of substance. Spain 1983-2010.

Fig. 6.18 shows the trend in the deaths due to an acute reaction following the use of psychoactive substances in Spain within the 1983-2010 period. The data provided is that of the percentage of deceased individuals in which each one of the substances or metabolites to which related were identified in the toxicological analyses.

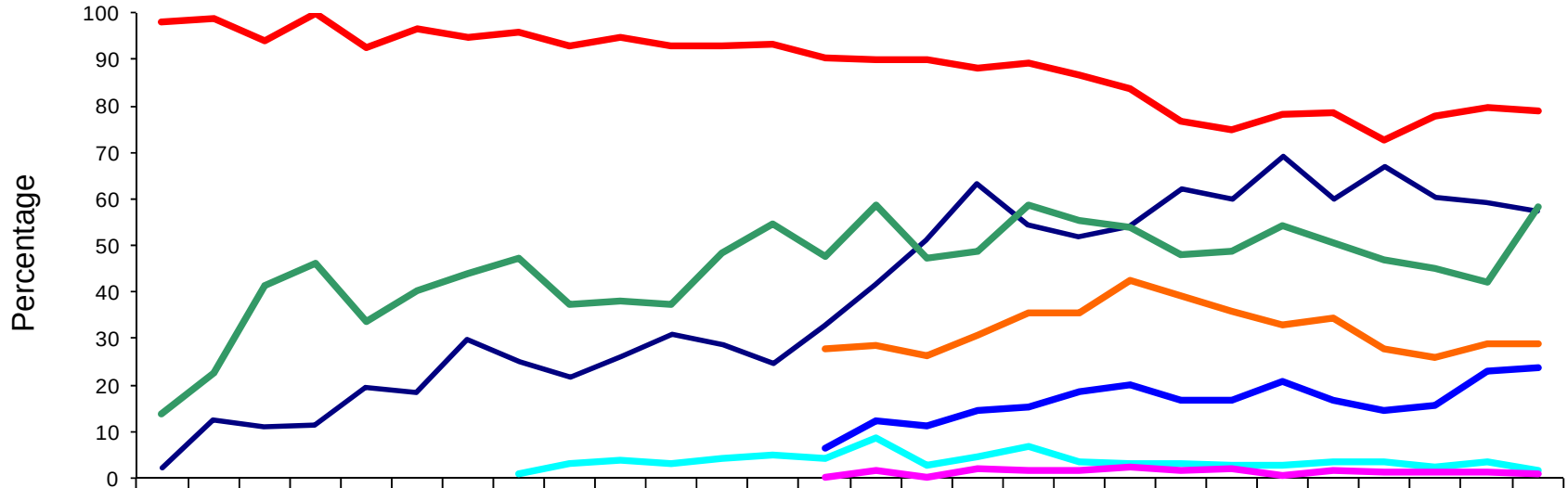
In 2010, opioids were the substance identified in the largest number of deceased individuals (79.1% of the samples), the upward trend which began in 2007 (72.8%) having continued. It is necessary to monitor how this trend evolves.

Hypnosedatives break with the downward trend which began in 2005, showing an abrupt rise and overtaking cocaine, which had been second-ranked over the past few years.

Cocaine continues the downward trend which began in 2007 (67%), being present in 57.3% of the deaths in 2010. Just as for the opioids, it will be necessary to see how these figures evolve over the next few years.

Poly-use of substances is the pattern most often found among those who have died due to an acute reaction to psychoactive substances.

Fig. 6.18. Trend in the percentage (%) of death due to an acute reaction following the use of psychoactive substances, according to the type of substance detected in the toxicological analysis. Spain*, 1983-2010.



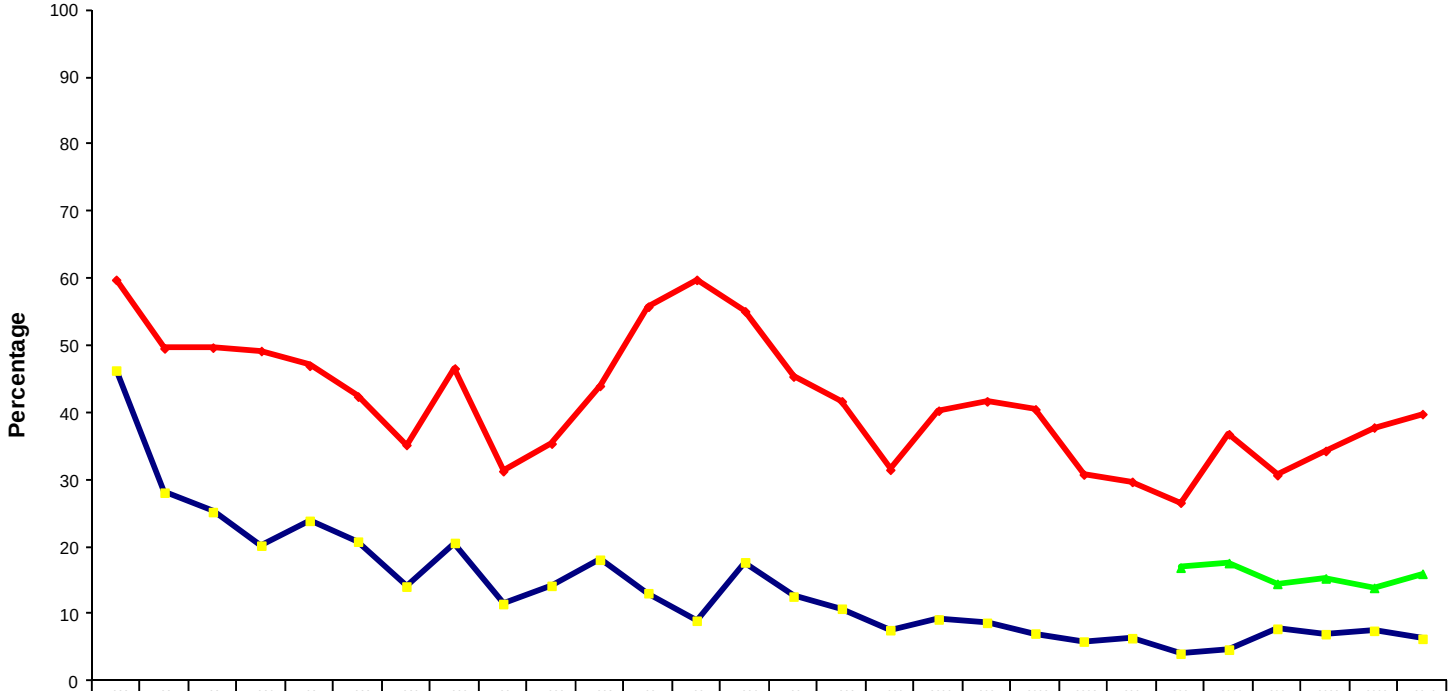
	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Opioids	98	98,8	93,9	100	92,4	96,6	94,8	96	93,1	94,9	92,8	92,9	93,4	90,4	89,8	90,1	88	89,4	86,8	83,8	76,7	74,9	78,20	78,7	72,8	77,7	79,8	79,1
Cocaine	2	12,5	11	11,5	19,3	18,4	29,6	24,8	21,6	26	30,9	28,8	24,7	32,7	41,4	51,2	63,3	54,4	51,7	54,2	62,2	60,1	69,20	60	67	60,2	59,1	57,3
Hypnosedatives	13,7	22,5	41,5	46	33,8	40,2	43,8	47,4	37,2	37,9	37,4	48,4	54,8	47,7	58,6	47,4	48,8	58,5	55,2	54	48	48,7	54,10	50,7	46,9	45,1	42,2	58,4
Amphetamines								1	2,9	3,8	3,2	4,3	4,9	4	8,6	2,8	4,5	6,9	3,4	2,9	3,1	2,6	2,60	3,6	3,6	2,2	3,5	1,5
Cannabis														6,5	12,2	11,3	14,3	15,2	18,7	20	16,7	16,7	20,90	16,8	14,6	15,6	22,8	23,8
MDMA														0,1	1,5	0	1,8	1,6	1,5	2,5	1,6	1,9	0,40	1,7	1,1	1,4	1,1	0,8
Alcohol														27,7	28,6	26,2	30,5	35,5	35,3	42,5	39	35,8	33,00	34,3	27,8	25,9	28,8	28,8

* Autonomous Communities which notify to the death indicator (50% of Spain's population)
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Drug-Related Deaths Indicator

Figs. 6.19 and 6.20 show the trend over the course of time in the data related to opioids and cocaine in greater detail, evaluating individually, in the case of the opioids: "opioids and no cocaine", "only opioids" and "opioids plus benzodiazepines". In the case of cocaine, the presence of "cocaine and no opioids", "only cocaine" and "cocaine with alcohol" are assessed.

An upward trend is found to exist, having begun recently (2007-2008) in the deaths in which “only opioids” or “opioids with substances other than cocaine” are detected. The downward trend in the deaths in which cocaine is detected seems to have slowed. It will be necessary to see how this evolves over the next few years.

Fig. 6.19. Trend in the percentage (%) of deaths due to an acute reaction to psychoactive substances in the toxicological analyses of which “opioids and no cocaine”, “only opioids” and “opioids plus benzodiazepines” are detected. Spain*, 1983-2010.

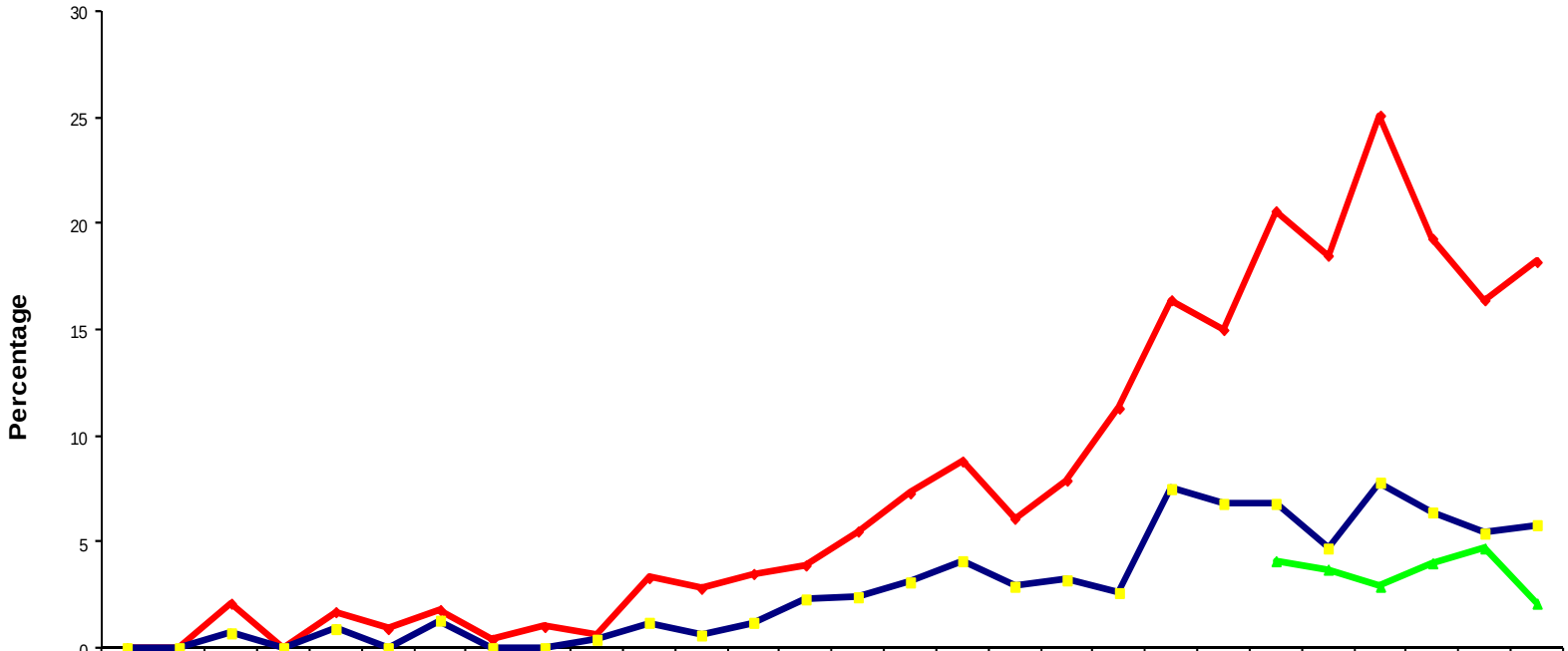


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Opioids and no cocaine	59,8	49,6	49,7	49,2	47	42,4	35,2	46,6	31,3	35,4	44	55,8	59,8	55,1	45,4	41,7	31,5	40,3	41,7	40,5	30,8	29,7	26,6	36,8	30,7	34,3	37,8	39,8
Only opioids	46,3	28,1	25,2	20,2	23,9	20,8	14,1	20,6	11,5	14,2	18,1	13,1	9	17,7	12,6	10,8	7,6	9,2	8,7	7,1	5,9	6,4	4,1	4,7	7,8	7	7,5	6,3
Opioids, benzodiazepines and/or alcohol																							16,9	17,6	14,5	15,3	13,9	16

* Autonomous Communities which notify to the death indicator (50% of Spain’s population)

SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Drug-Related Deaths Indicator

Fig. 6.20. Trend in the percentage (%) of deaths due to an acute reaction to psychoactive substances in which “cocaine and no opioids”, “only cocaine” and “cocaine with alcohol” are detected in the toxicological analyses. Spain*, 1983-2010.



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Cocaine and no opioids	0	0	2,1	0	1,7	0,9	1,8	0,4	1	0,6	3,3	2,8	3,5	3,9	5,5	7,3	8,8	6,1	7,9	11,3	16,4	15	20,6	18,5	25,1	19,3	16,4	18,2
Only cocaine	0	0	0,7	0	0,9	0	1,3	0	0	0,4	1,2	0,6	1,2	2,3	2,4	3,1	4,1	2,9	3,2	2,6	7,5	6,8	6,8	4,7	7,8	6,4	5,4	5,8
Only cocaine and alcohol																							4,1	3,7	2,9	4	4,7	2,1

Autonomous Communities which notify to the death indicator (50% of Spain’s population)
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Drug-Related Deaths Indicator

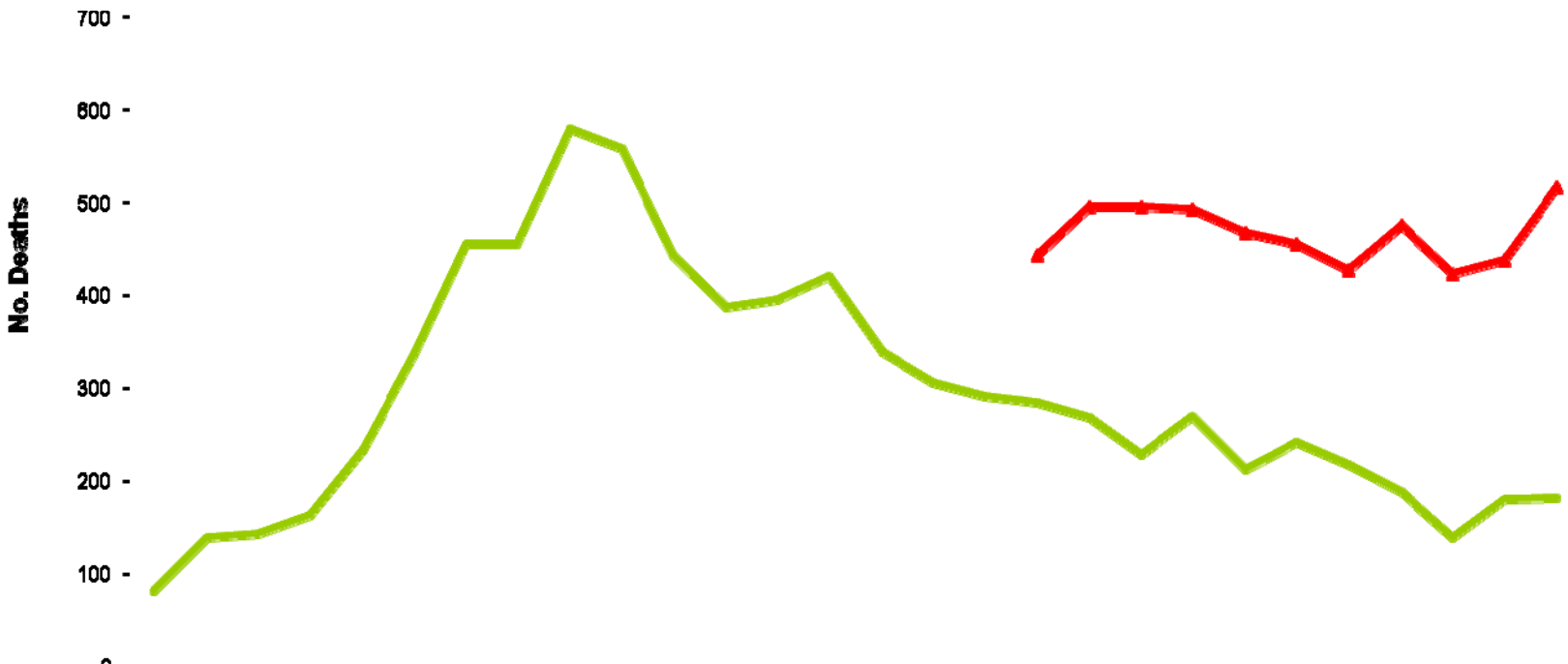
Trend in the deaths due to an acute reaction to the use of psychoactive substances. Spain 1983-2010

Fig. 6.21 shows the trend over the course of time for the deaths due to an acute reaction following the use of psychoactive substances in Spain.

The Autonomous Communities which notify the death indicator are not the same ones every year. Therefore, Line 1 shows the data from the Autonomous Communities which notify to the indicator (different ones depending on the year in question), and Line 2 shows the six Spanish cities which notify constantly, thus making the data more homogeneous. These six cities are those of the judicial districts of Barcelona, Bilbao, Madrid, Seville, Valencia and Zaragoza, it being advisable to explain that, for Seville, the data is estimated for the 1997-2000 and 2005-2006 periods, being estimated for Zaragoza for the 2003-2004 period. On the other hand, up until 1995, information was collected solely on the deaths due to an acute reaction to opioids or cocaine.

The results show that, overall, following the rapid rise noted during the 1980's associated with injecting use of heroin, a downward trend has been noted in the deaths, having continued in 2010.

Fig. 6.21. Trend in the deaths due to an acute reaction following the use of psychoactive substances. Spain [1, 2] 1983-2010.



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
1. Autonomous Communities death indicator																		444	498	496	493	488	455	428	475	424	438	517
2. Six Spanish cities	82	139	143	183	234	337	455	465	579	558	444	398	395	421	339	308	291	284	288	229	270	212	242	218	188	139	181	182

1. Autonomous Communities which notify to the death indicator (50% of Spain's population)
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Drug-Related Deaths Indicator

2. Selection of six cities from the judicial districts of Barcelona, Bilbao, Madrid, Seville, Valencia and Zaragoza.
SOURCE: Spanish Observatory on Drugs and Drug Addiction. Government Delegation for the National Plan on Drugs. Drug-Related Deaths Indicator

2. GENERAL DEATH REGISTRY

2.1. Methodology

In Spain, the National Institute of Statistics[16] (INE) keeps a general death registry including the causes of death classified as per ICD-10. The death-related databases are prepared in collaboration with the Autonomous Communities. The primary source of information are the Civil Registers, which furnish the National Institute of Statistics delegations with death reports on a monthly basis, The latest death database available at the national level is that of 2010.

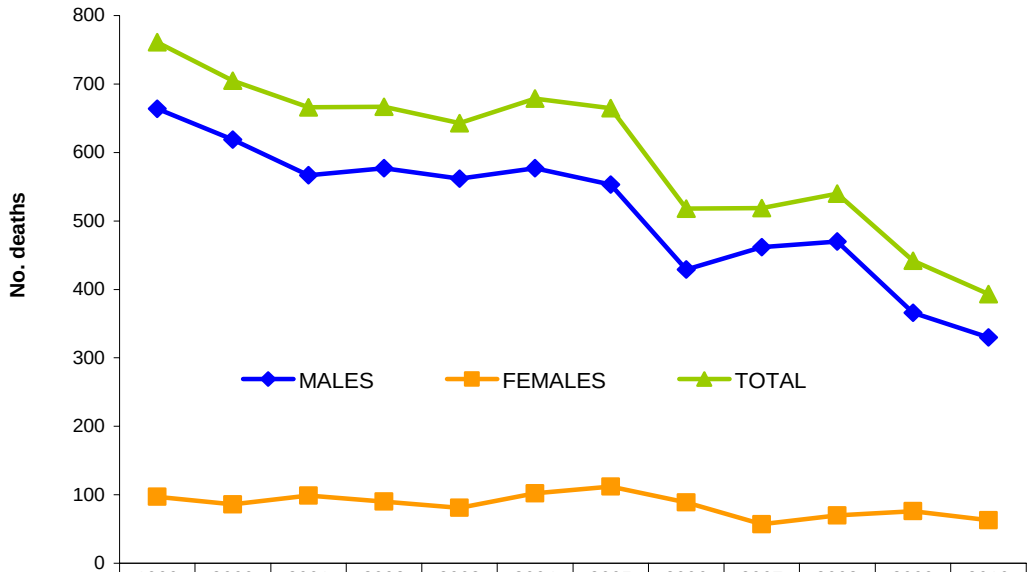
An analysis of the death rate is provided in following by selecting the ICD-10 codes proposed by the European Monitoring Centre for Drugs and Drug Addiction[17], which includes ICD-10 codes: F11-F12, F14-F16, F19, X42, X62, and Y12. The X44 code is added to these codes in order to adapt to the Spanish context. This last-mentioned code includes the cases of accidental poisoning due to exposure to drugs and is used a great deal in Spain for encoding deaths due to "overdose".

2.2. Results

Fig. 6.22 shows the trend in the number of deaths in Spain due to the use of psychoactive substances, broken down by genders, for the 1999-2010 period.

In 2010, a total of 393 deaths were encoded under the aforementioned ICD-10 codes. For the 1999-2010 period, a downward trend and male predominance is noted (82.8% in 2010).

Fig. 6.22. Trend in the number of deaths due to the use of psychoactive substances*, broken down by genders. Spain, 1999-2010



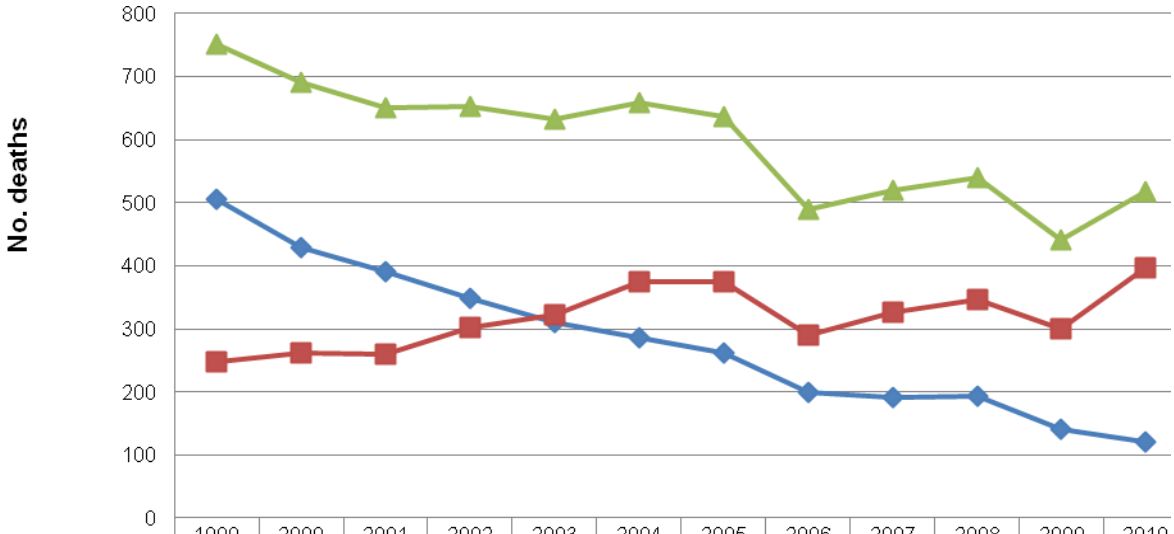
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
MALES	664	619	567	577	562	577	553	429	462	470	366	330
FEMALES	97	86	99	90	81	102	112	89	57	70	76	63
TOTAL	761	705	666	667	643	679	665	518	519	540	442	393

* ICD-10 Codes: ICD-10:F11-F12, F14-F16, F19, X42, X44, X62, Y12.
Source: Data from the General Death Registry. National Institute of Statistics.

[16] National Institute of Statistics. http://www.ine.es/
[17] The DRD-Standard, version 3.0 EMCDDA *Scientific Report*. EMCDDA/P1/2002. http://www.emcdda.eu.int.

Fig. 6.23 shows the trend in the number of deaths in Spain due to the use of psychoactive substances, broken down by ages, within the 1999-2010 period. Generally speaking, an upward trend is noted in the average age of the deceased individuals.

Fig. 6.23. Trend in the number of deaths due to the use of psychoactive substances* broken down by ages. Spain, 1999-2010.



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
<35	505	429	391	349	310	285	262	200	192	193	141	120
>=35	247	262	259	303	323	374	374	289	327	347	301	397
Total	752	691	650	652	633	659	636	489	519	540	442	517

* ICD-10 Codes: ICD-10:F11-F12, F14-F16, F19, X42, X44, X62, Y12.
Source: Data from the General Death Registry. National Institute of Statistics.

3. ESTIMATE OF MORTALITY BASED ON THE SPECIFIC DEATH REGISTRY AND THE GENERAL DEATH REGISTRY.

3.1. Methodology

To date, the results from two sources of information have been presented, the Specific Death Registry and the General Death Registry, but both have limitations. In order to attempt to minimize these limitations in the results, an estimate has been made of deaths based on the information available.

The Specific Death Index provides data on deaths from the notification made by the Autonomous Communities which notify this specific registry, but not all of the Autonomous Communities notify to this registry, some of the Autonomous Communities which do notify also not doing so for all of the judicial districts, but doing so by cities for areas which may vary from one year to the next, this therefore being a highly specific registry but one which does not have nationwide coverage and there being variations in the Autonomous Communities which do notify, depending on the year in question.

The General Death Registry does have nationwide coverage and although the quality of this death registry be good, generally speaking, an under-registration is known to exist in the deaths which the drug had a secondary bearing.

Therefore, to estimate the number of drug-related deaths at the national level, the specificity of the specific death registry is combined with the wide-ranging coverage (nationwide) of the General Death Registry. For this purpose, an under-registration factor is calculated as a result of dividing the deaths notified by the Specific Registry by the death from the General Registry, selecting solely the deaths in those cities/provinces[18] which periodically notify to both registries. Fig. 6.24 provides a diagram as to how this estimate is made.

Fig. 6.24. Diagram for the calculation of the estimate of the deaths due to illicit drugs in Spain.

$$\text{Estimate of deaths due to illicit drugs in Spain} = \text{Deaths due to illicit drugs from the General Death Registry} * \text{Under-registration factor}$$

$$\text{Under-registration factor} = \frac{\text{Specific Death Registry Deaths (selection}^{4}\text{ of cities/provinces)}}{\text{General Death Registry Deaths (selection}^{4}\text{ of cities/provinces)}}$$

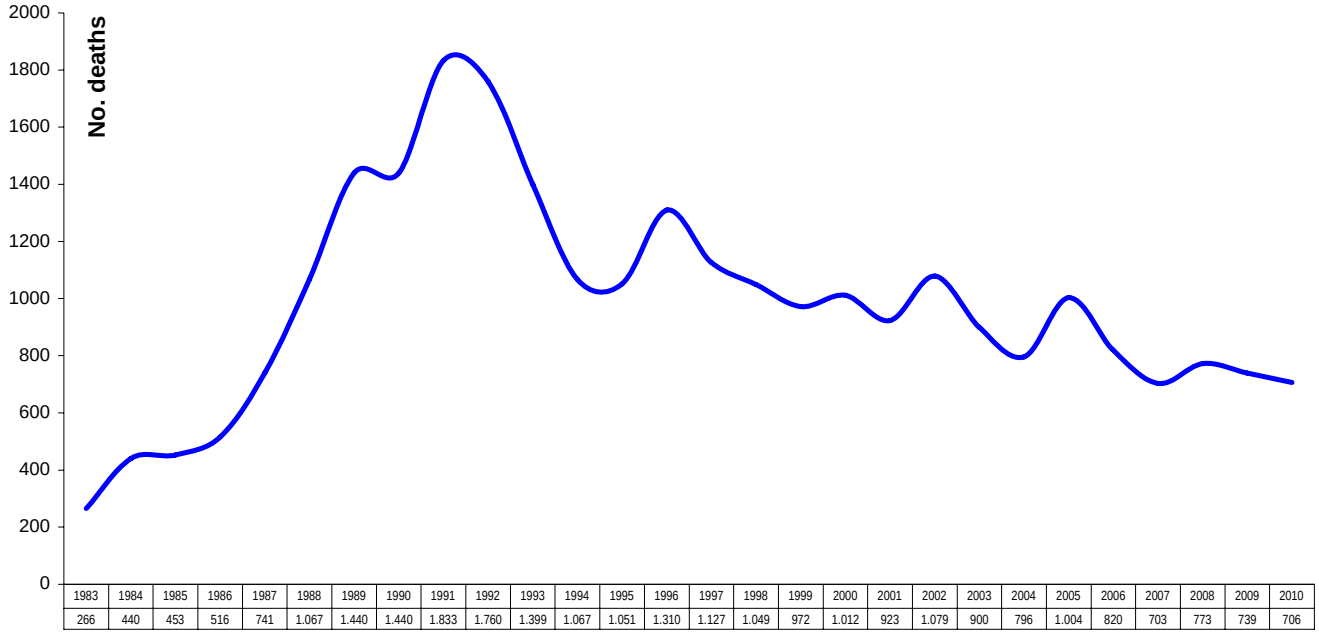
By applying this factor, the under-registration is corrected by approximately 40%, but it is known that the use of illicit drugs heightens the probability of dying due to different causes, the repercussion on the general death rate having been found not to be properly reflected. Therefore, this estimate refers to the minimum number of deaths secondary to the use of illicit drugs, this figure possibly being higher. More specific studies (cohort studies, proportional death rate studies, etc.) could contribute further information of major interest.

3.2. Results

Fig. 6.25 shows the data from the estimate of deaths due to illicit drugs at the national level within the 1983-2010 period. A downward trend is found to be continuing following the peak at the beginning of the 1990's. In 2010, 706 deaths are estimated, a total of 382,047 deaths having occurred in Spain that year.

18 Province of Álava, Province of Guipúzcoa, Province of Vizcaya, City of Bilbao, Province of La Coruña, Province of Lugo, Province of Orense, Province of Pontevedra. Autonomous Community of Murcia. Province of Ávila, Province of Burgos, Province of León, City of Ponferrada, Province of Palencia, Province of Salamanca, Province of Segovia, Province of Soria, Province of Valladolid, City of Valladolid, Province of Zamora, Province of Seville, City of Seville, Province of Málaga, City of Málaga, Province of Granada, City of Granada, City of Palma de Mallorca, City of Madrid, City of Getafe, City of Leganés, City of Majadahonda, City of Barcelona, City of Valencia, City of Zaragoza, City of Pamplona, City of Las Palmas de GC, City of Sta. Cruz Tenerife, City of Badajoz, City of Cáceres

Fig. 6.25. Estimate of the total number of deaths due to illicit drugs. Spain 1983- 2010.



1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
266	440	453	516	741	1.067	1.440	1.440	1.833	1.760	1.399	1.067	1.051	1.310	1.127	1.049	972	1.012	923	1.079	900	796	1.004	820	703	773	739	706

SOURCE: Specific Death Registry of the Spanish Monitoring Centre for Drugs and the General Death Registry of the National Institute of Statistics.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

7.1. INTRODUCTION

In general, the data provided in following refers to 2010, being the latest data available to date. In those cases in which the information refers to 2011, express mention thereof is provided.

As previously mentioned, the care provided for drug users is dispensed, mainly, at public centers or publicly-funded private centers. In the latter case, Non-Governmental Organisations (NGOs) are the ones managing the centers.

These centres provide treatment help and care for drug users. They also contribute to reducing the morbimortality and the healthcare-related and social problems associated with drug abuse by way of carrying out treatment programmes which are carried out at different types of centres, mention of which has already been made in other reports and in Chapter 5 of this document (outpatient care centres, hospital detoxification units, therapeutic communities, etc.)

As far as the specific resources for providing care for drug-dependent individuals is concerned, care was provided at outpatient centres for drug dependencies for a total of 93,294 people, this being a figure similar to that of 2009, which was 93,283. Care was provided for these patients at 526 outpatient centres.

Care was provided for a total of 7,596 users in the 128 therapeutic communities in existence in Spain in 2010, having meant a 6.62% drop compared to the 8,134 of 2009. Regarding residential treatment, additional information may be found in the Selected Issue “Residential Treatment for Drug Users in Europe”.

In the case of the hospital detoxification units, care was provided for a total of 3,984 patients in 2010, meaning a 15% rise compared to the 3,463 in 2009. There are 53 hospital detoxification units in Spain.

7.2. PREVENTION OF DRUG RELATED EMERGENCIES AND REDUCTION OF DRUG-RELATED DEATHS

As previously stated, the 2009-2016 National Drug Strategy includes risk reduction and harm reduction among its objectives.

The population groups which have the benefit of these programmes, which are also aimed at preventing drug-related emergencies and deaths, are:

- Drug user population sectors not subject to being included in abstinence-oriented programmes.
- Long-term heroin users.
- Population groups in a situation of marginalization or social exclusion (i.e. individuals living in marginal districts, groups connected with the “drug markets”, etc.).
- Groups which frequent places or take part in situations in which drug use is particularly easy.

In Spain, there are different types of centres and resources serving the purpose of preventing drug-related emergencies and reducing drug-related deaths.

Worthy of special note are the mobile units which go to different places where there are marginal drug users who do not come in to the treatment centres in order to furnish them with socio-sanitary support and prevent drug-related emergencies (outreach programmes). The 30 mobile units that were providing service in 2010 dispensed care for a total of 9,653 users.

These mobile units also total 8.09% of the methadone-dispensing points. This substance is always prescribed by a qualified professional.

In short, the mobile units are multipurpose, generally walk-up-access vehicles, the missions of which include: carrying out opiate replacement (methadone) treatments, taking samples, running diagnostic tests, providing first aid and preventing or aiding in drug use-related emergencies, as well as taking action in cases of danger of drug-related deaths.

The objectives of the drug consumption facilities are:

- To offer a target population comprised of intravenous drug users outside of the care-providing circuits preventive-educational interventions, emergency care and referral to other resources.
- To reduce the most frequent infections, the transmission of HIV and viral hepatitis.
- To identify emerging disorders.
- To reduce the number and consequences (mortality) of acute drug reactions.
- To facilitate access to the socio-sanitary networks.
- To lighten the social impact of intravenous drug use in public areas.
- To facilitate sterile materials, help for hygiene, food, first-aid, vaccines, etc.

The fact that they can inject themselves at these facilities is, although important, neither the main nor the sole reason for their existence. The important thing is that they will be able to contact professionals able to provide them with advice concerning the existing resources for providing care for their drug addiction and, in any case, improve their living conditions and health while they remain addicted.

Also, in view of the high degree of marginality of this subgroup of drug addicts, they are offered additional help, such as educational workshops on hygienic intravenous drug use and preventing overdoses.

In 2010, eight safe injection or “drug consumption facilities” were operating in the Autonomous Communities of Catalonia (6), Madrid (1) and the Basque Country (1), having provided care for a total of 8,217 injecting drug users. This figure means a 37.4% decrease compared to the 13,124 of 2009, due mainly to the major drop in the figure for the users for whom care was provided at these facilities in Catalonia.

Also the social emergency centres, which main purpose is to take in the drug-dependent population with the greatest problems regarding marginalization, they provide for their basic needs and put them in touch with other more demanding resources in the care-providing network and were operating in Spain throughout 2010. Specifically, 41 of these centres have provided care for 10,705 users.

Regarding the harm reduction aspect, these social emergency centres set priorities for the strategies aimed at reducing adverse drug reaction-related deaths as well as the prevalence of HIV infection and other disorders among opiate and cocaine users.

Apart from the above, the role of the 1,526 pharmacies which have programmes of this type is also fundamental. These pharmacies participate in some cases in dispensing methadone and in other cases in the needle and syringe exchange programmes.

In any case, one must bear in mind regarding the aforementioned harm reduction programmes which take part in the prevention of drug-related emergencies and in reducing deaths that the users of these programmes may possibly have been provided with care through more than one of these facilities in 2010, it therefore not being possible to add up the total number of users.

7.3. PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

As is well-known, the shared use of needles and at-risk sexual practices contribute to spreading different infectious diseases.

On the other hand, different research studies have revealed that the persons who inject themselves with drugs change their at-risk practices if they are provided with training and counselling, as well as the necessary tools for putting more hygienic behaviours into practice. This is the reason why many countries (including Spain) are stepping up those interventions making it possible to contact injecting drug users for the purpose of trying to modify the risky behaviours for their own health and that of those around them.

In Spain, the harm reduction programmes mentioned above are involved in the prevention and treatment of infectious diseases by way of the care provided to patients who are active drug users who come into these programmes.

Of special interest in this regard are the needle and syringe exchange and dispensing programmes, as well as the dispensing of sanitary kits (these kits usually include, in addition to a needle and syringe, disinfectant liquid, condoms, etc.) which are carried out in both outreach programmes as well as in more institutionalized centres and resources.

These programmes offered for the injecting drug user population for the purpose of reducing, insofar as possible, the risk of transmissible infections associated with the shared or simply unhygienic use of the injecting material.

Similarly, these programmes also afford the possibility of making early HBV and HBC diagnosis, HAV and HBV vaccinations and carrying out overdose prevention measures.

In 2010, the needle and syringe exchange programmes dispensed 2,672,324 needles and syringes through 1,029 exchange points.

Likewise, the drug consumption facilities mentioned in the preceding section herein take part in the prevention and treatment of drug use-related infectious diseases.

Maintenance programmes with opiate agonists (methadone and other substances)

In Spain, the legal framework of the methadone maintenance programmes (MMPs) is regulated by way of the Royal Decree of January 19, 1990 and Royal Decree 5/1996. The legislative framework regulates the methadone-dispensing facilities in the different Autonomous Communities and Autonomous Cities and specifies that, in each one thereof, there shall be a Commission for the accreditation of the centres and services which take care of carrying out these programmes.

As mentioned in other reports, a growing number of opiate-dependent (especially heroin-dependent) individuals in our country have been progressively joining substitution programmes from 1990.

In Spain, the methadone maintenance programmes provided care for 81,022 patients in 2010, meaning a 4.12% rise compared to the 77,811 in 2009.

These treatments were carried out in a total of 2,526 methadone-prescribing or methadone-dispensing facilities.

As far as the location of these facilities is concerned, 50.59% are located in a specific drug dependence treatment centre, 10.62% at prisons, 8.23% at hospitals, 8.09% in mobile units, another 8.09% at mental health centres, 7.65% at health centres, 3.73% in pharmacies and 3% in other facilities.

Also worthy of special mention is the fact that Buprenorphine+Naloxone (Suboxone®) having recently been included as one of the National Health Service benefits, having made the use thereof affordable in a patient profile stabilised on methadone, at low doses and good progress.

In Spain, Suboxone® is a medicine subject to special medical prescription (psychotropic) and to restricted medical prescription, classified as a substance of hospital diagnosis.

According to the data furnished (2011) by the Autonomous Communities and Autonomous Cities, a total of 1,350 individuals have been treated with buprenorphine/naloxone (suboxone). This figure is an initial estimate and will therefore have to be revised and updated.

7.4. RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS

Regarding the alcoholism care programmes, a total of 411 outpatient centres were in operation in 2010, having provided care for 61,231 patients, 70 hospital units having provided care for 3,162 and 57 non-hospital residential centres having provided care for another 3,133 individuals.

One must bear in mind that in the Mental Health network and in Primary Care, care is also provided for patients with alcohol abuse problems who have not been counted in the aforementioned figures.

Similarly, the Autonomous Community Plans on Drugs provided care in 2010 for individuals affected by drug use through other programmes: 77 programmes providing care for women, with 5,889 users; 95 programmes providing care for minors, care having been provided for 2,246 minors; 88 dual diagnosis care programmes, with 11,090 patients and psychostimulant user care programmes, with 3,766 users.

Psychiatric co-morbidity

As reported in the 2011 Report, the care provided for psychiatric co-morbidity is provided both at the centres providing drug user care and at the mental health centres. In 2010, as far as solely specific drug user care centres is concerned, the Autonomous Administrations reported the existence of 88 programmes for dual diagnosis care, which has provided care for 11,090 drug-dependent patients with psychiatric co-morbidity.

Traffic accidents

As previously mentioned in other reports, all of the Autonomous Communities and Autonomous Cities carry out activities for the purpose of preventing and reducing traffic accidents and the consequences thereof, particularly with regard to their relationship with driving under the influence of alcohol or other drugs.

In 2011, the breathalyzer tests performed on drivers by the Spanish Civil Guard Traffic Division (Ministry of the Interior) were stepped up yet further, more than five million of these preventive tests having been conducted, a total of 1.82% of which tested positive. As shown in the following

table, this percentage has undergone a major progressive decrease over recent years, although showing a slight rise in 2011.

Table 7.1 Breathalyzer Tests 2004-2011. Preventive tests. Spanish Civil Guard Traffic Division

	2004	2005	2006	2007	2008	2009	2010	2011
Preventive check tests	2,282,336	2,856,244	3,347,015	3,759,574	4,417,645	5,105,660	4,550,158	5,049,271
Positive	76,560	73,747	82,729	80,155	81,322	90,306	81,390	91,914
% testing positive	3.35%	2.58%	2.47%	2.13%	1.84%	1.77%	1.79%	1.82%

SOURCE: Spanish Civil Guard Traffic Division

Regarding the drivers who died in traffic accidents who had surpassed a 0.3 g/l blood alcohol level, special mention must be made of the drop in the percentage of these fatalities. In fact, in 2004, the percentage of drivers who died in traffic accidents who had surpassed this blood alcohol level over the total number of drivers who died on whom a toxicological analysis was conducted was 36.1%, whilst this percentage was lowered to 32.76% in 2011.

Regarding illicit drugs, the results of the toxicological analyses conducted on these drivers show a slight rise within the 2004-2011 period, having stabilized in 2009-2010. However, in the 2004-2011 period, there was an almost six-point rise in the percentage of drivers who died whose analyses revealed the presence of psychotropic drugs. The aforementioned data is detailed in the table provided in following as follows:

Table 7.2 Drivers who died in traffic accidents on whom analyses were conducted.Spain: 2004-2011

	2004	2005	2006	2007	2008	2009	2010	2011
Drivers who died on whom analysis was conducted	1,349	1,401	1,360	1,259	975	923	855	702
Percentage tested positive	42.1	41.39	37.2	39.31	39.79	41	42.46	45.01
% Positive blood alcohol levels (blood alcohol level>0.3g/L)	36.1	34.12	30.44	30.82	30.97	30	30.99	32.76
% Tested positive for illicit drugs	10.75	12.2	11.4	13.02	10.67	12.35	12.51	15.10
% Tested positive for psychotropic drugs	3.85	4.28	5.51	5.95	6.97	8.45	8.3	9.54

SOURCE: National Institute of Toxicology and Forensic Science.
Note: The sum of the three bottom rows of percentages having tested positive (blood alcohol level, illicit drugs and psychotropic drugs) is greater than the "Percentage tested positive" row because cases of polyconsumption were detected in some of the drivers analysed.

8. SOCIAL CORRELATES AND SOCIAL REINTEGRATION

8.1. INTRODUCTION

As in previous reports, the data provided in this section has been furnished by the seventeen Autonomous Communities and the Autonomous Cities of Ceuta and Melilla of which the Spanish State is comprised.

Very few programmes and resources mentioned in Table 8.1 under the heading of Education/Training Programmes and Employment Programmes quantify the users gaining access thereto as drug-dependent individuals, given that this is a matter of social reintegration resources for marginalized individuals or those at serious risk of social exclusion, regardless of whether or not they have any drug use-related problems.

A description is provided in following of the different types of resources and programmes available in Spain as far as social reintegration is concerned:

1. Social reintegration facilities. These facilities are physical spaces in which activities classified as social reintegration activities are carried out. They may be residential or non-residential.

Non-residential: Facilities in which reintegration activities or programmes are carried out on an outpatient basis:

- Treatment centres with reintegration activities and/or programmes. Including care treatment.
- Centres for reintegration activities and/or programmes, where no care treatment is provided.

Residential: Residential facilities are those providing lodging for drug-dependent individuals who are undergoing care treatment or who have completed the same but who need this resource before starting out living completely on their own. The modalities most used are:

- Therapeutic communities: residential centres with therapeutic treatment and reintegration programmes or activities.
- Flats, whether supervised or unsupervised. Taking a small number of drug-dependent individuals, the work of the educator, especially in supervised flats, usually being quite intensive.
- Residences: Differing from the flats mainly in size. This is a type of resource used very little in Spain.

2. Education and training programmes. Programmes and activities for the purpose of providing training, no matter what the type: academic, occupational, professional, social skills, etc.

Standard courses: Homologated by the Public Education System: School-Leaving Certificate; Baccalaureate; College Entrance; University Degree, etc.

Non-standard courses: Do not lead to an academic diploma but rather are for an integrating purpose both due to the knowledge taught and the acquisition of social skills they provide: Computer science; driver's license, etc.

Employment information, counselling and job-hunting actions**:** The objective is to get a job. These actions have been carried out a great deal in recent years by the Autonomous Communities with the creation of Services that train drug-dependents for hunting and getting a job and, at the same time carrying out a major mediating and monitoring activity with a view to possible employers.

Vocational training courses: In any case these courses involve an employment contract of any type. Some of these courses worthy of special mention are those organised as part of the Vocational Training and Integration Plans regulated by the respective Autonomous Employment Agencies and those organised by the NGOs or, in general, for groups in situations of social exclusion.

3. Employment programmes. Grouped under this heading are the programmes involving gainful employment by means of an employment contract of any type (apprenticeship, temporary, etc.) or which are a way for individual or cooperative self-employment.

Five groups can be considered:

- "Apprenticeship Workshops"
- "Special Employment Programmes"
- "Contracts Subsidized at Companies"
- "Incentives for Organizing Reintegration Companies"
- "Promotion of Self-Employment" (individual self-employment, cooperatives…)

Apprenticeship Workshops. Contract-based approach to gainful employment, normally apprenticeship (although may be a different type). The employer may be a self-employed individual, small company, NGO, not-for-profit foundation, etc. These workshops generally have to do with manual work. This modality includes Vocational Training Centres, Trade Schools and Employment Workshops, the main contents and functioning of which are regulated by the Public Employment Agencies.

Local Government Employment Programmes. Usually the job exchange most used when providing openings for drug-dependent individuals in the process of rehabilitation who have been referred from the public drug dependence care networks.

Subsidized contracts at companies. Activity aimed at managing openings for employing drug-dependent individuals at companies or entities, for which incentives are normally provided by way of an economic subsidy. Although the name suggests a subsidy, this may also be a regular, constant activity of contacting and mediating with employers.

Incentives for creating "reintegration companies". Companies of this type are based on a share of employment for individuals in a situation of social exclusion. They are usually started up by NGOs and have the economic support of the Administrations.

Promotion of self-employment (individual or cooperative)**.** Aid Programmes for setting up business as self-employed person or for forming cooperatives.

8.3. SOCIAL REINTEGRATION

Table 8.1 includes the data provided by the Autonomous Plans on Drugs regarding the number of social reintegration resources and programmes as well as the clients thereof. As previously mentioned in other reports, the number of clients of outpatient or residential facilities where the reintegration activities are carried out or through which the monitoring of the individual reintegration programmes is performed is not counted so as to avoid the clients of the employment integration and training programmes being counted more than once.

In 2010, the number of outpatient centres with therapeutic treatment, which also have social reintegration programmes decreased (2010: 206; 2009: 320). There was also a drop in the number of residential treatment centres (therapeutic communities) which have social reintegration programmes (2010: 96; 2009: 119).

On the contrary, the number of centres which carry out occupational and social reintegration activities, without offering treatment, has significantly increased (2010: 205; 2009: 126).

The rise in the number of clients counted in employment reintegration resources and programmes is confirmed, probably because social reintegration is been seen more and more as a fundamental aspect involved in the preparation for employment and getting a job, in a situation in which unemployment is on the rise in Spain as a result of the economic crisis. Special mentioned must be made of:

- The consolidation, in 2010, of the employment information, counselling and guidance programmes with 7,023 clients, although the number benefitting from the same has dropped compared to 2009 (8,506).

- As in previous years, the upward trend in the total number of clients of employment programmes continues (13,051 (2009: 12,729).

As regards to the housing needs as support for reintegration, according to the data furnished by the Autonomous Plans, the number of housing facilities increased in 2010, although lodging have been provided for 549 fewer clients than the year before (3,479 persons in 2009; 2,930 person in 2010).

Table 8.1. Social Reintegration programmes. Type, number of programmes and centres and number of cleints. Spain, 2010

	NO. PROGRAMMES AND/OR CENTRES	NO. CLIENTS
Treatment centres w/social reintegration activities and/or programmes	**206**	-
Centres for social reintegration activities and/or programmes (w/o treatment).	**205**	-
Residential treatment centres with social reintegration programmes (therapeutic communities)	**96**	-
Housing facilities	**167**	**2,930**
Education and training programmes	**707**	**7,023**
Employment programmes	**684**	**13,051**

SOURCE: Government Delegation for the National Plan on Drugs. Data provided from the Autonomous Communities and Autonomous Cities Plans on Drugs.

9. DRUG-RELATED CRIME, PREVENTION OF DRUG RELATED CRIME AND PRISON

9.1. INTRODUCTION

The Spanish law enforcement officers continue putting a lot of pressure on the criminals dealing in drug trafficking.

The number of known drug trafficking crimes has continued on the rise starting as of 2005, nevertheless adding up to a very small percentage of the total number of known crimes, around 1.4%.

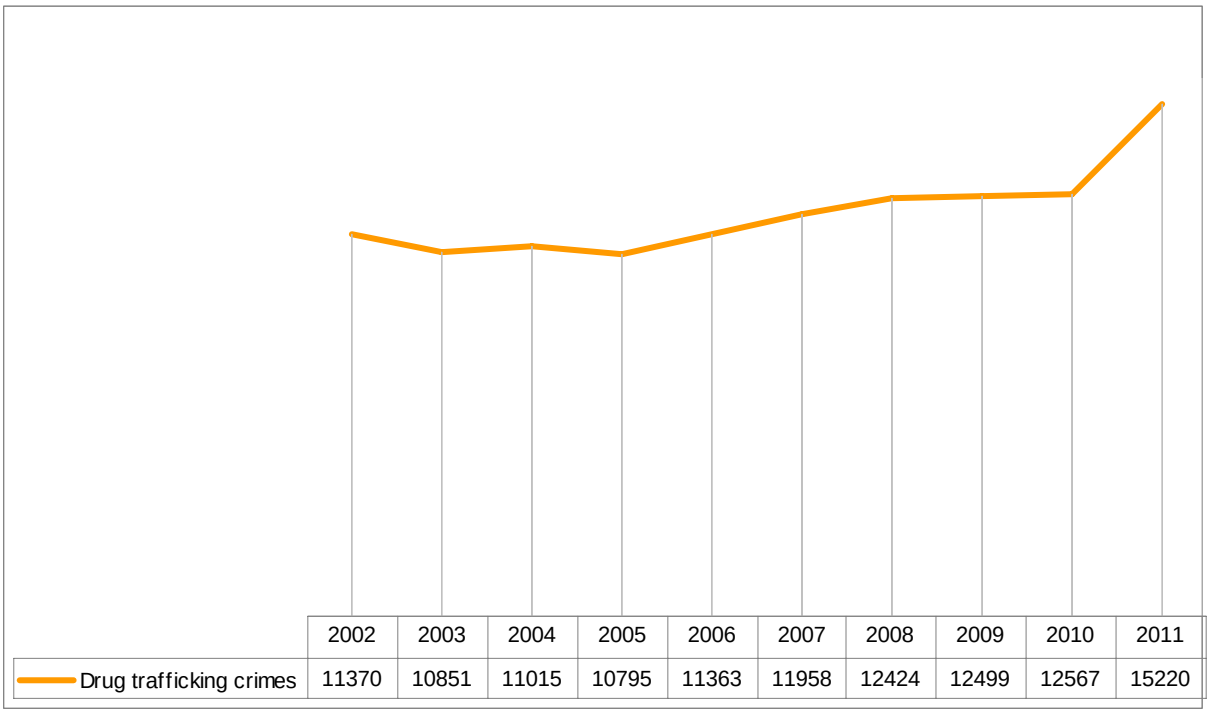
This casuistic is due especially to the greater number of arrests for cannabis trafficking, which gives rise in Spain to the majority of arrests for drug trafficking and the largest number of those reported for drug use or possession in public places.

The Operating Plans against retail drug trafficking, drug possession and public use can be said to be the police response preventing the most visible aspect of the trafficking in these substances.

9.2. DRUG RELATED CRIME

The following graph shows how the number of known drug trafficking crimes has been showing a rising trend over the last ten years. In 2011, the highest figure was recorded for this period, there having been a 21% rise over the year before.

Fig 9.1. Drug trafficking crimes, 2002-2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Drug trafficking crimes	11370	10851	11015	10795	11363	11958	12424	12499	12567	15220

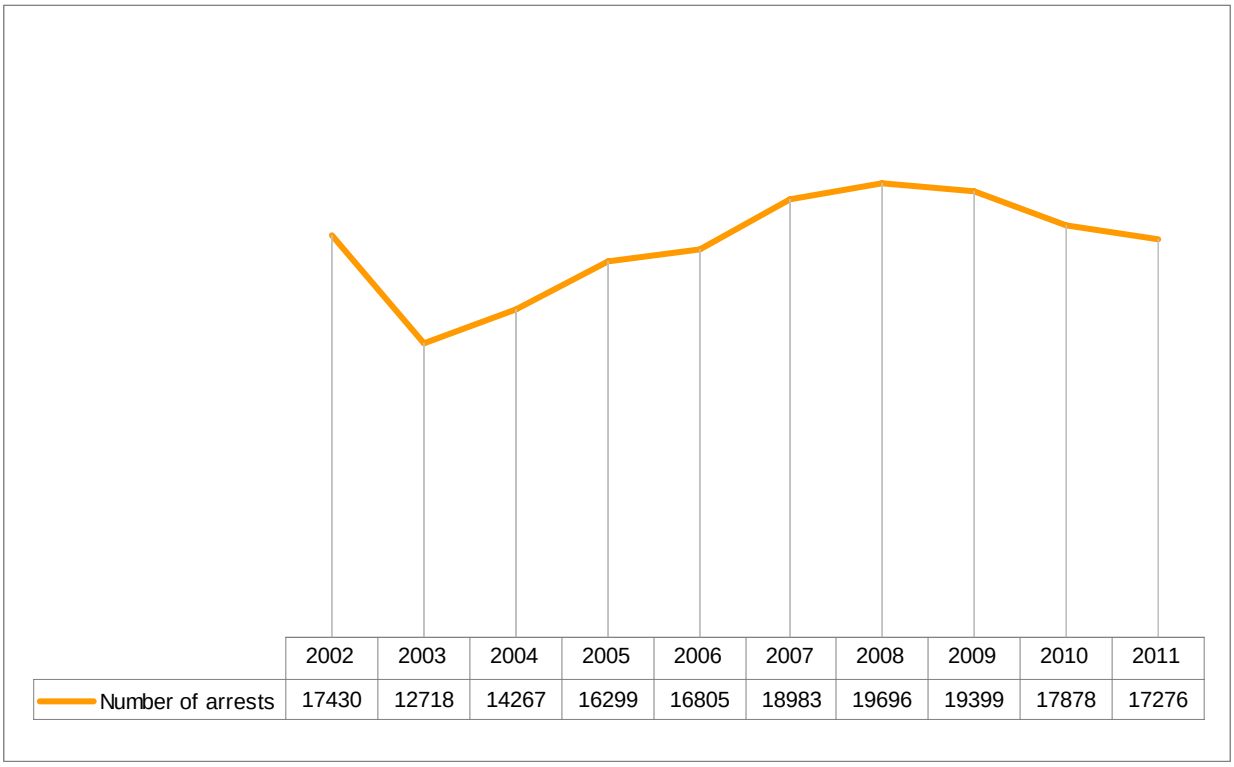
SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

9.3. DRUG LAW OFFENCES

Trend in drug trafficking arrests

As shown in the following graph, the number of arrests related to illicit drug trafficking offenses has dropped by 3.37 percent compared to the year before. This figure is obviously not correlated with the number of drug trafficking offenses committed, which, as previously shown, has undergone, on the contrary, a remarkable increase.

Fig 9.2. Drug trafficking arrests, 2002-2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Number of arrests	17430	12718	14267	16299	16805	18983	19696	19399	17878	17276

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Trend in arrests by drug families[19]

The following graph includes the figures for the last ten years, cannabis and cocaine being shown as the substances for which most arrests are made.

Regarding cannabis, the arrests have risen by 5 percent compared to the year before, maintaining a stable trend. Cannabis derivative drug trafficking leads to the largest number of drug trafficking arrests and has remained at very high figures over the last ten years.

Regarding cocaine, the arrests dropped by 12 percent compared to 2010 and are continuing the downward trend which began in 2008.

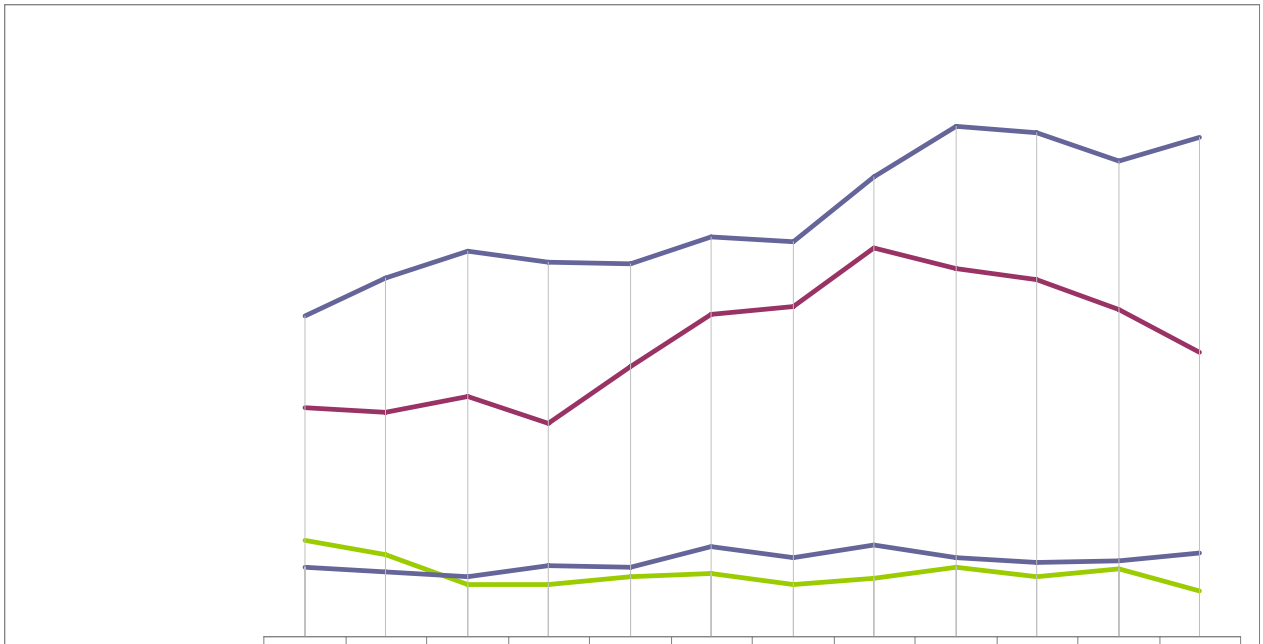
As shown in the table, 2007 was the year when the number of arrests rose all together for all the substances.

[19] The total number of arrests is not equal to the sum of the arrests for each drug family detailed, given that the arrest of a person leading to the seizure of various substances is counted as an arrest for each one of the substances seized that pertain to one same family.

The arrests regarding the opiate family show a 31 percent drop in 2011 compared to 2010, reaching the lowest figure since 2000.

In the arrests for hallucinogens and psychotropic drugs, there was an 11 percent rise over 2010. This increase breaks with the homogeneity in this figure in the year 2009 and therefore with the trend toward consolidating the number of arrests.

Fig 9.3. Arrests by drug families, 2000-2011



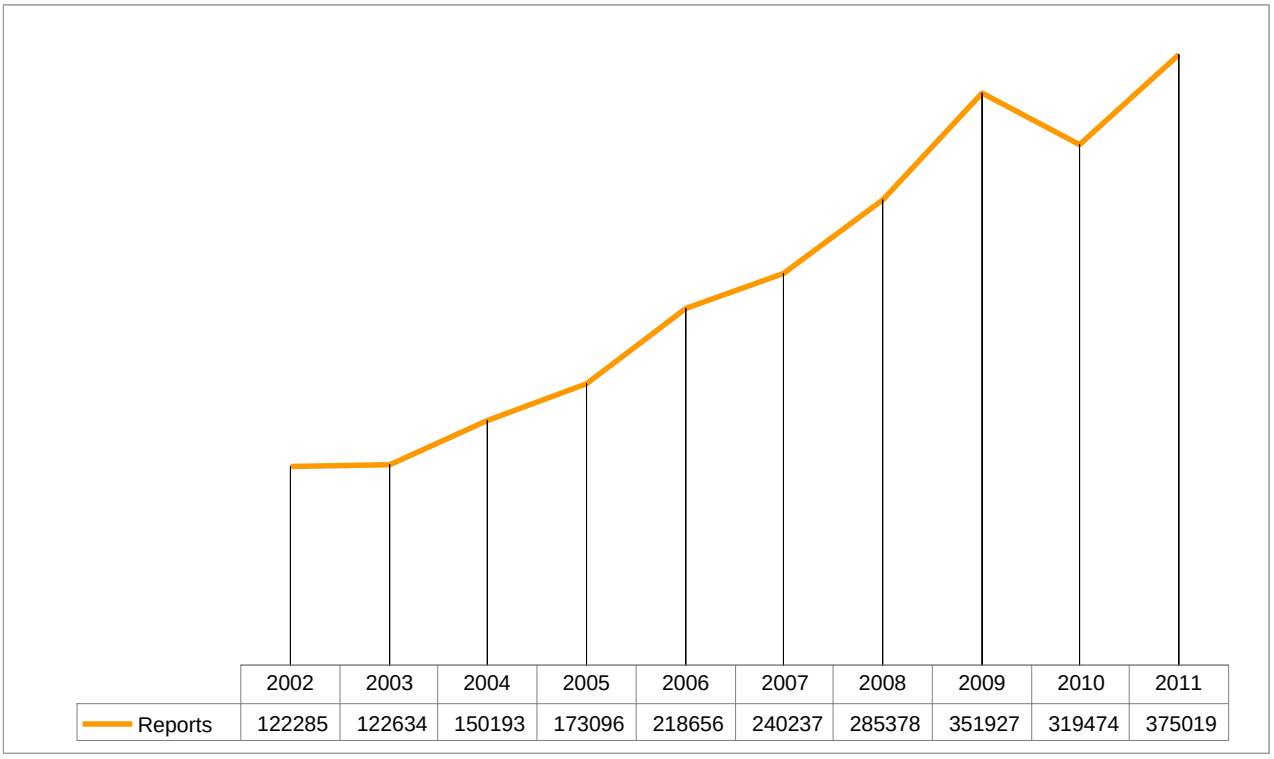
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Cannabis derivatives	7518	8408	9042	8769	8748	9359	9277	10763	11963	11799	11145	11707
Cocaine derivatives	5377	5268	5633	4997	6343	7571	7737	9111	8634	8366	7649	6684
Opiates	2243	1914	1214	1236	1407	1483	1222	1381	1613	1392	1585	1090
Hallucinogens/psychotr.	1617	1513	1408	1680	1626	2095	1858	2161	1859	1755	1760	1959

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Overall trend of the arrests for violation of Organic Law 1/1992 (possession or use of drugs in public)

In 2011, the largest number of police reports in the last ten years were filed, having risen by 17 percent over 2010 and by 6 percent over 2009, which were the years in which the largest number of police reports were filed. The following graph clearly shows the upward trend for these reports.

Fig. 9.4. Police reports, 2002-2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Reports	122285	122634	150193	173096	218656	240237	285378	351927	319474	375019

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Trend of police reports by families of drugs[20]

In 2011, the **number of police reports** by families of drugs has risen, except those related to the opiate group, which have dropped.

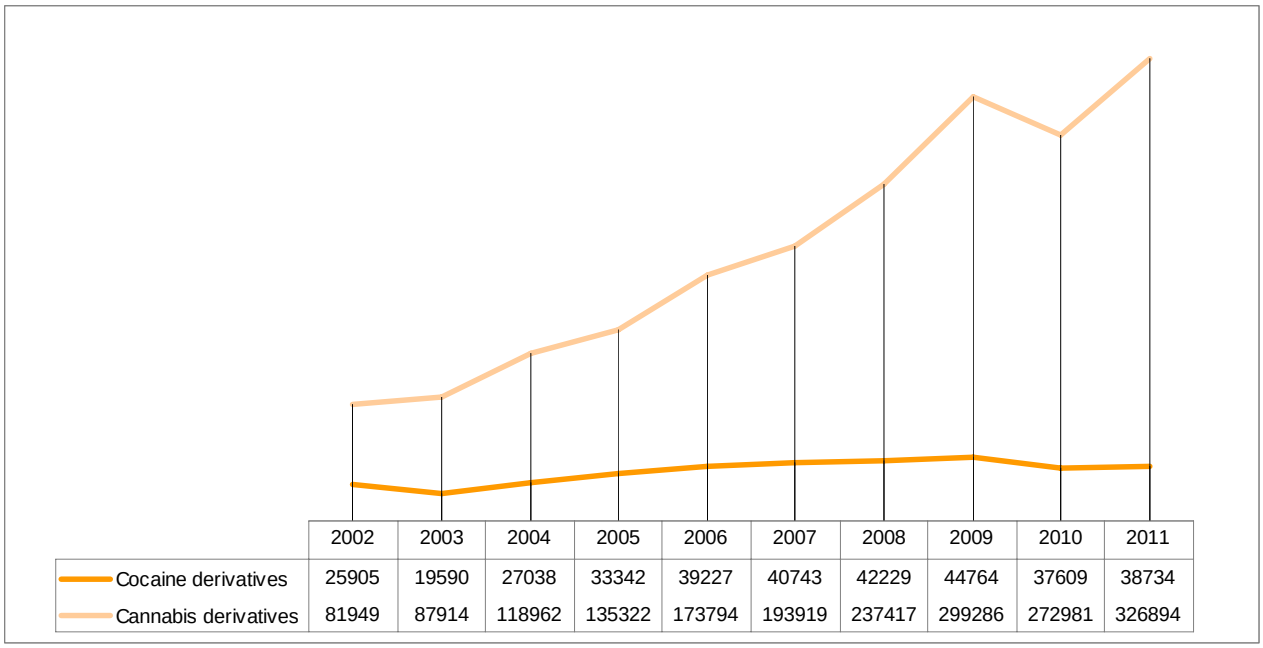
Most of the police reports for possession or public use are for cannabis derivatives, which, following a drop in 2010, rose by 20 percent in 2011.

By comparing the graph of total number of police reports to the cannabis-related police reports, the line connecting these values is almost identical, thus confirming the police reports for cannabis derivatives to be giving rise to the largest number of police reports in the total count.

On this same graph, it is also shown how, following a moderate rise over recent years, the police reports for cocaine derivative use dropped by 16% in 2010 as compared to 2009 to then rise back up by 3 percent in 2011.

[20] The total number of police reports is not equal to the sum of the police reports for each drug family detailed, given that the police report of a person leading to the seizure of various substances is counted as a police report for each one of the substances seized which are from the same family.

Fig. 9.5. Cannabis and cocaine derivatives, 2002-2011



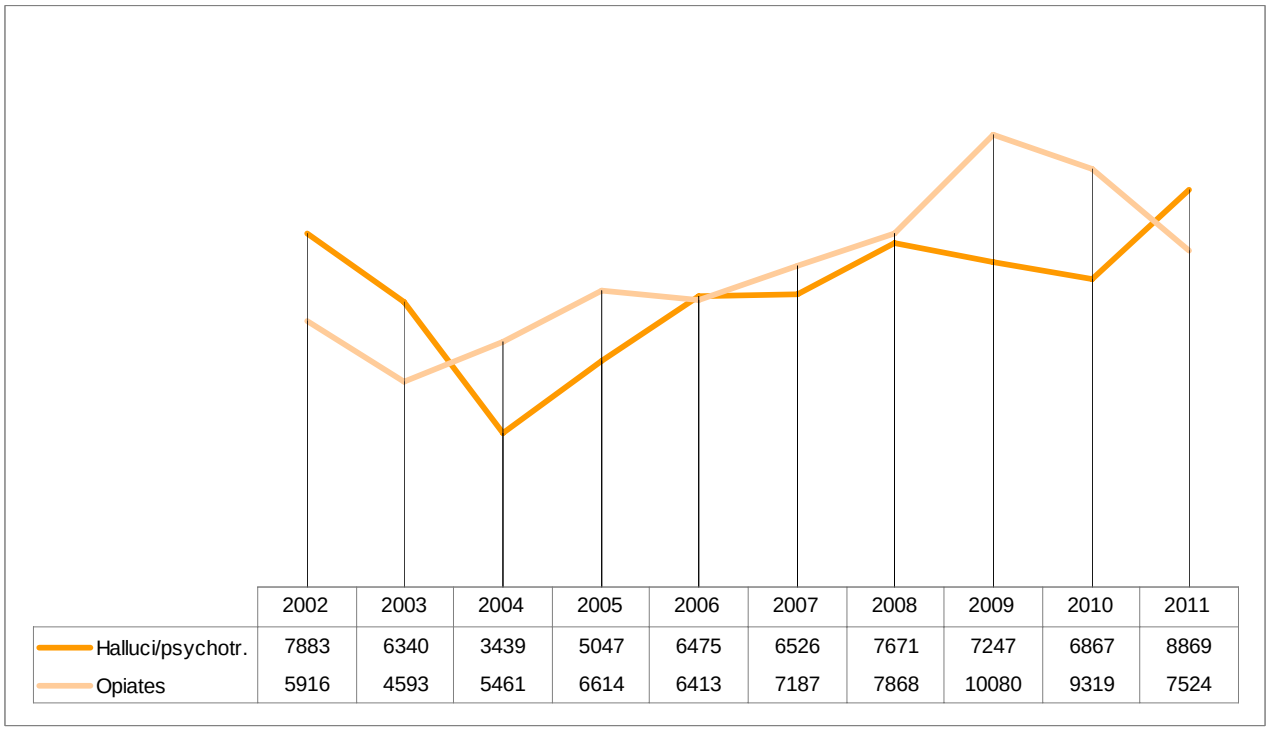
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Cocaine derivatives	25905	19590	27038	33342	39227	40743	42229	44764	37609	38734
Cannabis derivatives	81949	87914	118962	135322	173794	193919	237417	299286	272981	326894

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

The police reports for opiate use dropped by 19 percent in 2011, continuing the downward trend which began in 2009.

The police reports for use of hallucinogens or psychotropic drugs are showing the highest figure for the entire ten-year period, showing a 29 percent rise over 2010.

Fig.9.6. Opiates, hallucinogens and psychotropic drugs, 2002-2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Halluci/psychotr.	7883	6340	3439	5047	6475	6526	7671	7247	6867	8869
Opiates	5916	4593	5461	6614	6413	7187	7868	10080	9319	7524

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

In short, the cannabis derivative-related police reports in 2001 total 87 percent of all police reports, followed by cocaine derivative-police reports, totalling 10 percent; opiates, 2 percent and, lastly, hallucinogens-psychotropic drugs, 2 percent.

9.5. PREVENTION OF DRUG-RELATED CRIME

In 2011, the Operating Plans continued for police response to retail drug dealing and drug use or possession for such a purpose in the areas surrounding schools and in recreational nightlife settings.

These Plans are of an **essentially preventive nature** and, although they are permanent, so, they are in operation throughout the year, there are 4 time spans in which they are carried out as a priority, known as *step-up phases*, in which the police forces reinforce and target the preventive services toward the places of recreational nightlife and the schools and their surrounding areas for the purpose of dissuading retail drug dealing and use.

The results achieved in the four step-up phases carried out in 2011 are provided in the following tables:

Table 9.1. Plan for preventing retail drug dealing and use at "Schools and Surrounding Areas", 2011

Arrested for drug dealing	12
Points of sale deactivated	74
Police reports use/possession	2,187
Drug seizures	2,220
DRUG SEIZURES:	
Heroin (gr.)	11
Cocaine (gr.)	94
Hashish (gr.)	1,652
Marijuana (gr.)	4,892
Amphetamine sulphate-Speed (gr.)	1
MDMA (Ecstasy) (pcs)	33
Psychotropic drugs (pcs)	66

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Table 9.2. Plan for the prevention of retail drug dealing and use in "Recreational Nightlife Establishments", 2011

Arrested for drug dealing	279
Points of sale deactivated	312
Police reports use/possession	39,175
Drugs seized	41,920
Inspections in public places:	5,028
Police reports for allowing drug sale	136
Police reports for allowing admission to minors	20
Police reports for selling alcohol to minors	49
DRUG SEIZURES:	
Heroin (gr.)	360
Cocaine (gr.)	7,437
Hashish (gr.)	119,210
Hash oil (cc)	57
Marijuana (gr.)	155,541
Amphetamine sulphate -Speed (gr.)	2,128
LSD (dose)	251
MDMA (Ecstasy) (pcs.)	2,076
GHB – Liquid ecstasy (cc)	61
Psychotropic drugs (pcs.)	1,780

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

9.6. INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

The 2009-2012 National Strategy on Drugs falls within the framework of the public health policies, the main guiding principles being equity and intersectoriality. Similarly, this Strategy places emphasis, as the target population for the preventive and care-providing interventions, on those groups in particularly vulnerable situations, which include those populations with offense-related legal problems, including underage offenders, and on the prison system and the judicial context as scenarios for intervention.

In this regard, the 2009-2012 Plan for Action sets out as specific actions to be carried out within this scope:

- Validation and unrolling of programmes offered for underage individuals confined in reform centres.
- To promote prevention strategies targeting the prison inmate population being unrolled.
- To support harm reduction workshops being held at prison institutions.

- To collaborate in specifically unrolling drug dependence care programmes for young people confined in juvenile centres or who have had problems with the law.

- To foster the improvement of the quality and expansion of the treatment and reintegration programmes targeting the prison population as well as the alternative measures to prison, placing special emphasis on monitoring subsequent to release from prison.

- To collaborate in unrolling programmes, especially in judicial and police facilities, for offering legal, administrative and social support to those individuals who have committed offenses as a result of their addiction to drugs.

▪ ALTERNATIVES TO PRISON

The Government Delegation for the National Plan on Drugs has continued bolstering the programmes offering legal and social support to individuals who have committed offenses as a result of their addiction to drugs by unrolling a wide-ranging network of support teams for the purpose of implementing the measures aimed at avoiding imprisonment.

Thus, in 2010, the Government Delegation for the National Plan on Drugs has transferred funds to the Autonomous Communities for the consolidation and expansion of the programmes for providing assistance to arrestees at police stations and court facilities (Castile-La Mancha and Galicia); for promoting measures with individuals released from prison or serving their sentences under alternative circumstances (Galicia and Basque Country); and for the support of interventions with drug-dependent inmates (all of the Autonomous Communities).

Special mention must also be made of the transfer of funds to the Autonomous Communities of Andalusia, Castile and Leon and Catalonia for the implementation of programmes for combatting social exclusion and preventing delinquency.

Programmes for Alternatives to Imprisonment. Based on different sources, a description is provided in following aimed at providing an overview of the situation of these measures in our country:

- **Central Government Prison Social Services**. At December 31, 2010, a total of 234,935 sentences of alternative measures had been notified:

    - A total 89% consisted of community service work (CSW). It must be stressed that 76% were applied to road safety offenses and 15% to gender violence offenses. Alcohol abuse is highly prominent in these offense classifications.

    - Nine percent (9%) consisted of suspensions and substitutions.

    - Two percent (2%) consisted of safety measures.

  In 2010, the participation in the Road Safety Awareness Workshops – RSAWs has spread as a way of performing community service work (CSW), the figure amount to more than 48,000 convicts who have served their sentences this way. One must bear in mind that 76% of the individuals sentenced to CSW have been sentenced for road safety offenses, and that 62% of these offenses are for driving under the influence of alcohol[21].

[21] "Study of penal and sociodemographic profile of those sentenced to CSW" conducted by the Office of the Secretary of Prison Institutions

Article 49 of the Penal Code, by virtue of the amendment made by Organic Law 5/2010 of June 22nd[22], authorizes serving community service work sentence by way of the convict taking part in training or re-education programmes or workshops, drivers' education being one of those cited in the text proper.

- **Statistics from the Directorate General of Juvenile Justice of Catalonia**. In 2010, the courts notified this Directorate of a total of 17,319 petitions for enforcement of an alternative measure. A total 3.2% thereof consisted of drug use drug-free treatments for drug-dependent individuals.

  In 55.6% of the alternative penal measures being enforced at December 31, 2010, were on record for highway safety offenses, followed by gender violence offenses (18.94%).

  This data underlines the incidence of alcohol abuse in highway safety crimes, violent crimes, sexual assault, domestic violence and others, due to the disinhibiting effect of alcohol. Therefore, the Secretary General of Prison Institutions has signed an agreement with the Rehabilitated Alcoholics Association for collaboration in the intervention with those convicted for driving under the influence of alcohol-related highway safety offenses.

  Special mention must also be made of the programme for prevention-related intervention of the "Nueva Gente" Association in Salamanca. (A major number of these inmates have profiles of having committed highway safety offenses due to alcohol abuse or dependence). Similarly, the Highway Safety Strategy of Castile and Leon has as one of its objectives that of reducing traffic accidents due to drug use. (In this community, 23.3% of the alternative measures to imprisonment were enforced for alcohol-dependent individuals). Ceuta has also placed priority on preventing the risks involved in drinking and driving under the influence of alcohol.

  At January 1, 2010, a total of 560 inmates were in drug habit cessation treatment in a community resource in enforcement of a third penitentiary grade open prison regime on the condition of residential treatment. In that same year, care was provided for a total of 1,369 inmates in this type of community resources as a result of enforcement of conditional third penitentiary grade (Art. 182 of the Penitentiary Regulations).

Other interventions in the criminal justice system. Underage Offenders. Youths consider themselves to be invulnerable to the harm caused by their choices of behaviours and lifestyles. Nevertheless, drug use causes major physical, psychological and social alterations. The research studies which have been conducted on adolescent brain development show the importance of focusing prevention on youths. It is known that it is highly probably that those who have reached age 21 without having acquired addictions will not acquire addictions later on.

In childhood and adolescence, equal access to quality education is just as important as the family educational level. Therefore, early development interventions must be carried out aimed at preventing inequalities in health during childhood and adolescence.

According to different studies, the interventions that show an impact on the inequalities are those related to housing and employment. In Spain, the Commission for reducing Health-related inequalities has given a leading role to reducing inequalities during the first stages of life[23]. In fact, some ways of organizing economic educational and health-related resources perpetuate and spawn yet further inequalities.

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[22] Organic Law 5/2010 of June 22nd in amendment of the Penal Code regulated highway safety offenses by introducing parole as a safety measure. Parole is imposed in sentencing in conjunction with the prison sentence for the enforcement thereof following release from prison.

[23]. Social inequalities in childhood health. SESPAS 2010

The publication "Success factors associated with intervention programmes with underage offenders"[24] is for the purpose of serving as a reference tool aiding toward achieving a reduction, among the different institutions and professionals involved, in the repeat offender rate by means of the improvement of the intervention programmes on underage offenders.

In 2010, the Delegation continued transferring funds to the Autonomic Plans for the consolidation and expansion of the indicated selective prevention programmes (Aragon, Castile and Leon, Galicia and Basque Country). Similarly, the Autonomic Plans have made a considerable effort to unroll and consolidate programmes offered for this population, the following measures being worthy of special mention:

- **Andalusia**: Community prevention programme "Cities Facing Drugs" devoted to high-risk youths. This programme includes interventions with minors at juvenile protection and reform centres.

- **Asturias**: Carrying out community intervention measures with minors in social conflict and/or who are in problems with the law.

- **Balearic Islands**:
  - Secondary REFORM prevention programme for youths under judicial measures.

- In **Castile and León,** the following programmes are consolidated:
  - Selective prevention programme targeting families of adolescents with behaviour problems (juvenile delinquency, violence, etc.).
  - Programme for intervention with minors at risk of social exclusion, including the intervention programme at the Zambrana reform centre.
  - "Casa-Escuela Pía": capacity for 8 individuals for serving judicial measures
  - Special mention must also be made of the programme for reducing drug use-related traffic accidents as part of the Road Safety Strategy, one of the objectives of which is reducing youth fatalities.

- **Catalonia** continues carrying out selective and indicated prevention strategies and assistance strategies for underage offenders. The Limits programme offered for parents of underage offenders is being consolidated.

- **Extremadura** has gotten under way:
  - The "PIMICA" programme for intervention with underage offenders and minors with behaviour problems subject to measures of confinement in centres.
  - The "PAMICA" programme for educational-therapeutic family intervention with underage minors who have addictive behaviours. Offered for offenders referred by the juvenile court technical teams with a recommendation for educational measure in open environment.

- **Madrid**. Indicated Addiction Prevention Service. This is an Alternative Multi-Strategy Prevention Service aimed at reducing the risk factors and increasing the protection and resistance factors of adolescents and youths who use drugs and show a number of problematic behaviours.

- **Melilla**: Programmes offered for unaccompanied foreign minors residing in juvenile protection and reform centres.

[24] Santiago Redondo Illescas, Ana Martínez Catena Antonio Andrés Pueyo Departamento de Personalidad, Evaluación y Tratamiento Psicológico [Department of Personality, Evaluation and Psychological Treatment] Facultad de Psicología [School of Psychology] Universidad de Barcelona [University of Barcelona*. 2011 of Health, Social Policy

- **La Rioja** is unrolling an intervention programme for underage offenders.

- In **Navarre** the selective and indicated prevention programmes include underage offenders.

- The **Basque Country** carries out selective and indicated prevention programmes. One fourth of those enrolled in these programmes are convicts serving sentences.

The Autonomic Plans on Drugs can be concluded to be providing a response to at-risk situations through the selective and indicated prevention programmes, given the importance which an educational intervention carried out in due time has on preventing repeat offenses. In fact, research studies show a large percentage of the minors who have been confined in reform centres to then later go to prison.

Therefore, the prevention programmes offered for juvenile delinquents do not revolve around drug use, but rather emphasize social and personal vulnerability in unrolling selective and indicated prevention strategies connected with social and educational policies.

Programmes at Police Stations and Court Facilities. Information is provided in following on the individuals with judicial problems for whom assistance is provided by the arrestee assistance services at police stations and court facilities according to the data furnished by the Autonomic Plans on Drugs.

In 2010, assistance was provided for a total of 16,577 users in drug-dependent arrestee assistance programmes. Assistance was provided for a total of 1,794 of these individuals in police station assistance programmes, and 14,783 in court facility assistance programmes. Assistance was additionally provided for a total of 1,308 users in legal aid services.

It must be pointed out that these figures entail an underestimation of the actual number of cases for which assistance was provided, given that not all of the Autonomic Plans have reported data. Most of these resources are funded in full or in part by the Autonomic Plans.

Programmes in Prison Institutions. The studies underline the job position and prison stay as possibly being markers of the lack of social reintegration and of the difficulty of obtaining health system benefits; that any strategy for eradicating social exclusion must include the needs of the inmates who are released from prison; that the areas referred the most more staunchly withstand the social problems that go along with the release of prisoners; and that the prisoners have a high risk of death immediately following their release. Therefore, the interventions during the prison-to-community transition are of key importance.

This is the direction which must serve as the framework for the measures of the Government Delegation for the National Plan on Drugs and the Office of the Secretary General of Prison Institutions for the promotion of the social and occupational integration of prisoners.

Worthy of special note are the intervention programmes of the Autonomic Plans on Drugs with released prisoners:

- Aragón has designed a procedure for homogenizing the treatment of drug-dependent individuals who are in a situation of provisional freedom or who have been released from prison.
- The Canary Island government has implemented a specific legal aid service for inmates on parole.
- Galicia has designed and implemented the “ITINERE” programme for monitoring prisoners released from prison.
- In Catalonia, new circuits have been designed for referrals to assistance resources in the community environment.

9.7. DRUG USE AND PROBLEM DRUG USE IN PRISONS

PRISON POPULATION STATISTICS. Source: Office of the Secretary General of Prison Institutions of the Ministry of the Interior (including Catalonian prison population data).

In recent years, Spain's prison population is associated to a major degree with two relevant and related phenomena: drug trafficking and drug use (including alcohol) and the boom in illegal migratory processes. Our country is with Portugal and the United Kingdom in the groups of countries with the highest incarceration indexes, showing a rate of 162 incarcerations per 100,000 inhabitants (January 1, 2020).

At December 31, 2010, there were 73,929 individuals incarcerated in Spain, compared to the 76,079 in 2009. Figure 9.7 provides the characteristics of the inmate population for the 2000-2010 period:

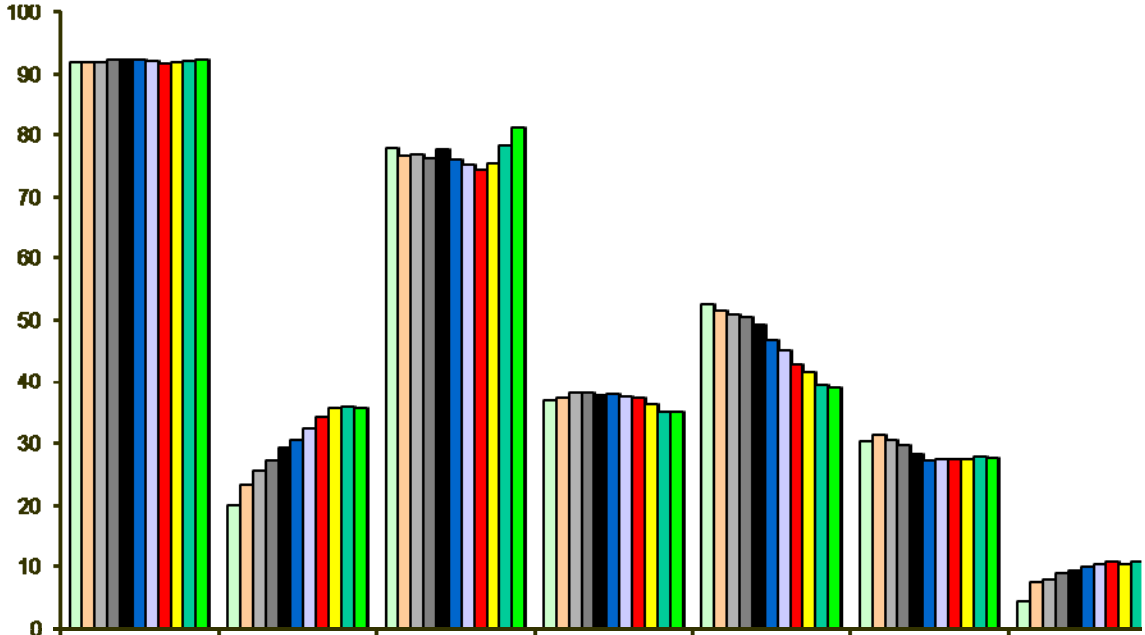
- The prison population is mainly male (92.2%), showing a growing rise in foreigners (35.6%). The main reason for imprisonment of the inmates from these countries is drug trafficking.

  A total of 39.6% of the females were foreigners, compared to 35.2% of the males. Males from Morocco total one of the largest numbers among foreign males. The largest percentage of the females are from Colombia. Spain has one of the highest female incarceration rates in Europe. Spain also has one of the highest rates of incarcerated foreign females.

- A total of 66.4% of the convicted prison population was in the 31-60 age range, compared to the 66.1% in this group in 2009. Spain has a prison population of an average age which is one of the eldest in Europe.

- By type of offence committed, for the 2000-2010 period, Fig. 9.7 shows a drop in those convicted for crimes against the socioeconomic order. This fact can be influenced by age and repeat offense variables, given that the studies indicate that as the delinquent individuals grow older, there is a shift in the type of offenses committed. Although other factors such as the changes there have been within the punishment framework may be having an impact, such as the inclusion of new offense classifications (domestic violence offenses and road safety offenses).

Fig. 9.7. Trends in the prison population profile. Spain, 2000-2010 (%)



	Males	Foreigners	Convicted	Age 31-40*	Property offense **	Public Health Offense	Personal Offense***
2000	91,9	19,9	77,8	36,9	52,6	30,2	4,2
2001	91,8	23,3	76,6	37,3	51,4	31,3	7,3
2002	91,9	25,4	76,8	38,1	50,9	30,5	7,9
2003	92,1	27,1	76,2	38,1	50,4	29,5	8,9
2004	92,3	29,1	77,6	37,6	49,3	28,1	9,3
2005	92,2	30,5	76,0	37,9	46,6	27,2	9,9
2006	92,0	32,2	75,1	37,5	45,1	27,3	10,2
2007	91,7	34,2	74,4	37,2	42,8	27,3	10,6
2008	91,9	35,6	75,4	36,1	41,5	27,3	10,2
2009	92,0	35,7	78,2	34,9	39,2	27,7	10,7
2010	92,2	35,6	81,1	35,0	38,8	27,6	11,2

* Percentages of the population sentenced under Organic Law 10/1995 and the revoked Penal Code.
** Property offenses: patrimony offenses and offenses against the socioeconomic order.
*** Personal Offense: homicide and the forms thereof and bodily injuries
SOURCE: Government Delegation for the National Plan on Drugs. Based on the Ministry of Interior Prison Statistics

The most prevalent offenses are still, first of all, property offenses (38.8% of the convict population), followed by public health offenses (27.6% of the convict population). By the gender variable, 39.5% of the males were incarcerated for property offenses, while 49.6% of the females were incarcerated for public health offenses. The females show a lower offender profile than the males, although with longer sentences due to the fact of drug trafficking being a more serious charge.

Different studies stress the fact that road safety offenses, violent crimes, sexual assaults and domestic violence offenses entail a high incidence of alcohol consumption. The study "*Las drogas en la delincuencia: su tratamiento en la Administración de Justicia*" [*Drugs in Delinquency: how dealt with by the courts*] (Muñóz Sánchez 2003) underlines that the large

volume of sentences has nothing to do with illicit drugs, but rather with alcohol. In fact, the road safety offenses are those which wind up being criminally charged most often, 90% of these offenses being committed under the influence of alcoholic beverages.

In this same regard, the study *"Prevalencia del consumo de alcohol en los trastornos relacionados con la población penitenciaria condenados por delitos contra la seguridad vial*" *["Prevalence of alcohol consumption in the disorders related to the prison population convicted for road safety offenses"] (*Monras et al. 2011) concludes that 88% of the sample studied showed indicators of alcoholism.

- Regarding whether or not first offenses, a total of 54.8% of the convicts were repeat offenders, the males to a greater degree than the females (55.5% vs 46.8%).

STATISTICS: PREVALENCE OF DISEASES ASSOCIATED WITH DRUG USE IN 2010. Source: Prison Healthcare Health Records (Ministry of the Interior).

The Spanish prison administration guarantees all inmates medical-healthcare equivalent to that which is provided for the population as a whole. In fact, healthcare in prison is one of the main tools of which the public health system avails for unrolling its strategy for combatting healthcare-related social inequalities. ("*The quality of Prison Healthcare in Spain*", May 2010). This is the main care-providing facility and gateway to all other public assistance for a large part of the marginalized population therefore vulnerable to a good number of diseases traditionally associated with social exclusion.

This healthcare has given rise to a downward trend in the most prevalent transmissible diseases in the prison environment. In 2010, the prevalence figures for diseases associated with drug use in the entire prison population were as follows:

- Prevalence of HIV: 6.5% of the entire prison population under the authority of the Office of the Secretary General of Prison Institutions, and 10% of the prison population in Catalonia. The main category for HIV transmission continues to be sharing injection material for administering intravenous drugs in both genders.

  According to Fig. 9.8, the downward trend is continuing in the prevalence of HIV in the prison environment. The AIDS incidence has decreased in both genders, and females are continuing to show lower rates than males.

Fig. 9.8. Trend in HIV prevalence in inmate population. Spain, 1996-2010* (%)

1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
22.7	22.7	20.0	18.6	16.6	14.6	12.8	12.0	11.2	10.0	9.0	8.6	7.8	7.0	6.5

* Catalonia not included.
SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the Office of the Secretary General of Prison Institutions.

- Hepatitis C prevalence: A total 23.4% of the entire prison population under the authority of the Office of the Secretary General of Prison Institutions and 21% of the prison population in Catalonia. The population affected is characterized by having started using drugs at an early age, long-term drug use, sharing needles and syringes and co-infection by HIV. According to studies conducted in the prison environment, a past history of drug use is the factor best predicting the possibility of having both of these infections.

  According to Fig. 9.9, the downward trend continues in the prevalence of hepatitis C in the prison environment. There may be different explanations for this reduction, one of the most prominent of which is the increase in the number of foreigners there are in prisons, given that they use drugs less often and there are fewer people infected.

Fig. 9.9 Trend of hepatitis C prevalence in prison population*.Spain, 2001-2010

2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
41.9	38.2	37.8	36.2	33.0	31.3	29.0	27.0	25.3	23.4

* Catalonia not included.
SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the Office of the Secretary General of Prison Institutions.

- Prevalence of inmates in treatment with antiretroviral drugs: 3.8% (2009: 4.5%) of the entire prison population under the authority of the Office of the Secretary General of Prison Institutions, and 4.8% of the prison population in Catalonia.

- The downward trend is continuing in the percentage of inmates in treatment in recent years. This trend is due to the decrease in the prevalence of individuals affected by HIV infections among those incarcerated.

- Prevalence of tuberculosis: 0.14% of the entire prison population under the authority of the Office of the Secretary General of Prison Institutions was in treatment for lung disease, as also was 0.15% of the prison population in Catalonia. Being HIV positive and shared use of needles and syringes for drug use are the main risk factors for developing this disease.

- Deaths due to overdoses in prison facilities. In 2010, a total of 153 deaths having occurred at the prison facilities or in the reference hospitals were notified to the Prison Health death register. At the prison centres in Catalonia, a total of 36 inmates died in 2010.

  - A total of 39 inmates died in prison facilities due to overdoses. Cocaine was detected in 17.9% of the toxicological analyses conducted in 2010, opiates with other substances being detected in all (Office of the Secretary General of Prison Institutions. Death Report 2010). In the prison facilities in Catalonia, a total of 16 inmates died due to overdoses.

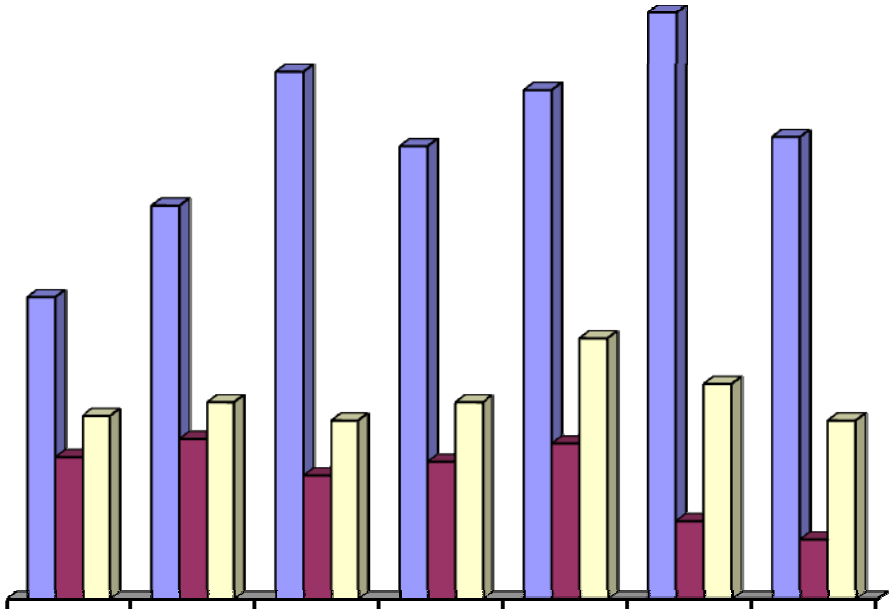
  - 13 inmates due to HIV infection. One inmate having died at prison facilities in Catalonia due to HIV infection.

  - Due to non-HIV natural causes, 101 deaths. Fig. 9.10 shows the spread by the cause of death (not including suicides and accidental or violent deaths). At the prison facilities in Catalonia, 19 inmates died of non-HIV natural causes.

- The death rate in the prisons under the authority of the central government was 2.83 per one thousand inmates in 2010. The age range showing the greatest number of deaths was the 40-45 age range.

- Another risk associated with drug use has to do with mental health, caused mainly, by injected cocaine use. According to the Report on Prevalence of Mental Disorders at Spanish Prison Facilities ("PRECA" Study), the prevalence of psychiatric disorders among Spanish prisoners is greater than among the general population, around 6 times greater.

Fig 9.10. Causes of death among prison population*. Spain, 2004-2010.



	2004	2005	2006	2007	2008	2009	2010
Natural non-HIV	66	86	115	99	111	128	101
HIV Infection	31	35	27	30	34	17	13
Overdose	40	43	39	43	57	47	39

* Catalonia not included.
SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the Office of the Secretary General of Prison Institutions.

STATE SURVEY ON HEALTH AND DRUGS AMONG PRISON INMATES (ESDIP) 2006.
http://www.pnsd.msssi.gob.es/Categoria2/publica/pdf/encuestaPenitenciaria2006.pdf

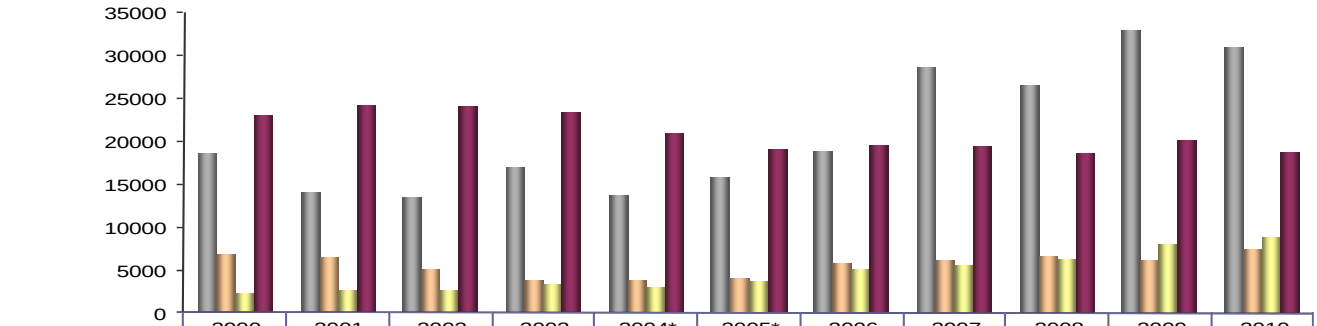
9.8. RESPONSES TO DRUG-RELATED HEALTH ISSUES IN PRISONS

The National Strategy on Drugs 2009-2016, which falls within the public health policies, stresses the prison system as a treatment intervention scenario, maintaining supervision over drug use in prisons. The 2009-2012 Action Plan of the aforementioned Strategy sets out specific actions to be carried out in this regard, such as:

- To promote prevention strategies being carried out targeting the prison inmate population.
- To support harm reduction workshops being held in prison institutions.
- To foster the improvement of the quality and coverage of the treatment and reintegration programmes targeting the prison population as well as the alternative measures to prison, placing special emphasis on monitoring following release from prison.

Care was provided for a total of 34,827 drug-dependent inmates from 89 prison facilities in drug dependence treatment programmes: 7,431 in outpatient programmes, 8,768 in modular programmes and 18,628 in methadone maintenance programmes (Fig. 9.11). On one hand, care was provided for a total of 29,963 inmates (2009: 29,772 inmates) from 78 prison facilities operating under the authority of the Office of the Secretary General of Prison Institutions in these programmes, amounting to a prevalence/day of 19.7% (2009: 19.47%), 10.1% in the treatments with methadone and 8.6% in the drug-free programmes without methadone (2009: 10.8% in the treatments with methadone and 8.6% in the drug-free programmes without methadone).

Fig. 9.11 Trend in the number of inmates in drug dependence programmes. Spain, 2000-2010



	2000	2001	2002	2003	2004*	2005*	2006	2007	2008	2009	2010
Preventive	18562	13959	13568	16953	13669	15804	18831	28521	26454	33003	31065
Outpatient	6680	6386	5019	3804	3727	4048	5759	6026	6562	6114	7431
Drug-free Units	2304	2631	2651	3213	2973	3661	5012	5577	6166	7934	8768
Methadone	23069	24304	24015	23353	20917	19010	19600	19390	18541	20055	18628

*The data related to the prison population in Catalonia is not included..
SOURCE: Government Delegation for the National Plan on Drugs based on data provided by the Office of the Secretary General of Prison Institutions and the Office of the Secretary of Prison Services of the Autonomous Community Government of Catalonia.

On the other hand, care was provided for 4,864 inmates from 11 prison facilities in Catalonia in these programmes: 3,040 inmates undergoing drug-free treatment and 1,824 in treatment with methadone. The organisational model of intervention in Catalonia differs from the rest of the Spanish State. In fact, the prison health services, including the care provided for drug dependencies and mental health, are integrated into the health network operating under the authority of the Catalonian Ministry of Health.

The programmes which are going to be detailed in following must be taken as permeable programmes, that is, the drug-dependent inmates may move from one programme to another depending on their treatment progress.

ABSTINENCE ORIENTED TREATMENTS (Detoxifications, Drug-Free Units, Therapeutic Communities in prisons).

- **Detoxification**
  The detoxification programmes are provided for all those individuals who are diagnosed, at the time of entering prison, as being active drug-dependent individuals who have not been included in treatment with methadone. The number of inmates included in planned detoxification in 2010 totalled 2,188 drug-dependent inmates at 27 prison facilities under the authority of the Central Government (Ministry of the Interior. Office of the Secretary General of Prison Institutions). The prevalence at December 31, 2010 was 0.13% of the prison population.

- **Drug-free programmes**
  Depending on the characteristics and needs of the inmate population and the architectural possibilities of the prison centre, the drug-free programme is carried out on an outpatient basis at the day centre and in a therapeutic module.

  In 2010, care was provided under this treatment modality (which includes outpatient care and care in treatment modules) for 16,199 inmates (2009: 14,048 inmates). At facilities operating under the authority of the Office of the Secretary General of Prison Institutions, a total of 13,159 inmates, and at prison facilities in Catalonia, a total of 3,040 inmates.

  - Outpatient drug-free programmes. The inmates for whom care is being provided live with the rest of the prison population and use the general resources of the facility. In 2010, care was provided for a total of 7,431 inmates under this treatment modality: a total of 6,742 inmates from 41 prison facilities operating under the authority of the Office of the Secretary General of Prison Institutions were included, with a prevalence of 4.34% of the prison population at December 31, 2010. And care was provided for 689 inmates at 6 prison facilities in Catalonia.

  - Drug-free programmes in specific treatment area. These measures are carried out in a specific module at the facilities and may be of the day centre type or treatment module type when they stay overnight in the module.

  In 2010, treatment in module treatment was provided for 5,562 inmates at 34 prison facilities operating under the authority of the Office of the Secretary General of Prison Institutions, with a prevalence of 3.7% of the prison population at December 31, 2010. Care was provided for another 2,531 inmates at 11 prison centres in Catalonia.

  Additionally, care was also provided for a total of 855 inmates at 9 prison facilities operating under the authority of the Office of the Secretary General of Penitentiary Institutions, with a prevalence of 0.59% of the prison population.

  Based on this data, the number of users in residential programmes has increased.

SUBSTITUTION TREATMENT

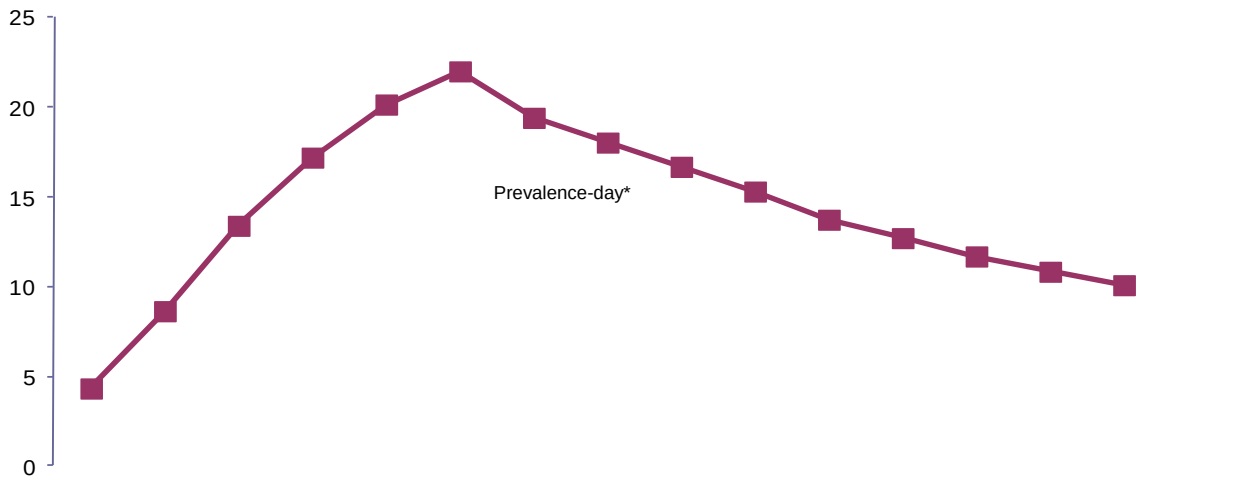
- **Methadone Maintenance Programmes (MMPs)**

Care was provided for a total of 18,628 drug-dependent inmates at 89 prison facilities in drug dependence treatment programmes (Fig. 9.10): In 2010, a total of 16,804 inmates at 78 prison centres operating under the Office of the Secretary General of Prison Institutions underwent treatment, with a prevalence of 10.1% at December 31, 2010 (Fig. 9.12). Additionally, 30% of the inmates in treatment with methadone were being provided with psychosocial care.

And a total of 1,824 inmates incarcerated at 11 prison facilities in Catalonia were provided with this type of treatment.

As of 2004, as shown in Fig. 9.12, there was a sharp drop in the number of inmates on methadone due to the changes having taken place in the use of drugs over recent years, given that the number of inmates who were cocaine users alone as the main drug increased, whilst there were fewer consumers of heroin alone or combined with cocaine in the same dose.

Fig. 9.12 Evolution of prisoners attended in methadone programmes. Spain, 1996-2010*



1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
4.3	8.7	13.4	17.2	20.2	22.0	19.4	18.1	16.7	15.3	13.75	12.72	11.7	10.85	10.1

(*) Percentage of the dependent prison population from the Office of the Secretary General of Prison Institutions who are undergoing treatment, given as a percentage of the total inmate population on a certain given date.
SOURCE: Government Delegation for the National Plan on Drugs based on data provided by the Office of the Secretary General of Prison Institutions

HARM REDUCTION MEASURES

- **Blood screening, vaccinations, provisions of disinfectants, provision of condoms**

Health education and preventive programmes have been carried out at all of the prison facilities, through both their own facilities as well as in coordination with the community facilities. These programmes are not offered only for drug-dependent individuals but also for inmates at risk of starting to use drugs while in prison, as well as the first-time inmates and the youngest inmates.

The number of inmates which have gone through this type of programmes totalled 31,065 inmates from all of the prison facilities throughout Spain. Fig. 9.10.

Special mention must be made of the fact that these programmes take on special importance in the prison in terms of the frequent, serious health problems these individuals have, for a major percentage of whom their only contact with the health system occurs when they enter prison.

The health education activities consist of:

- Safe sex workshops
- Risk reduction workshops
- Workshops on coping with stress, social skills, communicating skills and resolving conflicts.
- Health mediators

Healthcare interventions are also carried out:

- Health education for carriers of diseases
- Hepatitis vaccination
- Implementation of the programme for the prevention and control of tuberculosis, HIV infection and hepatitis C virus infection. These programmes are for the main purpose of detecting and treating both the infection and the disease early on among the incarcerated population.

Training health mediators as a peer education method is one of the most efficient and effective modalities in prisons.

- **Needles and syringe exchange**

All prisons have the technical and legal conditions for exchanging needles and syringes when there is a demand for sterile needles and syringes.

In 2010, there were 30 prison facilities operating under the Office of the Secretary General of Prison Institutions which were dispensing needles and syringes. In addition thereto, a total of 7,931 needles and syringes were given out at the Central Government facilities. In Catalonia, a total of 1,861 needles and syringes were given out to 195 inmates at 10 facilities.

As of the year 2006, a reduction was noted in the number of needles and syringes given out, due to this route being used to a lesser degree on the part of the prison population.

9.9. REINTEGRATION OF DRUG USERS AFTER RELEASE FROM PRISON

- **Therapeutic communities for offenders outside the prisons**

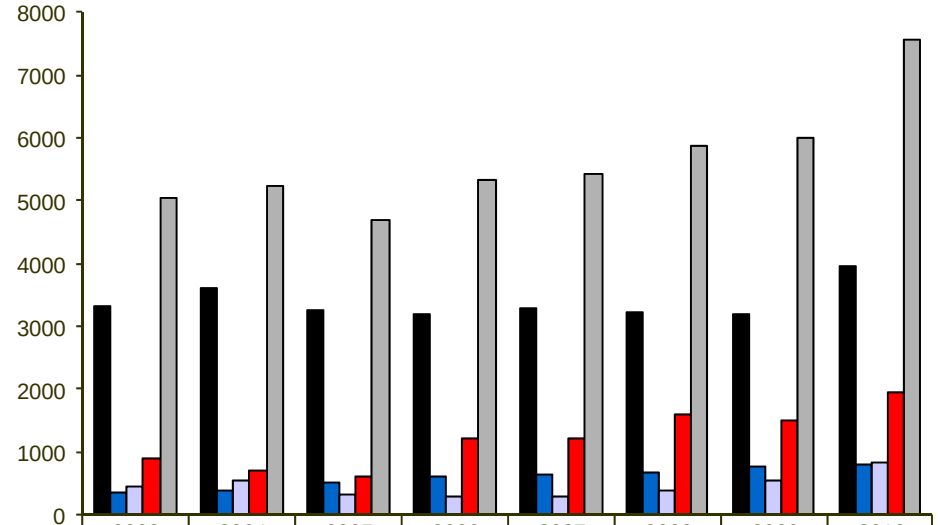
These are interventions which are carried out outside the prisons are regulated in the Prison Regulations that allows periodic or definitive access to community resources on the part of drug-dependent inmates.

In 2010, a total of 8,110 inmates were referred from the prison facilities, 7,560 inmates to treatment from the prison facilities operating under the Office of the Secretary General of Prison Institutions (Fig. 9.13):

- 1,949 Inmates to outpatient centres outside of prison
- 3,955 inmates to methadone programmes outside of prison
- 809 inmates to therapeutic communities outside of prison
- 847 inmates to other drug-free resources

A total of 550 inmates were referred to community treatment from the prison facilities in Catalonia.

Fig. 9.13 Referrals of drug-dependent individuals from Prison Institutions to community treatment facilities*. Spain, 2003-2010



	2003	2004	2005	2006	2007	2008	2009	2010
Methadone treatment	3.323	3.600	3.244	3.202	3.277	3229	3184	3.955
Therapeutic Communities	346	393	531	596	639	665	760	809
Others - Detoxification	460	540	314	307	283	400	546	847
Outpatient Centers	908	712	604	1.216	1.222	1587	1508	1.949
Total	5.037	5.245	4.693	5.321	5.421	5.881	5.998	7.560

* Data on the prison population of Catalonia not included.
SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the Office of the Secretary General of Prison Institutions

10. DRUG MARKETS

10.1. INTRODUCTION

Spain is not a drug-producing country, but it is a gateway to Europe for hashish and cocaine due to its geographical location and, to a much lesser extent, for MDMA-Ecstasy to America or heroin to Portugal.

In 2011, the number of heroin seizures dropped off, while those of hashish and MDMA (ecstasy) increased. Cocaine underwent a slight, barely significant increase. Lesser amounts of hashish, cocaine and ecstasy were seized, whilst greater amounts of heroin were seized.

In 2011, the seizures of controlled chemical substances (precursors) and non-controlled chemical substances rose considerably. Similarly, a total of four laboratories were dismantled, two cocaine finishing labs and one secondary cocaine extraction and finishing lab combined, and also a tablet-cutting and processing lab.

Insofar as prices are concerned, a rise was noted on the wholesale markets in 2011 compared to 2010 regarding cannabis derivatives and cocaine, while heroin prices dropped.

On the by gram prices on the street, cannabis derivatives are the only ones having shown a rise, given that cocaine and heroin prices lowered.

On the retail by dose market, the prices of cocaine and MDMA-ecstasy rose, while the heroin dose price lowered.

The degree of purity is dropping in cocaine, but tends to remain the same in heroin and to rise in the cannabis derivative THC.

10.2. AVAILABILITY AND SUPPLY

- **COCAINE**

Coca leaf cultivation and cocaine production. All of the cocaine seized in Spain comes from the Andean region of South America.

Means of cocaine distribution and routes in Spain and Europe. Spain continues to be used as a transit country for bringing cocaine into other European countries.

Cocaine is smuggled into Spain mainly by sea and by air along the routes detailed in following:

Conventional routes. There is no change with regard to the year before.

- African route. This route was first detected at the beginning of 2004, being Spain the first country to have found this route to actually exist. From 2004 to 2007, there was a rise in cocaine seizures along the coasts of Western Africa.

The seizures at the sea along the African coasts have currently dropped. Some western African countries are thought to currently be used as storehouses for gathering and storing the cocaine from Latin American to then transport it to Europe by air.

- **HASHISH**

Cannabis cultivation and hashish production. Practically all of the hashish seized in Spain comes from the Kingdom of Morocco.

Growing cannabis plants is found to be spreading in Spain, normally in homes and in small greenhouses to obtain marijuana for personal use and rarely for trafficking. Nevertheless, the estimated size of these cannabis crops is insignificant in comparison to the amount of cannabis seized and the amounts used as inferred from the cannabis use surveys.

Means and routes for hashish distribution in Spain and Europe. There is no change with regard to the year before.

- **DESIGNER DRUGS - MDMA**

MDMA-ecstasy production. There is no change compared to the year before.

Means and routes for distributing in Spain and Europe. There is no change compared to the year before.

- **HEROIN**

Opium poppy cultivation and heroin production. There is no change compared to the year before.

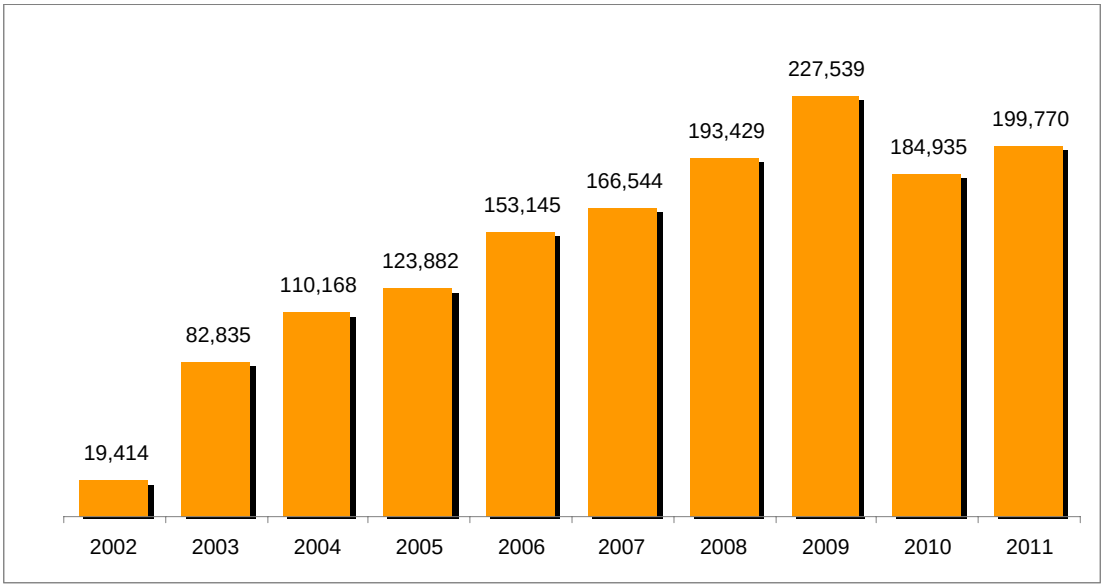
Means and routes for distributing heroin in Europe. There is no change compared to the year before.

10.3. SEIZURES

▪ HASHISH

Number of seizures. As shown in Fig. 10.1, the trend of the number of seizures of hashish is on the rise despite the drop in 2010. The number of seizures has risen by 8 percent compared to the year before, marking the second highest figure for the period analysed.

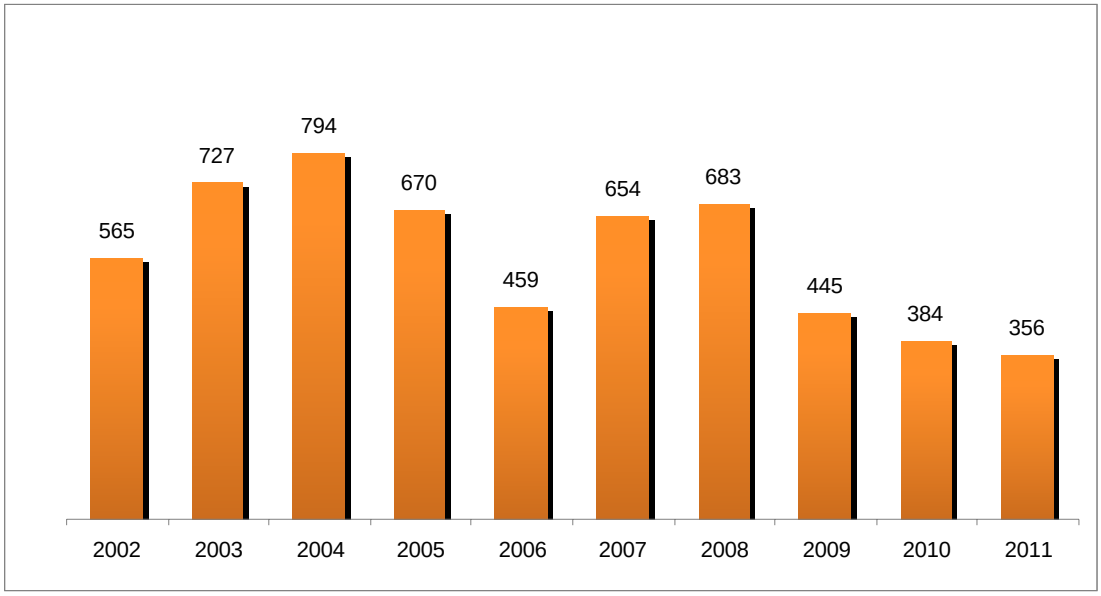
Fig.10.1. Number of hashish seizures, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Amounts seized in Spain. The amount seized dropped by 7% compared to the year before, making the lowest amount for the period under study, thus meaning that the seizures were of small amounts than in previous years (Fig. 10.2).

Fig. 10.2. Amounts of hashish seized in Spain (Tons), 2002-2011

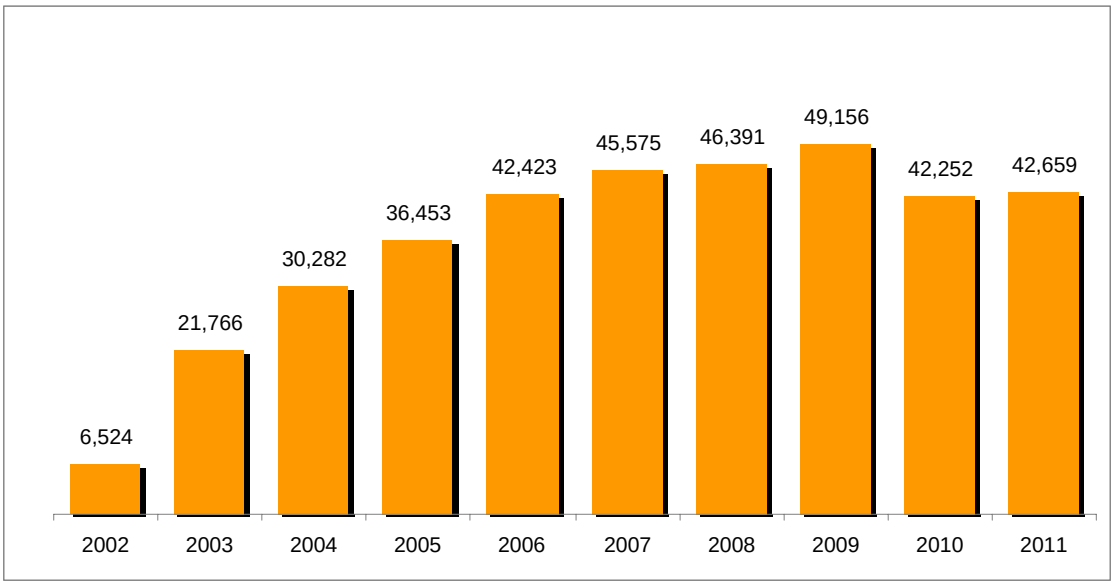


SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

- **COCAINE**

Number of seizures. The following Figure (10.3) shows there to have been a minor increase in 2011 in the number of seizures compared to the year before, specifically a 1% rise, it being possible to infer that the trend which, following a sustained rise up to 2009, reverted to figures similar to 2006, is continuing to a certain degree.

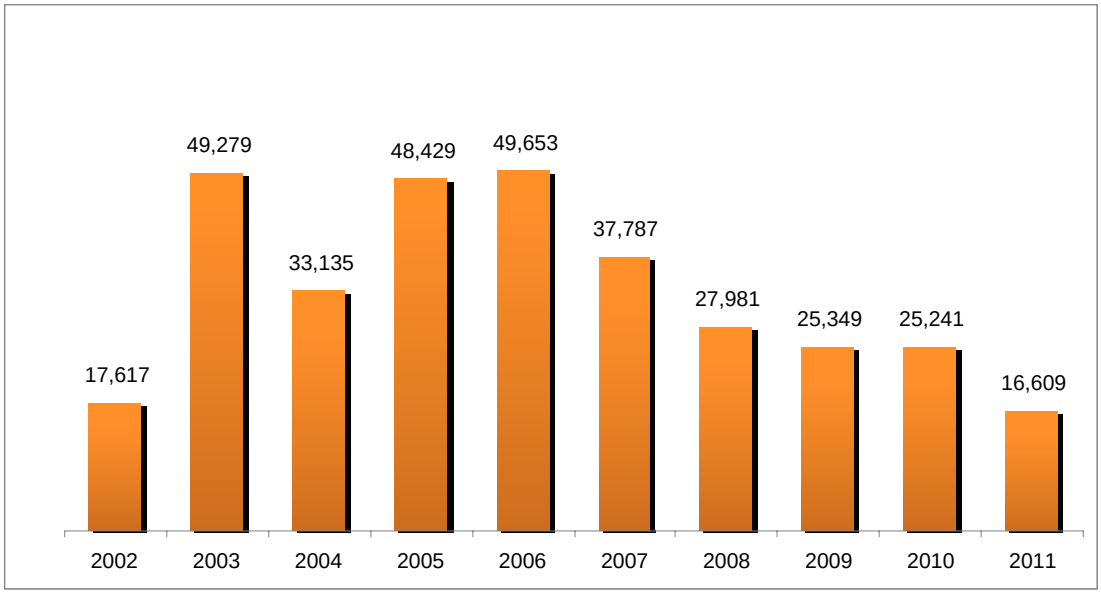
Fig. 10.3. Number of cocaine seizures, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Amounts seized in Spain. Although the number of seizures has undergone a slight increase, the amount of cocaine seized dropped by 34 percent compared to 2010, maintaining the downward trend and marking the lowest figure since 2002, as shown in Fig. 10.4. A total of 86 percent of all the cocaine seized was seized in solely 340 confiscation operations, thus indicating that most of the confiscations are made on small amounts of cocaine.

Fig. 10.4. Amounts of cocaine seized in Spain (Kg), 2002-2011

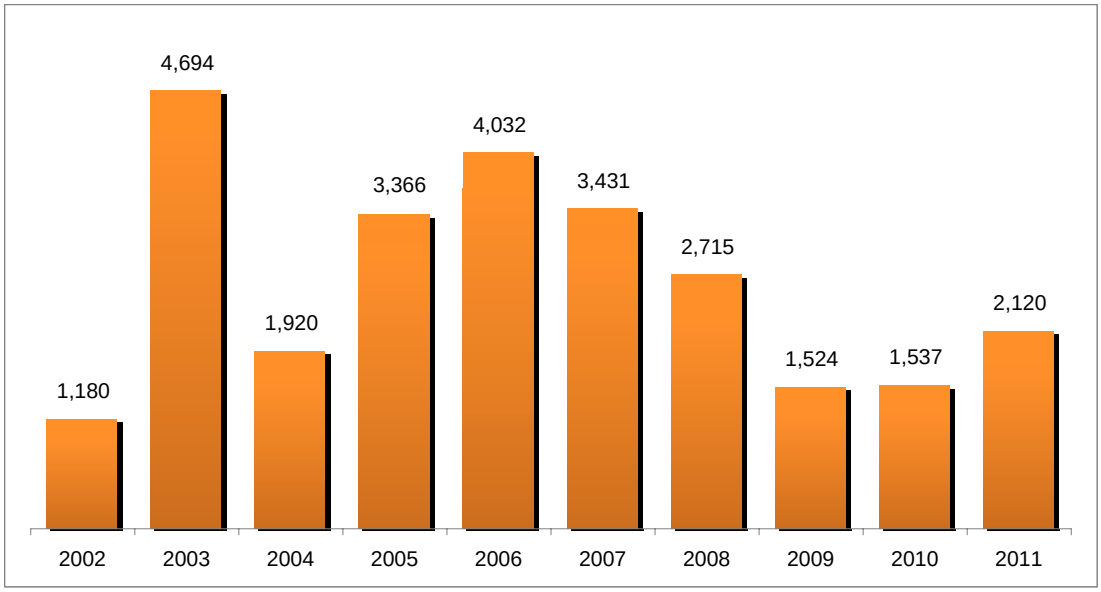


SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

- **MDMA - ECSTASY**

Number of seizures. Fig. 10.5 shows the number of MDMA-ecstasy seizures in 2011 as having risen by 38 percent compared to 2011.

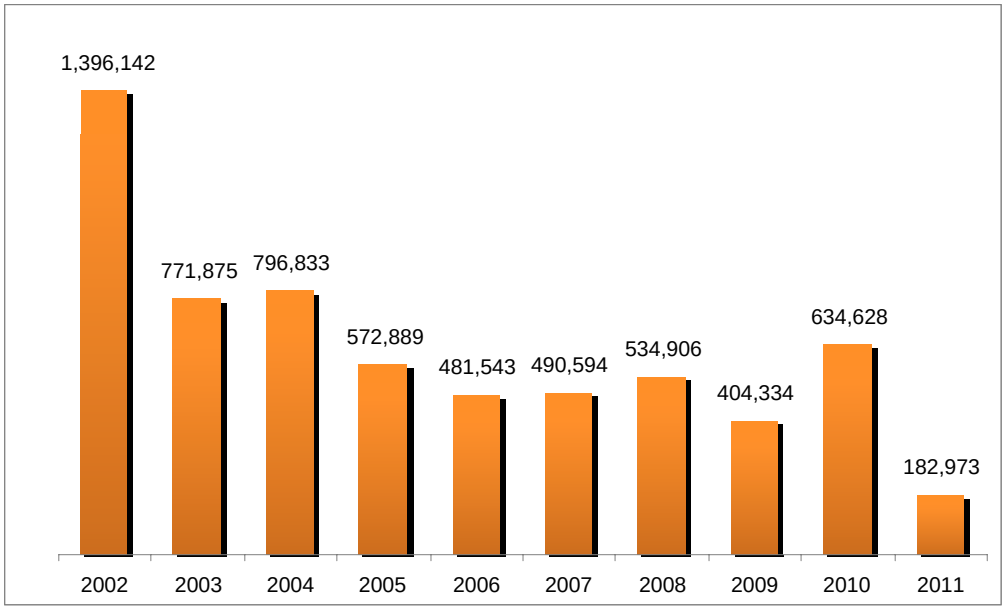
Fig. 10.5. Number of MDMA-ecstasy seizures, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Amounts seized in Spain. Despite the increase in the number of seizures in 2011, the total amount seized dropped considerably, 71%. This percentage means that the shipments seized averaged a small number of tablets (Fig. 10.6).

Fig. 10.6. Ecstasy tablets seized, 2002-2011

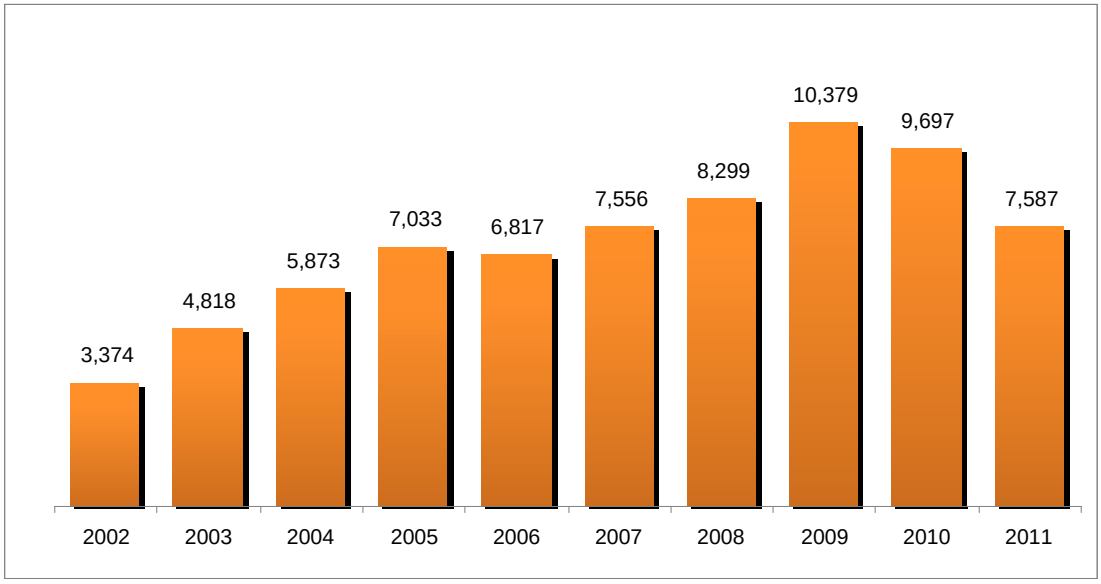


SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

- **HEROIN**

Number of seizures. Fig. 10.7 shows the number of heroin seizures to have been undergoing a sustained rise since 2002, despite a drop having occurred in 2010 and having continued in 2011. This drop is a 22 percent drop, down to figures comparable to 2007.

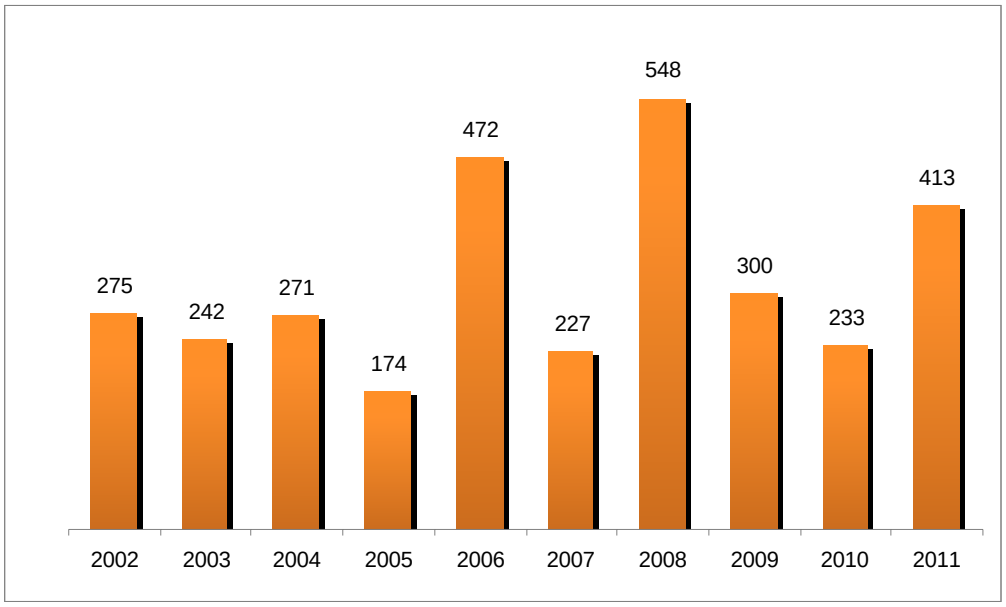
Fig. 10.7. Number of heroin seizures, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Amounts seized in Spain. The amounts of heroin seized rose by 77 percent compared to 2010 (Fig. 10.8).

Fig. 10.8. Amounts of heroin seized in Spain (Kg), 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

AMOUNTS OF PRECURSORS SEIZED

In 2011, there was a remarkable rise in the seizures of controlled substances compared to the year before. The two tables below show the substances and the amounts seized.

The most remarkable rise was generally in the controlled substances, mainly acetone, hydrochloric acid and methyl-ethyl-ketone.

Table 10.1. Substances and amounts seized, 2011

NON-CONTROLLED (EU)		CONTROLLED (EU)	
Ammonia (L.)	1,401	Acetone (L.)	6,834
Hexane (L.)	63	Hydrochloric Acid (L.)	581
Ethyl Acetate (L.)	7	Sulphuric Acid (L.)	862
Calcium Chloride (Kg.)	1,175	Ethyl Ether (L.)	75
Calcium Carbonate (Kg.)	26	Methyl-Ethyl-Ketone (L.)	8,801
Sodium Hydroxide (Kg.)	258	Potassium Permanganate (Kg.)	0.700
Hypophosphorous Acid (Kg.)	1	Toluene (L.)	11,342
Orthophosphoric Acid (Kg.)	1	Ephedrine (medicines, pcs, tablets)	70
Sodium Bisulphite (Kg.)	12		
Butyl Acetate (L.)	5		
Isopropyl Acetate (L.)	1		
N-Butyl Acetate(Kg)	1		
Ammonium nitrate (Kg.)	0.100		
Tetrahydrochloride (Kg)	0.100		
Iodine (Kg.)	0.100		
Active Carbon (Kg)	459		

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

LABORATORIES DISMANTLED

Four (4) laboratories were dismantled in 2011:

- 2 cocaine finishing labs
- 1 secondary cocaine extraction and finishing lab
- 1 tablet-cutting and processing lab

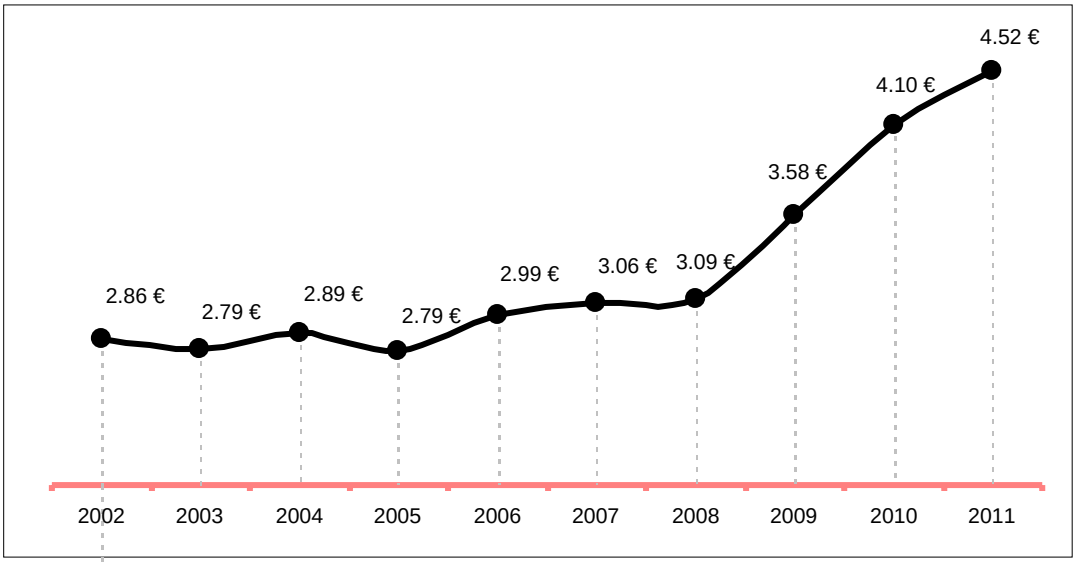
Apart from those mentioned above, small-scale cocaine adulteration and cutting points were dismantled, not being taken into account due to their minor importance.

10.4. PRICE/PURITY

▪ CANNABIS DERIVATIVES

Trend in marijuana prices. The **average per gram price** of marijuana, during the time period compared is 58.04% more expensive. The price is clearly evolving on an upward trend, especially as of 2008.

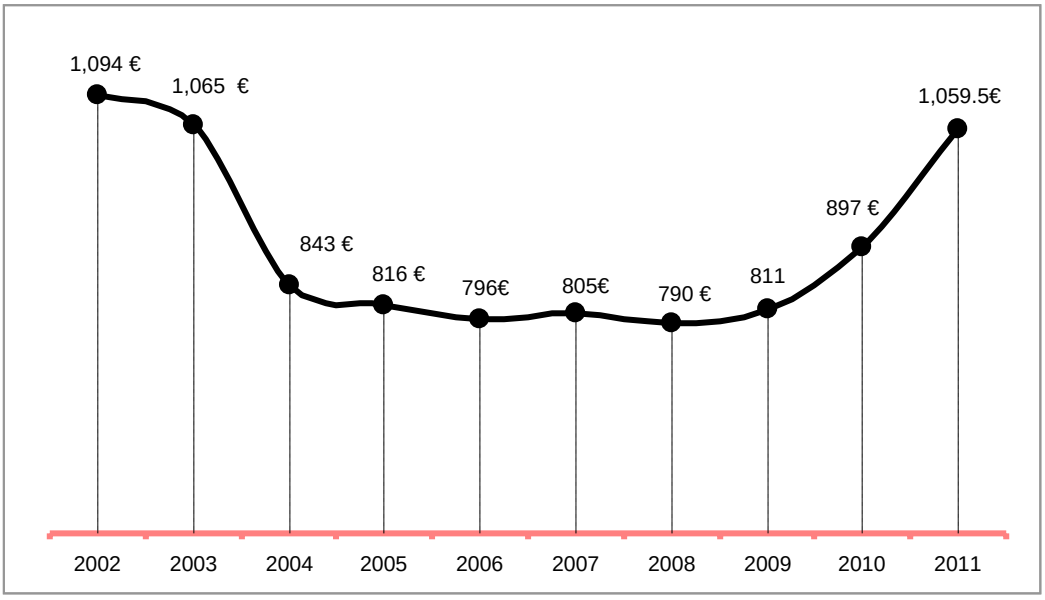
Fig. 10.9 Marijuana, price/gram, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

On the contrary, the **per kilo price** of marijuana is showing an overall downward trend with prices moderating since 2004, with a trend toward recouping.

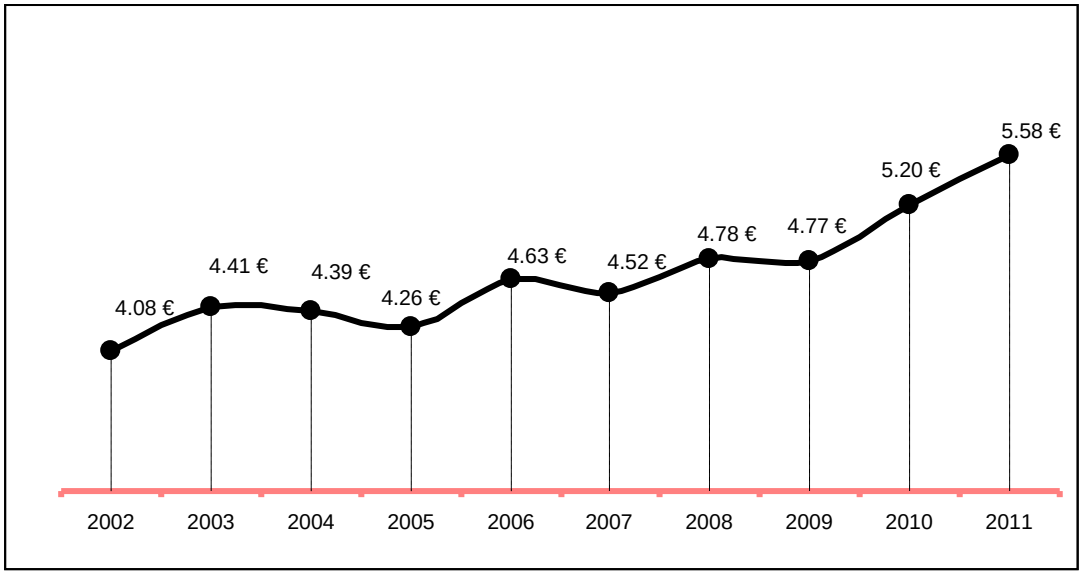
Fig. 10.10 Marijuana, price/kilo, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Trend in the hashish prices. There has been an upward trend over the last ten years on the **retail market**, such that the price of a gram of hashish in 2011 was 36.76 percent higher than in 2002.

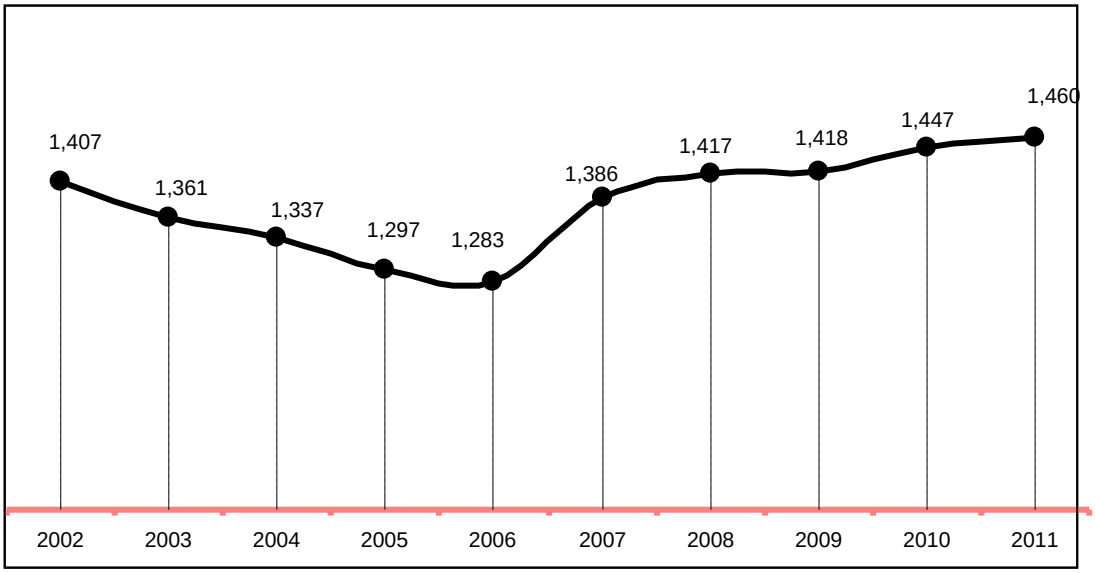
Fig. 10.11 Hashish, price/gram, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

After five years running of price rises on the **wholesale market**, an upward trend, which seems to be indicative of a clear recovery of the market that had a price of 1,495 € per kilo in 2001.

Fig. 10.12 Hashish, price/kilo, euros, 2002-2011

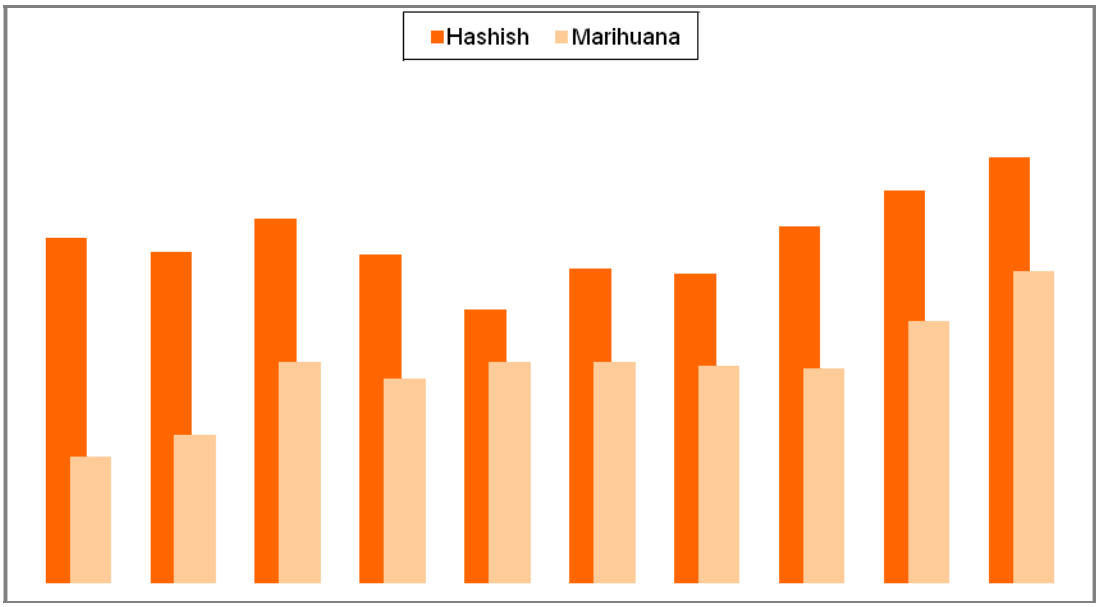


SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Trend in THC concentration. The property which modifies the capacity of hashish to cause effects in hashish users is mainly the degree of concentration of Tetrahydrocannabinol (THC), which varies due to the characteristics of the harvests, influenced especially by the selection of seeds, weather, soil quality and growing techniques employed.

As this aforementioned concentration does not depend on the traffickers and can, in itself, have a bearing on the prices, the annual averages found in the samples analysed[25] have been monitored, the findings being provided in the following graph, showing a rise in cannabis potency, especially in marijuana potency.

Fig. 10.13 Trend of THC (percentages), 2002-2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Hashish	12.4	11.9	13.1	11.8	9.8	11.3	11.1	12.8	14.1	15.3
Marihuana	4.5	5.3	7.9	7.3	7.9	7.9	7.8	7.7	9.4	11.2

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior
(*) The 2010 percentages could not be provided, the figures shown therefore being the average for 2009 and 2011.

Over the past year, 75 percent of the hashish resin samples analysed contained 10%-25% THC. A total of 86.4 percent of the marihuana samples likewise contained 5%-20% Tetrahydrocannabinol [(1)].

On the marijuana market, the THC concentrations have a direct impact on the retail market and a very slight reverse effect on the wholesale market.

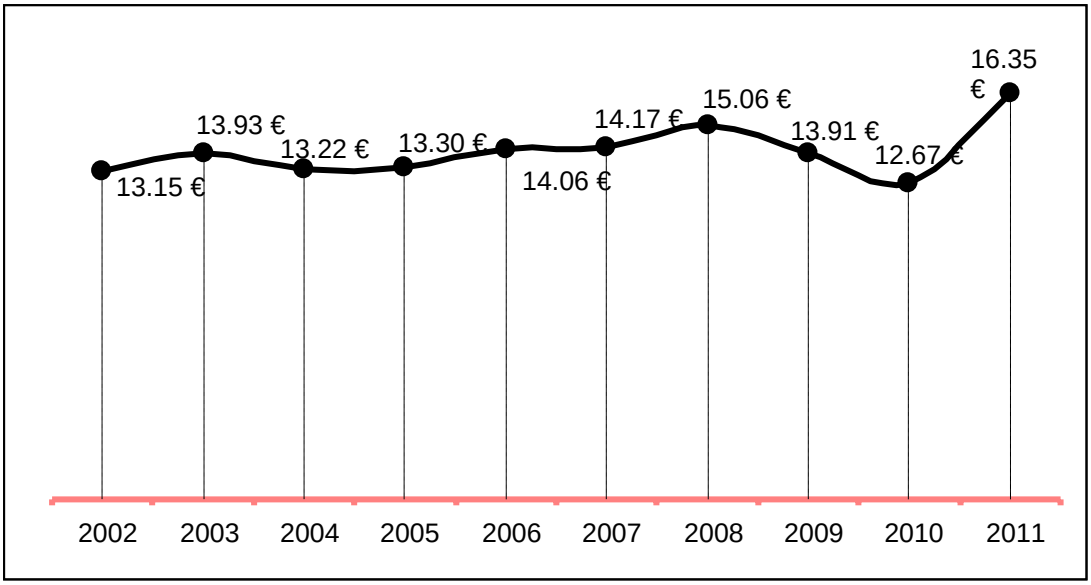
On the hashish resin market, the correlation is also direct but more moderate.

(1) Data provided by the Drug Service of the Spanish National Institute of Toxicology and Forensic Science. Madrid Department.

- **COCAINE**

Trend in average cocaine prices. Following a period of certain stability in the average per dose price, which has ranged from 13.15€ in 2002 to 12.67€in 2010, this price rose to 16.35€ last year, meaning a 24.33% higher price than in 2002 and a 29.04% higher price than the year before. This price is recouping the upward trend that had dropped off in 2010.

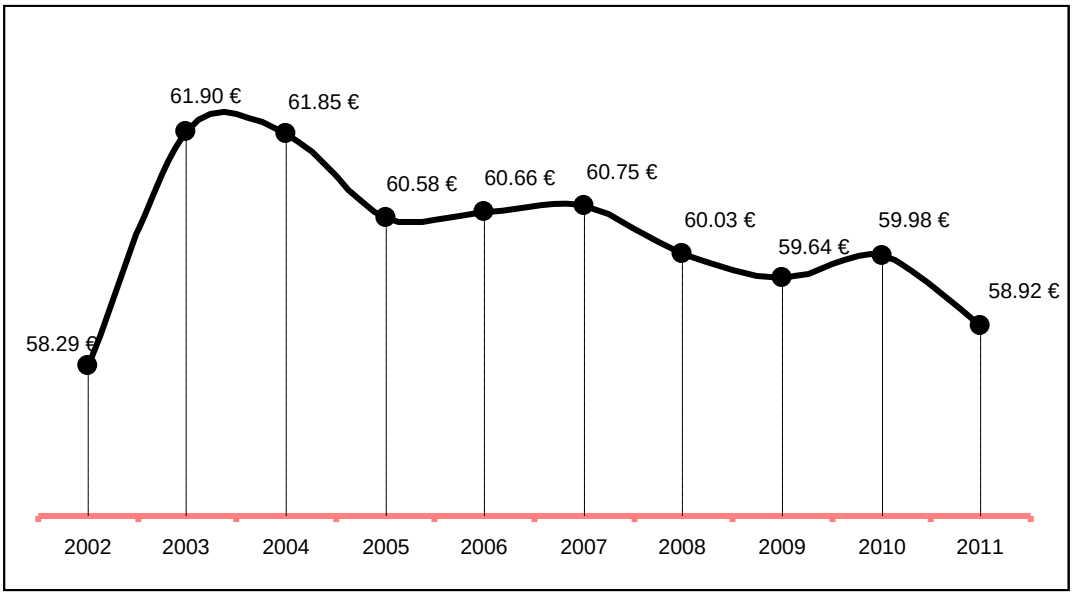
Fig. 10.14. Cocaine, price/dose, euros, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

In the period compared, the price per gram, following the price rises in 2002 and 2004, began a slow downward trend bringing the price down to only 63 cents higher than the 2002 price, thus showing a stable trend following the fluctuations at the first part of the ten-year period under study.

Fig. 10.15. Cocaine, price/gram, euros, 2002-2011

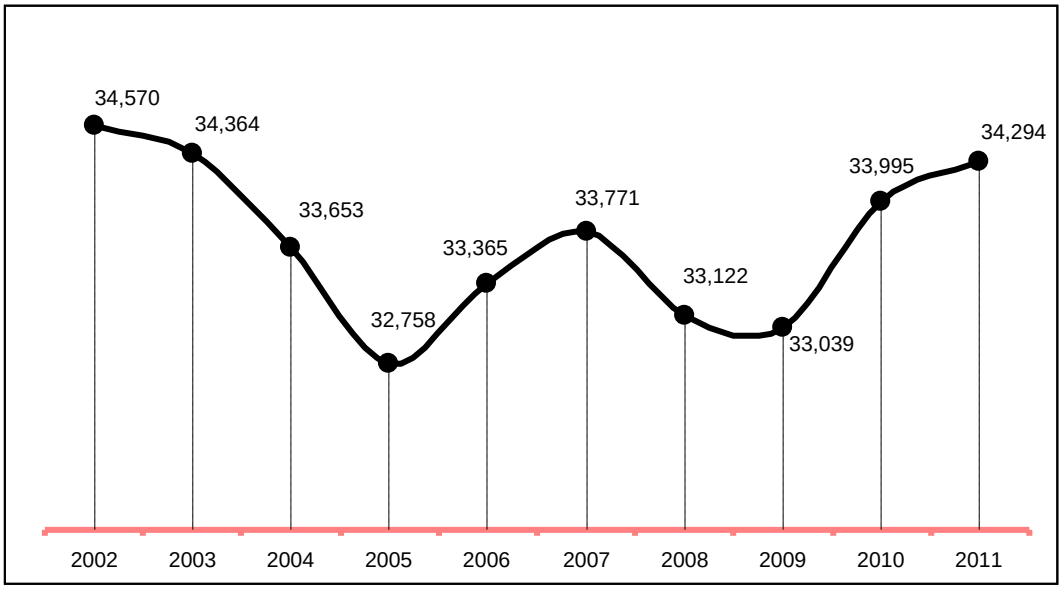


SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

The kilo is the basic unit of measure by which cocaine is bought in wholesale trafficking. For the time period under comparison, this price dropped from the 34,570 €/kilo of 2002 down to the 32,758 €/Kilo of 2005, meaning a 5.24% drop.

After recouping by approximately one thousand euros in 2007, this price dropped once again down to 33,039 € in 2009. Since that last year, two consecutive rises have been recorded, bringing the price in 2011 to 34,294 €/Kg. Nevertheless, the overall trend for the ten-year period in question is still a downward trend.

Fig. 10.16. Cocaine, price/kilo, euros, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

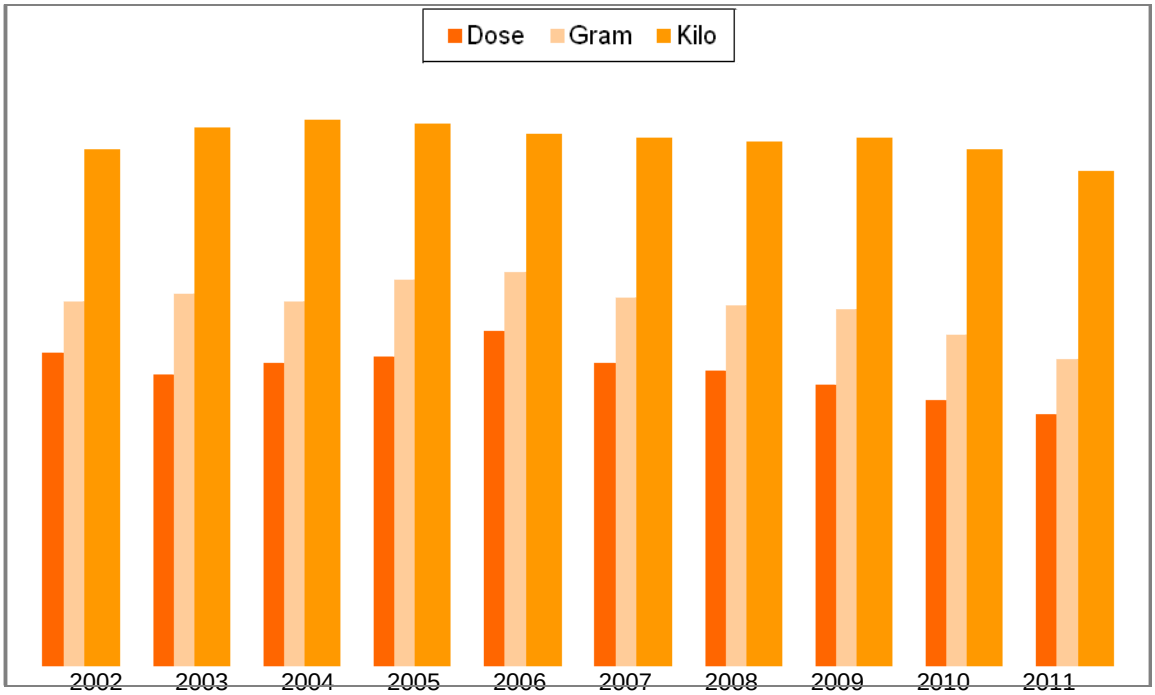
Trend in purity. The average degree purity in a cocaine dose has fluctuated from 43% in 2002 up to 34.50% in 2011. After having risen up to 46% in 2006, there has been a continuous drop since then, the lowest degree of purity of the last ten years having been recorded last year.

The trend of the purity found in the cocaine seized by grams remained the same up to 2009, except for 2005 and 2006, within the 49%-51% range. In 2010, the degree of purity dropped to 45.5% in 2010 and down to 42% in 2011.

The degree of purity on the middle market has then dropped by 22.2 percent compared to 2006 and by 17.6% compared to 2002.

The purity of the kilo currently totals solely 68 percent, the lowest degree for the ten-year period in question. This is 9.3% less than in 2004, the year in which the purest cocaine was recorded.

Fig. 10.17 Trend in cocaine purity



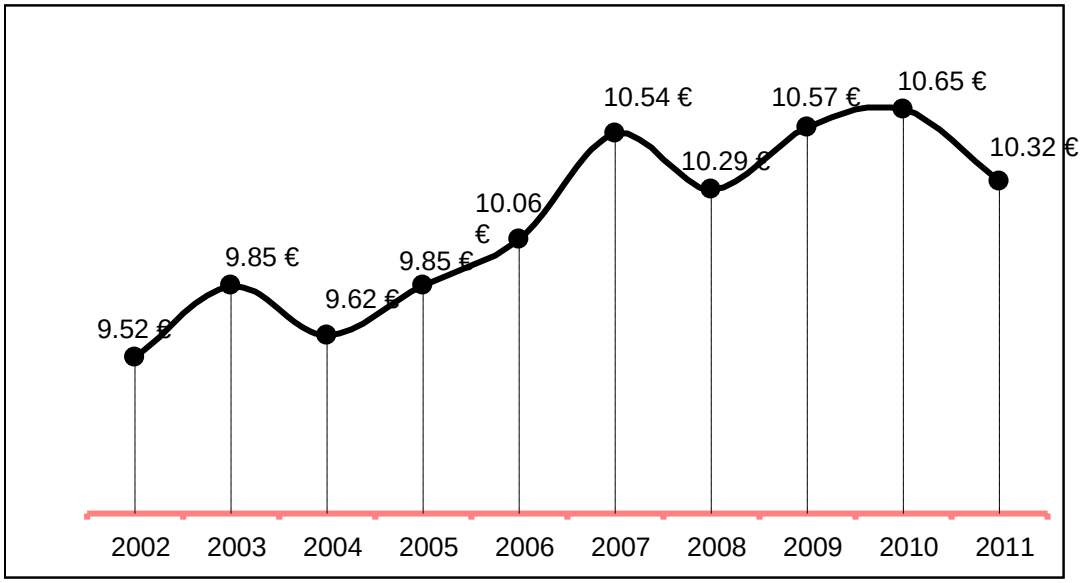
	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Dose	43.0	40.0	41.5	42.5	46.0	41.5	40.5	38.5	36.5	34.5
Gram	50.0	51.0	50.0	53.0	54.0	50.5	49.5	49.0	45.5	42.0
Kilo	71.0	74.0	75.0	74.5	73.0	72.5	72.0	72.5	71.0	68.0

SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

- **HEROIN**

Trend in the average prices of heroin. The average price of heroin has evolved on a constant upward trend, with downward movements at certain times over the past year, clearly marking an upward trend.

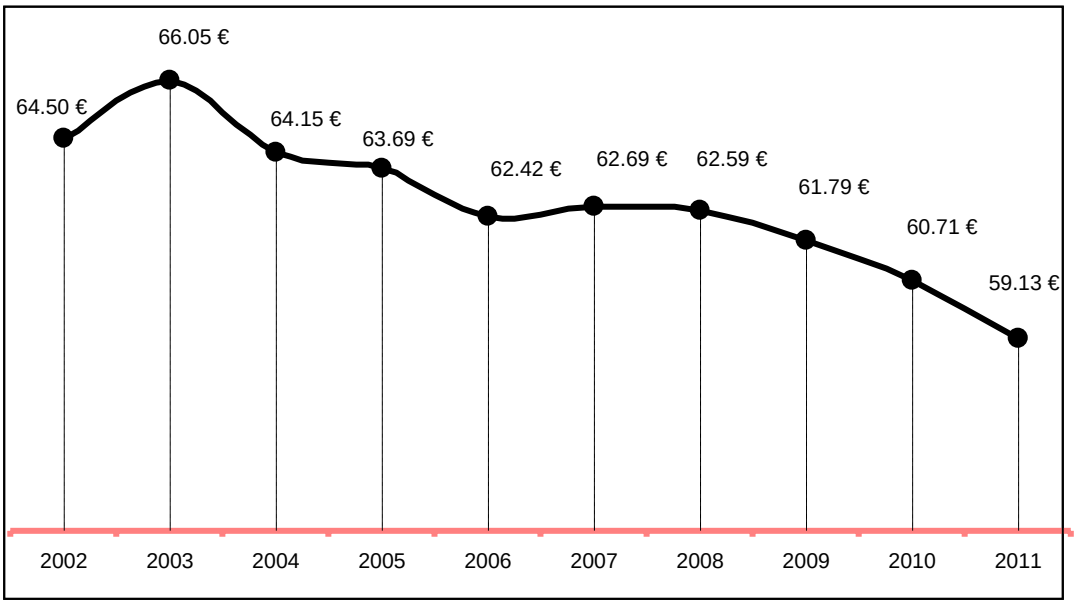
Fig. 10.18 Heroin, price/dose, euros, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

On the contrary, for this same period, the per gram heroin price is showing a downward trend.

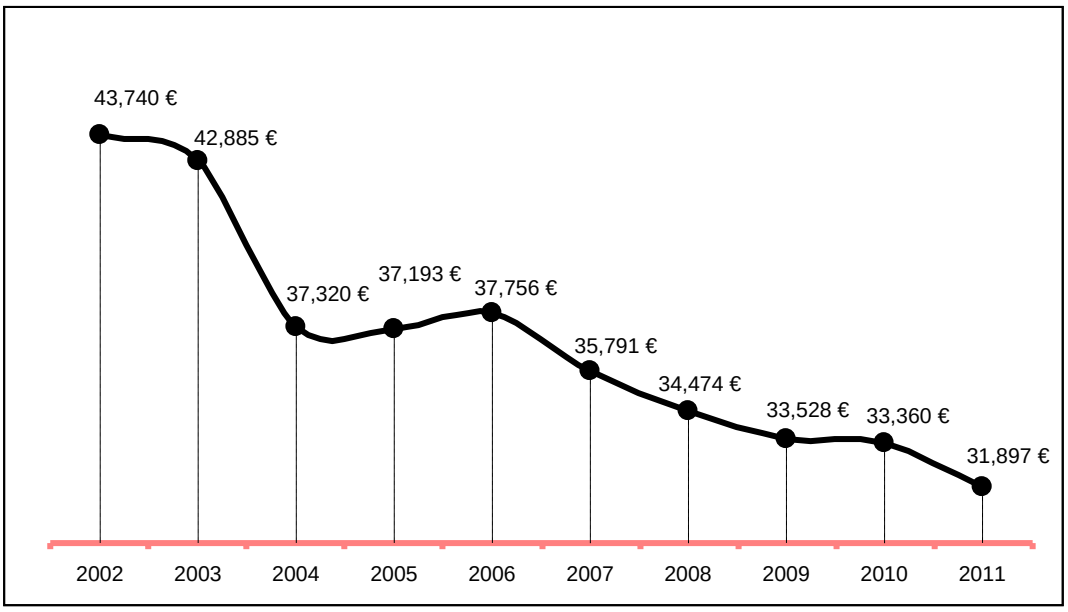
Fig. 10.19 Heroin, price/gram, euros, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

The kilo of heroin started out the period studied at a price of 43,740 €/Kg to then gradually drop down to the 31,897 € of 2011, for a 27% price drop. This price is 11,843 € lower than in 2002 and **1.463 68€** lower than in 2010, thus assuring a downward trend.

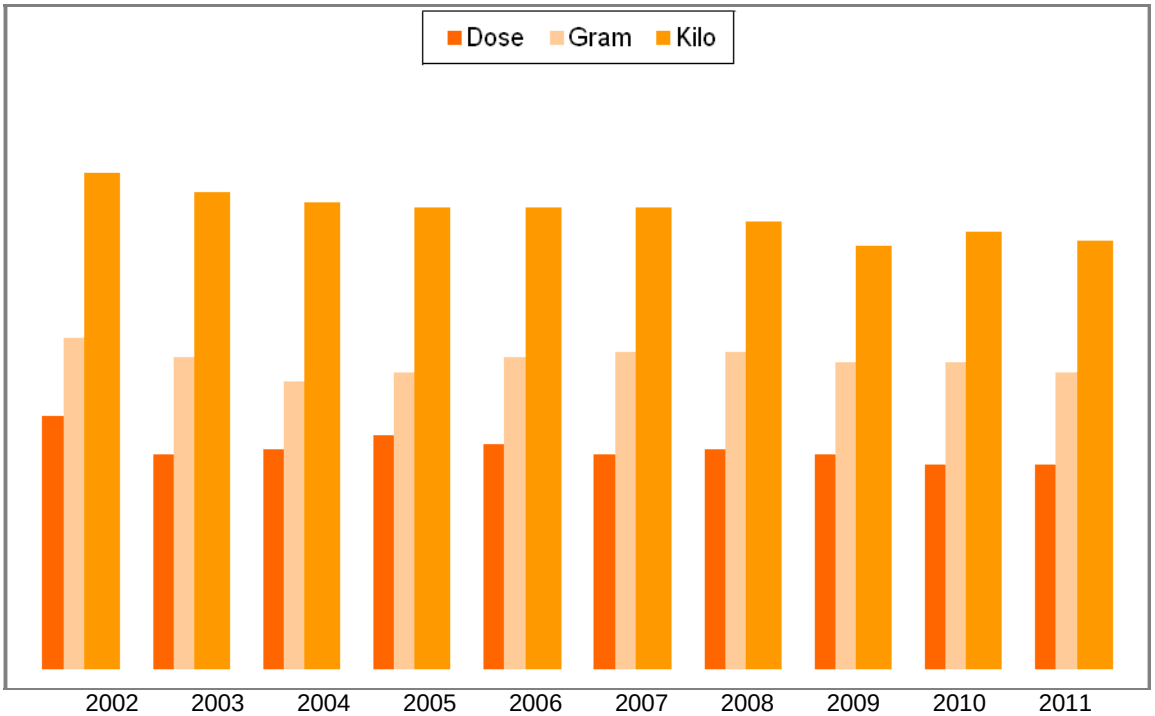
Fig. 10.20 Heroin, price/kilo, euros, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Trend in purity. There was a downward trend in dose purity for the period studied. The 2011 shipments were found to have a 21% purity, meaning 19.23% less pure than in 2002.

Fig. 10. 21 Eolution of heroin purity (percentage), 2002-2011



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Dose	26.0	22.0	22.5	24.0	23.0	22.0	22.5	22.0	21.0	21.0
Gram	34.0	32.0	29.5	30.5	32.0	32.5	32.5	31.5	31.5	30.5
Kilo	51.0	49.0	48.0	47.5	47.5	47.5	46.0	43.5	45.0	44.0

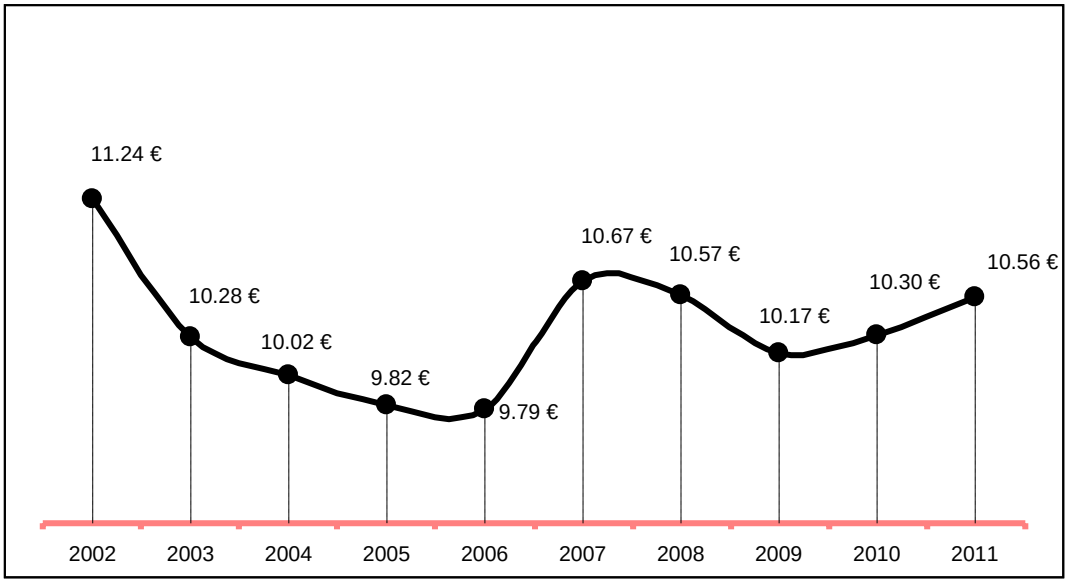
SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

The average per gram purity of heroin for the same period also dropped to a percentage 3.5 points lower than in 2002. It is now 10.3 percent less pure. In 2004, heroin reached its all-time low, 29.5%, having then recouped as of that time up to 32.5% in 2007 and 2008 to then once again drop to 30.5% in 2011. On the wholesale market, as far as purity is concerned, the kilo of heroin is on a sustained downward trend, which has been accentuated in recent years, having dropped from 51 percent in 2002 to 44 percent in 2011.

- **MDMA-ECSTASY**

The trend in the average price of an ecstasy tablet had been dropping over the last ten years up to 2006. After rising back up briefly by 9% in 2007 compared to the year before, the individual tablet price then fell back down in 2009 for the second consecutive year. Although the prices rose by 0.13€ in 2010 and by 0.16€ in 2009, the trend is downward overall.

Fig. 10.22 MDMA-Ecstasy, price per tablet, 2002-2011



SOURCE: Centre of Intelligence against Organised Crime. Ministry of Interior

Data collection methodology (prices and degrees of purity). There were no changes in the data collection methodology for determining the prices and degrees of purity of the drugs seized.

11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

CONTENTS

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11. RESIDENTIAL TREATMENT FOR DRUG USERS IN EUROPE

INTRODUCTION

This report conducts an analysis of residential treatment for drug users in Spain. A description is provided of residential treatment within the context of the care provided for addictions in our country, the different extant resources, its quantification and main numerical figures, the positioning of residential treatment within the care network, the conceptual models having a bearing thereon, the current perception of their usefulness and the challenges facing this treatment in the near future.

The following methodology was employed for preparing this report:

- All those responsible for the care provided for the individuals using drugs in the different Autonomous Communities were requested to complete a questionnaire. This questionnaire was sent to the 17 Autonomous Communities (the Autonomous Cities of Ceuta and Melilla do not have any residential facilities providing care for drug users).

- In-depth individual interviews were held with four of the aforementioned people in charge of these services (Andalusia, Catalonia, Valencia and Murcia), and with three people in charge of major entities in the care-providing sphere ("Fundación Salud y Comunidad" ["Health and Community Foundation], "Asociación Proyecto Hombre" and Spanish Red Cross).

- A discussion group of clients of residential treatments facilities was held, in which ten people took part.

- Many queries were placed with those responsible for residential treatment facilities managed by the RAIS Foundation (RAIS Foundation is an NGO created in 1998 for the main purpose of providing support for different groups in at-risk situations for their social incorporation. This Foundation manages activities including 4 centres in various Autonomous Communities in Spain).

- All of the above was rounded out by way of analysing numerous documents furnished by those requested to do so or those documents available in documentary or online databases.

HISTORY AND POLITICAL FRAMEWORK

1.1. History of residential treatment

Therapeutic communities have been and currently continue to be the reference facility for providing residential care for drug dependence. To familiarize oneself with the history of residential treatment, one must refer back to the past history of therapeutic communities, which had their beginnings in self-help groups of a major ideological, religious or charismatic nature, combined with a peer support methodology entailing a highly regulatory, hierarchical setup. In Spain, this was to a great extent the very beginnings of care being provided for drug dependence which sprang up during the 1980's heroin epidemic, before the public network came into being. In due course, entities such as "El Patriarca", "Proyecto Hombre" or even the "Church of Scientology" were of leading importance. This configuration currently remains in place solely in some therapeutic communities to be discussed at a further point in this document, which have nothing to do with the public network for the most part, having their own funding and care-providing systems, although they are still playing a minor role in providing care, especially regarding some profiles in certain territories.

The therapeutic communities underwent a professionalization process from the 1980's through the 1990's in Spain which differed to different degrees in different territories. The first regulations governing their operation came into being around 1985, they having been integrated into the public network for providing drug dependence care as of the point in time at which the National Plan on Drugs (1985) was first implemented, at all times as part of a care-providing network where the reference outpatient centres continued to be those mainly responsible for the treatment.

In the 1980's, the network of communities was set up under the "Proyecto Hombre", an entity inspired on the Italian Solidarity Centre, with a global social-educational and treatment programme which placed a major degree of importance on group work and one's time being occupied revolving around carrying out activities. During that same era, different professionals came together to form the Association of Drug Addict Therapeutic Community Professionals in 1986, a set of homologation criteria being set out ten years later for the therapeutic communities serving as a reference for the official accreditations which are currently in force for the most part.

The therapeutic communities were progressively configured as a care-providing resource and not as the basic resource, likewise being confined to an initial point in time of the intervention requiring conditions involving it being necessary for the individual in question to abandon their regular surroundings so as to be able to undertake a treatment process. Hence, the therapeutic communities were located mainly in rural environments, away from the urban environment, which, on one hand, favours the intensity of the treatment process and guarantees conditions of constraint and abstinence, but which, on the other hand, hinders undertaking a reinsertion process and working toward objectives of a social nature having to do with social relations, family relations and transition into work, etc. In addition to the professionalization of the therapeutic communities, the 1990's gave rise to another type of residential care-providing resources coming onto the scene, the treatment support and social reinsertion living facilities. The first versions of these facilities were the "reinsertion flats" in urban environments as an alternative to the rural environment in which the therapeutic communities had normally been located.

Throughout the first ten years of the 21st century, the therapeutic communities and all of the other residential treatment resources have been progressively adapting to the changes in the pattern of use which has been progressively taking shape in Spain, with different client profiles, despite a different image at times on the part of some professional sectors and the difficulties of adapting sometimes quite rigid structures. The growing use of cocaine, the major degree of poly-drug use and the use of other drugs in a recreational type of setting have had a major influence on the residential care-providing programmes.

It is important to point out the fact that when the therapeutic communities first came into being and then went through their subsequent configuration process, most were promoted and managed by entities of a social nature, what is currently known as the "Third Sector of Social Action", which, at the time, were mostly organizations of users, ex-users and their family members. The Public Agencies gradually having taken responsibility gained momentum as of the National Plan on Drugs having been put into practice, the funding falling almost always exclusively or mostly to the Public Agencies, although with different approaches for managing the therapeutic communities on the part of private entities. There have been very few cases in which these communities have been completely publicly managed.

Over the last fifteen years, according to official sociological studies, the social perception Spanish citizens have of drugs as being a problem has remarkably declined, such that this issue is now being considered to be of progressively lesser importance.

On the other hand, as previously mentioned, the client profile has also changed, there therefore being a less pressing need at this point in time to provide care for individuals who have a strong addiction to heroin at such specialized centres as the therapeutic communities. This has all led to the Autonomous Communities having worked more intensively over these years toward improving

the care-providing network in overall terms and on the reference care-providing facilities (which are the outpatient centres), as well as on the implementation of drug use prevention plans and programs.

1.2. Strategy and political framework of residential treatment

According to Spain's Constitution of 1978, "the State is organised territorially into municipalities, provinces and the Self-Governing Communities that may be constituted. All these bodies shall enjoy self-government for the management of their respective interests".

The Spanish State is currently comprised of 17 Autonomous Communities vested with a high degree of political and administrative autonomy. In all of these Autonomous Communities, there is a president and a parliament or legislative assembly of their own. The Autonomous Communities are vested with legislative and management powers of major importance concerning different matters, including all that which has to do with health, education, social services and the care provided for drug dependence. Each one of these Autonomous Communities has its own Statute of Autonomy which is configured as the basic institutional norm.

In addition to these 17 Autonomous Communities, there are two Autonomous Cities, Ceuta and Melilla, the degree of political and administrative autonomy of which is lesser than in the case of the Autonomous Communities, although they are vested with authorities over the care provided for drug dependence.

Generally speaking, the funding of the health services is the responsibility of the Autonomous Communities. Nevertheless, as far as the health care provided for the drug users in some of Spain's larger cities, the treatment resources are funded and managed jointly, to a greater or lesser degree, by the competent bodies of the Autonomous Community and Municipal Government in question.

All of the Autonomous Communities have their own law (at the Autonomous Community level) governing aspects related to drug dependence-related prevention, care and reinsertion. Similarly, the Autonomous Communities have prepared strategies and/or plans for action on drugs which are updated periodically.

These laws, strategies and action plans set forth the duties and powers falling to the Autonomous Communities proper and to the municipalities (in keeping with their populations), as well as the organizations coordinating between the Autonomous Community Government and the municipalities for greater efficiency and effectiveness of the measures to be carried out with regard to drug dependence. Thus, it has been set forth on an overall basis that the preventive and social reinsertion area falls to the Municipal Government, whilst the care-providing aspect falls to the Autonomous Communities.

Some exceptions exist in two realms. Firstly, as a result of the Municipal Government taking authorities upon itself, one of the most significant cases is that of the Municipal Government of Madrid, this being a situation which is referred to as "unvested powers"[26]. Also worthy of special mention is the authorities taken upon themselves by the provincial councils (Local Government) in the Andalusian model and in the Municipal Government of Barcelona. The data related to these unique individual situations are reflected numerically in the data furnished by the Autonomous Communities for this report, as is normally the case, in the data collected by the Government Delegation for the National Plan on Drugs.

The other major exception lies in some residential treatment facilities being considered social reinsertion resources. The boundary line between social assistance and social reinsertion is not

[26] For more information, please see the Selected Issue on "Drug Policies in Large European Cities".

the same throughout all of the Autonomous Communities, although, in principle, social reinsertion comes under the authority of the local government, it has been undertaken at least partially in many cases through the Autonomous Community administration, some housing as support for social reinsertion of drug dependent individuals being available therein. However, in practice, the differences in operation between these dwellings and other dwellings for social support for treatment (clearly under the authority of the Autonomous Communities) are quite nebulous, being operated at other times under care-providing and not social reinsertion departments.

Residential treatment falls within the care-providing area and therefore comes under the authority of the Autonomous Communities, which has given rise to broad-ranging specialization of the facilities, their configuration and their scope in each one of these Autonomous Communities.

The most innovative Autonomic Plans on Drugs in Spain have all included other addictions from a broader-ranging perspective within the care provided for drug dependence. The first step in this regard from a public health-oriented standpoint was the integration of care provided for individuals who have problems involving the use of legal drugs such as alcohol and tobacco. Another subsequent yet significant step was that of incorporating care for behavioural addictions (mainly compulsive gambling), where, in recent times, the phenomenon of the addiction to the new technologies, from internet to cell phones, has arisen, with variations evolving as fast as their use is evolving. The result thereof is that, in some autonomous networks, a commitment has been undertaken of referring to addictions in general and of trying to guarantee the care for these addictions, regardless of whatever type they may be, addictions to: new technologies, sex, work, certain emotional relations, etc.

Lastly, through the Central State Government, all of the drug policies which are carried out at the different territorial levels (central, autonomic or regional and local) configuring the National Plan on Drugs (Spanish Plan on Drugs) created in 1985 are coordinated. A Central Government Minister heads the National Plan on Drugs, the Government Delegation for the National Plan on Drugs operating under the authority thereof. This Delegation is responsible for the executive management, promotion, general coordination and supervision of the services in charge of updating and carrying out the National Plan on Drugs.

All of the foregoing has configured a very complete network for providing drug care which is reference point at the international level in some aspects. Therefore, the possibility exists throughout Spain of undergoing residential care within the public network when a person is experiencing a problem of addiction.

2. AVAILABILITY AND CHARACTERISTICS

There are two main facilities involved in residential drug dependence treatment: the therapeutic communities and the supporting homes or flats. There are some others which are also detailed despite their being on a completely minor plane than the therapeutic communities and the treatment support and social reinsertion flats, especially regarding the number of places. There are highly-specialized resources normally providing care for the specific needs of the individuals for whom they are providing care.

In all cases, the essential aspect of residential treatment is that of providing a controlled environment affording the possibility of progressing in the treatment process that will assure abstinence and will provide accompanying psychotherapy treatment as well as daily living habits and organization in daily life.

2.1. Types and characteristics of the residential treatment units

2.1.1. Types of residential treatment units

2.1.1.1. The therapeutic communities

The therapeutic community is resource provided for those patients lacking basic family or social support or for whom this support, although in place, is considered as being a hindrance for the patient's proper progress in the treatment due to the existence of dysfunctional relations, due to lacking a possibility of basic constraint or even encouraging drug use for some reason, such as the existence of family members or friends who use drugs. The therapeutic communities may also be suitable in certain situations in which, there not being any special problem in the social or family network, the drug user in question lacks self-control and skills for maintaining abstinence within their regular surroundings.

While residing in the therapeutic community, the professional relationship with the reference outpatient centre is discontinued, full responsibility for the treatment falling to the professional team of the therapeutic community. Therefore, the therapeutic communities must avail of a range of professionals capable of maintaining the treatment intervention as a whole, including healthcare professionals (physicians, nurses, and psychiatrists), professionals from the social field (social workers, social educators, employment counsellors, occupational therapists…) and psychologists, as well as auxiliary personnel at times.

Although currently only to a very small degree, the professional teams sometimes include individuals who have a past history of drug use, this having made it necessary for them to meet some minimum qualification requirements for the job position they hold.

2.1.2. Treatment support flats

In addition to therapeutic communities, there is treatment support housing and flats in several autonomous networks (at least six according to the provided information). These flats are residential facilities where the treatment is not centralized, but rather is carried out through the reference outpatient centre providing care for drug dependence. These outpatient centres are manned by a multi-professional team which sets out and manages the treatment, whilst added professional care is provided by way of the flats in a context making it possible for the treatment to be carried out as an alternative to the patient's social environment in an initial or intermediate stage. These flats are located in the urban environment, given that their function is not mainly that of confining patients within an isolated space, but rather that of making headway in a treatment process.

Just as in the therapeutic communities, this resource is provided for the patients lacking basic family or social support or for whom this support, although in place, is considered as being a hindrance for the patient's proper treatment-related progress.
Unlike the case of the therapeutic communities, the professionals who work in the flats do not have full responsibility over the treatment, but rather support the treatment under the indications of the reference outpatient centre. These teams are configured in many different ways depending on the requirements and characteristics of each facility. Thus, there may be a minimal-level configuration, in which the professionals do not possess any special professional qualification, in which case they confine themselves to keeping the rules for peaceful living amongst all and the relational guidelines for occupying time and leisure time set out through the reference centre, as well as keeping a check on the possibility of alcohol or drugs being used.

At the opposite end of the scale, there are resources manned by professional teams comprised of a number of professionals from the social field (social educators, social workers, occupational therapists…), the field of therapy (psychologists) or the health care field (mainly male nurses). In any case, although the professional team in the flat is trained to carry out a treatment programme on their own, their intervention is always under the coordination set out by the reference outpatient centre.

2.1.1.3. Social reinsertion flats

These are homes or flats located in the urban environment and are of a configuration and characteristics very similar to the treatment support flats. They differ from the treatment support flats in that they provide care for individuals who are in the final period of the treatment process, therefore meaning that the professional teams are comprised to be oriented more toward supporting the social reinsertion processes and the return to the initial social environment or achieving an alternative environment. In these flats, the intervention in the area of counselling and integration into employment become more highly intensive among those individuals who have difficulties due to lacking qualification or experience, as well as dealing with both the use of money and the relations within the working environment, especially if this environment has had a bearing on the drug use-related problems of the individuals in question.

The relations with the outpatient centres and the configuration of the professional teams are quite similar to those specified with regard to the treatment support flats.

2.1.1.4. Other facilities

This section has to do with residential facilities of certain specific characteristics, independently of whether they may be therapeutic communities, treatment or social reinsertion support homes or even hospital bed spaces. These facilities are being mentioned here given that their essence does not lie in their being located in a rural or urban environment or in the architectural shape or size of the centres (flats or therapeutic communities), but rather in certain characteristics which have to do with the individuals for whom the care is provided, by socio-demographic profiles of use, etc.

By specific substances

As previously mentioned, in the beginning, the residential facilities were focused mainly on providing care for a group of heroin users. Over the last twenty years, numerous studies confirm a change in the profile among drug users, a very strong trend toward poly-use and a clear-cut advancement of cocaine use having been noted which has progressively balanced out and modified the profile of the clients using these facilities. Most of the resources have progressively adapted to this changing situation by suiting the individual treatments to the individuals admitted to the resource regardless of the main drug used and incorporating any possible organic and psychological complications resulting from the same. However, some specific facilities have been

found for providing care for cocaine addicts which specialise in the possible psychiatric complications resulting from this addiction.
The greatest degree of specialization of resources based on the substance used has to do with alcohol, which, being an element for exclusion in this report, is therefore not discussed herein.

By specific types

In some Autonomous Communities which have an extensive care network as regards both the number of facilities and places, some highly specialized drug dependence treatment centres can be found which have been implemented to a highly limited degree or to no degree at all in the rest of the Autonomous Communities. In some cases, this specialization is not formal, but rather solely progressively comes into being in a more or less planned manner without however being specified in the description of these facilities. In others, however, such as is the case of the Autonomous Community of Madrid, there is a high degree of specialization. In this Community, which includes the municipal network of the Municipal Government of Madrid's Addiction Institute, there are facilities for the homeless, for providing care for highly-deteriorated chronic clients, for dual diagnosis patients, for self-management, for autonomy, etc.

The facilities for individuals with dual diagnosis-related problems are especially significant, being the paradigm of resource specialization (not only residential) and being highly valued by the individuals for whom care is provided and of major significance also when the drug care network is situated within the mental health field.

The Autonomous Community of Andalusia provides housing for drug-dependent individuals who have AIDS, although those heading this service entertain certain doubts as to it being advisable to consider these facilities as residential treatment facilities.

In the Autonomous Community of Catalonia's network, there is a special facility known as a "crisis centre""[27], based on an experience carried out in the Netherlands, in which the patient is admitted due to a subjective crisis episode, although there be no evident social, organic or psychiatric emergency involved, but rather a combination of several factors. This type of facility could replace the detoxification units at some point in the future. On being admissions involving very short stays (maximum seven days), the intervention plan must be organized by the centre to which the referral is made.

Facilities for minors

There are specific residential facilities for minors who have drug use-related problems in different Autonomous Communities, there being a certain degree of specialization on the part of some organizations (Dianova) in this type of care. Along general lines, the intervention with minors can be said to divert the focus from the addiction to place it on the personal plans, placing great relative importance on the development of the person as a whole so as prevent the use or addiction from taking hold.

Minors and adults living together has been considered as being a problem for minors, given that they consciously or unconsciously take adults as a point of reference, this being a major problem in their treatment process.

Facilities for females, couples or women with children

Information has been gathered on the existence of some residential resources provided exclusively for females, which ensures, on one hand, the existence of a sufficient number of places for females in the network and, on the other, affords the possibility of dealing with aspects specific to the

[27] No data have been provided; therefore they are not included in this report.

females who have problems of addiction. In the case of the Andalusian network, mention is made of facilities for women with children or couples with drug use problems. Information exists as to the presence of females in some therapeutic communities not having been properly managed, emotional relations coming to bear at a point in time of great far-reaching importance in the life of the individuals affected having interfered in the treatment processes, giving rise even to their dropping out of treatment.

2.1.1.5. Admission criteria

The admission requirements are usually set by each care-providing network, the main requirements having to do with the profile of use and the diagnosis, socio-demographic aspects, social environment, health status and obviously the degree to which the admission is voluntary.

Past history of use

The prime requirement for admission to a residential facility is the existence of a problem of drug use, drug dependence or drug addiction. In some cases, the profile of use is defined formally or by way of a distinction being made in practice, in the direction of a certain type of drug in particular, although most of the residential facilities have opened up their range of care to include any type of drug (even including alcohol in some cases). Similarly, there are some cases in which the residential facilities are likewise open to providing care for behavioural addictions not involving the use of drugs or in which drug use is not the main reason for admission. In these cases, compulsive gambling, addiction to sex, to the new technologies (videogames, internet, cell phone…), to work, to emotional dependence, etc. are included.

Socio-demographic aspects

Most of the residential facilities are for adults, although there are some residential facilities for minors only. Adults and minors living in the same facility has been identified years ago as a risk factor in the prognosis of the younger individuals, who, as previously mentioned, need a treatment in the residential facility which is more focused on defining their personal plans than on specifically treating the addiction.

Apart from the above, gender may likewise be a decisive factor in an admission to a residential facility. Most of the facilities have the number of places available for males and for females regulated, being in many cases exclusively for males, especially in the case of small-sized facilities (support and reinsertion flats). In this regard, there are two factors to be taken into account. On one hand, the architectural configuration proper of the centre, which determines the number of rooms set aside for each gender. The number of individuals for whom care is provided in the drug dependence care-providing network in Spain, care being provided for 83% males compared to 17% females. This has meant that the vast majority of centres are for males, although there are some facilities for females only. The second factor is taking sexual relations within the residential facilities into consideration and the regulation thereof in terms of different criteria and especially the incidence on how the patients' treatments evolve. At some centres, relations with one's spouse/partner are even limited during the treatment period. With regard to the gender perspective, there are professionals who have set out different aspects concerning the male-focused configuration of the drug dependence care-providing system proper.

Social environment

One fundamental criterion for admission to a residential facility is that of not having the basic social environment and family support necessary. This lack is considered in different ways in certain cases, although it is normally determined at the judgment of the reference centre team and mainly that of the social worker.

However, there are some cases (mainly on the part of some social entities which base their decision on a criterion differing from that of the Government Agencies) in which family support is considered, to the contrary, to be a fundamental requirement and a factor for the success of the treatment, the non-existence of which may be a criterion for exclusion ("Proyecto Hombre" may be one example in this regard, although their position has been changing over the past few years).

Health status

Practically all of the residential facilities require a health status affording the possibility of peacefully living together with others and adapting to the dynamic of the facility on the part of the individual proper and on that of the rest of the patients. This means the non-existence of infectious diseases in the active stage, when they entail a risk for the other clients, the non-existence of a physical disability preventing the self-dependence required at the facility, as well as the non-existence of psychiatric disorders. This last-named aspect is usually one of the main reasons for discrepancy at times in the process of adapting the criteria for inclusion among those responsible for the residential facilities and those responsible for the reference centres processing the referral.

Voluntary admission

Admission being voluntary is a fundamental requirement for being admitted to the residential facilities. This is a basic human right governed under Spanish legislation on patient autonomy, as well as a result of being considered a determining factor in the progress of patient's treatment. In this last regard, the evaluation of the patient's motivation as a criterion for success is at times reason for discrepancy between those responsible for the centres making the referral and those responsible for the residential facilities, where there is usually a more highly demanding criterion on the part of the latter. The degree to which admission is voluntary is usually determined in a document known as the "informed consent form" in those facilities which have progressed in recognizing patient rights, whilst being solely an undocumented practice at others.

The possibility of forced admission is quite limited in Spain and when carried out is always determined by way of a court decision, but does not take place regarding just simply drug users, but rather is for severe psychiatric disorders. This is accomplished by means of admission to hospitals or psychiatric centres for adults (normally persons legally incapacitated) or by means of court convictions as a result of behaviours governed by the penal system, in which case the prison system (which has two psychiatric hospitals) takes charge.

However, there are circumstances in the prison system which govern ways of serving sentences alternative to incarceration on the part of individuals who have drug dependence-related problems, in which the degree to which the individual's admission is voluntary could be considered to be conditioned.

Lastly, mention must be made of the times prior to admission to residential facilities. Although complete information is not available, there are sometimes waiting periods of up to two or three months for admission. This waiting period has been a source of controversy regarding its perhaps not being the best way of proceeding with regard to improving client motivation at the point in time of their admission, although this argument is being put forth by a minority at present.

2.1.1.6. Release from facilities

Whilst admission to the residential facilities is determined by the referral from the reference centres, patient release takes place independently of these centres in the case of the therapeutic communities, which take charge of the treatment process from beginning to end of the patient's stay. However, in the treatment support and social reinsertion homes, this aspect continues to come under the authority (normally shared) of the outpatient treatment centres. In both cases, the stay reaches an end for any of three main reasons: the time periods or objectives have been met,

voluntary release or expulsion. All of the releases of individuals for whom care is provided involve the documentation of the process by means of a report issued at the end of their stay.

The analysis of these reasons for leaving the facilities is, in conjunction with the ex-post evaluations, the fundamental criterion of efficacy and efficiency of these facilities, being determined in terms of the percentage of treatment releases.

Being released from the residential facilities does not imply the end of the treatment process, treatment still being continued through the reference outpatient centres, which may refer the patient to other residential or outpatient resources or continue the intervention exclusively through the outpatient centre until final release.

2.1.2. Approaches

The role which the residential treatment facilities play in the care-providing network in Spain is conditioned to a great degree by the past or current opinion of those heading the different Autonomous Communities as to the functions and benefits of these facilities. An assessment is provided in following as to the different approaches to the care provided for drug users and its implications in the configuration of the residential facilities.

2.1.2.1. Addiction as a mental health problem

The approach which has taken hold to the greatest degree over the past few years is that of positioning the care provided for drug dependence within the mental health network as a result of considering dependence on drugs to be a mental health-related problem. By way of this approach, a great deal of importance is placed on the residential facilities as isolation centres, with the implications thereof in a context set apart for the intervention and also for confinement. However, the classification of mental health services does not easily fit in well with the classification of the residential treatment facilities. The objectives of isolation, confinement and separate environment for the intervention seems to be achieved more readily in the larger residential facilities than in those smaller in size (support flats or housing in urban areas).

The mental health approach maintains a different professional opinion toward the professionals of the reference outpatient centres than toward the residential facilities as a result of their being responsible for the treatment. Although the role of the residential facilities is generally subsidiary to the role of that outpatient centres (and thus their teams of professionals), when the intervention is designed from the mental health perspective, the top-priority role is played by the psychiatry professionals and, to a lesser degree, by healthcare professionals, positioning the psychosocial intervention teams at a level of lesser importance.

This effect is on the rise due to the fact that there are currently very few psychiatry professionals in Spain, there being a scant likelihood of their being located at residential facilities. Generally speaking, the degree of specialization required in the field of mental health had not as yet made its way to the residential facilities nor does it have any possibility of doing so due to the conditions in which these facilities are funded.

In terms of organizational functionality, placing the care provided for drug dependence within the mental health network is not usually done on a full-fledged basis nor is this always done, in practice in terms of equality with the rest of the mental health facilities. The care provided for drug-dependent clients is carried out operating hierarchically under organizational units which act in parallel to all mental health activity as a whole, within any homogeneity of protocols for taking action or for outfitting and workloads being achieved. The trend toward integration into standardized networks has been confined, in practice, to simple organizational coverage, meaning that many times the residential treatment is not always one of the managing entity's priorities.

The mental health approach devotes special care to the “treatment”, understood as overcoming the mental disorder in question, in a process ranging from detoxification to habit cessation, entailing a major involvement of pharmacological support in the individual intervention in conjunction with individual psychotherapy greatly focused on the clinical aspects, which is some communities is quite markedly psychoanalytical in nature. And all this may lead to lesser importance being placed on the social insertion phase in comparison to that placed through other approaches.

From the perspective of actual complete rehabilitation of some patients being impossible to a certain degree, the mental health approach considers the residential facilities for drugs to be partial rehabilitation spaces during an acute episode of a mental disease. It also considers this period, regardless of the prognosis, as a physical recovery and timeout in very tough vital processes, not only for the patients for also for their families and close social networks.

This gives rise to a certain contradiction in view of the impossibility of care from a more social perspective, but also due to the impossibility of the abandonment of certain patients, some minimum resources therefore sometimes being managed in view of the non-existence of other facilities of an exclusively social type. Some managing entities advocate a hypothetical “socio-sanitary space” as an entity for referring patients who have chronic, irremediable disorders for the purpose of being able to free resources and professionals for the purpose of providing more effective care.

2.1.2.2. The social-educational model

One approach of major importance on the part of the therapeutic communities in Spain is the social-educational approach in response to considering the problem of addictions as being a bio-psycho-social problem. From this standpoint, the interrelationship among factors, consequences and biological and social symptoms is taken into account in the care provided for drug users.

This model is aimed at integrating these three health-related perspectives, there however being a major difficulty involved in drug care being administratively positioned in the social and health systems, these being systems with are dissociated from one another, whilst those defending this approach stress the coordination and collaboration among the different networks. The staunchest supporters of this approach tend to position the care provided for drug dependence in the social welfare system, the top reference point of which might be the Autonomous Community of Andalusia.

This approach has been employed for configuring a line of therapeutic communities which have been termed social-educational communities versus those of a psychotherapy-oriented line. The therapeutic communities stress the work of acquiring or recovering living habits and relations with others, placing great importance on the organization of structured and unstructured activities and social interactions which are carried out in formal and informal situations and environments affording the possibility of acquiring personal responsibility and decision-making skills. In this model, group intervention is of greater importance than individual intervention.

In some Autonomous Communities, the social welfare system and the health system come under the authority of one same Department, which could facilitate communications and coordination among different care-providing systems, however, in practice, no major differences are found to exist in comparison to other models: the strongest sub-system (health system) always taking precedence over the lesser system (the social system).

2.1.2.3. The psychotherapy intervention approach

With respect to the socio-educational approach, there is another approach committed to quite an in-depth psychosocial intervention. This approach is not predominant at this point in time in the care being provided for drug dependence in any Autonomous Community, but was indeed

predominant throughout a time in which psychological intervention was more highly valued than medical intervention.

From this perspective, the length of time spent in a residential resource is a privileged intervention space for working on personal factors having a bearing on the use in question, especially the emotional factors, where the patients can learn to interact socially, consolidate their own identity and learn to maintain social relations, also being aimed at a behavioural and motivational change and, in greater depth, a true process of "redoing" their lives.

The active involvement in the residential facilities can be noted in the treatments being more highly structured, entailing a great deal of individual and group intervention and practically all the time is taken up with therapeutic interventions, predominantly devoted to the psychological aspect

Although no Autonomous Community is known to have adopted this approach as essential to its network, the "Proyecto Hombre" social organization, highly important in this sector, could be said to be the entity most intensely maintaining psychosocial intervention. This organization acts within a framework of collaboration with the public network, although also maintaining its own individually-defining features and even its own model if its additional funding so allows. Through this model of the predominantly psychological as a preferred intervention context, this organization is committed to configuring highly well-rounded multi-professional teams, long stays and a strongly-structured intervention.

2.1.2.4 Public health approach

One important approach during the 1990's which is still in place is some autonomic networks is the public health approach. This approach places prime importance on the harm which the use in question causes, whatever the harm in question may be. A major degree of importance is placed on the residential facilities by way of this approach by encouraging their being made more flexible, promoting a certain revamping of the residential care provided and allowing for objectives other than abstinence. This is an approach used to a great deal in the case of those patients who are using opiate substitutes or in the process of making the strict demands on meeting objectives more flexible. This pre-eminently clinical perspective incorporates social insertion objectives into the treatment to a lesser degree due to its not having a direct, quantifiable effect on the disorder.

Significant headway has been made by way of this model in opening up the therapeutic communities to new client profiles, to admitting patients undergoing methadone treatments and making the more rigid models which existed when therapeutic communities first came into being more flexible. This has also afforded the possibility of bridging gaps by way of the different models to reach a consensus regarding the methodologies, systems for evaluating and monitoring the activity in terms of health objectives to be achieved. This has also been a model which has contributed a great deal to the processes of planning the care-providing network by being provided with and investing all of the experience of other public health processes and services. In some aspects, the care-providing network of the Municipal Government of Madrid's "Madrid Salud" Addiction Institute would be a fine example of the advantages of this approach.

2.1.3. Mix or integration of services

There are two opposite trends in residential care in different autonomic networks: those which are committed to the integration of all addictions and all profiles of use in the same facilities, regardless of what their characteristics may be; and those which are committed to the specialization of the different facilities in terms of different types of users, by substances (alcohol, cocaine), by specific disorders (especially dual diagnosis) or by social or demographic profiles (females, minors, immigrants…).

Some Autonomous Communities which avail of greater capabilities for planning, homologating the portfolio of services and training professionals are inclined toward integration with a perspective of universalizing the care provided (Andalusia would be a reference point in this regard), which also affords the possibility of a greater efficiency of the resources. This is likewise the trend which will likely be having the best prospects in a budget-cutting situation.

On the contrary, especially in autonomic networks which have sufficient resources and whose territories are not widely spread (the reference can be the Autonomous Community of Madrid) teams of professionals with a high degree of specialization are sought with the prospect of incorporating methodologies, techniques and teams which are advanced in each field. In this regard, one can hardly negate the need of specialized facilities, for example, facilities for females or for dual diagnosis patients.

Some of the trends which have come into being over the past few years for improving the care provided for profiles for which sufficiently high-quality care is not provided in the network according to their specific requirements (and which would require efforts for the improvement or specialization of the residential facilities) are in jeopardy of being suspended. This may be the case of homeless individuals addiction-related problems, mothers with children who cannot be provided with care by family members or other services, some groups of immigrants whose health is deteriorated to major degrees associated with highly problematic uses or profiles of users who have a long past history as users and who require a degree of care and assistance that, despite their stability, are excluded from the network of residential facilities for the elderly, in some cases due to the refusal to continue prescribing opiate substitutes (mainly methadone).

The Delegation for the National Plan on Drugs is working on a further expansion upon the portfolio of services which could be definitive for providing a solution to these opposing trends.

2.1.4. Integration of patients with opiate substitute treatment into residential treatment

In the 1990's, the opiate substitute programs, mainly methadone programs, became widespread in Spain. According to the data on patients for whom care was provided in methadone maintenance programs in Spain collected by the Delegation for the National Plan on Drugs, there was a relatively constant rise from 1993 to 2002, from 15,398 patients to 90,488 patients, there having been a slight decline in the following years, down to 83,374 patients in 2005, having remained stable over the past few years, the latest data available being for 2010, totalling 81,022 patients.

Just as for the vast majority of the services providing care for drug users, the residential facilities encountered major difficulties on undertaking the admission of drug users from methadone maintenance (opioid substitution treatment) programmes. However, the presence of these individuals is currently a situation accepted on a widespread basis throughout all of the facilities, there being extremely few residential facilities currently refusing to admit this type of patients. In fact, at many facilities, healthcare professionals having been incorporated into residential facilities has evolved along with the need for prescribing and dispensing this pharmaceutical drug.

Nevertheless, the professionals at some residential facilities have put pressure sometimes openly or covertly on the clients and the professionals in charge of prescribing (the physicians at the reference outpatient centres) to lower or discontinue the prescribed doses. This attitude on the part of some residential facilities is becoming progressively less frequent. It is also true that this pressure is more exerted than by the conviction of the professionals as a result of the conditions required by the Government Agencies. The widespread use of methadone in the programs for drug users has also contributed to this situation. Around 40% of the patients for whom care is provided within the care-providing network make use of this network without there being any difference among profiles and prognoses justifying, in practice, the existence of a criterion for the exclusion of the patients in relation to the use of opioid substitutes.

2.1.5. Levels of collaboration and relations among networks

2.1.5.1 Positioning and relations with the care-providing network

The residential facilities in Spain are considered as being second or third-level facilities within the public network. On analysing the drug care-providing network as a network within another more general network (normally the health or social welfare network); the facilities providing drug care would be a second-level facility. However, admission to the residential facilities is always through the first-level facilities in the drug network, the outpatient centres providing drug dependence care, addictive behaviour units or those termed similarly. Despite their being termed differently within the different autonomous networks, these centres are configured similarly throughout all of these networks and are manned by multidisciplinary teams generally including professionals from the fields of psychology, social work and medicine, which are usually rounded out with other health care professionals (nursing, psychiatry…) or social care professionals (social-employment counsellors, monitors, social educators, occupational therapists…).

The outpatient drug care centres are considered as being the first level in the drug dependence care-providing network and are those responsible for referring the patients to the residential facilities, the residential facilities being second-level facilities within the drug care-providing network. In relation to the health network (or social network in some Autonomous Communities), the outpatient centres would be specialized or second-level resources, whilst the residential treatment centres would be third-level resources.

The residential facilities operate under the authority of the reference facility in drug dependence care in Spain. Some minor difference being involved with regard to the system by which this care is carried out, the reference centres (outpatient drug dependence care centres, addictive behaviour units or similar) determine whether it is best for a patient to be admitted to a residential facility, they therefore being those responsible for determining the admission, without any spontaneous admission or admission at the decision of the residential facility proper being regulated.

This referral system usually works under single-list systems centralized within each one of the autonomic networks, although there be some exceptions in which this is regulated spontaneously through the reference centres proper, with a greater degree of autonomy. Referrals are made by means of referral reports which are issued through the reference centre, although the possibility exists in most cases of refusing to provide a place for the patient if the patient is considered as failing to meet the admission requirements.

Sometimes, a certain degree of discrepancy may exist in this regard between the reference outpatient centres and the residential facilities, the reference outpatient centres usually urging the admission (at times even due to being pressed to do so by the patients or their families), whilst the residential facilities are more demanding in some aspects. This is a strain which has also been found to exist in the subsequent communication among the professionals from both of these facilities during the stay in the case of treatment support housing (in the case of therapeutic communities, this does not come to bear because these contacts do not take place).

2.1.5.2. In sectorial dependence: Health versus social welfare

A general consensus exists as to drug addiction entailing certain aspects, in its origin and in the way in which it is approached, which come under the heading of health care and other aspects which come under the social welfare network. However, on having been configured as a specific network in Spain, it has always been positioned in one of these two networks. Throughout the last fifteen years, different changes have come about in the positioning of the drug dependence care system, situating it within the health network. Funding aspects may possibly have had some influence being the health system the most high-powered, best equipped and administratively best organized.

The technical implications of the drug dependence network being positioned within the health network have meant an increase of professionalization, some major advancements with regard to scientific evidence being taken into consideration in the treatments, an increase of listing of the interventions and all that has to do with evaluation. These implications have however been more difficult to apply to residential treatment, where the heterogeneity of the facilities, the lesser degree of homologation on the part of the teams of professionals and the interventions and the lesser presence of healthcare professionals thereof have meant fewer advancements having been made.

Similarly, the care-providing network has sometimes been perceived on the part of those responsible for health care as being a group of facilities difficult to understand and to place, without any orderly planning or this network has been updated or eliminated. However, during the previous years of economic growth, there had been a heightening in professional qualification and in the practices of the residential facilities, although not always having been due to planning but more as a result of the dynamics proper of this sector.

In the processes of integrating the drug dependence care-providing network into the health or social welfare departments, we often come across aspects “inherited” from the prior organization as a result of the impossibility of undertaking, in standardized management, the specialities of this network and therein primarily the needs for planning and leadership. This has sometimes meant the management of the services being turned over to certain units whilst the responsibility for the coordination and planning of the services is left to others. Despite this type of administrative organization being hard to position within the civil service system, it affords the possibility of maintaining a greater degree of care provided and dynamism in the care-providing network, which has some major implications, in turn, on the residential centres when this is the case.

2.1.5.3. Administrative management: Services agencies versus the socio-sanitary space

The care-providing network being integrated into the different Autonomous Community Ministries has led to this network being added into the respective administrative organizational charts. The evolution of the health network (the major network in the case of drug care) tends to be organized into a service provider network, one of the priorities of which is the application of efficiency and profitability-related criteria, as well as the classification of the care by means of drafting portfolios of services. Positioning the drug dependence resources in the respective organizational charts has entailed some difficulties regarding equating the existing organizational systems and modifying the prior practices. This process if giving rise to different management-related approaches in the residential treatment facilities which may be having some major repercussions for this network in the future on being facilities easily within the existing systems.

The socio-sanitary space, which pursues integral individual-oriented care and which is often called upon (appealing to the organized coordination among systems) to provide a response to unfulfilled needs which do not obviously fit into any of the services in each network, may possibly be affected to a greater extend in this process, possibilities of coordination and planning of services providing responses to these situations being lost.

2.1.5.4. The relationship with the third sector as promoters and providers

Regardless of whatever management model may be implemented (the approaches used the most for funding with the private sector are agreements, contracts and subsidies, where each Autonomous Community goes by its own individual system), the vast majority of the residential resources are managed by private entities placed in charge thereof by the Government Agencies. The vast majority of these entities are entities which pertain, in turn, to the Third Sector; NGOs, associations, foundations and, in some cases, religious entities. Within the scope of the foundations, some are public or semi-public however dealing, in practice, with residential facilities involves dealing, in parallel, with the management of the third sector entities, and the perception

that the public authorities have of these facilities is conditioned mainly by their view of the management carried out by the social entities.

In many cases, the third sector entities contribute by supplying volunteer personnel for managing the residential facilities, thus lowering the cost of these facilities. Nevertheless, a certain degree of debate exists as to it being best to incorporate volunteer personnel, due to the difficulties of assuring the necessary qualification requirements and violating the volunteering-related agreements which rule out volunteers taking the place of paid personnel.

In the information gathered to write this report, some of those in charge have been found to be of the opinion that these entities are innovative, realizing and adapting to the changes more readily and being comprised of committed individuals, whilst in other cases they are perceived as entities set up to defend individual interests related to self-employment, lacking professionalism and suitable management criteria. In the information gathered, the perception which the public authorities have of the residential facilities and the not-for-profit entities is noted as being quite similar. It is for this reason that some aspects related to the Third Sector will be dealt with in further depth herein in following.

2.1.5.5. The management model: From subsidy to contract

Over the past few years, a trend has been being noted toward a change in the management model of the residential facilities, which is in some way a change which the Third Sector proper has been making overall. The coming into being of the services carried out by the Third Sector and clearly that of the residential treatment services have been funded for the most part through the Government Agencies and, to a small degree, by the clients and their families proper and to a negligible degree by other sources of private funding (religious faiths and savings and loan bank benevolent funds, for the most part). This public funding has been done under the legal convention of the subsidy. Subsidies imply granting financial resources to an entity for carrying out a certain social purpose in particular, the entity in question being under the obligation of justifying the expenditures made. The obligations and the possibilities of planning and controlling the activity on the part of the Administration in this legal convention (due both to its legal regulation and the dynamic which has taken hold in practice) is limited to and aimed much more toward the justification of the funds provided having been spent for the planned purpose and not so much at achieving specific results. The subsidy approach is usually carried out on a small volume of funding, at least when done in terms of competition. This has given rise to a special approach which has been the signing of agreements between a Government Agency and a Third Sector entity, which has been the legal convention under which the residential facilities have been maintained on numerous occasions. However, due to the intervention of the Government Agency control and intervention systems, a limitation has been being placed on this funding system, given that it is not guaranteed that this funding is done under circumstances of transparency and equity, but rather by way of a subjective decision on the part of public authorities in charge of certain bodies.

It is for this reason, as well as due to the growing public responsibility over the planning and control of this activity and in undertaking the residential activity as something of its own, that the funding by means of subsidies has progressively evolved toward conventions regulated under the legislation governing public contracting. This is a mechanism which has been progressively coming to bear in parallel to the participation of the private sector in providing public services, the residential facilities being found to continue to be massively provided by Third Sector entities.

Within this context, there is a growing trend toward services being purchased on the part of the Government Agencies within a context of competition, transparency and equality of conditions in accordance with the legislation governing government contracting, which, in any case, will hardly modify the composition of the entities which are providing services in this regard, given that the

residential care market requires major investments and a high degree of specialization whilst entailing very little or no economic profitability in most cases.

2.2. Availability and accessibility at the national level

The data provided in following is rather a precise approximation regarding the quantification of the residential resources currently existing within the Spanish State, it however being necessary to take some clarifications into account in the quantification. The diversity of residential resources, its different classification and the difficulties involved in obtaining complete, homogeneous information all make it difficult to determine an exact figure for the data on the extant resources, the number of places, facilities and individuals for whom care has been provided.
Another factor which may give rise to imprecise information is the converging data for 2010 and 2011. Despite the data requested referring to 2011, in some cases, some information is for the year before, which may give rise to some minor deviations, which, in any case, do not alter the fundamental information, given that all of the data on number of places and individuals for whom care was provided is for 2011. Similarly, it has also been necessary to modify some of the information provided in order to homogenize the criteria set out by the European Monitoring Centre on Drugs and Drug Addiction (EMCDDA). The data related to exceedingly short stays as well the stays exclusively for detoxification have been excluded, it also having been ruled out to include those cases in which treatment was provided only for alcohol addiction. Nevertheless, the interpretation of this data has included a subjective criterion in some cases in the classification of the centres, which would entail, in turn, changes in other care-providing-related data[28].

2.2.1. Distribution of centres, places and clients

The following Table provides all data distributed by total number of places, the number of clients for whom care was provided, the number of centres and the ratio between the number of clients and number of places per population[29]. There were a total of 4,506 places in residential facilities in Spain in 2011, care having been provided for a total of 9,312 individuals.

[28] Some of the information from the Autonomous Community of Madrid may be imprecise, given that this Autonomous Community uses a somewhat different system for classifying facilities. The referring data includes the places from the Municipal Government of Madrid's Addiction Institute (more than half thereof).

[29] Data taken from the official municipal register of residents at January 1, 2011.

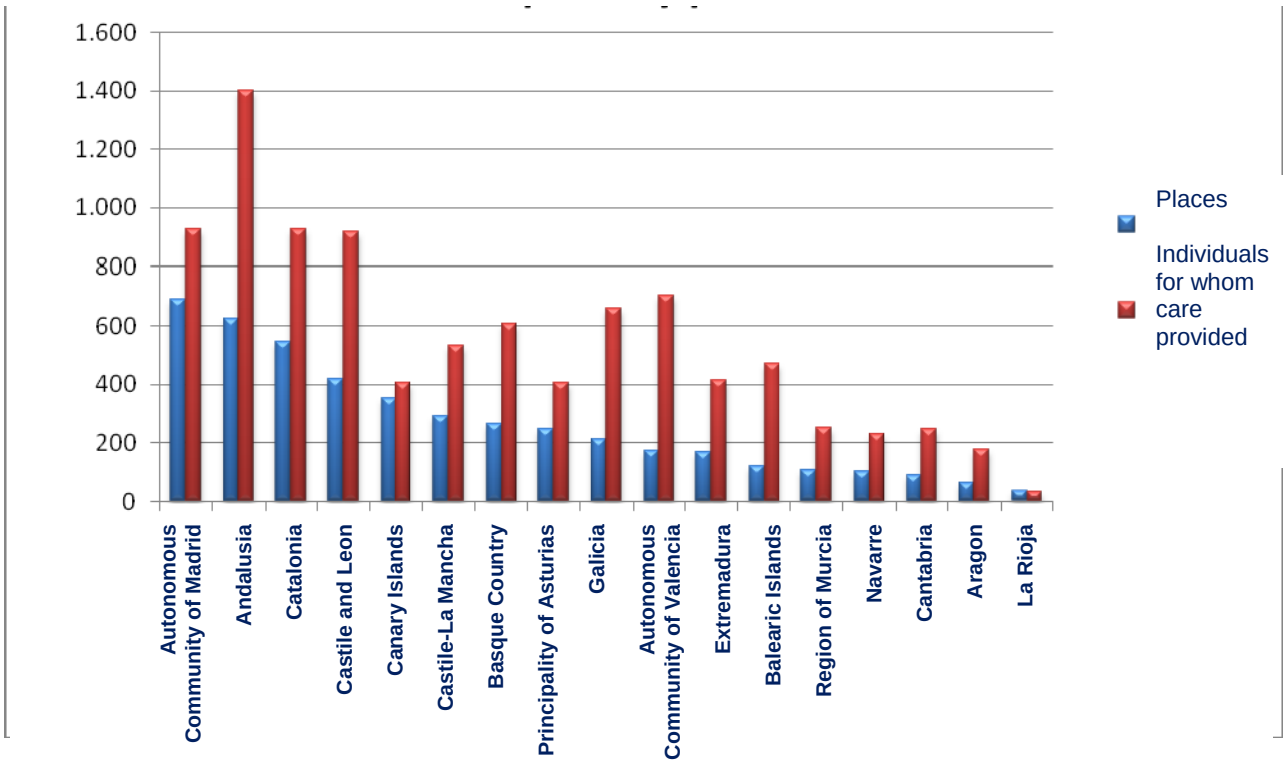
Table 11.1 Total places, clients for whom care was provided, centre number and clients/places ratio and places/population ratio.

Autonomous Community	Places	Clients for whom care provided	Centres	Clients/places ratio	Places/ inhabitant x100000	Population
Andalusia	623	1,402	46	2.25	7.4	8,424,102
Aragon	63	178	2	2.83	4.7	1,346,293
Cantabria	90	247	2	2.74	15.2	593,121
Castile and Leon	417	919	9	2.20	16.3	2,558,463
Castile-La Mancha	293	530	12	1.81	13.9	2,115,334
Catalonia	547	928	18	1.70	7.3	7,539,618
Ceuta	0	0	0		0.0	82,376
Autonomous Community of Madrid	689	926	54	1.34	10.6	6.489,680
Autonomous Community of Valencia	173	702	9	4.06	3.4	5,117,190
Extremadura	169	415	10	2.46	15.2	1,109,367
Galicia	211	659	10	3.12	7.5	2,795,422
Balearic Islands	122	470	3	3.85	11.0	1,113,114
Canary Islands	352	407	11	1.16	16.6	2,126,769
La Rioja	35	32	1	0.91	10.8	322,955
Melilla	0	0	0		0.0	78,476
Navarre	101	231	3	2.29	15.7	642,051
Basque Country	266	608	7	2.29	12.2	2,184,606
Principality of Asturias	249	406	4	1.63	23.0	1,081,487
Region de Murcia	106	252	7	2.38	7.2	1,470,069
Total	**4,506**	**9,312**	**208**	**2.07**	**9.5**	**47,190,493**

2.2.1.1. Number of places and clients by autonomous communities

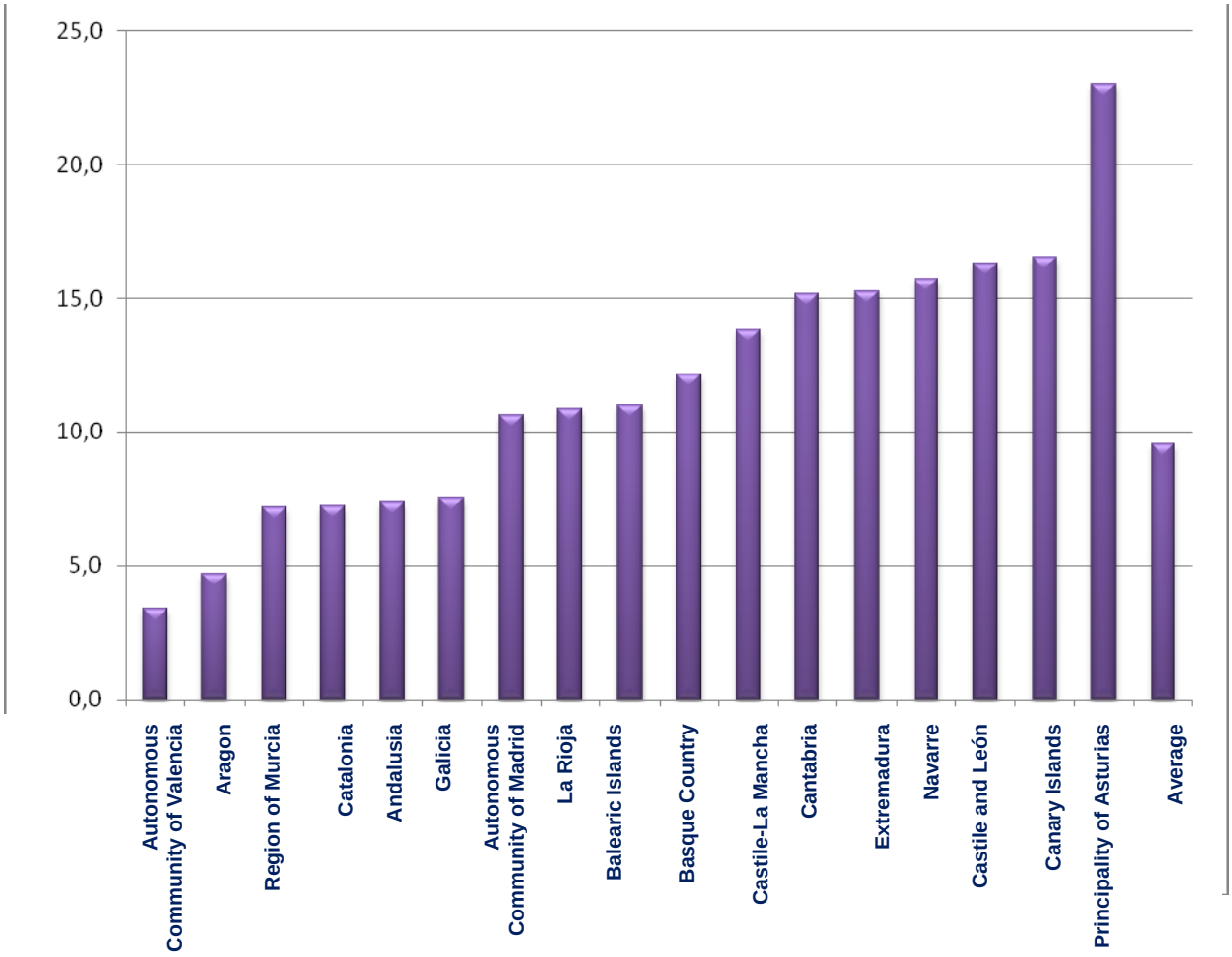
The largest number of places is in the Autonomous Communities of Madrid (689), Andalusia (623) and Catalonia (547). These are the three Autonomous Communities which have the largest absolute number of inhabitants, thus affording the possibility, in an economy of scale, to apply greater planning and specialization criteria without it being possible for us to be able to give more details regarding this study.

Figure 11.1 Breakdown of number of places and individuals for whom care provided



On calculating a ratio of the number of places available per inhabitant (per 100,000 inhabitants), 9.5 residential treatment places are found to exist in Spain for every 100,000 inhabitants, thus meaning one place for approximately every 5,000 inhabitants. Some major differences however exist with regard to the availability of places depending on the Autonomous Communities in question. The Autonomous Community which has the largest number of places per inhabitant is the Principality of Asturias (23 places per 100,000 inhabitants), followed by a major group of Autonomous Communities having a small number of inhabitants, ranging from half a million to two and a half million inhabitants. The most highly-populated Autonomous Communities are situated at around the average or slightly below, with the exception of the Autonomous Community of Valencia (3.4 places per 100,000 inhabitants), the fifth-ranked of the most highly populated Communities (not including the two Autonomous Cities of Ceuta and Melilla, which are not large enough to develop residential resources and are ranked in last place).

Fig. 11.2. Places per inhabitant x 100,000

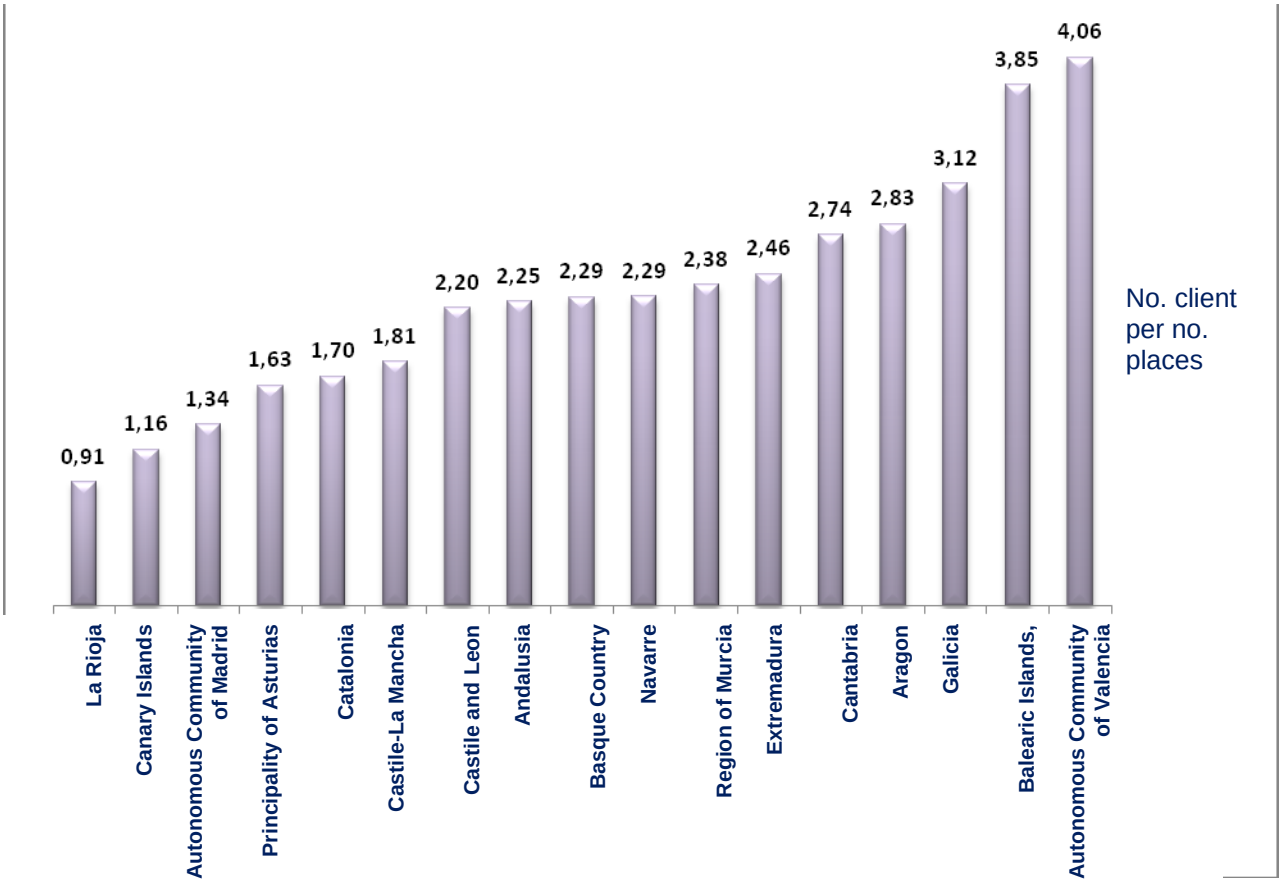


A marked difference exists on the part of the Autonomous Community of Asturias, with 23 places per 100,000 inhabitants, which is nearly 150% higher than the average (9.4), whilst the second-ranked position held by the Autonomous Community of the Canary Islands could be due to the fact of this being an island chain, a fact setting this Autonomous Community apart from others which would justify the importance of the therapeutic community due to the need for isolation within a context of highly limited geographic dimensions. In fact, the Canary Island Government has made an effort to expand the therapeutic communities in order to be present on almost all of the islands. This is a hypothesis which is not confirmed in the case of the Balearic Islands, although in this case, the presence of residential facilities of a private type, to which reference will be made at a further point herein, is particularly significant. The fact that this Autonomous Community has a noticeably higher per capita income might explain the difference.

2.2.1.2. Ratio between the number of places and the number of clients

On analysing the ratio between the number of individuals for whom care has been provided in relation to the number of places available in each Autonomous Community, the data is found to vary, ranging from a number of clients lower than the number of places in La Rioja, implying that care was provided for a lesser number of individuals than places available, to the Autonomous Community of Valencia, which has provided care for more than four times the number of individuals than the number of places it has available.

Fig. 11.3. Ratio of individuals per place



Two opposite indicators having a bearing on this factor: the ratio of occupancy of the resource and the number of days of care provided. The diversity of the information available has not made it possible to process these two indicators. The range of days of care provided for one same patient determined as optimum for the different resources could fall anywhere within a range of three to fourteen months. Some information has been furnished indicating that, in some cases, the budget cuts are affecting the maximum number of days a resource can be used, so that care may be provided for a larger number of individuals at the same cost. This would therefore be an efficiency-based criterion. On the contrary, the largest number of days could be said to be an indicator of the facility functioning well, with the ability to achieve adherence to the treatment on the part of the individual admitted and therefore with a lower degree of dropouts and expulsions from the programme, increasing the number of treatment releases and the subsequent ability to maintain abstinence.

2.2.1.3. Breakdown by types of centres

In relation to the types of centres which are determining in the section on availability, a list is included in following showing the number of centres, the number of individuals for whom care was provided and the number of places available according to the types of centres detailed (2011 data).

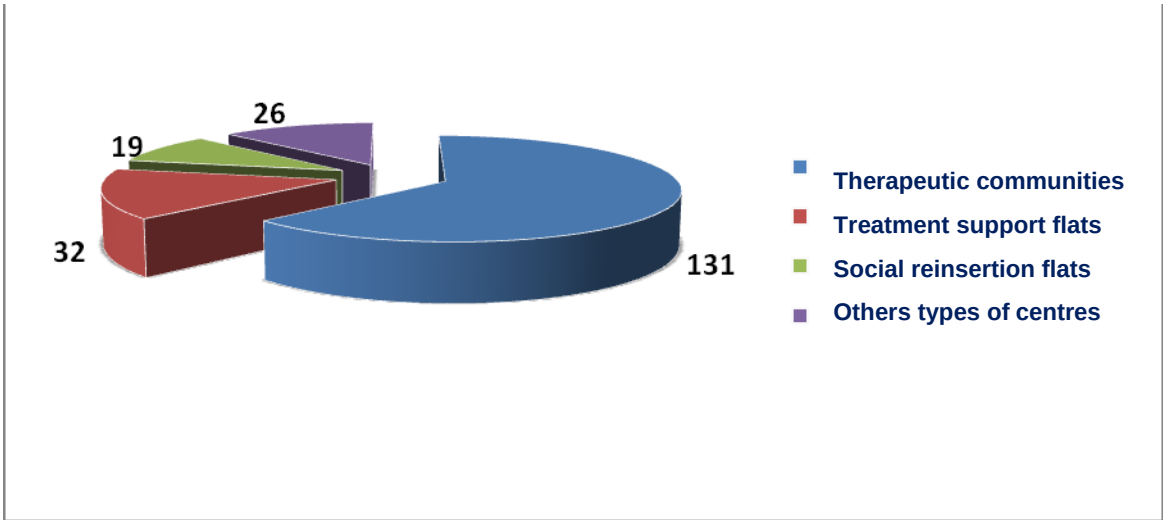
Table 11.2. Ratio number of centres, individuals for whom care provided and places available

Type of centre	Centres	%	Clients	%	Places	%
Therapeutic communities	131	62.98%	8,075	86.72%	3,568	79.18%
Treatment support flats	32	15.38%	961	10.32%	373	8.28%
Social reinsertion flats	19	9.13%	224	2.41%	165	3.66%
Other types of centres (*)	26	12.50%	52	0.56%	400	8.88%
Total	**208**	**100.00%**	**9,312**	**100.00%**	**4,506**	**100.00%**

(*) 1 cocaine users treatment centre located in a hospital, 5 support flats to any users with AIDS, 1 short treatment centre and 19 resources difficult to classify (flats or centres supporting the stabilization, personal autonomy or other care) are included. Some of the centres are specified in section 2.1.1.4 (Other facilities).

As shown in the Table above and on the graph below, the majority of the residential treatment facilities in Spain (more than 60% of the centres) are therapeutic communities, providing nearly 80% of the places available and providing care for more than 86% of the clients.

Fig. 11.4. Number of residential treatment centres. Spain, 2011



2.2.2. Residential treatment funding

2.2.2.1. Cost of residential treatment

Regarding the cost of the treatments and the way in which funded, these treatments are funded publicly for the most part, regarding both the percentage of expenses to be paid as well as the number of cases in which applicable, as previously stated. Regardless of the management model, two different ways exist for the residential facilities to obtain income:

- The proceeds from public income determined by the **quantification of places** available and occupied which are placed under contract, officially arranged or subsidized. In these cases, the information furnished is found to vary greatly, ranging from around 20€ per day up to around 100€ per day for each place.
  In some cases, the funding provided to the managing entities by the Government Agencies depends on the intensiveness of the treatment in question, as in the Catalonian model,

entailing three degrees of intensiveness in terms of the ratio of professionals (in terms of the hours of treatment per week, 128 € - 243 €), giving rise to different amounts of public subsidy (approx.. 30€ - 60€ per day). In other Autonomous Communities, this is not quantified so precisely, but the public funding is indeed conditioned to the professional intervention which is provided.

Whether or not the places available are occupied is a criterion many times determining the funding with which the entities managing the facilities are furnished on the part of the Government Agencies. Many management contracts stipulate a cost per place occupied and a percentage per place unoccupied (usually around 80%, given that the fixed costs of the facilities are quite high and cannot be modified depending on unforeseen deviations).Another factor which has a bearing in this regard is the existence of a single list for referral to places at different facilities, which is centralized through the care-providing network. This is the most common system employed. There are some significant exceptions however, such as the case of Catalonia, in which the referrals are made through the reference outpatient centres, whilst the treatments are not totally free of charge, which may mean that the economic differences among the different services may condition the choice made by the patients based on criteria totally unrelated to the treatment.

As previously mentioned, the diversity of the information and the fact of no shared information system existing would require a much more in-depth investigation in order to be able to precisely state this information.

- The public income determined by the **total cost of the facility**. Information is provided on the total cost of the facility without any reference to the cost per individual place. To find this item of data, the fitting operations must be performed. This is usually the case of the publicly-managed facilities. In this case, the figure is usually above the previously-mentioned general maximum range.

- The income provided by way of annual **subsidies** from different sources. In this case, widely-varying processes for the filing of applications for subsidies may be found on the part of different Administrations (autonomous communities and municipal) and on the part of private bodies. In most cases, the income from the subsidies is usually rounded out through other ways of funding and even by way of other subsidies from different sources.

- The income provided by the **clients** depends on their ability to make a contribution (and that of their family members) and on the system set out in their Autonomous Community. This is normally always a minor part of the total cost of the treatment, although sometimes not being the case, clients contributing different amounts or others who contribute nothing sometimes living together in one same facility and undergoing one same treatment. In most of the Autonomous Communities, the cost for the patient is free of charge in all of the residential services. Similarly, in some cases, the care-providing network proper facilitates there being individual subsidies indirectly or from other Government Agencies for those cases in which the patients have no income or family support. In the Autonomous Communities in which economic contributions are made, these contributions usually range from 200€ to 800€ monthly.

Except in the case in which the resource is funded in full, as mentioned in the second case (total cost of the facility), the different channels of income do not usually rule out one another, but rather, on the contrary, progressively round out one another, likewise giving rise to the variations in certain ones having a bearing on the rest.

The factors having the greatest influence on the cost of the resources are their size and the personnel costs, which depend, in turn, on whether the teams or more or less complete, that they be comprised of more highly-qualified and specialized professionals (the psychiatric resources are the most costly, following by the general medical practice resources) and whether or not the

professionals be public service employees (noticeably higher cost). The larger size of the facilities makes it possible to organize professional teams comprised of a greater number of higher-quality professionals compared to the small-sized facilities.

Despite the difficulty and imprecision of providing a figure for the annual cost of residential treatment, a projection could be made on the basis of the number of places currently existing according to the information furnished. Thus, taking as a reference which could be the average cost per place of 50€-70€ per day, the 4,506 extant places would render an annual cost within the range of 82 million euros to 115 million euros annually. By dividing this figure by the 9,312 individuals for whom care was provided in 2011, this would mean a cost per residential treatment within the range of 8,800€ and 12,300 € annually.

2.2.2.2. Publicly and privately-managed facilities

On the questionnaires sent out to the Autonomous Communities, information was requested as to whether the residential facilities were public or private. This question regarding terming them as public or private has not always been answered based on the same criterion, but, generally speaking, the publicly-managed facilities are considered to be those facilities under the ownership of the Government Agency or a foundation of a public nature which holds the rights and obligations regarding the installations and the personnel of which is subject to the civil service legislation. To the contrary, privately-managed facilities have been considered as being those in which a private entity, whether a not-for-profit entity or a company, holds said ownership. For the most part, the facilities are privately-managed and, save a limited number of exceptions, are managed by not-for-profit entities, mostly foundations and associations, although also by religious institutions in some cases.

According to the foregoing, one must therefore bear in mind that all of the data which is included in the following sections refers to residential treatment facilities and places which are funded by the Government Agencies, are included in their care-providing offer and are recognized thereby, as a result of which they may be considered, in many aspects, to be those ultimately responsible from the legal standpoint.

However, a different criterion is employed in some of the information furnished, public places being considered as being those furnished with funding by the Government Agencies under different approaches, private places being those not receiving this funding. Thus, public and private places may sometimes be found co-existing with one another within one same facility. This is the case, for example, of the Region of Murcia, where most of the entities have “public and private” places. This is likewise the case of Catalonia, where there is no total funding of places, therefore leading to the places (normally) funded in part as being public and those for which this partial funding is not provided as being private.

The following Table shows more than 90% of the centres to be privately-managed and, by a slightly lower percentage, also the number of places and clients[30].

[30] Please note that the total number of clients provided with care does not tally with those of previous tables for the reasons previously stated.

Table 11.3. Types of centres, number of clients, places and clients/places ratio

No. centres			No. clients			Places			Client/places ratio		
Public	Private	Total	Public	Private	Total	Public	Private	Total	Public	Private	Total
18	190	208	824	5745	6569	603	3903	4506	1.37	1.47	1.46
8.65%	91.35%	100.00%	12.54%	87.46%	100%	17.62%	82.38%	100%			

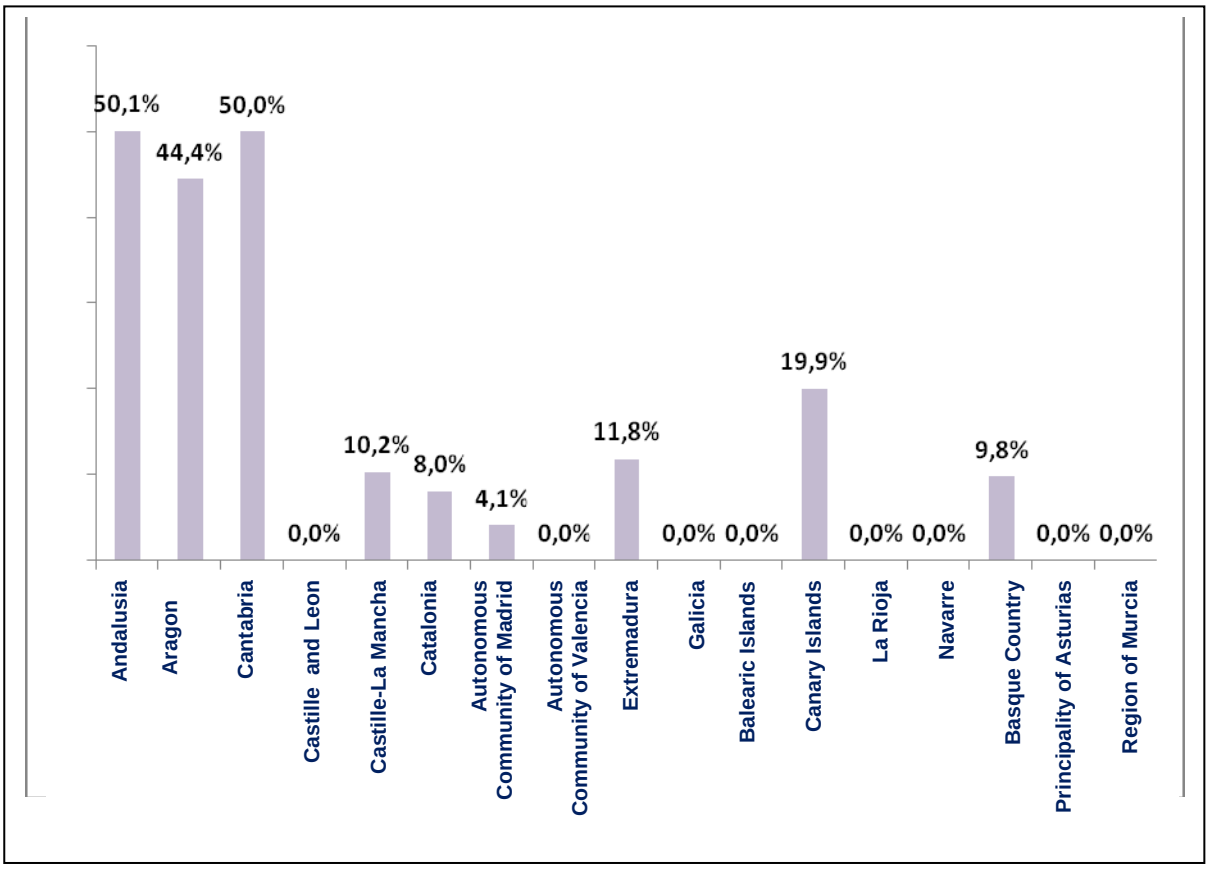
The differences in the percentages between places and centres is due to the fact that, whist there are some public therapeutic communities, no case is known of any publicly-managed flats or homes with a much smaller number of places.

In the entire residential treatment network, the ratio between the number of individuals for whom care was provided and the number of places available is 1.46 individuals/place/year. However, whilst care was provided at the publicly-managed centres for 1.37 individuals in each place in 2011, care was provided for 1.47 individuals at the privately-managed centres. As previously discussed, in order to be able to interpret this information, it would be necessary to avail of a breakdown of ratios of occupancy and percentages of success in the different places, as well as determining maximum times in the different facilities (usually stays of around six months, but these differ in the different autonomic networks and types of facilities).

When distributing these publicly or privately-managed places by regions, more than half of the Autonomous Communities are noted as not having any publicly-managed centre and the rest, with the exception of Andalusia, having one or two therapeutic communities publicly-managed compared to all of the privately-managed resources. The graph provided in following shows the percentage of publicly-managed places compared to the total number of all those places existing within each Autonomous Community[31]. The Autonomous Community of Andalusia is that which has the largest number of publicly-managed places in the entire network, the publicly-managed places totalling more than 50% compared to those privately-managed.

[31] In some cases, projections have been made based on the number of centres as a result of lacking precise information.

Fig. 11.5. Publicly-managed places (percentage)



Over the last few years, partly following the guidelines set under the 2000-2008 National Strategy on Drugs and partly as complaints put forth by the professionals, a trend has arisen of including the care provided for drug-dependent individuals in the standardized health system. In this regard, some case (Cantabria) has come to bear in which a therapeutic community was turned over to be managed by a public foundation. This trend has been much more intense in the case of the reference outpatient centres, but was always a slow process entailing some major complications with regard to meeting all of the requirements set forth for functioning at the administrative level, especially in the employment-related aspect. Quite a major wage gap often exists between the professionals in the public sector and the professionals in the privately-managed therapeutic communities, which has posed a problem with regard to making further headway in this process and may possibly have put it on hold under the current economic circumstances.

Generally speaking, the aforementioned data includes only those places which are funded through the Administration, which leaves two large groups outside of our ability to for analysis: the non-professional therapeutic communities[32] and the "private clinics" (the cost of which is paid in full by the patients in both groups).

The non-professional therapeutic communities are usually managed by evangelical religious entities and lack, at least in part, the professional teams and accreditations required by the Government Agencies in order to be considered healthcare establishments, their activity however being allowed without any existing guarantees of professionalism. They have been criticized for contributing more to indoctrination than to therapeutic intervention. These communities are more similar to the first self-help therapeutic community model, where individuals with a past history of addiction were turned into therapists albeit lacking professional training. Their main advantages, as

[32] Their number does not total a significant volume.

is widely known, is their being completely willing to immediately take admissions of individuals who do not meet the necessary conditions at the accredited facilities due to a lack of prior processing, not having the documentation available, lack of fitting assessments, etc. The limitations in the services and conditions they are have sometimes given rise to the intervention of the Government Agencies.

The latter of these two types of facilities, referred to in this report as the “private clinics”, are facilities accredited as healthcare centres manned by different teams of professionals who provide their services exclusively to the patients and their families, without requesting any type of funding from the Government Agencies. Far from being a hindrance, the lack of public funding is precisely their main appeal, on targeting a sector of the population possessing high purchasing power preferring to go to centres offering a certain degree of exclusiveness. They therefore avoid contact with individuals with many different habits and problems, keeping complete secrecy as to the existence of a drug use-related problem and demanding a number of services unrelated to the treatment and closer to high-quality hospitality services. Generally speaking, this type of establishments are completely unrelated to the public treatment network, are registered as general healthcare centres or centres of another type and although their existence be known, they provide no data concerning the care they provide and are therefore not included in this report. In some case, they are mentioned but no specific data is provided.

Along general lines and according to the information gathered indirectly, these treatments include medical and psychological aspects, although they are usually less demanding regarding the latter of these two aspects as far as what is required of the patient and minimize the social aspects. Their cost may vary within the range of 1,000 to 5,000 euros monthly.

At an intermediate level, there are many residential facilities combining the existence of public places funded in full or by a very large percentage by the Government Agencies with private places which are paid for in full by the clients or their families. Some information exists as to the trend toward the decline in the public contributions sometimes being equated with the private places.

3. QUALITY MANAGEMENT

3.1. Accreditation requirements

Along general lines, the residential facilities need twofold accreditation: as a health centre and as a drug care network centre. These accreditations are determined in all cases by the Autonomous Communities by means of their own legal and administrative regulations and may entail registration in the pertinent administrative registries following fulfilment of the respective requirements.

In the case of the therapeutic communities, who have more complete teams of professionals and always include healthcare professionals, the two accreditations are required.

However, generally speaking, the treatment support, reintegration or other type of flats or homes are not usually under the obligation of being registered in the healthcare centre registry, although they must sometimes register in an administrative registry for social centres similar to the healthcare centre registry although entailing different requirements.

For the accreditation required by the drug care networks, they usually set a number of minimum requirements, such as the existence of a treatment program, a professional team, adequate facilities, internal regulations governing rights and obligations of the individuals for whom care is provided and the positioning of the facility in question within the network treatment circuit.

3.2. Quality systems implementation

The process of quality systems being introduced into residential treatment facilities is still as yet in its very early stages in Spain, its implementation is normally carried out more out of the willingness and on the initiative of the managing entities that out of a planned choice of the drug dependence care-providing network. As previously explained, the care provided for drug users comes under the authority of the Autonomous Communities, in their respective health and social welfare departments, and insofar as these departments value and promote the implementation of quality systems, a certain correlation comes to bear in their being implemented in the residential treatment facilities. Thus, the possibilities and requirements for the implementation of a quality system throughout the drug network is going to depend upon the rate at which they are instituted in the health (or social) network of the Autonomous Community in which they are located and the decisions thereof in this regard.

Many of the facilities are positioned within a drug care network which avails of an advanced management and information system into which indicators are incorporated for analysing the activities carried out, the available structure and the results achieved, but which cannot in any case be considered quality management systems. The existence of satisfaction surveys and studies among clients or professionals is being promoted.

The preparation of documents stipulating portfolios of services in conjunction with the respective evaluation systems is standard practice in different autonomic networks, but the existence of these documents does not guarantee their being implemented in the network facilities.

In other territories, the incorporation of standardized quality systems, normally ISO 9000 or EFQM, for the management of the facilities funded thereby is considered a merit. This valuation may take the form of taking this aspect into consideration in awarding contracts or in granting subsidies, despite regulatory limitations existing hindering significant value being placed thereon. Normally, the implementation of quality systems in addiction care facilities in Spain does not depend on these incentives, but rather on a greater awareness as to the importance thereof on the part of the entities themselves.

Other actions found for promoting the implementation of quality systems, such as the funding of training processes (Autonomous Community of Andalusia), care process management guides or similar initiatives.

The most advanced case which has come to light is that of the Autonomous Community of Valencia, which has carried out a quality accreditation process for drug dependence prevention and care services and centres in 2011 through a public institute operating under the Autonomous Community of Valencia's Ministry of Health (INACEPS). However, from the information available at the point in time of the writing of this report, there is no knowledge of any residential facility which has been granted this accreditation, which must also be on the initiative of the entities and not demanded by the public authorities.

Over the past few years, a progressive implementation of EFQM and ISO 9000 quality systems and the adaptation of ISO 9000 for the not-for-profit entities under standard ONGCONCALIDAD [QUALITYNGO] (only in Spain) has been seen in entities which manage residential facilities, there being information from numerous entities which have fully implemented or are in the process of implementing the same and being granted accreditation. In the Principality of Asturias, the four extant centres possess accreditation of the implementation of one of the two main models (ISO or EFQM) on the initiative of the entities themselves.

3.3. Information and management systems

One of the main aspects of the care-providing networks is the existence of a unified information system. This system is based on criteria which vary greatly from one Autonomous Community to another, the most advanced are those which incorporate online management of the entire case record file in a manner shared with all of the other facilities in the drug care network (Valencia, Andalusia). Its existence and full implementation make it possible to improve the planning and management of the places available in the different facilities, to improve access times, shorten times for the professionals due to different reports and documents being issued automatically and the mining of care data. Similarly, depending on their evolution, subjective biases can be eliminated from diagnoses and interventions.

This type of management systems are often incorporated initially into the reference outpatient centres in the first place and then progressively into the rest of the resources in the network. In this case, the therapeutic communities are usually ranked at the top of the list in the order of incorporation into the system, far above the smaller-sized flats or homes.

At the opposite end of the spectrum, the systems which have evolved to the least degree solely send out documents for keeping up with the information but do not become involved in management, not even in the existence of a unified list of admissions (Catalonia).

3.4. The effectiveness of the residential facilities

It is a common practice among the therapeutic communities for their activity to be regularly measured and an annual report prepared providing an account of their main indicators. These reports usually include indicators related to the profiles of the clients for whom care has been provided (age, gender, patterns and past history of use, health status, by whom referred, socio-demographic variables…) and activity indicators. The activity indicators usually include total number of admissions, occupancy ratios, lengths of stay and releases, as well as its classification.

The percentage of satisfactory releases (known as "treatment releases") as a result of objectives or similar having been met is usually considered a factor of success. Based on the information furnished, the treatment releases usually fall within the range of 30%-75% of the releases. The varying data is conditioned to the objectives which are set by the different facilities for classifying a release as a treatment release, which may also be conditioned by the specialization in the access

profiles, by the entity's management criteria and by criteria concerning the conceptual model employed. Therefore, it is quite difficult to draw a comparison among these items of data.

There are, however, various public and private entities which have tried to conduct research concerning the success of the residential facilities, normally the therapeutic communities or the care-providing programmes within which these communities are placed. This research includes post-release and longitudinal studies aimed at verifying the continuance of the changes in the clients several months or years after the fact, with different variables, one of which is logically abstinence. In this regard, studies have been carried out on the therapeutic success of their programmes on the part of organizations such as "Proyecto Hombre" or the "Fundación Salud y Comunidad". These studies find 30%-40% success rates per admission in addition to finding the programs in which the patients stay for at least eleven months to be more effective. However, the different conditions under which these studies are conducted and the difficulty involved in gauging the same and drawing a comparison among them make this a difficult and controversial issue. To make a rigorous approximation, it would perhaps be necessary to conduct a specific study on the evaluation and meta-evaluations of care-providing facilities.

4. DISCUSSION AND FUTURE PROSPECTS

4.1. Trends in the treatment demand since 2000

4.1.1. The impact of the crisis on patterns of use

To date, the available evidence shows no impact of any sort due to the crisis on the types and prevalences of use or in the care-providing profiles. One of the hypotheses being examined is a change in the patterns of use over the past few years with a rise in recreational use of drugs. The lesser availability of income in general in Spanish society may possibly reduce the recreational use and hence curb the rise in cocaine use. On the contrary, the rising unemployment rate could give rise to greater social instability and an increased degree of "escapist" use related to difficulties of managing one's own life. This type of use could lead to an increase in the needs for residential treatment or the modification of certain care-providing criteria in the future depending on these changes. Along this same line, if social-employment reinsertion has been difficult regarding certain patients, it is practically impossible in the current situation, which would require an in-depth analysis as to including employment insertion-related objectives in some individual treatment programs.

4.2. Challenges

4.2.1. The impact of the crisis

The main challenge coming to bear over the next few years in residential drug treatment is that of remaining in treatment under the conditions in which treatment has been carried out over the past few years. The uncertainties regarding funding affect the number of places, the professional services offered in the resources, the lengths of stay and the cost of these services for the individuals for whom care is provided. The challenge will be greater in the specific resources which have been started up in the network and in the treatment and reinsertion support housing in comparison to the therapeutic communities.

4.2.1.1. The reduction in facilities

According to the information furnished, more than half of the Autonomous Communities have made some type of cutback in the funding of residential treatment, although, generally speaking, this could be termed a freeze or slight decrease which, without having precise information, could be estimated at around 10% based on data from 2011. However, this reduction has not meant, in the vast majority of cases, a proportional decline in the number of places available, but rather that the average cost per plaza is being lowered. The reductions in the number of places have more of a major effect on the treatment support and social reinsertion housing and less directly on the therapeutic communities.

Mention has already been made previously of the fact that, in one case or another, information has been furnished indicating a limitation on the maximum length of time for staying at the resources, which hinders its analysis at this point in time. Another modality for cutting costs without reducing the number of places is the possibility of stays five days a week, on weekdays, allowing patients to return home on the weekends. This is a complicated initiative which, should it be carried out, must ensure that the patient's treatment process is not altered.

These reductions in the number of places would also have to include (in this case sufficient information has not been gathered to make any contribution, there solely having been 10%-20% estimates) the indirect declines which arise in those case in which the clients make part of their contributions, due to their inability of doing so in an overall decline in the incomes in Spain and especially due to the drop which has taken place in some Autonomous Communities in the

minimum incomes, the only income which some of the clients and potential clients of these centres collect.

Based on the information obtained in different interviews, discussion groups, document analysis and information in the media, there has been little social response in view of the cutbacks in residential facilities. The existence of a social response in different Autonomous Communities has been made known, where different social entities or its professionals headed protest actions in view of the closure of drug dependence care resources, including different residential resources. This scant social response is due to the difficulty of organizing the group of individuals for whom care is provided, who, of everything, on being asked, are aware of the difficulty the closing of residential facilities involves, making statements of the type "… *the problem of being kicked back out onto the street…" or " … it's going to be real expensive getting hooked on drugs again or relapsing, because there's not going to be anywhere to go…",* admitting even that the residential resources provide *"… a certain degree of control and solution, (that) will cease to exist …".* This scant social response sometimes goes along with the perception of guilt and not being worthy of the care provided, on the part of the individuals themselves and on that of the general population.

The main doubt entertained is how far the impact of these reductions will go, whether this will go so far as to involve residential facilities ceasing to exist in some territories, some of the managing entities permanently closing (it is already known that many small-scale entities have ceased to exist) or whether they will solely be reduced in number and be put in a more precarious situation. Many of the social partners are of the opinion that it takes many years and many resources to create a care-providing network, whilst it takes only a very short time for them to disappear without considering all of the investment made.

4.2.1.2. Contribution to the service expenses on the part of the patient proper (co-pay)

The co-pay phenomenon which already exists in some of the autonomic networks, as has been discussed in the section devoted to costs and funding, might also be an approach used by some Autonomous Community Administrations to maintain the funding of the residential facilities despite this meaning that some patients who so require may not be able to gain access to these facilities.

Similarly, the existence of specialized residential facilities, such as those provided for minors with use-related problems or for the homeless, women with children and dual diagnosis patients run the risk of being those affected first and foremost by the budget cuts. These facilities ceasing to exist would require these patients being integrated into larger-scale centres having better possibilities of funding without their possibly being able to meet their specific care-related needs with the same degree of quality as the care with which they are currently being provided.

4.2.2. Trends toward improvement halted

One of the main trends which has occurred over the past few years has been the progressive professionalization of this sector. In most of the resources, the integration into the health network has meant an increase in the health services provided, in both general care as well as psychiatric or nursing care. An increase has also taken place in the specialization of the services of a psychosocial nature which are offered, entailing higher-level qualification of the different professionals which has afforded the possibility of including aspects related to integration into employment with the social relations or with specific psychological aspects.

The funding cuts will likely entail the professionalization process which has taken place in residential treatment over the past few years being halted to a certain degree or even backsliding. This decline will probably be progressive if the trend noted during these years of economic crisis continues, affecting mainly the makeup of the professional teams, the breadth of the range of disciplines, working hours and working conditions, with a reduction in working days, types of hiring

and qualification required, in a certain way coherently with the way in which the employment market in Spain is evolving.

4.3. Added value of residential treatment

4.3.1. Usefulness of the residential resources

In the information gathered, different criteria can be established for determining the usefulness of the residential resources as perceived by different people with whom we spoke.

The main reason alleged for justifying the existence of the residential facilities is the inability to carry out the treatment on the part of some patients in their regular social environment. This inability is manifested by their drug dependence, the complete lack of self-control, serious deficits in behaviour and personal and social life, the lack of social-family support, as well as prior failures in other treatment modalities.

Other aspects which these facilities provide are a minimum "break" or "time out" for the patient (who has the benefit of a time of abstinence within a long past history of use) as well as for their families, basic needs of accommodations and upkeep being covered and the providing of basic and health care which would otherwise not take place.

4.3.2. The perspective of care-provided individuals

The clients of the residential facilities usually take part in the everyday life at the centres to some degree, where there are evaluation and planning meetings held, although it is not often at these meeting that the evolution of the patients is dealt with, which is kept within an exclusively professional framework (at least in the majority of cases).

Therefore, an attempt has been made to mirror the viewpoint of the individuals for whom care is provided at residential centres in a discussion group comprised of ten people of differing profiles and experiences. Some of the main conclusions reached are set out in following.

The patients resoundingly state the usefulness and need for this type of facilities. The essential aspect of their contribution is "*stabilization and recovery of coherence"*, saying that if these resources were not to exist "*my life would be very different, much worse",* even going to far as to say that *"I would likely be dead"* or, referring to a fellow patient in a past experience, *"I saw him come back to life"* in the therapeutic community. Centres like these make it possible *"to grow, mature, to know the right way to behave, to get to know yourself better".*

The aspects which the clients value most highly at the residential facilities are the way they are treated by the professionals, their professionalism (the confidence and knowledge they convey), the method and the degree of demand and discipline. They do not place the same value on the social support among fellow clients or self-help (something which was characteristic of the initial therapeutic communities), nor the coverage of basic needs of accommodations and upkeep (they even criticise those who make use of these resources this way with explicit mentions of evangelical communities).

One of the aspects which clearly mark their classification of the resources lies in the existing degree of demand and discipline, opinions being found to be divided in the group among those who require an almost military degree of order and discipline and those who consider this type of resources to have "demoralized them more". This group's overall conclusion was that each type of resource serves different personal profiles. They say that there are many "downer" times and that it is very difficult to see a treatment through to the end.

They however stress that the resources are useless unless the patient has strong willpower and motivation, mentioning different positive and negative experiences, although they also acknowledge the professionalism of the treatment team when anyone "*comes in without any motivation and makes it".*

One of the significant resources named is the centre managed by the Brothers of the Order of San Juan de Dios, devoted to dual diagnosis patients, where they helped *"toward creating an awareness of this [mental] disorder"* and understanding the role which use played therein.

With regard to the differences among different residential resources, those who have been clients clearly perceive the disparity between the isolation-oriented nature of the therapeutic community and the social nature of the flats or homes. In their opinion, this disparity is justifiable in terms of the need for protection and for more personal than social work. However, they do not perceive any major differences between the different types of flats, not being able to name any at all on their own initiative. On being asked about specific classifications, they determined that one cannot look for work in the treatment support flats, but can do so in the reinsertion flats.

In regard to whether or not the facilities are for both males and females, those who have been clients of these resources acknowledge their preference for living with people of both genders, but also the difficulties which can arise on taking up relations as a couple at points in time of recovery given that "*they get you off track"*, as they mention having happened to some of them.

Most of the individuals who took part in this group had lived in more than one facility (this was a top-priority criterion for configuring the group), this being the reason why they could state their opinions regarding the effectiveness of the treatments. Generally speaking, they say that, despite the subsequent relapses, they have always been useful to them in their recovery, speaking of periods of several years without relapses and holding out hope against any relapse into drug use occurring in the future.

The negative consequence of a shortage of these facilities, according to care-provided individuals, is revealed more explicitly when the impact of the crisis is discussed.

4.4. Challenges for the future

4.4.1. Guaranteeing residential treatment

The top-priority suggestion which must be made within the current context is to establish the guarantee of access to residential treatment as a resource fundamental to providing addiction care. These facilities ceasing to exist or being significantly fewer in number could give rise to a collapse in the care-providing system and would involve many individuals with addition-related problems finding themselves in a situation of very marked social exclusion.

4.4.2 How broad the residential treatment range

All of the information gathered indicates that the care offer, specifically the residential treatment offer, is not uniform in its successes for all groups of patients. Therefore, it is necessary to guarantee a broad-ranging residential treatment offer for different profiles, which can be done by means of different degrees of intensiveness in the treatment care, by individualizing the care programs, by specialization of the facilities or by any other means.

The degree of demand for both accessing as well as staying in the treatment programs can and must be different for different profiles, and it is necessary to guarantee that this diversity of methodologies is maintained, whilst also demanding compliance with a number of standards regarding basic issues (installations, professionalism, rights and obligations, abiding by the legislation, etc.)

Establishing one single model of care as well as one single methodological model for all clients could mean treatment failures, in practice, for most of the clients due to the care being incapable of meeting their needs.

4.4.3. Care for specific situations and profiles

Independently of whether or not the trend is toward the specialization or the universalization of the residential facilities, it is necessary for there to be a broad range of possibilities in the treatment offer to guarantee care being provided for situations outside of the norm, such as those of minors with use-related problems, females, women with children, homeless individuals, immigrants in especially vulnerable situations, dual diagnosis patients and many other cases. Heretofore unknown profiles or those which may arise at some later time and different situations requiring a sufficiently broad-ranging care-providing offer and also as far a residential treatment is concerned must be provided with care in order to guarantee universal access to health at this level.

4.4.4. Stable residential alternatives for a certain group of patients

Reference has been made in this report to the contribution of a residential environment in carrying out a treatment program. However, there is a concern shared by many professionals regarding the non-existence of residential alternatives for individuals who complete a treatment process or who could stay on with professional support in situations entailing a certain degree of control although without any major alternatives for social reinsertion.

In this regard, one might think of low-demand living facility alternatives for individuals who have completed one or more treatment processes for whom there is no prognosis of improvement, although in whom a destabilization or worsening may arise if some basic conditions are not met.

In this regard, one group which does not have adequate residential care is that of the elderly people who have use-related problems, have survived many years of addiction and have reached a stable situation until the death of their parents. In these cases, it might possibly be necessary to deal with the idea of long-term residential centres for providing care for a now chronic, aged profile (some experience in this regard has been found to exist).

4.4.5. Innovation in the configuration of residential facilities

Independently of the conceptual and methodological models which are employed and which have been previously analysed, the architectural configuration of these facilities may condition the possibilities for patients making progress in their treatments. In this regard, small facilities provide for a greater ability to individualize and for professional supervisory, whilst the large facilities provide for a greater efficiency of the resources.

Therefore, architectural models should be explored which will make it possible to make the advantages of one configuration and the other compatible with one another and to make them flexible. One reference in this regard may be the buildings such as the Carmen Sacristán Centre managed by the RAIS Foundation with the support of the Municipal Government of Madrid's Addiction Institute, in which a large-sized building is divided into spaces facilitating individualization and cosiness of the facilities like homes, whilst crossing a quasi-concealed floor level guaranteeing homogeneous professional presence in each one of these "homes". Thus, the management-related advantages of a large centre are combined with the possibilities of efficiency in the provision of professional services which would not be possible in small-sized centres.

4.4.6. Advancements in scientific knowledge

The high cost of the residential treatment facilities, especially within a context of economic strife, requires the recognition of its usefulness based on scientific evidence and the discrimination of the

variables (personal, social, health-related, use-related, moments in life and in the treatment circuit, etc.) making it advisable over outpatient alternatives. In this same regard, it would be important to make a greater evaluation of the efficacy and efficiency of these facilities within a medium and long-range framework.

A greater deal of agility and flexibility would likewise be necessary on the part of the residential facilities in adapting to the changing needs and to the demands which are determined by scientific evidence.

Although the advancements made over the past few years reveal a scenario differing greatly from that of twenty years ago, it is still important that science be what rules over the models of the residential facilities above and beyond any ideology or beliefs of the different managing entities.

Within the scope of scientific evidence, some major advances have been being made over the past few years in biomedical and neurobiological research which are not always implemented in the clinical and therapeutic approach and which may have not exclusively pharmacological implications.

4.4.7. Promoting social-employment reinsertion

It is common knowledge that there are large number of patients who have long past histories of use who have evolved positively in their use and health-related situation, but who have not done so in the social sphere. Although the therapeutic communities may possibly not be the ideal facilities for making headway in this regard, the social reinsertion housing would indeed be ideal and must delve deeper into the social reinsertion methodology and distinguish themselves more from the treatment support dwellings. Within the current economic crisis context, a review must be made as to what the best degree of intensiveness may be concerning the efforts which are devoted in the residential area to the employment insertion programs. Although having a job can be decisive in maintaining abstinence after leaving the residential facilities, devoting efforts to employment insertion in the treatment objectives in the current economic situation requires major efforts which, in most cases, would surpass the final outcomes achieved. A review should therefore be made of the range of employment insertion objectives which are feasible and suitable in each situation.

4.4.8. Setting out the portfolio of services

A common portfolio of services within the national health system may foreseeably be configured in the near future due, in part, to implications of the current economic crisis and in part due to the on-going debate concerning the differences in the services provided to people in Spain– especially however not only health services –in one Autonomous Community and another.

This possibility may be an opportunity for this portfolio of services to specify the type of addiction care facilities which must exist in the different autonomic networks. This portfolio of services being set out could have some major implications for the residential facilities. The reference facility, the therapeutic community, being included in the portfolio of services would serve for its consolidation and homologation in the services themselves which should be provided thereby as a facility.

4.4.9. Better coordination

Some of the experts consulted point out the need for better coordination between the residential facilities and the reference outpatient centres. In the case of the therapeutic communities, some of the top-priority aspect would include improvements in the continuity of the treatment process from prior to admission to after release, as well as the information which is conveyed throughout the entire process. In the case of living accommodations, the improvement must be focused on the professional interventions which are carried out in both types of facilities being complementary to one another.

4.4.10. Improvements in management

The implementation of unified management and information systems which has taken place in some of the autonomic networks has meant some significant advancement in improving planning, especially with regard to the timing and in the dimensioning of different resources in the patients' treatment circuit. Similarly, these systems also implement quite some major improvements in the possibility of exploiting the information which can mean, in turn, improvements in research and evaluation.

Yet another further advancement would be that of instituting a unified care-providing activity information system making it possible to guarantee equity and an aggregate state-wide view, on the design of which work is currently being done.

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INTRODUCTION

In January 2011, according to the official data from the Spanish National Institute of Statistics (www.ine.es), Spain's population totalled **47,190,493 inhabitants**. According to this figure, Spain is the fifth most highly-populated country in the European Union.

This population is spread out among 8,116 municipalities. Around 60% (4,855) of these municipalities have fewer than 1,000 inhabitants, 30% (2,502) having 1,000-10,000 inhabitants. Solely 0.16% of these municipalities (13 municipalities) have more than 300,000 inhabitants. Madrid (Spain's capital city) and Barcelona are the only two Spanish cities having more than one million inhabitants.

Table 12.1 Number and percentage of Spanish municipalities by population size

TOTAL MUNICIPALITIES	Under 1,000 inhabitants	1,000 - 10,000 inhabitants	10,000 - 50,000 inhabitants	50,000 - 100,000 inhabitants	100,000 - 300,000 inhabitants	Over 300,000 inhabitants.
8,116	4,855	2,502	614	82	50	13
	(59.82%)	(30.82%)	(7.56%)	(1.01%)	(0.62%)	(0.16%)

Spain hence has thirteen municipalities (or large cities, to employ the European Monitoring Centre's terminology for this Selected Issue) which have more than 300,000 inhabitants (Alicante, Cordoba and Valladolid must be added to the 10 indicated by the European Monitoring Centre).

Confining ourselves to what has been requested by the European Monitoring Centre, this report will make reference solely to the **ten most highly-populated cities** in Spain, including the capital city, which total, in all, 9,207,859 inhabitants, meaning 19.51% of Spain's population.

According to Spain's Constitution of 1978, "the State is organised territorially into municipalities, provinces and the Autonomous Communities which may be constituted. All these entities enjoy autonomy for the management of their respective interests".

The basic organisational unit is the municipality. The province is comprised of a group of municipalities. In Spain, there are currently fifty provinces. Both the municipalities and the provinces have their own legal status, although, through the provincial governing bodies (Provincial Councils), the principles of solidarity and a balance among the municipalities is guaranteed and the municipalities are supported for carrying out certain services.

The Autonomous Communities are territories which may be comprised by: a) provinces bordering on one another and sharing historical, cultural and economic characteristics b) island territories or c) a single province of historical regional status and those regarding which the Constitution recognizes the right to self-government, as previously mentioned.

The Spanish State is currently comprised of 17 Autonomous Communities, which possess a major degree of political and administrative autonomy. In all of these Autonomous Communities, there is a President and their own parliament or legislative assembly. The Autonomous Communities have been vested with highly important legislative and management authorities over different matters,

including all that which has to do with health, education, social services and the care provided for drug dependencies.

Each one of these Autonomous Communities has its own Statute of Autonomy which is configured as its basic institutional standard.

In addition to these 17 Autonomous Communities, there are two Autonomous Cities, Ceuta and Melilla, their degree of political and administrative autonomy being lesser than in the case of the Autonomous Communities, although they have also been vested with authorities in regard to the care provided for drug dependencies.

All of the foregoing has given rise to what is referred to as the “State of Autonomies” having been instituted in Spain.

The ten Spanish cities regarding which this report is being made are located in nine different Autonomous Communities:

- The capital of Spain (Madrid) is located in the Autonomous Community of the same name (Autonomous Community of Madrid).
- Barcelona, in the Autonomous Community of Catalonia
- Valencia, in the Autonomous Community of Valencia
- Zaragoza, in the Autonomous Community of Aragon
- Murcia, in the Autonomous Community of Murcia
- Palma de Mallorca, in the Autonomous Community of the Balearic Islands
- Las Palmas (Grand Canary Island), in the Autonomous Community of the Canary Islands
- Bilbao, in the Autonomous Community of the Basque Country
- Lastly, two cities (Seville and Malaga), in the Autonomous Community of Andalusia.

In 1979, the first democratic elections were held in Spain’s municipalities following the passage of the Constitution of 1978. In this historic period (late 1970’s and especially throughout the 1980’s), there was a boom in drug use in Spain and in the health and social problems related thereto. Although the illicit substances used the most were cannabis and cocaine, heroin use (mainly injected) had a much greater social and health-related impact, on being much more closely linked to committing crimes and the epidemic of AIDS and other infectious diseases.

All this had a major bearing on determining the actions taken by the municipalities concerning this matter (especially in Madrid and Barcelona, the two cities with the largest populations, and where the effects of drug use were more readily visible) both regarding the implementation of activities and programmes and getting the first municipal Plans on Drugs under way.

1. LARGE CITIES: FUNCTIONS AND RESPONSIBILITIES IN DRUG POLICY

1.1 Municipal government organisations and coordination with other broader-ranging Autonomous Community or State Entities.

According to the laws of Spain (Law 7/1985 of April 2nd, Governing the Bases of Local Government and Law 57/2003 of December 13th on Measures for the modernization of local government), the municipality is the "basic local unit of the territorial organisation of the State, being endowed with its own legal status and full capacity for fulfilling its end purposes".

The municipal government and administration fall to the Town Council, comprised of the Mayor and the Council Members. The Council Members are elected by secret, direct, free and equal balloting and vary in number in terms of the population of each municipality. The Mayor is elected by the Council Members and has the main duty of heading the government and the administration of the municipality.

The Plenary Sessions, comprised of all the Council Members, are presided over by the Mayor, the duties thereof including the control and supervisory of the governing bodies as well as the approval and amendment of the budgets.

Apart from the above, there is a Local Government Board in all of the municipalities which have more than 5,000 inhabitants and is comprised of the Mayor and a number of Council Members not greater than one third of the legal number thereof, appointed and relieved of their duties by the Mayor, rendering accounts to the Plenary Session. The duties thereof include that of assisting the Mayor in the exercise of the duties thereof.

The Deputy Mayors serve as acting Mayor, in the order of their appointment and in the cases of vacancy, absence or illness, being freely appointed and relieved of their duties thereby from among the members of the Local Government Board-

Large cities

Law 57/2003 of December 13th on Measures for the modernization of local government set forth a specific organisational regime for a number of municipalities (mainly those having larger numbers of inhabitants), including those whose populations total over 250,000 inhabitants, given the major degree of complexity of the political-administrative structures thereof. The bodies necessary for these municipalities are the Plenary Session, the Plenary Session Commissions, the Mayor, the Deputy Mayors and the Local Government Board.

The Mayor's Office is the main executive body heading municipal policy, government and administration. The Mayor is the ultimate representative of the municipality and is responsible for the political management thereof to the Plenary Session. In these municipalities, the Mayor has less management or executive duties than the Mayor of a smaller municipality, because in the case of the most highly-populated municipalities, Law 57/2003 makes provision for a "strong" Local Government, vested with ample functions of an executive nature and which is constituted as an essential joint collaborating body in heading Town Council policy.

The Mayor may appoint Deputy Mayors from among the council members serving on the Local Government Board, in the order in which they were appointed, to serve as acting Mayor in the cases of vacancy, absence or illness.

The Mayor may appoint to the Local Government Board any person who is not serving as a Council Member, provided that they do not total more than one third of the members of the Town Council, which reinforces the executive profile of this body. In any case, the Local Government

Board is politically accountable to the Plenary Session for its management jointly without detriment to the direct responsibility of each one of the members therefor for their management.

The functions of the Local Government Board include:

- Approval of the planned ordinances (municipal-level legislation) for of the regulations.
- Approval of the draft budget.
- Unrolling the economic management, authorizing and making expenditures regarding the matters under the authority thereof, make expenditures previously authorized by the Plenary Session and staff management.

The City Councils of these large cities will have to create districts (their own territorial divisions) endowed with management bodies in order to promote and further citizen involvement in the management and improvement of municipal business matters. Each district will be presided by one city council member. For example, mention may be made of the fact that the city of Madrid has 21 districts, and the city of Barcelona 10 districts.

In these large cities, there is to be a City Social Council comprised of representatives from the most representative economic, social, professional and citizens' organisations, the duties of which include issuing reports, studies and proposals concerning local economic development, strategic city planning and major urban projects.

Lastly, for the defence of citizen rights before the municipal Administration, the City Council Plenary Session is to set up a special Suggestions and Complaints Commission comprised of representatives from all the political groups comprising the Plenary Session, which will have the authority to supervise the activity of the municipal Administration and will submit an annual report to the Plenary Session, in which it will explain the complaints lodged and the deficiencies found to exist in the functioning of the municipal services. This Commission may also draft extraordinary reports when the seriousness or urgency of the events so advise.

Regarding the relationship of the municipalities with other autonomous and state entities, please refer to item 1.5 of this "Selected Issue".

1.2 Drug policy-related areas and services under the authority of the cities. Their funding

Generally speaking, in terms of what is set forth under the State and Autonomous Community legislation, the municipality has authorities over a wide range of matters. For the purposes of which may be considered to be of greatest interest regarding the drug policy, special mention may be made of the following (obviously always bearing in mind the scope and intensity of the measures carried out is highly variable, in terms of the population of each municipality):

- Safety in public places
- Protection of public healthfulness
- Participation in the management of primary health care
- Provision of social services and of social promotion and reintegration services.

The main areas for taking action in Spain's large cities in regard to the drug policy are related to prevention and social reintegration, as well as maintaining safety and public order on the streets and public areas. In Spain's cities dealt with in this report, numerous, varied activities and programmes for heightening awareness and preventing drug use at the school, family, community, youth leisure-time and entertainment levels, etc.

Besides, the cities have an important duty of regulating and supervising the control of public establishments where alcoholic beverages may be consumed (bars, restaurants, cafeterias, etc.)

by laying down rules, by way of the municipal Ordinances, concerning opening and closing times, serving drinks in certain areas of these premises, control of customer behaviour, etc.

Generally speaking, the funding of the health services comes under the responsibility of the Autonomous Communities. Nevertheless, as far as providing healthcare for persons who use drugs in some of Spain's cities dealt with in this report is concerned (especially in the two most highly-populated cities – Madrid and Barcelona), the funding and management of the treatment resources and of the harm reduction programmes is done, to a greater or lesser degree, jointly with the competent bodies of the Autonomous Community and of the City Government.

1.3 Municipal Strategies or Plans for Action

All of the cities in Spain which are dealt with in this report have a municipal Plan on Drugs, with the exception of two: Malaga and Las Palmas (Grand Canary Island).

In the case of Malaga, as of 1995, the drug dependence prevention measures have been included in the municipal Social Welfare Plans. At this point in time, the Fifth Municipal Social Services Plan, 2009-2013 is currently in force. According to information provided by the municipal authorities, they are currently working on drafting a Plan on Drugs, which they expect to have completed in December 2012.

Regarding Las Palmas (Grand Canary Island), This city has a Municipal Healthy Habits Programme which has been being implemented mainly at the school level for the last five years. Similarly, they are planning to start working on drafting a Plan on Drugs toward the end of 2012.

The first Municipal Plans on Drugs in Spain were approved and implemented in Madrid (1988) and Barcelona (1989), the second most highly-populated city in Spain, which is logical, taking into consideration that drug use had a most remarkable impact on the large cities, as previously stated herein. It must also be said that whilst some cities have been progressively updating and adapting their Plans on Drugs to the changes which had been taking place, others preferred to draft new Plans.

Hence, for example, while Madrid had only two Municipal Plans on Drugs (the first one in 1988 and the current Plan, covering the 2011-2016 period), Barcelona has approved seven; Bilbao, four; and Seville, three.

Precisely as shown in Table 12.2, four of the eight Plans currently in effect include in their general objectives and within their framework of action not only drugs (legal and illegal) but rather other addictions of the behavioural type, mainly compulsive gambling.

At the end of this report, some webpages are included for consulting the Plans on Drugs currently in effect in the eight cities which have such a Plan. Regrettably, no translation into English is available in any case. Apart from the above, mention must be made of the fact that, in the cases of Barcelona and Palma de Mallorca, the text is in Catalan, a language which is also official – in conjunction with Spanish- in both of these cities.

Table 12.2 Municipal Plans on Drugs in Spain's ten large cities

Cities	Municipal Plan	First Plan	Current Plan	Drugs and other addictions (compulsive gambling, etc.)
Madrid	YES	1988	2011-2016	**Drugs + addictions**
Barcelona	YES	1989	2009-2012	**Drugs**
Valencia	YES	2004-2008	2004-2008	**Drugs + addictions**
Seville	YES	2000-2003	2008-2011	**Drugs + addictions**
Zaragoza	YES	2007-2010	2007-2010	**Drugs + addictions**
Malaga (*)	NO			
Murcia	YES	1996	1996	**Drugs**
Palma de Mallorca	YES	2004-2008	2004-2008	**Drugs**
Las Palmas (Grand Canary Island)	NO			
Bilbao	YES	1998-1999	2011-2014	**Drugs**

(*) The Fifth Municipal Plan on Social Services, 2009-2012 includes measures for the prevention of drug dependencies.

The most outstanding aspects of the Plans on Drugs of the cities dealt with in this study, aimed at affording an overview are presented in following:

a) The most elaborate Municipal Plans on Drugs including a greater degree of detail with regard to diagnosing the situation, degree of coordination, theory-based approach, objectives (general and specific), lines of action, anticipated evaluation, etc. are those of Madrid and Barcelona.

Nevertheless, it must be stressed that all of the other Municipal Plans also make a major effort toward describing the situation in their territory (using epidemiological studies at different levels), as well as in setting out the objectives to be accomplished, the scopes of action, the unrolling of specific measures and the anticipated evaluation, some detailed indicators being provided in certain cases.

As far as evaluation is concerned, special mention may be made of Bilbao's Plan on Drugs, 2011-2014, Seville's Plan on Drugs, 2008-2011 and Palma de Mallorca's Plan on Drugs, 2004-2008.

b) The measures and programmes for which provision is made under the Municipal Plans on drugs fall within the framework of that which is set forth under the Autonomous legislation and, in the case of the most recent Municipal Plans, in the two Spanish Strategies on

Drugs approved to date (2000-2008 Strategy and 2009-2016 Strategy). Generally speaking, the greatest contributions to the Municipal Plans revolve around the preventive aspect, which, on the other hand, is the one that has been developed to the greatest degree at the theoretical level and specific activities in the texts of this Plans – and in the social reintegration aspect.

The prevention aspect includes more detailed descriptions of the measures and programmes to be unrolled at the family, school, community and other levels. In this regard, it is important to stress the major efforts all of these Municipal Plans on Drugs are making with regard to unrolling programmes and measures in at the leisure-time and entertainment level targeting the young population. Regarding social incorporation, the Municipal Plans deal mainly with aspects of training and integration into the working world targeting drug users in treatment and rehabilitation.

c) The programmes and resources related to the care-providing and harm reduction aspect come under the authority of and are implemented by the Autonomous Communities. Nevertheless, the city of Madrid, as will be explained at a further point (Section 2) of this report, has a major number of care-providing resources which it funds either by way of its own budgets or in collaboration with the Autonomous Community of Madrid.

Something similar is true in the case of Barcelona, where the body managing the Plan (Barcelona's Public Health Agency) is an autonomous organisation comprised of representatives from the City Council (60%) and from the Autonomous Community (40%), presided by the Mayor of Barcelona. The funding is also shared in the same percentage by these two institutions. The city of Bilbao also jointly funds different care-providing resources charged to its own budgets in collaboration with the Autonomous Community and the "Diputación de Vizcaya".

d) Concerning funding, the cities which have the greatest economic resource are Madrid, as detailed at a further point herein, with 29.4 million euros in 2011, and Barcelona with 7.7 million euros, also in 2011. Regarding the other cities, it is difficult to calculate the exact amount, given that, in many cases, the different municipal areas contribute variable amounts of their budgets to carrying out drug dependence-related measures. Nevertheless, the overall amounts are less than one million euros and may fall within the 200,000 – 800,000 euro range.

1.4 Coordination of the Municipal Plan on Drugs

Be they titled as they may, all of the Municipal Plans on drugs has coordinating organisation into which different aspects of the municipal government are integrated (health, social services, youth, citizen safety, etc. These organisations are usually headed by a Councilperson or by an Area Delegate grouping together several Council Offices, under whose authority there is sometimes an individual coordinator with technical authorities.

1.5 Relationship between the municipal drug policies and others at the Autonomous Community or State level

It must be pointed out that all of the Autonomous Communities has their own law (of an autonomous community scope) governing aspects related to prevention, the provision of care and reintegration concerning the matter of drug dependencies. Similarly, the Autonomous Communities have written Strategies and/or Plans for Action on Drugs, which are updated periodically.

These laws, Strategies and Plans for Action set out the duties and authorities falling to the municipalities (in keeping with their population) as well as the coordinating setups between the

Autonomous Administration and the municipalities for greater efficacy and efficiency of the measures to be carried out in relation to drug dependencies.

Additionally, all of the Autonomous Communities has coordination and support structures set up at both the technical and economic levels) with the municipalities located within their territory for carrying out drug dependence-related programmes and measures.

Lastly, it is through the Central Government that all of the drug policies which are being carried out at the different territorial levels (central, autonomous community (or regional) and local) are coordinated by configuring the National Plan on Drugs (Spanish Plan on Drugs) created in 1985. This National Plan on Drugs is headed by a Government Minister, to whom the Government Delegation for the National Plan on Drugs reports. The Delegation is responsible for heading, promoting and overall coordinating and supervising the services in charge of updating and implementing the National Plan on Drugs.

Over the 27 years throughout which the National Plan on Drugs has been in existence, it has been situated in two sectorial areas: a) Health and/or Social Services b) Interior. At this time (2012), the Minister of Health, Social Services and Equality is the person ultimately responsible for this National Plan, the Government Delegation for the National Plan on Drugs reporting to said Minister.

At this point in time, the 2009-2016 National Strategy on Drugs approved by the Government in January 2009 is currently in effect. This Strategy sets out the principles, general objectives and scopes of action which are going to be guiding Spain's policy on drugs throughout said eight-year period. This Strategy is configured as a common framework for action on the part of all of the Government Administrations (state, autonomous community and local) and of the private social entities concerning this subject. This Strategy makes provision for being unrolled in two Plans for Action one of which is being implemented for the 2009-2012 period.

Both the Strategy as well as the 2009-2012 Plan for Action make reference to the role and duties to be performed by the Local Administrations and the ultimate body representing the same, the Spanish Federation of Municipalities and Provinces. The 2009-2012 Plan for Action sets out in one of its actions that of "fostering the coordination and cooperation between the Government Delegation for the National Plan on Drugs and the Autonomous Community and Local Administrations".

Support of the Government Delegation for the National Plan on Drugs for the local entities concerning unrolling drug dependence prevention programmes

The Delegation grants economic subsidies to local entities on an annual basis so that they may carry out programmes with healthy activities providing alternatives to the use of toxic substances among youths during their free time. The target population for these programmes are mainly juveniles and young people (sometimes also their families) and are funded through a special Fund set up with the assets confiscated for illicit drug trafficking and other offenses related thereto.

The local entities which are eligible for being granted these subsidies are:

- The capital cities of provinces or autonomous communities and island governments.
- The municipalities which have a population of 100,000 inhabitants or above.

In either of these two cases, the entities applying for the subsidy must have prepared a plan on drugs covering their territorial scope.

Table 12.3 shows the subsidies granted to the Spanish cities dealt with in this Selected Issue over the last three years.

Table 12.3 Subsidies granted to the large cities in Spain charged to the Government Delegation for the National Plan on Drugs, 2009-2011

CITIES	2009	2010	2011	TOTAL
Madrid	151,156	183,568	286,993	**621,717**
Barcelona	108,014	115,248	156,842	**380,104**
Valencia	19,921	20,584	22,134	**62,639**
Seville	28,262	29,452	41,475	**99,189**
Zaragoza	58,376	82,835	97,177	**238,388**
Malaga	80,000	86,665	96,425	**263,090**
Murcia (*)				
Palma de Mallorca	45,654	56,546	(**)	**102,200**
Las Palmas (Grand Canary Island) (*)				
Bilbao	52,339	89,392	128,000	**269,731**
TOTAL	**543,722**	**664,290**	**829,046**	**2,037,058**

(*) These two cities have never applied for a subsidy.
(**) Did not apply for a subsidy in 2011.

1.6 Municipal networks at the state level

The most far-reaching network of local entities in Spain is the Spanish Federation of Municipalities and Provinces (FEMP). Although practically 99% of all of its members are municipalities, Provinces (comprised of groups of municipalities located within a certain given territory) as well as the Island Governments also belong to this Federation. The Island Governments are comprised of groups of municipalities on the island comprising the Autonomous Community of the Balearic Islands and the Autonomous Community of the Canary Islands. In all, this Federation's membership totals approximately 7,300, representing more than 90% of Spain's Local Governments.

The Spanish Federation of Municipalities and Provinces (FEMP) was formed in 1985 and was declared to be a Public Benefit Association by means of Council of Ministers Resolution of June 26, 1985.

The Spanish Federation of Municipalities and Provinces (FEMP) is the Spanish Section of the Council of European Municipalities and Regions (CMRE) and official headquarters of the Ibero-American Organisation of Inter-Municipal Cooperation (OICI)

The main goals of the Spanish Federation of Municipalities and Provinces (FEMP) are:

- Promoting and defending the autonomy of the Local Entities.

- Representing and defending the general interests of the Local Entities before other Public Administrations.

- Furthering and consolidating the European spirit at the local level, based on autonomy and solidarity among the Local Entities.

- Promoting and fostering relations of friendship and cooperation with the Local Entities and their organisations, especially within the European, Ibero-American and Arab scope.

- Providing, directly or through societies or entities, all types of services for the Local Governments and the organisations operating under its authority.

- Any other purpose which has a direct or indirect bearing on the Federation members.

The Spanish Federation of Municipalities and Provinces (FEMP) operates by way of different Commissions. One is the Social Issues Commission, the objectives of which include the prevention of drug dependencies through the promotion of a healthy culture and an improvement in the social welfare in the family, at school and in the community. In this regard, the measures it carries out are for the purpose of:

- Reducing or preventing the use and/or abuse of legal drugs, illicit drugs and other addictive behaviours and therefore the problems associated with such use.

- Promoting healthy living habits.

- Further strengthening a culture of preventive health, which includes refusing using drugs.

The Spanish Federation of Municipalities and Provinces (FEMP) and the Government Delegation for the National Plan on Drugs signed a Framework Working Agreement on November 23, 2001, one of the clauses of which sets forth that both parties shall sign a Specific Agreement every year in which they will specify the measures to be carried out concerning drug dependencies.

As of that time, a Specific Agreement has been being signed every year, in which both parties collaborate in carrying out different measures in regard to drug dependencies. These measures take the form of supporting local entities (generally medium-sized) for carrying out programmes and activities related to the prevention, informing and heightening awareness concerning drug dependencies, sharing experiences and best practices among professional of these local entities; promoting continuous training of the municipal technicians on the subjects related to drug dependencies, etc. Additionally, the Spanish Federation of Municipalities and Provinces (FEMP) manages a Database of Municipal Plans on Drugs.

2. CASE STUDY: THE CAPITAL CITY (MADRID)

A) General data on the city of Madrid

The city of Madrid covers an area of 60,430.8 hectares, its population totalling 3,265,038 inhabitants at January 1, 2011. A total of 2,710,228 of these inhabitants are Spanish citizens, and remaining 16.9% being foreigners. The following table shows where these foreigners come from (Source: Spanish National Institute of Statistics).

Table 12.4 Foreign population in the city of Madrid

ORIGINALLY FROM	No. Inhabitants	% Population
Latin America and Caribbean	255,459	46.05%
EU (27-15)	77,296	13.93%
Rest of EU (15)	52,067	9.38%
Other Countries Asia and Australasia	51,473	9.28%
Africa	38,917	7.01%
Other European Countries	14,075	2.54%
Other OECD Countries	13,645	2.46%
Unknown	51,878	9.35%
TOTAL	**554,810**	**100%**

This figure has dropped by 9.73% compared to the year before. *(Source: Directorate General of Statistics – Municipal Register of Inhabitants)*

The registered unemployment rate at December 2011 was of 225,382 individuals, totalling 13.7% of the working-age population. *(Source: Sub-directorate General of Statistics and Computer Science of the Spanish National Public Employment Service (SEPE)).*

There is a major gypsy population living in the Autonomous Community of Madrid as a whole, currently totalling 65,000-70,000 people, practically 10% of Spain's gypsy population, they totalling 1.4% of the total population in the City of Madrid. The gypsies are spread out throughout the city as a whole, although they are concentrated mainly in the city centre and in the urban sprawl in the southern part of the city. (Source: Gypsy Secretariat Foundation).

B) Studies on the drug problem in Madrid (city and Autonomous Community)

- Household survey on alcohol and drugs in the Autonomous Community of Madrid : weblink
- Household survey on alcohol and drugs in the Autonomous Community of Madrid: At the Workplace (2009-2010): weblink
- Survey on drug use among secondary school students in the Autonomous Community of Madrid (2008): weblink
- Indicators of problem drug use in the Autonomous Community of Madrid (2010): weblink. Prepared by the Autonomous Community of Madrid Anti-drug Agency based on data gathered on: Admissions to treatment for Drug abuse or dependence in the treatment network; Hospital

Emergency Care Records related to psychoactive drug use; Deaths due to acute reactions to psychoactive substance use.

- European Survey on Health in Spain, 2009. Determining factors regarding health. Drug use (cannabis, cocaine), alcohol: weblink

- Monitoring System for Risk Factors Associated with Non-Transmissible Diseases targeting the Youth population of the Autonomous Community of Madrid 2010:

    - Weblink to general report
    - Weblink for alcohol
    - Weblink for illicit drugs

In following, some particularly important items of data from two recent studies are detailed.

Household survey on alcohol and drugs in the Autonomous Community of Madrid (this is the Autonomous Community in which the city of Madrid is located). 2009-2010

The psychoactive substances which have a more far-reaching potential for abuse are alcohol and tobacco. A total of 94.5% of the population has drunk alcohol sometime in their lives. Also for the frequencies of use within the last 12 months and within the last 30 days, alcohol was the substance showing the highest prevalence figures. For tobacco, nevertheless, the highest prevalences were found to exist for daily use.

Among the substances on the illegal market, cannabis showed the highest prevalences for all of the frequencies of use studied: sometime in your life (36.7%), within the last 12 months (11.6%) and within the last 30 days (8.4%). Cocaine was the second most widespread substance on the illegal market: 12.2% of the population having tried it and 2% having kept using it to some degree over the past 12 months.

Ecstasy, hallucinogens and amphetamines showed prevalences of use within the last 12 months of around 1%, heroin and volatile inhalable substances being used less among the population. Regarding daily use, tobacco was the drug most used (33.3%), followed by alcohol (10.6%), cannabis (2.1%). The daily use was not stated for any of the other substances.

Survey Findings

1. General:

    A. Alcohol is the substance showing the highest prevalence in the three types of frequencies: experimental, sporadic or recent and habitual.

    B. Tobacco is the substance used most on a daily basis (33%).

    C. Males show higher prevalences for all of the substances, except tranquilizers and sleeping pills.

    D. By ages, illicit drug use is associated with the younger ages. In regard to the prior surveys, the average age of starting drinking alcohol and using ecstasy has lowered, remaining stable or rising for all of the other substances.

    E. In the Community of Madrid, the consumption figures are slightly higher than for the country as a whole for all of the substances, except for the use of cocaine and in regularly drinking alcohol, which are slightly lower.

2. By substances:

   A. Experimental use of **tobacco**, which had been dropping off as of 2003, increased and, to a lesser degree that of the last 12 months (from 41% to 46%) and that of the last 30 days (from 38% to 42%). The percentage of "ex-smokers" has increased, above all among young people. The average age of first use remains at 16.7 years of age.

   B. The results of drinking **alcohol** show a rise in the three frequencies of consumption compared to 2007, reaching the levels of 2005. The majority of those surveyed drink alcohol on weekends, more frequently in the age 15-24 population. Beer (48.4%) and mixed drinks or rum and cokes (27.1%) are those most drunk on weekends.

      At-risk behaviours:

      - A total of 34.2% of those under 18 years of age report having experienced drunkenness at some time within the last 12 months.
      - Drinking 6 or more drinks on one same day within the last 30 days prior to the survey was reported by 14% of those surveyed.

   C. **Cannabis** is the illicit psychoactive substance most used. Experimental use is on the rise, the level of use remaining stable for the other frequencies: within the last 12 months and regularly. The average age of first use is 18.8 years of age, the greatest degree of use being recorded within the 15-24 age range.

   D. **Cocaine** is the second psychoactive substance on the illegal market most used in the Autonomous Community of Madrid, after cannabis. Experimental use is rising significantly and sporadic and regular use has dropped off slightly compared to 2007. A total of 0.7% of the inhabitants of Madrid report having used cocaine within the last 30 days. The average age of first use of use is 21.7 years of age, the 25-34 age range showing the greatest amount of use.

   E. The highest degree of perceived risk is that of the uses of heroin, cocaine, ecstasy and tobacco. Drinking 5-6 drinks on the weekend is what is perceived to entail the lowest degree of risk.

   F. The substance perceived as being more readily accessible by the population continues to be cannabis. There has been an increase compared to previous years regarding the perception of availability for obtaining these substances.

Data on the city of Madrid: Consumption among adolescents within the 15-16 age range enrolled in the 2nd year of Secondary School-Leaving Certificate Studies. (Prepared by Madrid Health based on the data provided by the Autonomous Community of Madrid from the SIVFRENT Youth Survey, 2010.

Tobacco:
Tobacco is the substance used daily with higher prevalences among adolescents residing in Madrid, one out of every ten students ages 15-16 smoking daily, this percentage having dropped off compared to previous years, the habit being more frequent among females (11.1%) compared to 9.4% of the males.

Regarding the time-related trend, daily use has been found to have lowered in the 2005-2009 period to a statistically significant degree both in the total for the sample, in the females and in those of a younger age (age 15).

Alcohol:
Alcohol is the substance showing higher prevalences in sporadic consumption. Within the 30 days immediately prior to the survey, six out of every ten adolescents had drunk alcohol at least once.

The percentage of at-risk drinkers in terms of the amount of their alcohol intake is 5.9%. The time-related trend over the past few years shows a drop in the percentage of at-risk drinkers, 13.1% in 2005 and 5.9% in 2009. This consumption takes place mainly on weekends, which gives rise to binge drinking patterns: 30.6% having drunk excessive amounts of alcohol on one same occasion within the last 30 days, binge drinking being defined as drinking 60 cc or more of pure alcohol within a short period of time (one evening or night) within the 30 days immediately prior to the survey; 41.7% reporting having experienced drunkenness at least once during the last 12 months.

Illicit drug use:
One out of every three adolescents within the 15-16 age range residing in Madrid has experimented with some illegally-sold drug.

The illegally-sold substance used the most by adolescents residing in Madrid in 2009 was cannabis, over 26.5% having tried cannabis at some time. The prevalence of recent cannabis use (used sometime within the last 12 months), although high, has undergone a major drop compared to previous years, from 29.3% in 2005 to 16.4% in 2009.

The same downward trend is found in the current use (cannabis use within the last 30 days) which was 18.2% in 2005, 12.2% in 2007, 11.9% in 2008 and 10.3% in the 2009 study.

Over-the-counter tranquilizers have been tried by 8.6% of the adolescents, according to the last survey in 2009, the prevalence being higher among females (11.6%) than among males (7.9%). Use within the last 12 months was reported by solely 1.3% of those surveyed. The differences found in the years analysed are not statistically significant, it therefore not being possible to say that the use of these substances has become stable.

Experimenting with cocaine has decreased within the period analysed (2005-2009) from 5.3% in 2005, 2.8% in 2007, 1.8% in 2008 and 2% at present. The recent and current consumption figures also show a downward trend, not being over 1% in the latest study. A total of 55% of the students say they have been offered use at some time.

Based on the fact of the average age of first use of substances sold on the illegal market except cannabis is at 17 years of age, very low prevalences are logically found in the ages analysed. According to the latest study experimentation with inhalable substances (1.1%), hallucinogens (0.9%) and ecstasy and amphetamines (0.8%) would be the next-ranked substances in importance.

The survey explores whether adolescents have been offered illegally-sold drugs by third persons, a total of 55% thereof stating having received such offers at some time.

Polyconsumption:
To analyse the concurrent consumption of substances, the following has been taken into consideration: daily tobacco use, drinking alcohol within the 30 days immediately prior to the survey and experimentation with any illegally-sold drug.

According to this criterion, 34.6% of the adolescents within the 15-16 age range do not consume any substance in the aforementioned frequencies. Another 34.8% use one single drug and the remaining 30.5% two or more drugs.

Information on abused substances:

The Survey explores whether adolescents residing in Madrid have been provided with information on the illegally and legally-sold drugs either through teachers or technical personnel at the schools or through their own parents.

Regarding tobacco, a total of 71.5% of the adolescents have been provided with technical information at their school, 82.3% having received information on alcohol and 72.2% on illegally-marketed drugs. A total of 62% of those surveyed received information of the three types described, tobacco, alcohol and illegally-sold drugs within the school environment and 12% stating not having been informed regarding any.

Similarly, parents are a major source of information on drugs prone to abuse for adolescents, eight out of every ten adolescents having received information on alcohol, 77% on tobacco and 60% on illegally-marketed drugs. Over half of the adolescents residing in Madrid are informed by their parents regarding all of these substances.

C) Regulatory framework

Spain's 2009-2016 National Strategy on Drugs makes reference to coordination as a "basic principle for properly unrolling the strategy", stressing the major role played by the Local Administrations and the acknowledgement of the fact that "the success of a general policy on drugs requires the cooperation of the Local Administrations…"

At the Autonomous Community level, the following is worthy of special mention:

Autonomous Community of Madrid Health Planning Law 12/2001 of December 21st, Article 139 of which sets out the following regarding the devolving of authorities to the Local Corporations:

1. *"The Local Corporations may be granted authorities devolved from the Autonomous Community Health Ministry provided that they accredit being able to fully carry out the healthcare-related duties assigned thereto as falling within their own province under the legislation in force and obtain accreditation for such authorities in whatever manner may be determined under regulations.*
2. *Said authorities may solely be devolved when the principle of financial responsibility is fulfilled and the economic results of their management are undertaken in accordance with the principle of municipal autonomy."*

Law 5/2002 of June 27th governing Drug Dependencies and Other Addictive Disorders sets out under Article 45 thereof the authorities of the local corporations by referring to the case of the municipal governments having more than 20,000 inhabitants as follows:

"The municipal governments of more than 20,000 inhabitants have at least the following responsibilities and authorities:

- *The approval and unrolling of the Municipal Plan on Drug Dependencies and other addictive disorders, prepared in coordination and in keeping with the criteria set forth by the regional Agency having authority of the subject of drug dependencies and that which is governed under the Law currently in force.*
- *The unrolling of whatever prevention programmes may be carried out exclusively within the scope of their municipality.*
- *Fostering social participation and support for whatever not-for-profit institutions are carrying out the measures in the municipality for which provision is made under the Municipal Plan on Drug Dependencies.*

Under Article 44 thereof, reference is made to the body which has province over this matter: the Autonomous Community of Madrid Anti-Drug Agency. In the Strategy Plan of the aforesaid agency, it is stipulated that *"In the Autonomous Community of Madrid, the municipal governments also have to capacity to draft specific policies for prevention, provision of care and reintegration regarding the matter of drug dependencies and are also vested with authorities over inspection-related matters and, in any case, enforcement of the penalties for which provision is made under Law 5/2002".*

As far as the local level is concerned, the **Anti-Drug Commission** created on July 31, 1987 prepared the first Municipal Anti-Drug Plan, which was passed at an extraordinary Plenary Session held on May, 6, 1988.

In November 2004, the Municipal Plenary Session passed the statutes of the autonomous "Madrid-Salud" (Madrid-Health) agency, the organisation of which includes the "Addiction Institute of the City of Madrid", which has inherited the authorities of the Municipal Anti-Drug Plan. On March 17, 2011, the New 2011-2016 City of Madrid Plan on Addictions was passed.

D) The approach to drug dependencies in the city of Madrid

In January 1987, the first Municipal Drug Dependence Care Centre was gotten under way in the "Puente de Vallecas" District. Shortly thereafter, on July 31st that same year, the Anti-Drug Commission was created, which, being presided by the Mayor of Madrid, brought together representatives from the different municipal political groups.

This Commission had the mission of preparing a diagnostic of the situation of the drug dependencies in the city of Madrid and setting out the measures to deal with the same. Within this Commission, the work was done for preparing the Framework Document for the Municipal Anti-Drug Plan, which was finally approved with the consensus of all of the political groups represented at an extraordinary Plenary Session held on May 6, 1988, as previously mentioned.

In the course of the following years, the objectives of this first Municipal Anti-Drug Plan have been progressively expanded upon: the design and unrolling of prevention programmes aimed at reducing both the supply and the demand for drugs, the setting up of a wide-ranging, diversified network of resources for the treatment and social reintegration of the drug-dependent population, the setting up of coordination facilities among different municipal areas and all of the other public administrations having authorities over the area of drug dependencies and promoting social participation in carrying out the preventive and care-providing programmes.

The Anti-Drug Commission, which plays an important role in monitoring the Municipal Anti-Drug Plan, was enhanced in 1992 by way of the incorporation of the main non-governmental organisations which were working in the field of drug dependencies: "Cáritas Madrid", Spanish Red Cross, the Federation of Association for the Provision of Care for Drug-Dependent Individuals and Their Families (FERMAD), the Anti-Drug Addiction Help Foundation (FAD), the Spain's "Proyecto Hombre" Solidarity Centre and Spanish Union of Associations for Drug-Dependent Care (UNAD).

The Municipal Government of Madrid thus clearly and decidedly took upon itself an extremely important responsibility in unrolling preventive and care-providing policies in the field of drug-dependencies and has carried out the major task of coordinating with other institutions and with the association-related network of our city as a way of providing an overall, integrating response to this problem.

In 2004, the autonomous "Madrid Salud" (Madrid Health) agency was created and, within this agency, the Addiction Institute, which undertakes the authorities of the prior Municipal Anti-Drug Plan. Under this new setup, a major rise took place in the material and human resources allocated to providing care for addiction to substances as well as those others which progressively arise in

the society, such as compulsive gambling, which has made it possible to significantly boost the measures in all of these Areas.

The care provided for drug dependences in the city of Madrid is currently organised in terms of the following objectives:

- *Controlling the drug supply,* in which the Municipal Police Force plays a major role, is for the purpose of preventing or reducing the supply of illicit drugs within the scope of the city of Madrid and seeing to compliance being rendered with the regulations on the promotion, advertising and sale of alcoholic beverages and tobacco.
- *Controlling the demand for drugs*, with the following levels of intervention:
  - *Prevention*, the objective of which is to reduce consumptions of tobacco, alcohol and/or other drugs and to delay the age of first use, as well as reducing the risks associated with consumptions when consumption takes place. The programmes and services which the Addiction Institute of the City of Madrid devotes to this objective are organised in terms of the different field of action (educational, family, workplace, community and special risk).
  - *Integral care*, the objective of which is to offer those individuals who show abuse or dependence on alcohol and/or other drugs, the care and the resources necessary to integrally deal with both their addiction-related problems as well as the harm and consequences resulting from the consumptions involved, by achieving the greatest possible degree of integration into the society and the improvement of their health and quality of life, as well as that of their family and social environment. The programmes and services which the Addiction Institute of the City of Madrid devotes to this objective are organised in terms of 3 levels of intervention: Resources for detection and basic *in situ* care, Outpatient centres for the treatment and social reintegration of the individuals affects and support resources (hospital, residential, training-employment, leisure-time, etc.)

In the field of social addictions, the Addiction Institute-Madrid Salud has the objective of generating a counselling and/or therapeutic space of an outpatient nature based on scientific evidence which will afford the possibility of taking in, assessing and treating compulsive gambling.

In the city of Madrid, it is the Addiction Institute which takes on most of the authorities over both the prevention and the treatment and reintegration of drug dependencies. Care is provided for a total of 65.5% of the drug-dependent patients at centres operating under the Addiction Institute, and the preventive programmes are implemented in all of the 21 districts of Madrid. The resources devoted to these two fields of action are currently rounded out with the centres and programmes which the Autonomous Community of Madrid Anti-Drug Agency makes available to the residents of Madrid (detailed in Section F of this document).

E) City of Madrid Plan on Addictions, 2011-2016

This new Plan is aimed, without veering from its prior path, toward enhancing the addiction-related measures with new programmes, strategies and scopes of action in keeping with the trend which the phenomenon of drug dependencies and other addictions have been undergoing over the course of the years, placing particular emphasis on the aspects related to the quality of the services and continuing improvement.

In this regard, the process of preparing the new Plan has included a broad-ranging task of participation, which started out with placing an inquiry with experts by means of the DELPHI method, as a result of which it was possible to identify a number of issues found to be indispensable to be put to debate and delved into deeper for the purpose of ascertaining what the

priority lines of action of this new Plan on Addiction must be, as well as the most appropriate strategies for dealing with this at all levels.

The resulting debates on the key point were held with wide-ranging participation. More than 40 institutions and social organisations were actively involved in preparing the Plan on Addiction as well as part of the Addiction Institute staff.

For the purpose of carrying out progressively more highly effective actions, work has been done on defining and implementing an integral care model stemming from continuing planning rounding out the preventive, care-providing and social reintegration strategies such that this continuum will make it possible to provide a response to the needs which come to bear with each individuals in the different situations regarding consumption and in compliance with the objectives proposed in each case.

The Plan on Addictions for the city of Madrid focused from a standpoint of reaching out to the citizens and their needs, by integrating the following into their network for providing care for drug dependencies:

- Preventive programmes for educational, family intervention with minors at risk.
- Services for recruiting drug-dependent individuals and providing them with care in their own settings.
- Outpatient treatment centres and resources supporting integral treatment (hospital units, therapeutic communities, flats and resources supporting reintegration).
- Community mediation programmes aimed at reducing the social impact of addictions in peaceful co-existence.

Additionally, transversally to the actions carried out at the different levels, the Plan on Addictions includes the objective and actions for guaranteeing the quality and continuing improvement of the services rendered within all the scopes of intervention.

1. Plan principles and guiding criteria

- **Ethical commitment**. To defend all of the measures unrolled within the framework of this Addiction Plan taking into account the ethical principles of beneficence, autonomy, justice and harmlessness.

- **Integral focus**. To conceive addictions as a complex, multi-causal, multi-factorial phenomenon by fostering responses which take into account the different factors involved. All through the implementation of a biopsychosocial model both for the prevention and for the provision of care of rehabilitation of the addictions and the consequences thereof on the different facets of the lives of these individuals and their surrounding environment.

- **Universality and equity.** To facilitate, under conditions of equity and non-discrimination, access of the entire population to the preventive, care-providing and social reintegration, of a public nature, free-of-charge, depending upon their needs, by providing special care for those social groups most highly vulnerable or which have the greatest difficulties accessing and taking advantage of these services and resources.

- **Cooperation and interdependence**. To promote the coordination and cooperation among the different public networks, social organisations and institutions as a strategy for organizing responses in keeping with the complex, multi-factorial nature of addictions.

- **Integration and standardization**. Focus all of the interventions processes carried out (whether of a preventive type or those having to do with continuing “care-rehabilitation”) on the ultimate goal of achieving the greatest possible degree of social reintegration by selecting,

whenever possible, the use of extant standardized resources and fostering family and social ties being maintained or recovered.

- **Adaptability to innovation**. Foresee and keep abreast of the social changes in general and specifically those which are continually taking place within the scope of addictions by monitoring how they evolve for the purpose of ascertaining the emerging needs and being able to organise a flexible response well-suited to these needs.

- **Community participation**. To set up the facilities enabling the active involvement of the public institutions, the non-governmental organisations and social agents, the community services or resources, volunteers, citizens in general and the individuals affected per se and their families by facilitating the organisation of agile, global responses to the needs posed.

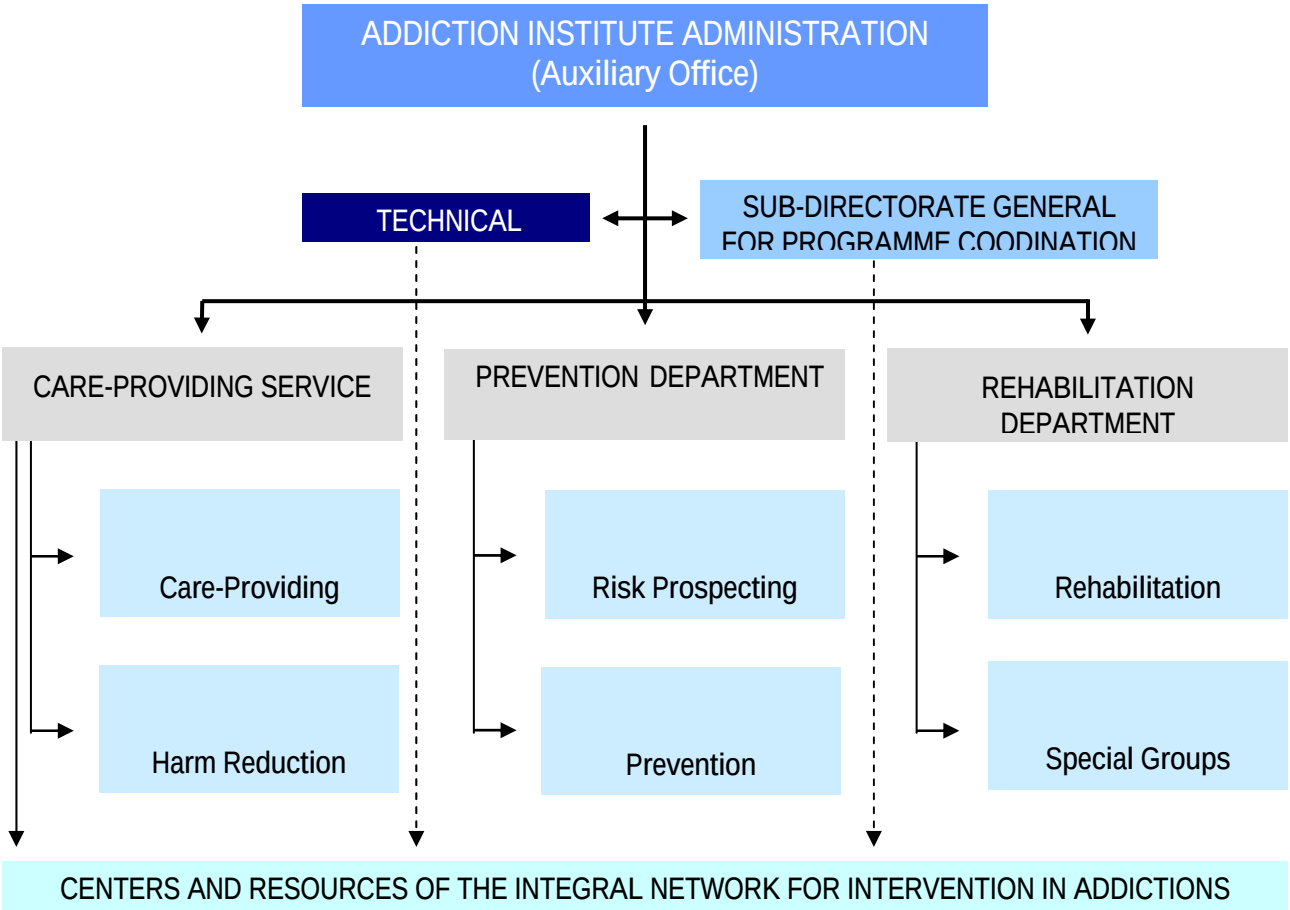
- **Quality.** To focus the actions of the Addiction Institute on continuing improvement, seeking client satisfaction, the efficiency and effectiveness of the system, through training processes, research and continuing assessment. In this regard, the current Plan advocates moving forward in the implementation of programmes in which a solid basis of their, empirical validation of the interventions and evaluation will be core elements in the way of proceeding based on scientific evidence.

2. Organisational structure. Coordination

As previously stated, the Addiction Institute of the city of Madrid comprises part of “Madrid Salud” (Madrid Health), which is an autonomous agency of the Municipal Government of Madrid, endowed with its own individual public legal status, its own patrimony and autonomy of management for fulfilling its purposes. Since its creation in 2005, “Madrid Salud” has had the mission of managing the municipal policies concerning the matter of public health and drug dependencies within the municipality of Madrid. In 2011, “Madrid Salud” was placed under the Environment and Mobility Area of Government, having authority over Public Health and Drug Dependencies, heading by the Area councilperson, to whom it falls to head the strategy thereof, as well as the evaluation and control of the outcomes of the activity hereof.

The Addiction Institute of the city of Madrid has the mission of managing the municipal policies on the subject of drug dependencies and other addictive disorders in the city of Madrid which encompass the municipal measures regarding the provision of care, prevention, rehabilitation and evaluation in the field of addictions, training and research in these fields and all those measure which may fall to the Institute for accomplishing its missions.

The Addiction Institute is organised as follows in 2011:



The main coordinating lines carried out through the Addiction Institute are:

- Coordination, within the "Madrid Salud" framework proper, with the Public Health Institute concerning matters of far-reaching importance for prevention and for integral treatment of addictions, including: Clinical analysis laboratory, Health Promotion and Environment Service, Technical Division of Monographic Centres (Youth Centre, Oral Health Centre, Cognitive Loss Centre and Health Habits Centre) and Occupational Health. The Public Health Institute is responsible for promoting health and preventing diseased among the citizens of Madrid by way of promoting healthy habits, food safety, the improvement of environmental health, sustainable integration of animals into the city and the management of the Occupational Hazard Prevention Service of the Municipal Government of Madrid.

- Coordination with other municipal services and areas which have province over the missions of the Addiction Institute, including those such as the Government Area for Family and Social Services, Government Area for Economy, Employment and Citizen Participation, Municipal Police, Environment.

- Coordination with the Autonomous Community of Madrid Anti-Drug Agency, the agency responsible for managing addictions in this Autonomous Community, for jointly preparing strategic intervention plans for the city of Madrid, participation in the coordination structures of the Anti-Drug Agency and maintaining addiction-related working agreements.

- Coordination with other public networks: Primary Health Care and Mental Health Network (these networks pertain to the Autonomous Community of Madrid).

- Coordination with the Government Delegation for the National Plan on Drugs in carrying out programmes, research and publications in keeping with the guidelines of the National Drug Strategies and for international cooperation.

- Coordination with the Spanish Federation of Municipalities and Provinces (FEMP) for the preparation of technical documentation and publications, training activities, research and communication.

- Coordination with Third-Sector entities: Foundations, NGOs and associations which carry out activities, programmes and services for the addiction-related prevention, treatment and rehabilitation.

- Coordination with Universities and Official Professional Associations.

3. Prevention of drug dependencies

The Addiction Institute unrolls a bonelike addiction prevention model which creates methodological synergies with all of the preventive actions aimed at preventing other at-risk behaviours which come to bear during adolescence and/or the pre-teen years.

For this purpose, this Institute channels all the interventions through the Addiction Prevention Centre, which is considered to be the backbone integrating the actions and programmes which are carried out at the educational level, at the family level, at the community level and at levels at special risk.

3.1 Educational level

3.1.1" Programme for the prevention of drug dependencies and other addictive disorders within educational contexts. "Prevenir en Madrid" ("Preventing in Madrid")

This is a programme offered for Elementary School, Secondary School and Baccalaureate students which employs a participation-oriented methodology based on cooperative learning. This programme provides different written and audio-visual materials to be used in the classroom, adapted to each instructional level.

This programme's main objectives are:

- To provide the faculty with the skills to carry out a proper preventive intervention within the educational context.
- To improve the students' connection with the school as one of the main conditions safeguarding against drug use-related behaviours.
- Heighten the troubleshooting capabilities in at-risk situations, as well as the skills for withstanding social pressures leading to conflicts.
- To contribute to improving the quality of life at the school.

This programme's main innovative features compared to other programmes are:

- Its ability to contribute to improving the quality of life at the school.
- The fact that it is not necessary for the faculty to be "experts" in drug dependencies to carry out this programme.

It is carried out in keeping with five modalities entailing different degrees of demand or commitment:

- Training Programme for Current Faculty Members:
  Through a joint training programme between the Addiction Institute of the City of Madrid and the School of Psychology of the Complutense University of Madrid ((UCM), the faculty members on staff may take an Expert Course with accreditation by way of the Complutense University's *Own Diploma*, a s well as being awarded credit hours for the curriculum. This course consists of a textbook module and an in-classroom practical application module, guided by the technical prevention team, which takes responsibility for monitoring the application.

  Teacher Training School Student Training Programme:
  Offered for the Teacher Training School students who wish to take instruction on preventing drug dependencies as part of a subject comprised within their course of study. A specialized training of future primary school teachers is carried out, making it possible to implement the programme modules during practice teaching assignments.

- On-the-Job Teacher Training Programme:
  Offered for teachers wishing to take instruction on preventing drug dependencies, this programme's design is adapted to the school's specific needs. To this end, a custom-made application is designed to analyse each request and prepare a proposal in keeping with each centre's expectations and needs.

- Direct, In-classroom Intervention Programme:
  Aimed at guaranteeing short-term objectives being met, this programme is implemented directly with the student body through a team of prevention specialists.

- University Intervention Programme:
  Universities are the cradle of preventive mediators who will be doing their work in the future in different sectors, becoming reference points for the society in which they live. Modular programmes are carried out, based methodologically and in their technical contents on "Prevenir en Madrid" ("Preventing in Madrid"), adapted to each university school and each group (students, teaching staff and related personnel). Work is also done with other institutions in the areas surrounding the residence halls, libraries, leisure-time establishments, etc. due to their being places where this population gathers and carries out activities.

3.1.2 Preventive intervention activity with adolescents and youths in situations of particular risk

The Addiction Institute Prevention Department carries out measures for individuals and groups who, due to several risk factors being involved, are more highly vulnerable to developing at-risk behaviours. Because these are direct actions on an individual or group, this intervention is carried out on their different relational levels: the school, family, peer group and, of course, the community, understood as the closest surrounding environment.

From this perspective of a unified, global intervention, one of the most important missions of the prevention team is to identify and make a connection with these individuals or groups of characteristics making them most highly at-risk, in their own environment.

- "Prevenir en Madrid" ("Preventing in Madrid") Programme for selective prevention: This is a programme offered for teachers and students (preferably 14-20 years of age) from public

and private schools. This programme is carried out in formal settings (classroom) however employing a fun, participation-oriented methodology by way of sports activities, artistic workshops, etc.

- Especially vulnerable families: These situations can be detected through the intervention which the technical team carries out at the school level with families (Parents' Associations-AMPAS) or by way of the prevention measures carried out with the associative network.

- Community work: Community work is done in the districts both through coordination structures (health boards, prevention boards, district teams, etc.) and in the day-to-day interventions in the different areas where actions are being taken. In this intervention, adolescents and young people with specific needs requiring an intervention by the prevention team are detected for the purpose of channelling the different needs of the individual in question and identify the resources.

- Strategies aimed at intervention with natural groups or with those groups which form around an activity or shared interest. The sports-related groups are outstanding along this line.

- Individual intervention according to a protocol set out for this intervention.

3.2 Family level

The family-oriented prevention programme has progressively developed specific intervention protocols adapted to the different intervention needs of families. The objective is to continue evaluating the efficacy of the interventions and progressively adapt the processes in order to provide responses not only by way of an individual intervention, but also by way of group-oriented intervention and through the new management training strategies (work with small groups and similar conflicts).

The family-oriented interventions carried out through the Addiction Institute fall within the framework of the instruction/training, counselling and guidance processes.

3.2.1 Family guidance service

- Individual intervention:

  This intervention is started by way of a structured interview conceived in preventive terms for evaluating and recording the situations put forth by those requesting guidance. The objective is to make a brief assessment of how serious the family situation is in terms of the risk and protection-related factors, after which different options can be offered through this service proper which are in keeping with the different situations:

  - On-the-spot guidance concerning a specific aspect which can be remedied at the interview proper.
  - Offering a somewhat broader-ranging guidance – counselling period, generally of no more than three or four get-togethers, by way of which it is possible to more amply achieve the objectives set and/or make an "*in situ*" evaluation of the interested party or family member who has given rise to the need for consultation, normally an adolescent child.
  - Possibility of the family being able to take part, along with other families, in some group which is well-suited to their needs.
  - Referral to other programmes or services considered to be best-suited for dealing with a specific set of problems the family has.

Whether the intervention ends in the service proper or is referred to another facility, it is important to leave the possibility open of the family being able to return for consultation whenever they may need to do so. This connection of support that is established between the guidance team and the families facilitates both the possibility of conducting a follow-up with certain families who so require and also of providing direct care for some specific family member (generally children) regarding whom it is considered advisable to intervene.

- Group intervention. Instructional work with families:

  The work with groups of families that the prevention department does specifically takes the form of:

  - Informative sessions
  - Instructional sessions
  - Sessions devoted to family guidance and dealing with risk

3.3 Community level

One of the main cores of addiction-related prevention is the active involvement and participation of all of the social agents. This community dimension of prevention requires specific knowledge and skills being acquired on the part of the social sectors, in addition to the public responsibility of offering the training and resources necessary for meeting these requirements, some of the most important of which are:

3.3.1 Training social mediators

Social mediator training is offered mainly for reference point individuals pertaining to the different community structures. The contents on which work is done are aimed at detecting risk situations, shortcomings in health education or relational problems (among peers, family…), actively stimulate participation in healthy leisure-time activities, etc. Following some basic contents being conveyed, social mediator training is flexible and is adapted to the needs and demands of the entities where it is being offered.

3.3.2 Intervention with the Municipal Police Mentor Officers

The Mentor Officers comprise a group within the Municipal Police Force combining criteria of police intervention with minors and outreach whilst maintaining their police intervention and penalizing capacity. Therefore, they are key elements when organizing the twofold endeavour of controlling the supply and reducing the demand.

The prevention department carries out a joint intervention Protocol detailing the instructional aspects of this group as well as the contents to be expanded upon in their work with minors. The Mentor Officers intervene mainly at the school and open environment levels.

They offer a lecture series at the school revolving around legal and penalty-related aspects, leaving the topics related to drug use and the prevention thereof to the Addiction Institute's technical team.
They work with minors in the open environment by detecting situations of the consumption of alcohol and/or use of other drugs and referring to these minors to the prevention team. They also have the authority to get in touch directly with the minor's family, informing them of the situation and offering the intervention of the Family Guidance Service.

3.3.3 Prevention of drug use at the workplace

Complex situations can be encountered at the workplace, differing from those found in other environments, entailing added risks for drinking alcohol or using other drugs. One of the first actions which must be taken is managing to get the companies and the employees proper to take an interest regarding both all that which has to do with the repercussions which each one of these substances has on one's occupational know-how and responsibility.

3.3.4 Instruction and preventive information on social networks

Informing via social networks is designed to be through different digital media yet with the same objectives:

- To generate a necessary "critical thinking process" among adolescents and youths concerning alcohol and other drugs
- To achieve a progressive social positioning focusing on a less permissive way of perceiving drug use.
- To make reliable, anonymous guidance resources more readily available.

3.4 Global prevention data, 2011 (2011 Addiction Institute of Madrid "Madrid Salud" Report

- Educational level: Interventions took place at 743 schools by educating 3,611 teachers and 74,662 students.
- Risk level: Selective intervention programmes: A total of 2,085 individual interventions were carried out with adolescents and youths in situations of special risk. Interventions were also carried out with 8,678 adolescents in areas of active use.
- Family level: There were interventions with 4,214 families.
- Community level: A total of 3,032 community mediators were trained and 45,418 young people took part in leisure-time activities alternative to substance use in 9 districts of Madrid.

4. Integral network for providing care for drug dependencies in the city of Madrid

4.1 Levels of intervention

4.1.1 First level or entry level

At this level basic care-providing programmes and guidance, information, early detection and recruiting services are included. These are the "entranceway" to the network. They motivate treatment, foster adherence to treatment and facilitate referral to the second-level resources. The Addiction Institute has a night-time centre for providing basic socio-sanitary care and a mobile harm reduction unit. These resources are included and detailed at a further point in this document (Section 2.1.3 Harm Reduction Services, in Section 2.1 Four areas of drug policy in capital cities).

4.1.2 Second level. Outpatient centres. Drug Dependence Care Centres

In 2011, the municipal network had eleven outpatient centres located throughout different districts in the city of Madrid, open on a walk-in basis or by way of referral from primary

health care, social services or from other institutions or entities. In addition to these eleven centres, there were six outpatient centres operating under the Autonomous Community f Madrid (the overall details of these seventeen centres are detailed at a further point herein, under Item F).

The outpatient centres providing care for drug dependencies operating under the “Madrid Salud” Addiction Institute Network are centres of a socio-sanitary nature which are equipped with an ample team of technicians pertaining to different professional disciplines, such as physicians, psychologists, social workers, occupational therapists, nurses, lab technicians, nursing assistants, administrative personnel and services personnel. These professionals possess a high degree of technical qualification and specialization due to their loyalty to their professional, long professional experience (average stability, 15-20 years) and to the continuing training process promoted through the organisation proper, contributing as added value the generation of scientific knowledge backed by a major number of scientific research studies and publications.

These outpatient centres serve as the core around which the integral intervention with the patients revolves and are the reference centres in the treatment network, coordinating the measures taken by the different services involved in the rehabilitation process. It is in these centres that the personalized intervention process is designed and coordinated with each patient.

4.1.3 Third level. Services and resources supporting the treatment and rehabilitation

In order to provide an appropriate care-providing response in keeping with the many different profiles for which the Addiction Institute provides care, it has a broad-ranging network of centres, services and resources for supporting the treatment and rehabilitation of drug dependencies, including both its own services and those it manages indirectly by way of contracts or agreements with different companies, entities and non-governmental organisations.

Table 12.5 Third-level resources for supporting treatment and rehabilitation

THIRD-LEVEL RESOURCES	2011 INDICATORS
Basic Night-time Socio-sanitary Care Centre	479 users
Mobile Harm Reduction Unit	270 patients
Immigrant Care Service (ISTMO)	985 patients
Hospital Unit and Day Centre for Dual Diagnosis Patients	43 places 224 admissions
Places under arrangements in Therapeutic Communities	127 places 381 admissions
Places under arrangements in Flats for supporting treatment and rehabilitation	114 places 352 admissions.
2 Day Centres	55 places 153 patients
1 Pharmacy under arrangements for processing methadone + 3 Mobile Units for dispensing methadone	50,000 doses/yr
200 places under arrangements with the Official College of Pharmacists at pharmacies for dispensing methadone	94% occupancy
Reintegration Training Workshops	461 patients
SOL: Social-Employment Guidance Service	946 users y 535 occupational reintegration
Programme for intervention in drug dependencies in the Police Courts of Madrid	3,946 arrestee guidance interviews
Community mediation programme for reducing the social impact of addictions in peaceful co-existence among citizens	1,726 interventions

4.2 Integral care-providing process

The Addiction Institute bases its measures on an integral drug dependence care-providing model distinguished by a number of characteristics: interdisciplinary, multi-dimensional approach, networking, individualization, confidentiality and flexibility, taking social rehabilitation as being the ultimate goal to be achieved by means of the entire intervention process.

This integral care-providing process is divided into the following phases:

- Responding to the initial demand. After actively listening to the demand, some initial data is gathered in order to determine whether there is any reason for placing priority on the care (pregnancy, risk for under age or elderly dependents under their responsibility, high-risk style of use, presence of physical or psychiatric diseases or disorders requiring urgent treatment, risk of self-inflicted injuries, threat to the safety of others, etc.) whilst at the same time

providing the patient with the necessary information and motivating the patient to begin treatment.

- Interdisciplinary assessment and multi-dimensional evaluation. The interdisciplinary team conducts an evaluation of the patient in terms of the following dimensions or areas: health and personal self-care, psychopathology, substance use, family, social-relational, training-employment and leisure/free-time area.

- Design of the personalized intervention programme. Based on the results of the multi-dimensional evaluation, the interdisciplinary team designs a Personalized Intervention Programme (PIP). Once agreed to with the patient, this personalized Programme is the tool by virtue of which the different specific measures and the necessary resources (own or external) are organised and the different interventions are combined with one another depending on the patient's needs and progress. One figure worthy of special note in this phase of the process is that of the *Professional of Reference,* whose mission it is to guide and mentor the process whilst also being the spokesperson for the team, given that this is a strategy facilitating the integration of the different actions in which the patient takes part in his/her rehabilitating process.

- Carrying out the PIP. Once the intervention programme has been set out and agreed upon for each patient, the programme is then carried out, consisting basically of putting into play the methodology, strategies, specific measures and the necessary resources. Saving individual differences and each individual patient's pace of change, some phases or sub-processes can be determined in carrying out the personalized intervention programme:

  a) Detoxification and/or stabilization. By way of this process carried out over a set time span, the drug-dependent person goes from the situation of using one or more substances to a situation of abstinence from using said substances. During the process, a number of measures of different types (pharmacological, psychological, restriction measures, etc.) are put into play making it possible to deal with whatever clinical manifestations may arise on ceasing to use the substance(s) having given rise to the dependence. In other cases, detoxification objectives but rather reduction of use, lower-risk use or stabilization of substitutes or other legal drugs are set.

  b) Habit cessation and rehabilitation. During this process, new treatment strategies – whether of the healthcare, psychological, occupation, educational or habit re-education or other types – are gotten under way aimed at facilitating the patients overcoming the fears and stresses, the acquisition of personal skills of different types which will make them resistant and less vulnerable to the risks of use, recouping constructive social and family relations, acquiring and enjoying healthy, enriching leisure-time pursuits and seeking new values and lifestyles which will facilitate their social rehabilitation and taking upon themselves the challenge of living without depending on a substance.

- Evaluation of results. The PIP also comprises a tool facilitating the evaluation of the changes which progressively take place in the patients during the intervention processes. These changes become patent on each one of the axes in comparison with the objectives set. The information gathered by way of this continuing evaluation process, the periodicity of which is decided upon by the treatment team responsible in each case, serves as a guide as to the work to be done and affords the possibility of knowing, when the patient exits the programme, the quality and magnitude of the changes which have taken place and the comparison of these changes with the patient's situation at the point in time of the first evaluation and with the objectives which had initially been set in each one of the dimensions of the intervention, in other words, making it possible to make an evaluation of results.

- Post-release follow-up. The evaluation of results mentioned in the immediately preceding section hereinabove is the starting point for conducting a patient's post-release follow-up. Once the intervention has reached an end, but it at the patient's wishes or by recommendation of the treatment team after having achieved the anticipated changes in the different areas of

intervention, it is interesting to ascertain up to what point certain changes are maintained over the course of time.

4.3 Care provided for social groups with special problems or needs.

Also worthy of special mention is the fact that, at the Addiction Institute, it is considered top-priority to devote a special effort toward adapting and assigning resources in regard to those social groups which posed special problems or needs, whether in accessing the network resources, in maintaining and making the best of the treatment programme or in the always complex process of social reintegration:

- Adolescents and youngsters. The centres have professionals who are experts in providing care for adolescents, youngsters and their families with specific resources facilitating the treatment intervention and achieving the normalizing educational objectives. We have the only urban therapeutic community for treating adolescents and youngsters on an in-patient basis.

- Chronic drug-dependent patients and/or patients with cognitive impairment. This includes elderly patients, patients with long histories of drug use, multiple relapses and long-term treatments. The main drugs abused are alcohol and opiates. The Addiction Institute avails of harm reductions programmes for the treatment thereof which are designed for covering their special needs: alcohol detoxifications in a hospital setting for patients over 65 years of age (resource unique to the Autonomous Community of Madrid Drug Dependence Care Network; places for admission to specific Treatment Communities for physically and/or mentally-challenged patients and home care for handicapped drug-dependent persons. The objective thereof is to facilitate the changes in lifestyle which are related to the consumption in question and reduce the risk of social exclusion.

- Dual diagnosis patients. These patients are in more serious condition and have a worse prognosis and evolution in treatment on having a psychiatric disorder in addition to their addiction. This gave rise, in 2004, to the “Madrid Salud” Addiction Institute having gotten a specific residential facility (Dual Diagnosis Centre) under way, having made it possible for these patients and to be stabilized and having improved their subsequent evaluation in the outpatient treatment. This centre was a pioneer and is the only facility in existence which provides a response to dual diagnosis of all of the centres providing care for drug dependencies throughout the entire Community of Madrid. The “Madrid Salud” Addiction Institution also has residential facilities (flats) for supporting treatment and rehabilitation specialized in dual diagnosis patients for the purpose of facilitating their rehabilitating process, such that, in 2011, it was made possible to achieve a 20% reduction in treatment drop outs, which are so frequent in this type of patients when an integral treatment is not provided. Educational and pre-employment activities adapted to their circumstances are also offered.

- Homeless drug-dependent individuals. A person may come to be in a situation of homelessness due to many different factors: economic precariousness, health problems, alcoholism, other addictions and mental disorders. According to the latest “Samur Social” report, there are 2,000 homeless people in Madrid, a total of 600 of whom are living in the street. According to this report, there is a 43% prevalence of alcoholism, 16% prevalence of other drugs and a 14.5% prevalence of dual diagnosis.

- In view of this situation, a protocol for taking action was gotten under way as of 2007 jointly between the Addiction Institute and the Homeless Persons Care Network of the Family and Social Services Area for the purpose of providing specific care by bolstering the coordination of measures and resources through both of these municipal areas. The outcome has been an improvement in the quality provided to these patients and in the management of the economic resources. The Addiction Institute provides care annually for an average of 600 people

pertaining to this group, fifty percent of whom has alcoholism-related problems, and makes available to them specific residential resources for relieving the situation of uprootedness and social exclusion which is so often found in these patients.

- Individuals with special needs due to differences in origins, culture, language or ethnic background. The Addiction Institute gets specific measures and resources under way for overcoming language problems as well as for facilitating the integration of these patients by putting a stop to the psychosocial impairment caused by their addiction on doing away with added barriers for access to treatment.

- Individuals involved in problems with the law. The "Madrid Salud" Addiction Institute has a programme for counselling judges and information drug-dependent arrestees, thanks to which close coordination is achieved between the justice administration and the treatment Network, which facilitates adherence to the treatment and the rehabilitation of those involved.

Integral care: Overall data, 2011 (2011 "Madrid Salud" Addiction Institute Report)

In 2011, treatment was provided for a total of 9,337 patients at the 11 outpatient centres in the "Madrid Salud" Addiction Institute care-providing network. Care was provided for 3,281 patients using opiates as the main drug, a total of 2,744 of these patients having been prescribed pharmacological treatment with methadone and 128 patients with the buprenorphine-naloxone combination due to: the individual variations (secondary effects, rapid metabolizers, pharmacological interactions, etc.), difficulties for achieving effective doses with methadone and in detoxifications of the chronic therapy with the same. Treatment was provided for 2,707 patients whose main drug habit was drinking alcohol. A total of 1,895 patients who used cocaine and other stimulants as the main drug were provided with treatment. The patients who had been using cannabis as the main drug totalled 726 in number. During the period in question, care was provided for 1,087 families of drug-dependent individuals.

The profile of the population for which care was provided was as follows: 80% males averaging 42.4 years of age and 20% females, averaging 43.5 years of age. A total of 87% of the population for whom care was provided were Spanish citizens, 47% being unemployed working-age population.

In 2011, a total of 2,065 new patients were admitted for treatment, for 44% of whom the main drug was alcohol and 26%, cocaine and stimulants.

Care was provided for 471 adolescents and youngsters entailing psychoactive substance abuse or addiction. A total of 89 thereof were in the 14-18 age range, 90% using cannabis as the main drug. Care was provided for 382 patients in the 19-24 age range, 19.9% of whom were using cocaine and stimulants as the main drug, whilst as high as 60% of this age range were cannabis users.

During this period, care was provided for 635 homeless drug-dependent patients, 85% of whom were males averaging 46 years of age, for 50% of whom the main drug as alcohol and for 40%, opiates.

The "Istmo" immigrant population intervention service provided care for 985 foreigners. A total 43% of those for whom care was provided came from Eastern European Union Countries, 15% from Maghreb Countries and 8% from South American countries. The main drug used was alcohol among 56% and opiates among 27%.

Care was provided for 2,852 dual diagnosis patients during this period. The disorders most often associated were: 35%, mood disorders; 21%, personality disorders and 11% psychotic disorders. Among this group of patients, the main drug was alcohol for 33%; cocaine for 28% and opiates for 26%.

The percentage of unscheduled abandonments in the treatment and rehabilitation support resources (voluntary releases, not following the rules) dropped to 20% compared to 2010, there was a 60% drop-out rate.

The Social-Employment Guidance Service (SOL), the mission of which is to foster full integration into employment of the drug-dependent individuals and youths with at-risk consumptions, provided care in 2011 for a total of 946 cases, 83% of whom were males falling mostly within the 36-45 age range, 75% of whom had completed school-leaving studies or lower-level studies, 86% being unemployed. A total of 48.73% of those making use of this Service took part in workshops training in skills for employment.

Similarly, due to the fact that in the current context, job offers are becoming progressively more scarce on the employment market for those persons who are undergoing treatment for a drug dependence problem an endeavour has been carried out through the Social-Employment Guidance Service (SOL) with 445 companies for the purpose of heightening awareness and getting them actively involved in improving the employability and insertion into employment of those using this service and thus integrate them into the network of socially-committed companies.

The Social-Employment Guidance Service (SOL) has a system for carrying out a post-release follow-up on those for whom care is provided in this programme which provides evidence on the actual social-employment integration of the population for which care has been provided once they have left the treatment centres, which is highly useful for assessing the impact of the intervention, the stability and the consolidation of the advancements achieved. The 2011 annual report underlines the fact that the percentage of those surveyed who are working upon release from the Drug Dependence Care Centre (DDCC) (39.7%) remains the same, and six months later (37.8%), and that they state quite a high degree of satisfaction regarding the relations with bosses (85% at release from the DDCC and 78.5% at 6 months) and with their fellow workers (90% at release from the DDCC and 76,7% six months afterward.

The Advisory Service for judges, information and the provision of care for drug-dependent arrestees located at the Police Courts located at “Plaza de Castilla” in Madrid is provided by virtue of a Working Agreement between the Autonomous Community of Madrid Ministry of Justice and Interior, the Autonomous Community of Madrid Health and Consumer Affairs Ministry – through the Anti-Drug Agency- and the Municipal Government of Madrid through the Autonomous “Madrid Salud” Agency. During 2011, advisory was provided for a total of 3,946 drug-dependent arrestees (1 or more interviews), 1,362 family members of drug-dependent arrestees (1 or more interviews) and 4,904 court operators. A total of 2,649 expert opinions were issued, and the professionals from this Service appeared in 1,244 court proceedings. In 693 cases, they supplied the prescribed dose of methadone to drug-dependent arrestees who were in the jails and who were included in opiate substitute treatment programmes at the point in time of their arrest.

In 2009, the Programme for non-drug dependent Individuals Convicted for Public Health Offenses was started up at the request of Madrid Prison Supervision Court No. 1. This programme is offered for those non-drug dependent individuals convicted for public health offenses who are on probation. The main objectives of this programme are: to heighten the awareness of those individuals convicted for public health offenses concerning the consequences resulting from drug use and/or trafficking; making possible actions for redressing or repairing the harm caused to society, preventing further criminal acts from being committed and favouring social reintegration. In 2011, there were interventions with 136 convicts with individual interviews, group sessions and visits to impacting resources for the purpose of heightening the convicts’ awareness regarding the harm which their unlawful actions cause.

The Community Drug dependencies Mediation Programme is for the purpose of reducing the peaceful coexistence-related conflicts caused by the concentration of drug-dependent individuals in public spaces in the city of Madrid. This Programme is offered for both the drug-dependent individuals who gather in certain areas of the city, giving rise to attitudes of rejection of the part of

the society as a whole as well as on the part of residents and merchants in those same areas. In 2011, this programme was carried out in 10 areas of the city of Madrid: in 8, continuously and at certain set times in two areas. A follow-up was conducted of 109 drug-dependent individuals, with whom a total of 1,118 interventions were carried out (information of treatment centres, healthcare resources, legal aid, etc., as well as referral and/or accompaniment in certain cases). Interventions were made 81 times with the area residents and 80 times with managers of business establishments.

5. Quality assurance

The Addiction Institute of the city of Madrid undertakes the commitment to quality and evaluation of the services set out in the Municipal Government of Madrid's Modernization Plan, in which the framework is set out for a number of measures aimed at placing the municipal organisation in a position of spearheading the Government Agencies for the ultimate purpose of reaching out better to citizens, making headway toward excellent in providing public services, incorporating the information and communication technologies and implementing a new, effective, transparent and open management culture.

The Addiction Institute has basic management objectives including committing to quality, citizen-oriented service and the occupational advancement of its employees. To this end, this Institute stands on four pillars: 1) Evaluation 2) Continuing training 3) Research 4) Improving communication.

In 2011, "Madrid Salud" and, in conjunction therewith, the Addiction Institute, has been granted +400 quality accreditation by the European Management Excellence Club (European Foundation for Quality Management).

5.1 Evaluation

The Addiction Plan of the city of Madrid stipulates evaluation as being an indispensable tool for analysing the organisational and effectiveness of the interventions, affording the possibility of assessing the results and effects achieved, facilitating the alignment of the human, technological, funding-related and organisational resources for accomplishing the objectives thereof.

The Addiction Institute has configured a system for monitoring at several levels, making it possible to monitor its interventions and guarantees its objectives being met in full:

- Budget Management Indicators System: Aimed at the evaluation of the programmes and fulfilment of the budgeting goals.

- Budget of the Addiction Plan of the city of Madrid (2011). Included therein are both the budget managed directly by the Addiction Institute (25,775,503 euros) and that devoted to supervising the supply of alcohol and other potentially addictive substances managed by the Municipal Police Force (3,682,789 euros). The two added together total 29,458,292 euros, as itemized in the following Table.

Table 12.6 Addiction Plan Budgets, 2011

DESCRIPTION	2011 BUDGET
MUNICIPAL POLICE FORCE BUDGET ALLOCATED TO CITY OF MADRID PLAN ON ADDICTINS: SUPERVISION OF THE SUPPLY OF ALCOHOL AND OTHER POTENTIALLY ADDICTIVE SUBSTANCES (*)	**3,682,789**
ADDICTION INSTITUTE BUDGET	**25,775,503**
Unspecific and specific prevention within the different scopes of action	2,220,803
Care provided for addictions	18,250,654
Social-employment rehabilitation of addicted patients	3,918,362
Fostering participation in the third sector	469,002
Quality, training, research and management policies	**916,682**
TOTAL 2011 CITY OF MADRID PLAN ON ADDICTIONS	**29,458,292**

(*)Estimated budget

A total of 98.95% of the Addiction Institute Budget (26,775,503 euros) was allocated. This budget was cut back by nearly 15% compared to 2010. The budget decrease fell mainly on Section II (expenditures in goods and services necessary for carrying out the activities). This made it necessary to reorganise the resources for the purpose of continuing to provide quality care for those using the services without any noticeable loss of the network's potentials. Charged to the 2011 budget year, the Addiction Institute signed agreements with 9 institutions, some of the most outstanding of which were the Red Cross, Cáritas, the Foundation Against Drug Addiction (FAD), FREMAP (Mutual Society), Spanish National Open Distance-Learning University (UNAD) and UCM Foundation. It has granted subsidies to 89 entities and has signed arrangements with 24 associations.

Concerning the budgeting goals having been met, special mention must be made of the fact that the 2011 budget has 13 objectives and 37 indicators. A 94.6% degree of compliance (only two indicators did not achieve the planned goal) was achieved.

System for evaluating citizen needs, expectations and satisfaction:

As of 2004, the Addiction Institute has been preparing a "Survey on the satisfaction of those using the drug-dependent care centres (DDCCs) and those using the Addiction Prevention Programme (APP)". This Survey is aimed at measuring the degree to which those using these services are pleased with the services provided and the weak points and strong points they have encountered for the purpose of suiting the services offered thereby and the quality thereof to the commitments undertaken to the citizens.

In 2011, the main results were: A total of 65% of those using these services considered the care provided by the DDCCs to have been excellent or very good, this having been the opinion of a larger percentage than in the 2010 survey (57.9%). Those using these services rated them with a

satisfaction score of 7.6 on a ten-point scale. Regarding the evaluations of the different professionals, the score given by those using these services fell within the 3.4-3.6 range on a five-point scale. The scores given to the therapeutic communities were within this same range, as was that of the Employment Counselling Service, which scored 3.2.

Suggestion and complaint system:

The Addiction Institute takes part in the suggestion and complaint system gotten under way by the Municipal Government of Madrid, aimed a analysing the suggestions and complaints filed by the citizenry as well as the responses issued by the divisions involved and the measures taken with regard thereto. The commitment undertaken to the citizens by way of the "Services Charter" is to provide a response to at least 80% of the suggestions and claims filed within two weeks or less. IN the case of the Addiction Institute, it received a total of 27 suggestions and complaints in 2011, a response having being provided to 90% of which within the appointed time frame.

"Services Charter. Commitment to citizens" System

The Addiction Institute Services Charter was approved by the City of Madrid City Council on February 8, 2007. By means of this public document, the Addiction Institute stipulates and informs citizens of the services it offers and under what conditions, the responsibilities and commitments of those rendering these services to certain standards of quality, the rights of the citizens in regard to these services, the responsibilities they undertake, in exchange for the same on receiving them and the ways of participation for the purpose of guaranteeing continuing improvement.

This Charter clearly sets forth the commitments of quality to be achieved, measured by means of a number of evaluation indicators (30) for both facilities as well as the professionals (how treated, friendliness, data confidentiality, knowledge of the professionals, etc.) which determine the degrees of satisfaction of those using these centres. The evaluation of the aforesaid charter is conducted annually. In the 2011 evaluation, 90% of all of the commitments had been met.

Integral Management Team:

All of the aforementioned tools described hereinabove additionally converge at the Integral Management Team (IMT) of the Addiction Institute and the "Madrid Salud" Autonomous Agency. The IMT gathers in an orderly manner all of the information which each system has individually gathered progressively, providing a fast and simple overall view of this Institute's functioning.

According to the principle as to it being possible for all activities to be measured with decision-making-focused parameters, the main indicators are gathered which, on a monthly and/or quarterly basis, assure that the activities carried out are going in the right direction and are affording the possibility of evaluating the results of a management in relation to its objective and goals.

Each system of indicators has been color-coded (green, yellow, red) alerting as to the degree to which the goals are being met. The following Table shows the major annual indicators for 2011 on the continuum of prevention, provision of care and rehabilitation. Some of the IMT management indicators are made public for the knowledge of all citizens through the City Monitoring System.

Table 12.7 Integral management team: indicators and results, 2011

INDICATOR	RESULTS	WARNING LIGHT	PERIODICITY
Adolescents and youths taking part in activities for fostering and promoting a healthy leisure time	45,418	GREEN	Monthly/Annually
Number of families with whom interventions were preventively made (DDP+medium and high-demand interventions)	7,047	GREEN	Monthly/Annually
Schools where addiction prevention interventions were carried out by school year groups.	703	GREEN	Monthly/Annually
Number of Teachers taking part in addiction prevention training processes.	4,214	GREEN	Monthly/Annually
Number of students taking part in addiction prevention training processes.	74,660	GREEN	Monthly/Annually
Number of community mediators taking part in addiction prevention training processes.	2,870	GREEN	Monthly/Annually
Volume of patients for who care was provided at the Addiction Institute Drug Dependence Care Centres	9,337	GREEN	Quarterly/Annually
Volume of drug-dependent adolescents and youths for whom care was provided at the ACC and DDCC	471	GREEN	Quarterly/Annually
Number of employment rehabilitations in patients for whom care provided at the AI Network Treatment Centres	535	GREEN	Monthly/Annually
Users in process of social-employment rehabilitation in the "SOL" Employment Counselling Service	946	GREEN	Monthly/Annually
Percentage occupancy in treatment support resources	90%	GREEN	Monthly/Annually
Average Addiction Institute service delivery time	6 DAYS	GREEN	Monthly/Annually.
Percentage of requests for Addiction Institute services to which response was provided within stipulated time frame	94.36%	GREEN	Monthly/Annually

Objective treatment results evaluation system

The objective is to improve the quality of the care provided for the patients on the part of the interdisciplinary Addiction Centre teams by means of implementing a stringent, objective measurement system affording the possibility of evaluating the evolution of these patients throughout the treatment and the effectiveness of the different treatment strategies, whilst also serving as a basis for addiction-related research.

This System falls within the framework of the Integral Care Model set out in the Plan on Addictions and provides objective information on a patient's situation and evolution in a total of 7 dimensions (vectors) on which drug dependence usually has a bearing (health and self-care, psychopathology, consumption, family-related, social-relational, training-employment and leisure time). Following the

pilot study conducted on a sample of 138 patients, this model has been corroborated as being useful to a good degree, as well as being suitable for and sensitive to the indicators selected for measuring the variations arising in the different dimensions studied.

Computer systems

The Addiction Institute being aware of evaluation systems being based on the reliability and quality of the data obtained, has made an extremely major effort toward improving its computer systems. This Institute currently has three large-scale systems of records managed and integrated into the Municipal Government of Madrid Data Processing, further detailed in following.

- SUPRAMADRID (Unified Addiction Registry System of Madrid). This System was implemented in 2007. The records of the patients previously saved in the former computer application used at the Municipal Government of Madrid Drug Dependence Care Centres were migrated into this application. This new application was a significant advancement over the former system, given that this application:

    - Remarkably improved patient records, given that, in keeping with this Institute's multidisciplinary focus, it includes records by areas (medical, psychological, social, occupation and dispensary).
    - Facilitates data migration into the Municipal Government of Madrid's Cumulative Drug Dependent Persons Registry.
    - Also includes a complete Schedule for each centre, thus facilitating managing the time of the professionals at these centres.
    - Includes a system for managing the places for treatment support resources and patient rehabilitation which is interrelated with the patient's record and follow-up.
    - Facilitates data mining by way of a statistics module and a mining system crossing variables and times.

- Automated methadone dispensing. Methadone is strictly-regulated narcotic requiring reports being filed periodically with the Pharmaceutical Inspection services. In this regard, due to the large number of doses which are administered throughout the year (518,770 in 2011), it is necessary to technically hone any possible minimal glitches in the official accounting of this substance, thus assuring the patient's correct dosage schedule as prescribed.

  Maximum 1% margins of error are handled in the daily accounting at pharmacies, which would strictly cover the possible losses due to the routine handling of the chemical solution, which also entails an optimization of the costs related to the administering of this substance.

  The centres providing care for drug-dependent individuals have automated dispensing machines which are used by the professionals in charge, who enter each patient's dose and the variations, if any, into the specific dispensing computer system. The automatic dispensing machines also have options via their software for managing and following up on the doses administered to the patients. This system expedites the care dispensed and facilitates the weekly pharmaceutical supervision which is carried out at the dispensing laboratories.

- ADIGES (Prevention Registry System). A computer system has been developed for managing addictions through the Addiction Institution Prevention Department. ADIGES, as this system is called, makes it possible to record and mine all of the prevention-related actions taken in the city of Madrid. One distinguishing aspect of this system is that it avails of geographical locating tools for all of the registry elements: resources, actions and individuals. Worthy of special mention is the geolocation and categorizing of the different at-risk zones related to different items sold and substance use.

ADIGES is organised into modules adapted to the different areas of intervention in which the Prevention Department works:

a) Educational area. All of the Secondary Schools in the City of Madrid and all of the other Schools at which interventions have been made are recorded. The intervention registry includes a detailed account of sessions and groups held.

b) Risk area. A distinction is made between individual and group interventions. The entire process of the intervention is registered, from a description of the starting situation, to the working areas and objectives, down to the referrals and coordination with other resources.

c) Community area. This area includes all those resources comprising part of the intervention network in which the different actions are carried out. The social mediator training activities carried out at associations and resources are also recorded.

d) Family area. Record of interventions at the Addiction Prevention Service for Families for interventions both in person and by telephone. The family group sessions held at Schools are also recorded within this scope.

The four ADIGES registry modules are integrated with one another, relating the data recorded in each one of the areas. This integration prevents duplicated records and the resulting data mining errors.

5.2 Training

The city of Madrid Plan on Addictions includes as one of its objectives that of bolstering the training and recycling of its workers by means of continuing training, fostering the sharing of experiences among its professionals and the dissemination of best practices.

In 2011, the Addiction Institute professionals have taken an average of 52.5 hours of training. A total of 7 internal training courses have been taught plus three at the Master's or Expert level in collaboration with universities and official professional associations.

Apart from the above, 27 professionals on staff at the Institute have taken part in 53 training measures as instructors.

Similarly, the Addiction Institute takes part, by virtue of working agreements signed with universities and other institutions, in the textbook-practical training of undergraduate and graduate students. In 2011, a total of 46 of the Institute's specialists mentored the practice work of 78 students pertaining to different universities.

5.3 Research

The city of Madrid's Plan on Addictions, in keeping with the recommendations of the European strategy on drugs and Spain's National Plan on Drugs, includes among its objectives that of bolstering research in the different areas of addiction-related intervention. Integrating research in practice guarantees a higher quality of the services and a better and faster implementation of the scientific advancements in the prevention, diagnosis and treatment of diseases, including addictions, as part of a Public Health problem.

In 2011, the Addiction Institute has taken part in 23 research projects. Similarly, it has prepared 21 scientific publications entailing a hit factor of over 34 points for the last five years.

5.4 Improvement in communication

The city of Madrid's Plan on Addictions commits to improving external and internal communication and includes the same among its objectives for the purpose of guaranteeing the quality of its interventions, this being understood as an activity which is an inherent part of this organisation's life.

For improving internal communication, in 2011, the Addiction Institute got AYRE-Addictions under way, a communication tool which, distinguishing between two levels (an external level for the entire Municipal Government of Madrid staff and another internal for the Addiction Institute workers), incorporates collaboration and participation-related tools in conjunction with other more conventional information-organizing systems, all of which is aimed at heightening information transparency and clarity, facilitating upward and downward communication throughout the organisation and improving the satisfaction of all its members.

Regarding external communication, the Institute specialists prepared a set of 23 technical documents which are available to citizens via the Municipal Government of Madrid website (Madrid.es).

The Institute is also promoting the use of the information and communications technologies as essential aspects for improving the providing of the services to citizens. In 2011, certain services were made available to the citizens via the www.serviciopad.es website.

F) Information and data on the city of Madrid: Centres and services (both those operating directly under the Municipal Government of Madrid and those operating under the Autonomous Community of Madrid, through the Anti-Drug Agency).

Source: "Madrid Salud" Addiction Institute Report, 2011; Autonomous Community of Madrid Anti-Drug Agency Report, 2011.

In 2011, the city of Madrid has 17 drug dependence care centres. The overall patient-related data for 2011 are:

Patients in treatment: 14,257

New patients: 3,186

Patients readmitted: 1,638

Patients on methadone: 4,482

Dual Diagnosis patients: 3,630

The following Table provides information on other resources (residential and other types of facilities):

Table 12.8 Care-providing and rehabilitation resources, 2011

RESOURCES		
RESIDENTIAL RESOURCES		**OTHER RESOURCES**
Therapeutic Communities	- 187 places, adults - 19 places, under age 25 - 25 paces, pregnant women	**401 places** at Pharmacies
		2 Social-Employment Guidance Services centres
Flats as treatment and rehabilitation support	326 places	**11 Occupational Skills Workshops**
Detoxification Units	- 19 places, hospitals - 8 places, Outpatient Detoxification Support Unit	Intervention Programme in Drug Dependencies at Madrid Police Courts
Integral Cocaine Care Centre	45 places	Immigrant Care Service ("Istmo")
Dual Diagnosis Centre	40 places	Community Mediation Programme for Reducing the Social Impact of Addictions on Peaceful Coexistence among Citizens
		Addiction Prevention Service

2.1. Four areas of drug policy in the capital: Madrid

2.1.1 Local policing strategies against drugs scenes/drug trafficking

The Municipal Police Force of Madrid's framework of authority sets out objectives including the following:

- Preventing/reducing the supply of drugs in leisure-time establishments, recreational activities and public entertainment, as well as to minors.
- Preventing drugs being offered and used in public spaces
- Preventing/reducing the use of alcohol and other drugs when driving motor vehicles and motorcycles.
- Collaborating in prosecuting public health offenses within the framework of the legislation in force and working agreements, placing special emphasis on retail drug dealing to end users.

The following actions are carried out for accomplishing these objectives:

- Making periodic inspections of establishments: patrolling and reporting any situations of drug trafficking or drug use and tolerance of the same.

- Patrolling around areas where leisure-time and entertainment establishments are grouped.

- Patrolling around schools at the start and end of the school day and also during break periods.

- Patrolling and inspecting commercial establishments located in the areas around schools in prevention of the sale of alcohol and tobacco to minors.

- Patrolling and inspecting leisure-time or recreational activities open during school hours which are located in the near vicinity of schools.

- Contacting the schools for immediate, specialized response to reports of drug trafficking or use therein (Police Mentor Officer Service, patrolling public areas, gathering and relaxation areas).

- Controlling and reporting the “botellón” (binge drinking outdoors in public areas) phenomenon. This term makes reference to adolescents and youths gathering in parks, plazas or other public areas to drink large amounts of alcoholic beverages, especially on weekend evenings/nights.

- Conducting citizen safety inspection checks in areas where large numbers of people gather (parks, public squares, fairs).

- Conducting preventive breathalyzer checks of a general nature on a 24/7 basis according to scheduled campaigns.

- Conducting specific high-intensity campaigns with breathalyzer tests during at sensitive times and hours: weekend evenings/nights in the vicinity of leisure-time areas.

- Ongoing surveillance of the consumption of alcohol and/or use of other drugs on the part of drivers involved in traffic accidents or violations. Instruction of those arrested for highway safety violations.

- Coordination with other municipal areas and services involved in providing care for addictions.

- Coordination with the National Police Force for the eradication and investigation of offenses within the framework of the Organic Law on Security Forces and Corps and working Agreements and Protocols which are signed for this purpose.

- Detection, surveillance and intervention at points of retail drug trafficking, conveying information to the National Police Force.

Table 12.9 Drug trafficking control data, 2011

OBJECTIVES	INDICATORS	2011
Prevent / Reduce supply to minors	No. mentor Officers	**158**
	No. schools with "Safe Routes to School"	**19**
Prevent / Reduce supply and use in public	No. calls	**15,429**
	No. surveillance measures in parks by the Environment Unit and Squadron	**4,600**
Prevent / use in drivers	No. complaints due to alcohol consumption in public in relation to the calls	**101,070**
	No. students taught highway safety	**18,456**

Narcotic trafficking and illicit drug possession: regulation

The Penal Code currently in force (Penal Code Organic Law 10/1995 of November 23rd) prohibits and penalties all those acts of growing, processing or trafficking which promote, Foster or facilitate the illicit use of toxic drugs, narcotics or psychotropic substances. In this regard, the mere holding, possession or availability of said drugs with the intention of devoting them to trafficking or disseminating them constitutes a criminal offense. Likewise punishable is the manufacture, transport and distribution as well as holding the products catalogued as precursors for such purposes.

The Penal Code also stipulates as a Road Safety offense driving a motor vehicle or motorcycle under the influence of toxic drugs, narcotics, psychotropic substances or alcoholic beverages. Any driver who, being requested to undergo the tests stipulated under law for verifying these facts who were to refuse to do so is committing a serious offence of disobedience (Articles 379 and 380).

Personal use and the possession of drugs for such use, although not punishable under criminal law are indeed penalized administratively. In 1992, the Law for the Protection of Public Safety (Organic Law 1/1992 of February 21st) was passed, under Article 25.1 of which it is set forth that "*Use in public places, streets, establishments or means of transportation as well as the illegal possession thereof, even if not intended for trafficking of toxic drugs, narcotics or psychotropic substances constitutes serious public safety violations provided that they not constitute a criminal offense, as also is leaving in the aforesaid places any utensils or instruments used for said consumption"*. Therefore, the fundamental aspect of this behaviour is not mere consumption, but rather the public nature of the place where said consumption takes place.

Similarly, it is set forth that "*Tolerance of illegal use or the trafficking of toxic drugs, narcotics or psychotropic substances on public premises or in public establishments or the lack of diligence on the order of preventing the same on the part of the owners, administrators or those in charge thereof"* also constitute an offense (Art. 23.1).
Depending upon the how serious the violation may be, the penalties are as follows:

1. *Minor violations: fine of up to 300 €*
2. *Serious violations: fine of 300 €- 30,000 €*
3. *Very serious violations: fine of 30,000 € - 600,000 €*

The penalties imposed for these violations may be suspended if the person having committed the violation undergoes cessation treatment at a duly accredited centre or service in the manner and for the length of time set forth under regulations (Art. 25.2).

Royal Decree 1079/1993 of July 2nd further expands upon aforesaid Article 25 of Organic Law 1/1992 by stipulating all that related to the penalty suspension procedure. According to this Royal Decree, in keeping with the rehabilitating purpose, the suspension of a penalty may be applied to those who are frequent or regular users, it being possible to achieve full, final remission in those cases in which the offender satisfactorily completes their cessation treatment.

Care provided for users fined for drug use or possession in public places or establishments at the "Madrid Salud" Centres (Public Health Institute).

In this activity, care is provided for those users fined by the Law Enforcement Bodies for use/possession of toxic substances in public and those referred by from the districts by the Prevention Specialists when they detect a sporadic use of these substances.

The objective is to prevent people who start sporadic use from going on to a situation of abuse or dependence.

In 2011, care was provided for a total of 216 users with an administrative fine or record for use or possession of toxic substances in public. This figure marks a 26% drop compared to 2010. The age range is age 14- 55+. Sixty percent of the cases are under 25 years of age. Regarding the substances which gave rise to the fine or record, cannabis is involved in 79% of the cases. The other substances which are preferentially consumed are cocaine (17.5%), the use of which dropped by 6.5% compared to 2010, meta-amphetamines and amphetamines.

REGULATORY ASPECTS:

Penal Code Organic Law 10/1995 of November 23rd

Protection of Public Safety Organic Law 1/1992 of February 21st

Royal Decree 1079/1993 of July 2nd, governing administrative remission of drug-related sentences

2.1.2 Interventions in recreational nightlife settings

Outstanding within the scope of prevention is the "Are you going out today?" programme. This is a direct action programme for preventing and reducing risks in drug use among adolescents and youths who go to nightlife entertainment areas on weekends. Sometimes, the interventions involve the general population, taking advantage of festive events. In all the interventions, priority has been placed on those areas in which there is a greater deal of drinking alcohol and/or use of other drugs. This programme is carried out in an open environment and has a mobile facility (tent) outfitted with audio-visual equipment. In 2011, 60 weekend activities have been held, with a total of 7,926 participants.

The outdoor binge drinking phenomenon has taken on major importance over the past few years in Madrid as in other large cities in Spain. This phenomenon poses a twofold problem. On one hand, it is a public health issue, resulting from the abuse of alcoholic beverages at frequently very early ages at which the health risks are multiplied; whilst, on the other hand, it is a problem of peaceful coexistence among citizens as a result of the noise, filth and unsafeness it causes for the residents

living in the areas where binge drinking takes place. This dual aspect must be taken into account when dealing with this problem and suggesting solutions for a remedy.

Through the public instances, an attempt has been made to seek solutions for curtailing the problems posed by drinking alcohol and using other drugs during night-time recreation by young people. The strategies set out for this purpose are varied and have gone from promoting a more healthy offer of leisure-time recreational activities to passing municipal ordinances governing drinking alcoholic beverages.

The Autonomous Community of Madrid (the Regional in which the city of Madrid is located) has enacted Law 5/2002 of June 27th for the purpose of setting out the rules governing the authorities and measures of the public and private entities intended for preventing and providing care for drug dependencies and other addictive disorders, and the integration of drug dependent individuals or those with other addictive disorders.

Article 55.2 thereof classifies drinking alcoholic beverages outdoors in public as a minor violation. Those responsible for such an action, as those committing the same, are the natural persons or bodies corporate, customers, owners or managers of entities, centres or services which commit actions or omissions classified as violations under this Law and, in the case of minors, the parents or legal guardians shall be held liable jointly for the payment of the fines resulting from these violations. (Article 53.1 and Article 53.2 c) of Autonomous Community of Madrid Law 5/2002 of June 27th). The penalty for this violation, classified as minor, consists of a fine ranging from 300 euros to 30,050 euros.

Similarly, “Neither the sale nor consumption of alcoholic beverages outside on the street shall be permitted, save in open-air cafés or fairs or local festival or similar days governed under the respective municipal ordinance.” (Article 30.3, Autonomous Community of Madrid Law 5/2002 of June 27th).

Law 5/2002 of June 27th does not grant the Municipal Governments penalizing power for processing the violations classified under law, but rather solely inspection-related duties regarding the same, the penalizing power falling to the Autonomous Community of Madrid (Arts. 41.2 f, 52.5 and 61).

On the other hand, the Municipal Government of Madrid passed the Noise and Heat Pollution Protection Ordinance of February 25, 2011 to take the place of a 2004 Ordinance.

In the section setting forth the grounds of the Ordinance of February 25, 2011, the importance is established of “guaranteeing good peaceful coexistence among citizens regarding the noise-related nuisances for citizens both inside their homes and outdoors resulting from behaviour in the vicinity and people out in public areas, It is inherent to the authorities of the Municipal Governments to guarantee this peaceful coexistence, which entails assuring, in neighbourhood relations, the respect for rest and relaxation and making it possible to normally carry out the activities inherent to the other business premises or dwellings”. In this regard, the Ordinance stipulates that “phenomena such as binge drinking in the streets which entail massive noise being caused must not prevent the exercise of the right to personal and family privacy”.

This Ordinance governs, under Article 45 thereof, the behaviour of citizens in the outdoor environment, where it is set forth that said behaviour must be kept within the limits of good peaceful coexistence among citizens, without any noises which disturb the rest and relaxation and peace of the residents inside their homes and those outdoors on the street. Violation of that which is set forth under this Article is classified as a minor violation entailing a penalty in the form of a fine of up to 750 euros.

This Ordinance also sets forth that in the case in which the person having committed the violation is under age 18 but over 14 years of age shall be held jointly liable with their parents, legal guardians, foster parents or legal or de facto caregivers, in this order, for the economic penalty imposed for reasons of failure to fulfil the legal duty of preventing the administrative violation with which the minor in question is charged (Article 52).

The Municipal Government also makes provision for declaring hospitals, senior citizen facilities or schools as areas of special noise protection and areas of special protection (Art. 10 & Art. 13).

Therefore, the binge drinking activity will have a twofold penalizing aspect, on violating both the Autonomous Community of Madrid Law governing Drug Dependencies and other Addictive Disorders, which prohibits drinking alcohol in outdoor public places as well as the Noise Ordinance. The former of the two penalties will be remitted to the Autonomous Community of Madrid, which will submit it to proceedings, and the latter will be processed by the Municipal Government proper.

REGULATORY ASPECTS:
MUNICIPAL GOVERNMENT OF MADRID ORDINANCE on Protection Against Noise and Heat Pollution of February 25, 2011
Autonomous Community LAW 5/2002 of June 27th on Drug Dependencies and Other Addictive Disorders
NOISE LAW 37/2003 of November 17th
EUROPEAN PARLIAMENT AND COUNCIL DIRECTIVE 2002/49/EC of June 25, 2002 on environmental noise assessment and management

2.1.3 Harm reduction services (Low threshold services for problem drug users)

The services and resources detailed in following are all of those in existence in the city of Madrid, both those operating under the Municipal Government proper and those operating under the Autonomous Community of Madrid. The data is for the year 2011 and is overall in nature, not being broken down into different Administrations (local or autonomous community government). The source used in the 2011 Anti-Drug Agency Report.

- Mobile harm reduction services. 6 vehicles.

  These services are for that group of drug-dependent individuals who are involved in long-term, serious, active use who are living out in the street with no supporting social/family networks and whose physical condition has declined to a major degree. These drug-dependent individuals frequent particularly depressed places usually located on the outskirts of Madrid, having no services and which may be termed “highly marginalized areas”. These are people with a high prevalence of injecting drug use who present infectious-contagious diseases such as AIDS, tuberculosis, different types of viral hepatitis or sexually-transmitted diseases.

  At the same time, they present different situations of being uprooted: they may be homeless, illegal immigrants, involved in prostitution, have legal problems (have no residence permit, no papers, etc.) and/or judicial problems (pending court proceedings, frequent prison stays), are not dispensed any health care whatsoever, nor come in for standardized health check-ups due to not having a social security card or simply due to the effect of chronic drug use which alters any healthy habit or routine and plunges addicts into a world of letting themselves go in which repeated use is their own daily goal.

  These services include a mobile unit which provides care in the downtown area of the city and also carries out harm reduction programmes for the homeless alcoholic population.

  The demand for better care for the aforementioned users makes it necessary to provide services through mobile units which contact and attract a large number of individuals for their

incorporation into the standardized health care, social services and specific drug dependence care centres.

The measures carried out include: medical and health care, handing out sterile injection material, health education and information on lower-risk use, prescribing and dispensing methadone, social intervention and basic nutrition.

- Socio-sanitary contact and emergency centres: 3 CENTERS

  Providing food, hygiene and health care during night-time hours for those drug-dependent individuals who so require, thus contributing to improving their health and preventing marginal behaviours.

  These services are for a group of drug-dependent individuals involved in long-term, serious, active use who are living out in the street with no supporting social/family networks. Having no identification documents, not officially registered as a resident of the city, no health card and a vast majority with problems and basic survival and personal hygiene.

  These centres are duly authorized, with a number of minimal spaces: treatment and health care room, offices, dining hall and lounge, restrooms, showers, laundry and clothing. The service is provides every day of the year.

  Services offered: Health care, Information and Guidance, Meals, Basic hygiene care, Rest.

- Harm reduction care centre (CARD): 1 centre

  Located in the "Las Barranquillas" area, in addition to providing the services mentioned in the immediately preceding paragraph hereinabove, also has a safe injection room where the users can inject themselves safely and be given health-related advice of a practical nature.

Overall data on the harm reduction services in 2011 (2011 Anti-Drug Agency Report)

In 2011, all of these resources as a whole gave out 603,776 needles and syringes. The needle and syringe return rate is 76%. On the other hand, a total of 111,060 condoms were given out. In the harm reduction resources, other materials are also given out: aluminium foil, bags of acid, acid water, little cookers, tubes and biosanitary waste containers. A total of 400 vaccinations were given: tetanus, hepatitis B and others. The harm reduction resources made a total of 1,182 referrals to the network of drug dependence care centres.

All of the harm reduction facilities together as a whole carried out a total of 35,593 health-related interventions. These health-related interventions included having provided care for a total of 131 acute drug reactions and having performed a total of 6,804 first-aid treatments.

2.1.4 Responses to the smart shops and the new synthetic drugs (Responses to head/smart shops)

Over the past few years, a great number of shops have opened in Spain under the name of growshops or smartshops where it is possible to purchase plants, seeds, clothing, cosmetics, objects and utensils for growing different drugs.

The smartshops sell "Smart" products which come from the stimulant plants and sometimes with combinations of extracts of substances and natural plants. Some of these shops also sell seeds and growing material, and fertilizers, lamps and all types of utensils and information for growing cannabis plants can be found there.

In view of the proliferation of these businesses, the Administration has attempted, in principle, to limit their activity, given that some of these products, according to Law 29/2006 of July 26th governing guarantees and rational use of Medicines and Health Products, are not considered medicines on not having been evaluated by the Medicines Agency (Ministry of Health, Social Services and Equality). Therefore, on the effects thereof on the users being unknown, they are considered illicit and are taken off the market.

Other products are marketed as nutritional supplements, but are not approved under the name of special food products on not fully complying with that which is set forth under Article 2 of Royal Decree 1809/1991 of December 13th, although it is acknowledged that some of the Smart products are extracts of medicinal plants present in duly registered and authorized pharmaceutical specialties.

With the publication of ORDER SCO/190/2004 of January 28th setting forth the list of plants which sale to the public is prohibited or restricted for reasons of its toxicity, it becomes clearer that the cannabis plant cannot be sold, being subject to administrative penalties under the Medicines Law if sold. Nevertheless, as far as cannabis seeds and paraphernalia related to its growing is concerned, nothing is said, therefore there is a legal loophole that put the smartshops on the borderline of the legality, given that many of their products are not included on the list of prohibited substances.

REGULATORY ASPECTS:

Law 29/2006of July 26th on guarantees and rational use of Medicines and Health Products

Royal Decree 1809/1991 of December 13th from which the mentions or markings making it possible to identify the lot to which a food product pertains are set out

ORDER SCO/190/2004 of January 28th stating the list of plants the sale to the public of which is prohibited or restricted for reasons of the toxicity thereof

2.2. Current issues in capital cities: Concerns and challenges for the future

In the current economic crisis situation, rationalizing resources is more necessary than ever. This places all of us under the obligation of taking part in getting measures under way to help toward curtailing spending. Intervention in addiction is not beyond these circumstances, as evidenced by the measures which have progressively been taken over the past few years.

In view of the possible measures to be adopted, one must bear the following aspects in mind:

- Need of guaranteeing that a balanced treatment network, capable of continuing to provide a response to the problem of drug dependencies in the City of Madrid will remain in place, especially for the most vulnerable groups. All thereof, by providing quality care which will assure the effectiveness of the treatments in keeping with the recommendations of scientific evidence.

- Need of maintaining addiction prevention programmes which, adapting to the current economic situation will make it possible to reap the profits of the work done until now by using and taking best advantage of the major potential of the new information and communications technologies.

- Try to alleviate the effect which the economic crisis will have on drug use. At the 2010 Conference of the International Society for the Study of Drug Policy, an analysis was made of the effect which the economic crisis will be having on drug use in Europe. In

this regard, it is warned that the current drug-related problems may be affected directly if the poorest drug users resort to more efficient and more dangerous routes for administering drugs (injecting), drug sales rise to make money, drugs are used more to combat stress and problems or, indirectly, if the treatment services or accessibility thereto are reduced.

It is considered top-priority to maintain:

1. **An Addiction Prevention Service,** encompassing prevention at the family level and intervention with underage users. **The direct preventive activity with schoolteachers and students,** as well as the **training of mediators** in preventing drug dependencies and other at-risk behaviours for social services and health services, public entities and services and law enforcement bodies (Municipal Police, National Police, etc.)

2. A **balanced, sound** drug dependence **care network adapted** to the current situation of addictions in the City of Madrid, ranging from a biopsychosocial model for meeting the special needs of the least fortunate groups and preventing drug dependence-related problems in the peaceful coexistence among citizens, not to mention the relative importance which must be placed on treating alcoholism.

3. **Specific care for homeless drug-dependent individuals** referred by the city's Emergency Social Services. It must not be overlooked to what a great degree providing care for the most vulnerable groups is socially profitable.

4. The **harm reduction-oriented services**, given that not having these services would not only have repercussions on those for whom they are provided on not facilitating their access to the treatment centres and resources, but also on the community due to the risks for public health.

5. **Provision of care for dual diagnosis patients,** due to these patients having more serious problems and worse prognoses and treatment evolution.

6. **Treatment with opiate substitutes other than methadone** for all those patients who, due to individual variations (interactions, methadone contraindications, presence of anti-methadone antibodies, etc.) require a substitute treatment alternative to this substance.

7. **Prevention and treatment of addictions in the working environment.**

12. DRUG POLICIES OF LARGE EUROPEAN CITIES

Links of interest:

- "Madrid Salud" Addiction Institute: http://www.madridsalud.es/adicciones/adicciones.php

- Municipal Government of Madrid (Madrid.es): http://www.madrid.es/portales/munimadrid/es/Inicio/Ayuntamiento/Salud/Adicciones?vgnextfmt=default&vgnextchannel=d4ea0c5600847010VgnVCM100000dc0ca8c0RCRD

Local Drug Plans:

- Madrid: See links above
- Barcelona: http://www.aspb.cat/quefem/documents_drogodependencies.htm (in Catalan language only)
- Valencia: h*tp://www.valencia.es/ayuntamiento/drogodependencias.nsf/0/C733C1192B3C8DF3C12572D4003C62A3/$FILE/Documento2004-2008.pdf?OpenElement&=lang=2*
- Seville
- Zaragoza
- Malaga: Has no Plan on Drugs
- Murcia
- Palma de Mallorca: Has no link. Available only in the Catalan language.
- Las Palmas (Grand Canary Island): Has no Plan on Drugs
- Bilbao: http://www.bilbao.net/cs/Satellite?c=Page&cid=3000047255&language=es&pageid=3000047255&pagename=Bilbaonet%2FPage%2FBIO_homeArea

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Legislation:

Organic Act 5/2010 of June 22nd enacted in amendment of the Penal Code, governing highway safety violations

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LIST OF TABLES USED IN THE TEXT