REPORT TO THE EMCDDA
By the Reitox National Focal Point

"SPAIN"
DRUG SITUATION 2002

REITOX

INDEX

SUMMARY

MAIN TRENDS AND DEVELOPMENTS

The present report on the drug situation in Spain in 2002 has been drawn up by the Spanish Focal Point, the Government Delegation for the National Plan on Drugs (GDNPD), in accordance with the guidelines established by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), as part of the 2003 REITOX grant agreement for an action. The selected issue on co-morbidity has been produced by Dr. Pérez de Los Cobos (Hospital de la Santa Creu y San Pau, Barcelona).

The 2003 report addresses the drug phenomena in Spain and gives an overview of the most relevant developments regarding the institutional and legal framework, the supply control, the epidemiological situation and the drug demand reduction interventions that have taken place during the reporting period. The report also provides in depth information on three selected issues (evaluation of national Strategies, cannabis problems and co-morbidity).

Being Spain a decentralised country, the activities developed by the different institutions that build up the National Plan on Drugs (national, regional and local administration as well as NGO) have been taken into consideration when preparing the present report.

The Spanish Monitoring Centre for Drugs and Drug Addiction provides updated information on the drug phenomena on regular basis. In Spain, General Population Surveys[1] have been carried out in 1995, 1997, 1999 and 2001 and school surveys in 1994, 1996, 1998, 2000 and 2002.

First of all, during the reporting period no significant developments have taken place regarding the institutional and legal framework. Nevertheless it can be highlighted the approval of the regulations (Orden/Int /2437, 2002, 4th of October) regarding the composition and functioning regime of the National Institute on Drugs Research and Training; the Institute starting to operate means the fulfilment of the investigation and training priorities determined in the National Strategy on Drugs.

The Institute acts as an instrument of promoting and improving the quality of the programmes in this matter. In fact, on October 2002, took place the First Conference of the National Institute on Drugs Research and Training, where 30 participants were involved.

Secondly, as for the drug situation in Spain, no major changes have taken place since the previous report was submitted. Cannabis is the substance most commonly used, being the recreational setting the main environment for using this drug, especially in the case of young people. However, its social-sanitary impact is limited. There is a special concern about contradictory information received by the young people that cause a decrease in the perception of risk.

Nevertheless, it is important not to forget that heroin is a drug whose use is decreasing in Spain but this substance is still the one that generates the highest volume of socio-sanitary problems and the greatest demand for health care.

Besides, the increasing of cocaine-based problems has become a source of social-political concern. In the case of amphetamines and ecstasy use, their use is relatively widespread, but health or social problems due to the use of these substances have not been detected at the present time. Also, their use is more extended among young

[1] During 2003 a new General Population Survey is been carried out.

people and also in the recreational setting. In fact, there is at the present time in Spain a phenomenon of polydrug use linked to leisure and recreational purposes.

Not many changes have taken place since the previous report about AIDS and acute reaction experienced after taking drugs. There is a current stabilization of the AIDS incidence in levels still high it seems to indicate that the impact of the new anti retroviral treatments has reach the highest top and it is needed to activate the preventive interventions to avoid new infections.

Within demand reduction, prevention is the main objective of the National Plan on Drugs. In this field, some progress has been made: In 2002, two Action Plan of the Autonomous Community of Andalucia and Cantabria have been approved and in both cases prevention is showed as a main area of intervention taking as reference the National Strategy on Drugs 2000-2008.

As regards to evaluation and results, two of the most spread programmes applied regularly at schools in Spain (The adventure of life and Ordago) have been evaluated not only the program itself but also the results that will be available for next national report.

Outside the school ambit, the prevention programmes are particularly wide; during 2002 the Government Delegation for the National Plan on Drugs supported a research on prevention programmes for risky young people in Spain and 4 programmes with the same target were included in EDDRA database.

It is very important the widespread of the web page www.sindrogas.es, carried out by the GDNPD and started in 2002 which objective is to provide information about drugs in Internet; it is targeted mainly to young people and provides alternative leisure activities as well.

Also, some NGO have been working and developing guidelines for harm reduction programmes in recreational setting.

Treatment services and re-integration programmes have been implemented according with the present needs. Innovative initiatives taking place in particular environments, such as prisons, are also mentioned.

Regarding supply control, the data on drug-seized show a general decrease except for ecstasy seizures, that can be interpreted as the representation of an adjustment process between the modus operandi of drug dealers and the institutional reaction. In the case of heroin, it fits with the decreasing data about consumption. The hashish continues being the most seized substance in Spain during 2002.

The number of people arrested for drug trafficking has slightly increased and represents 7.75% of the total arrested people in Spain. Cannabis and derivatives continues being the substance that caused most arrests, and opiates shows a decreasing trend related arrests.

There is a progressive increase of the sanctions imposed in accordance with Organic Law 1/1992, which shows a higher supply/demand of cannabis and cocaine users and less for synthetic drugs. The sanctions for use or possession for consumption of heroin have decreased almost 50% between 2001 and 2002, which seems to confirm the demand reduction trend.

The last section analyses the three key issues focused this year on evaluation of Drugs National Strategies, cannabis problems and co-morbidity.

Regarding the first key issue, evaluation is a key point for the Spanish Drugs Strategy, which not only refers to it when setting the general frame but also includes a special chapter on this topic linked to information systems. The Strategy foresees a midterm evaluation in 2003 and a final one in 2008. At present, the midterm evaluation is being performed by the Government Delegation for the National Plan on Drugs. It is therefore an internal evaluation with the advantages and drawbacks this exercise has, taken into account the complex network of interests that interacts when performing the evaluation.

The main advantage of this type of evaluation is the wide range of information collected from the different information sources. It can be considered a comprehensive evaluation that takes into account all the areas that make up the Autonomic Plans on Drugs (prevention, treatment, social reintegration, training, research, institutional co-ordination and budget).

Concerning the second key issue, as it is mentioned before cannabis is the most common used illegal drug in Spain, especially among young people. Its spreading has been come with a continuous decreasing of the perception of risk of this substance and it has been created around it a culture that emphasizes its qualities and its harmlessness that probably helped it. The own consumers point out several negative effects associated to cannabis use and the treatment demanded for cannabis is increasing considerably. Some figures about cannabis demand for treatment, prevalence, patterns and specific interventions are shown in this section.

Finally, regarding co-morbidity key issue it is important to highlight that the implementation of specific resources for treating co-morbidity has began in some Spanish regions. During 2002 a 'Unit of Dual Pathology for Alcoholic Patients' started its activity in Catalonia. The section shows in deep the co-morbidity situation in Spain and also the author points out some responses to improve co-morbidity and the future policy directions needed to provide adequate services to illicit drug users with mental health problems.

PART 1

NATIONAL STRATEGIES:

INSTITUTIONAL AND LEGAL FRAMEWORK

1.- DEVELOPMENTS IN DRUG POLICY AND RESPONSES

1.1. Political framework in the drug field

In Spain the National Strategy on Drugs (2000-2008) is the reference document in the drugs field. During 2002, the activities included in each of the three main performance fields covered by the Strategy – drug demand reduction, drug supply control and international co-operation - have been implemented.

The prevention of drug use is considered as the fundamental axis upon which the Strategy is articulated, being the top priority performance settings the school, the family, the workplace, the community and the media. In particular, the prevention of alcohol and tobacco use and the prevention of the emergent recreational drug use are considered top priorities.

Supply control activities based on the fight against international organizations, the national distribution of illegal drugs and the fight against the retail drugs sale are also essential due to Spain geographical location.

Lastly, international co-operation is an area of special importance due to the trans-national character of the drug phenomena. Spain has continued acquiring a stronger commitment in the international debate on drugs towards the defence of a common policy on drugs within the European Union and the development of regional collaboration and co-operation mechanisms, especially with Latin America and the acceding and candidate countries, at multilateral and bilateral level.

1.2. Legal framework.

Two regulations[2] were passed in 2002 in order to place under control 2C-B, GHB, zolpidem and PMMA, in accordance with the decisions taken by the Commission on Narcotic Drugs at its 44th session and with the Council Decision of 28 February 2002 concerning control measures and criminal sanctions in respect of the new synthetic drug PMMA.

In October 2002, a regulation[3] was passed defining the composition and functioning of the National Institute on Drugs Research and Training (Instituto Nacional de Investigación y Formación sobre Drogas, INIFD). The Institute, foreseen in the Spanish National Drugs Strategy (2000-2008), will strengthen the research and training activities carried out in Spain in the drugs field.

Two international treaties signed by Spain entered into force in 2002:

[2] -Orden SCO/469/2002, de 19 de febrero, por la que se incluyen determinados principios activos en el anexo I del Real Decreto 2829/1977, de 6 de octubre, por el que se regulan las sustancias y productos psicotrópicos.
- Orden SCO/1906/2002, de 15 de julio, por la que se incluye la sustancia parametoximetilanfetamina (PMMA) en la lista I del anexo I del Real Decreto 2829/1977, de 6 de octubre, por el que se regulan las sustancias y productos psicotrópicos.

[3] Orden INT/2437/2002, de 4 de octubre, por la que se regula la composición y régimen de funcionamiento del Instituto Nacional de Investigación y Formación sobre Drogas.

- Co-operation agreement [4] between the Government of the Kingdom of Spain and the Government of the Peoples´ Republic of China against organised crime, which foresees the parties' co-operation against the illicit trafficking of narcotic drugs, psychotropic substances and chemical precursors as well as against money laundering.

- Co-operation agreement[5] between the Kingdom of Spain and the Government of the Republic of Guatemala on drug abuse prevention and control of narcotic drugs and psychotropic substances illicit trafficking.

The Autonomous Communities of Madrid[6] and Castilla-La Mancha[7] passed two laws that put them on a level with the other Autonomous Communities where the drug phenomenon is fully taken into account by a specific law.

The Parliaments of the Autonomous Communities of Cataluña[8] and Valencia[9] passed two laws, that raise the minimum legal age for buying alcoholic beverages.

In addition to this, article 16.2 of the law 19/1993, 28th December, on measures to prevent money laundering was amended by the law 44/2002, 22nd November, on measures to reform the financial system. The Executive Service of the Commission to prevent money laundering and monetary offences (Spanish Financial Intelligence Unit) is legitimise to have direct access to the statistical information on international movements of capital and economic transactions reported to the Spanish Central Bank, in accordance with the legislation applicable to such operations.

It can also be mentioned a new law[10] that establishes the fiscal regime applicable to non for profit entities and financial incentives to patronage. This law determines that the income obtained by non for profit organisations providing treatment to drug users are exempt from the income tax.

In 2003, a new law[11] that regulates the funds seized from drug trafficking abrogates the previous law on this issue.

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[4] Convenio de cooperación para la lucha contra la delincuencia organizada entre el Gobierno del Reino de España y el Gobierno de la República Popular China, hecho ad referéndum en Pekín el 25 de junio de 2000.

[5] Acuerdo entre el Reino de España y el Gobierno de la República de Guatemala sobre cooperación en materia de prevención del consumo y control del tráfico ilícito de estupefacientes y sustancias psicotrópicas, hecho "ad referéndum" en Guatemala el 9 de julio de 1999.

[6] Ley 5/2002, de 27 de junio, sobre Drogodependencias y otros Trastornos Adictivos, de la Comunidad Autónoma de Madrid.

[7] Ley 15/2002, de 11 de julio, sobre Drogodependencias y otros Trastornos Adictivos, de la Comunidad Autónoma de Castilla-La Mancha.

[8] Ley 1/2002, de 11 de marzo, de tercera modificación de la Ley 20/1985, de 25 de julio, de Prevención y Asistencia en Materia de Sustancias que Pueden Generar Dependencia, de la Comunidad Autónoma de Cataluña.

[9] Ley 4/2002, de 18 de junio, por la que se modifica la Ley 3/1997, de 16 de junio, sobre Drogodependencias y otros Trastornos Adictivos, de la Comunidad Valenciana.

[10] Ley 49/2002, de 23 de diciembre, de régimen fiscal de las entidades sin fines lucrativos y de los incentivos fiscales al mecenazgo.

[11] Ley 17/2003, de 29 de mayo, por la que se regula el Fondo de bienes decomisados por tráfico ilícito de drogas y otros delitos relacionados.

Three regulations[12] regarding the educational curricula have been passed.

In 2003 also article 91 of the Penal Code has been amended[13] regarding the parole of prison inmates once half of the sentence has been served and inmates agree to attend a detoxification program.

1.3. Laws implementation

No information available.

1.4. Developments in public attitudes and debates

No information available.

1.5. Budget and funding arrangements

In 2002, the national Administration managed a budget of 66.600.521€. Of this amount 24.617.750€ were transferred to the Autonomous Communities and Cities, which Plans on Drugs managed a budget of 157.291.705€.

[12] - Real Decreto 830/2003, de 27 de junio, por el que se establecen las enseñanzas comunes de la Educación Primaria.
- Real Decreto 831/2003, de 27 de junio, por el que se establece la ordenación general y las enseñanzas comunes de la Educación Secundaria Obligatoria.
- Real Decreto 832/2003, de 27 de junio, por el que se establece la ordenación general y las enseñanzas comunes del Bachillerato.

[13] Ley Orgánica 7/2003, de 30 de junio, de medidas de reforma para el cumplimiento íntegro y efectivo de las penas.

PART 2

EPIDEMIOLOGICAL SITUATION

2.- PREVALENCE, PATTERNS AND DEVELOPMENTS IN DRUG USE

2.1. Main developments and emerging trends

Over the last decade there has been an improvement in the quantity and the quality of epidemiological information on illegal drugs, enabling better knowledge to be gained about temporal and geographical consumption trends, and their repercussions. In the improvement of the validity and comparability of the collection methods and analysis of information has influenced the obtained experience along years as well as the improvement of the technical infrastructure. In Spain over the last decade the General Population Survey on Drugs (carried out each two years), the School Survey on Drugs (also carried out each two years) and the indicators regarding drug problems and supply control have consolidated.

On January 1st 2003, for example, an amendment of the key indicator treatment has gone into effect, in order to incorporate some variables and recommendations of the European standard TDI. In particular, 5 new variables were added: type of treatment centre that makes the notification, reference source, coexistence (with who he/she lives) in the 30 previous days to the treatment, lodging type in the 30 previous days to treatment, and use frequency of the main drug in the 30 previous days to the treatment. Other minor changes were also introduced in the categories of the variables, as the new code for the use of mixture of powdered heroin+cocaine and another for the use of heroin+cocaine mixture bases.

Taking advantage of changes made in the treatment demand indicator, in January 2003 there were changes in the two other indicators: emergency services and mortality related directly with drugs use. In the case of the urgencies indicator all emergency episodes with mention of the use of psychoactive substances or drugs (except those with mention exclusively of alcohol or tobacco use) began to be collected and not only the ones directly related its the use. This means that any emergency episode in which clinical history mentioned no-medical use of psychoactive substances, is mentioned, will be collected, including the infectious complications, as well as injuries or traumatisms due to external causes (accidents, aggressions, self made injuries). The main reason to change the selection criteria and to adopt the mention of drugs criterion (the one used in U.S.A or in the city of Barcelona) is that on an important proportion of the emergency episodes the doctor indicates in the clinical history that the individual has used drugs, but it does not mention if the urgency is related or not with this use, and often neither indicates how long before the episode the use has taken place (one hour, one week, etc.). Other times the doctor establishes the relationship in terms of probability. For not wasting the evidences that the doctor provides on to the relationship between the urgency and the drug use, a new variable with 2 categories is introduced that tries to collect this evidences. Other modifications introduced in the emergency services indicator were the extension of age interval from 15-49 to 15-54 years and the literal collection of all the diagnoses of emergency services mentioned in the clinical history, in order to code them later according to ICD-10 .

Regarding the mortality indicator (specific registry of mortality) the changes introduced in January 2003 consisted basically on enlarging the age interval to collect information from 15-49 years old to 10-64 years old, and to introduce the variables nationality and birthplace.

During 2003 some progress has been carried out in connection with the EMCDDA recommendation to obtain information on the number of drug related deaths from the General Registry. In Spain traditionally it has been difficult the use of the General Mortality Registry (GRM) because it underestimates these deaths. For this reason in 1987 a specific registry based on the Forensic Anatomical Institute and in the National Institute of Toxicology was created. This registry has shown the temporary evolution of this type of deaths very well and continues working at the present time covering a population near to 20 million inhabitants (almost 50% of the total Spanish population). However, the possibility has been explored of using the General Mortality Registry as EMCDDA recommends, but the figures provided by the specific registry are approximately 1.5 higher times than those provided by the GRM, so at the moment, it is not advisable to abandon the specific registry. In any case the comparison between the two registries has allowed to calculate the index of underestimation of the GRM and to obtain for the first time an estimation of the mortality directly related with drugs in 1999 and 2000 concerning the whole country. Regarding the mortality in drug users, progress has been made in the analysis of the cohort of Barcelona that offers very interesting results for the period 1992-1999.

Regarding the key indicator infectious diseases in drug users, the second survey of drug users in treatment is been carried out (the first one was carried out in 1996). In this occasion the survey is addressed to 2000 heroin users and 1000 of cocaine users under treatment for abuse or dependence of these drugs. In this survey a sample of saliva is collected that will allow to obtain the patient's serologic situation in terms of HIV (more doubtful in the case the hepatitis C virus). Also questions are addressed about the HIV serologic situation (self-reported) and sexual and injection risk behaviours.

Since 2001 the sample used in the General Population Survey on Drugs has been adapted to the EMCDDA recommendations; and it is targeted at population aged 15-64 years old. Likewise, all the analyses are carried out from then on using the whole series of surveys (1995, 1997, 1999 and 2001) targeted at the population aged 15-64 years old.

Finally, concerning the estimation of the problematic use of drugs some progress has been made as well. The estimations of the prevalence presented in previous reports were referred exclusively to the problem opiates users. In this report for the first time some estimations are presented about the number of problem cocaine users. At national level, the methods used until now were the demographic method applied to data of treatment admissions for drugs abuse and the multiplicative method of treatment and of mortality. Some deficiencies in the available basic information for provinces and autonomous communities have blocked the application of the multivariate method. There are estimations made with the capture-recapture method for some geographical areas and concrete years, but its use at national level is not possible because personal identifications are needed to check different databases of known drug users (treatment, mortality, arrested people, etc), and these personal identifications are not transmitted at central level by confidentiality reasons.

The main features that portray the use of psychoactive substances in Spain can be described as follows. There has been a clear decrease of the most problematic drug use, such as the opiates consumption, mainly heroin, and intravenous drug use. It can also be mentioned the hegemony of the recreational use of drugs (mainly alcohol, cannabis, ecstasy and cocaine). As well as the growing number of women who use

illicit drug, the reduction of the age of initiation into the use of some drugs (as cannabis or ecstasy) and the consolidation of poly-drug use as the dominant pattern.

A gradual transition has been taking place in Spain, whereas the use of the so-called recreational drugs (alcohol, cannabis derivatives, cocaine, ecstasy, amphetamines and speed) is progressively changing the model prevalent in the eighties and early nineties, based on heroin and the social and health problems linked to its use. The use of substances such as cannabis, and on more limited levels, cocaine, ecstasy and amphetamines, for recreational purposes, has generated a normalizing process of social accommodation with respect to the use of these substances. Subsequently there has been a decrease in the social alarm the use of these drugs generated in the past.

This phenomenon, together with the increase and diversification of the assistance programmes, particularly the expansion over the last years of programmes providing opiate substitutes, and the control of the more serious health problems associated with heroin use -control of HIV infection and reduction of the deaths caused by acute reaction-, have contributed to a decline in the mention of heroin in the social debates on the dominant drugs existing in Spain.

Nevertheless, despite the improvements with relation to heroin, a substance which registers constant and prolonged reductions both in the number of users and in the problems associated with its use, it still can not be forgotten that, in Spain, after tobacco and alcohol, this substance generates the highest volume of socio-sanitary problems and the greatest demand for health care. At the moment, the most serious problems caused by heroin are probably due to the existence of an important volume of highly dependent smokers or snifers who can evolve to injection if the favourable circumstances are given, and in the high overdose risk and hepatitis C infection that recent or sporadic injectors have.

Despite the prevalence of cannabis use by young people in our country, its social-sanitary impact is still quite limited. Nowadays, this substance occupies the third place among those illicit drugs that trigger demand for treatment. Although the associated problems still have a long way to go to reach those of heroin and cocaine, these problems have increased since 1995.

Although in the last three years the problems caused by cocaine seem to have stabilized, over the last ten years, there have been significant increases in cocaine-based problems (increasing demands for treatment, emergency episodes where cocaine is mentioned and death due to acute drug reaction with toxicological analysis positive for cocaine). This increase is an important source of social-political concern. Also, the use of cocaine among opiate consumers, including those persons receiving methadone treatment, can have important repercussions on their health and the evolution of the AIDS epidemic and hepatitis. In the last years problems linked to the use of crack (mainly called “base” in Spain) have been noted, although they have not created social concern.

Amphetamines and ecstasy consumption is relatively spread. But there is a limited volume of demand for treatment and up to now health or social problems due to the use of these substances have not been detected. It is important to highlight the recent appearance of problems associated to the use of new drugs, mainly gamma - hidroxibutirato (GHB) and ketamine.

Finally, it is necessary to mention that the problems related with hypnosedatives use have increased (tranquillisers and somniferous). In fact, between 1996 and 2001 there is an increase in the number of treatments for abuse or dependence of these drugs and in the proportion of emergency episodes and deaths directly related with the drugs where hipnosedatives are mentioned. In most of the cases the hipnosedative consumed is benzodiacepines. However, the type of benzodiazepine most consumed has changed. Some years ago the favourite one for the problematic consumers and the one that generated more problems was the flunitrazepam (Rohipnol$_R$), and at the moment it is the alprazolam (Trankimazin$_R$).

2.2 Drug use in the population

Cannabis

Cannabis is the illegal drug most used in Spain. According to the 2001 General Population Survey on Drugs, 24.4% of the Spaniards aged 15-64 years have used cannabis at some time in their life; 9.9% in the last year and 6.5% in the last month. The consumption levels are higher among young people aged 15-29 years old (35.9% has consumed some time in the life, 19.7% in the last year and 12.8% in the last month), men (31.9%) and urban population from metropolitan areas with more than 400.000 inhabitants (30,2% in cities from 400.000 to 1.000.000 inhabitants and 28.9% in those with more than 1.000.000).

According to the 2002 School Survey on Drugs, 36.9% of the students aged 14-18 years old had consumed cannabis some time in their life; 32.4% in the last year and 22% in the last month. Testing with cannabis is higher than 50% among the 18 year-old students. As for the general population, the cannabis use is more extended among boys than among girls in the prevalence three-mentioned.

In Spain it is consumed mainly Cannabis sativa resin (hashish) blended with tobacco via smoking. The use tends to be occasional and limited in time, due surely to the eventual occurrence of unpleasant psychological effects, as anxiety or panic crisis, or to the smallest potential in abuse of the cannabis in relation to drugs such as nicotine or opiates. However, in 2001, 1.6% of the people aged 15-64 years-old consumed this drug daily and, during 2002, 3.6 % of the scholars between 14 to 18 years were daily or almost daily cannabis consumers (20 days or more per month), figure that increases progressively with the age, being more than a 5% at the age of 17 years old.

The average age of first cannabis use was 18,4 years old in 2001 for the population aged 15-64 years and 14,7 years during 2002 for students aged 14 to 18 years old, being in both cases the illegal substance with the youngest starting age. In 2002 the average daily cannabis use (regarding consumption days) among students aged14 to 18 years was of 3,3 joints. This quantity increased in a unit ("joint") with regard to the year 2000.

Synthetic drugs (amphetamine, ecstasy, LSD, other/new)

Use of these substances is much less extended than cannabis among the Spanish population. In 2001, last prevalence for ecstasy use was 1.8%, 1.2% for amphetamines or speed, and 0.7% for LSD or hallucinogens for the Spaniards aged 15-64 years-old.

The use is more extended among young people. The last year prevalence for ecstasy between young adults aged 15-29 years was 4.6%, for amphetamines or speed was

3%, and for LSD or hallucinogens was 1.6%. On the other hand, in 2000 the prevalence of amphetamines consumption during the last year among students aged 14-18 year old was 3.7%, that of ecstasy was 4.1% and that of hallucinogens was 3.1%.

The average age of first ecstasy use of Spaniards aged 15 to 64 years old was in 2001 about 20 years old and regarding amphetamines and hallucinogens about 19 years old. In 2002 students aged 14 to 18 years began to consume the three types of substances approximately at 15.5 years old.

Amphetamines are usually taken in pills or powder (speed) and ecstasy in pills. They are generally taken orally, although some amphetamine users take them nasally (sniffing/snorting). Ecstasy use is most prevalent among the youngest age group (15-24) and is probably fairly evenly spread across all socio-economic groups. Use tends to be experimental or occasional and is rarely habitual or compulsive.

In fact, in 2001 more than half of those who had tried ecstasy did not consume it during the 12 previous months to the survey, and more than a half of those who had consumed it in the last period did not consume it during the last 30 days. There are no almost daily ecstasy consumers; use frequency is usually monthly or weekly and only a small part is increasing and has a higher use (instrumental o compulsive).

Users' perception that increased dosages or frequencies increases the unpleasant effects and decreases the pleasant or positive effects may dissuade many users from frequent or high consumption. This does not mean that users do not occasionally indulge in fairly heavy sessions of use. Thus, in 1998 31% of pupils aged 14-18 who had taken ecstasy stated that they had taken 3 or more tablets in a single session. Moreover, a group of heavy or compulsive users can be identified. Ecstasy tends to be consumed in discos and bars, at parties or at the weekend. Ecstasy was initially associated mainly with various types of techno music. It is probably, however, that use patterns have diversified and that its use is increasingly less associated with a specific type of place, music or ambience and that it has lost much of its role in the identity of specific groups.

Ecstasy and amphetamine users frequently take other drugs, such as alcohol, cannabis, cocaine and hallucinogens. In 2001 more than half of the people between 15-64 years old that had consumed ecstasy during the previous year, had also consumed cocaine, 88.1% cannabis, 41.3% amphetamines and 23.5% hallucinogens. Together, in the year 2002, 91% of the students aged 14 to 18 years that had ever consumed ecstasy, had also consumed cannabis and 69.6% cocaine, 59.5% amphetamines and 43.7 % hallucinogens. By contrast, concurrent use of heroin or benzodiazepine is rare, except among heavy users. Additionally, there are signs that heroin users are including ecstasy and amphetamines among the broad panoply of products they consume.

The use of hallucinogens takes place in the same recreational/party setting as ecstasy and amphetamines and is characterised by an even more experimental and sporadic use, probably because it is relatively common for users to experience unpleasant effects. LSD is the substance most used, although there has probably been a certain amount of testing with new synthetic and organic hallucinogens. Use seems to have levelled off in recent years, and even it has decreased among students aged 14-18 years old.

Heroin/opiates

General Population Surveys usually give figures for the monthly or annual prevalence of less rather lower than 1% for the Spanish population aged over 15.

Students' population between 14-18 years old shows prevalence lower than 1%. Both in 2000 and 2002 0,5% of these students had tried it some time, and 0.3% during the last year. Starting age of students to use was 14,8 years as an average.

In section "2.3. Problem drug use" some estimation about the prevalence of the heroin consumption in Spain is included.

Cocaine/crack

In 2001, 4.9% of the Spaniards aged 15-64 years old had consumed cocaine some time in their life and 2.6% during the last year.

Among young people the levels of consumption are even higher. In 2001, recent use of cocaine (within the last year) among the population aged 15 to 29 years old is 5%. In 2002, 7.4% of the students aged 14-18 year-old had consumed cocaine at some time in the life, 6.0% during the last year and 3.1% in the last 30 days. This prevalence's increase with the age so that at the age of 17 and 18, 11.6% and a 16.6 % respectively of the students had experienced it; therefore there is an increasing regarding the year 2000 in both sexes. Use is more extended in men than in women, both regarding general population and student population. While in the students' population use starts as an average at 15.7 years old, in the population aged 15 to 64 years the average age to start use is 20.3 years old.

The use of cocaine base is still relatively rare among the general population, and it affects heroin consumers mainly. In 2001, 0.4% of the population aged 15-64 years old had consumed it at some time in their life. However, in areas where heroin is mainly smoked, as Gran Canaria, it can have spread quite widely among certain marginal groups that do not take heroin, such as sex workers, for example.

The cocaine available in Spain is usually cocaine hydrochloride, often mixed with caffeine but free from dangerous adulterants. Its purity (percentage of pure cocaine in the total weight) is very variable, but tends to be high. Crack is usually manufactured by the users themselves heating cocaine hydrochloride with an alkali (usually liquid ammonia). However, in some Autonomous Communities of the southwest (Andalucia, Extremadura, Canarias and Ceuta) there is probably already a stable market for these substances (Barrio et al. 1998b).

Two basic cocaine use patterns have been identified. The prevalent one is characterized light consumption patterns (sporadic use of moderate quantities), usually nasally. The other one, often among opiate consumers, is characterized by the frequent use of important quantities, generally intravenously or lung. Among students, use is mainly occasional and, according to what they say, is linked to leisure and free time. The two main reasons to consume are a wish to try new sensations (62.9%) and the enjoyment (50.4%). Other reasons mentioned are for dancing (23.9) and for not sleeping (15.2%).

Cocaine users tend to consume of other drugs as well. In the general population (aged 15-64 years) 79.1% of those who have consumed cocaine during the last year, have

also consumed cannabis, 41.4 % amphetamines, 38.6% ecstasy and 21.6% hallucinogens. 92.4% of the students aged between 14 to 18 years old that consumed cocaine at some time in the year 2002, had also used cannabis, 57.6% ecstasy, 48.5% speed and 35.3% hallucinogens.

In fact, there is at the present time in Spain a phenomenon of polydrug use linked to leisure and recreational purposes. This consumption pattern is more frequent among young men.

2.3. Problem drug use

Until a few years ago, heroin, mainly administered intravenously, was responsible for most of the social and health problems linked with illegal drug use in Spain, despite the low levels of prevalence. However, in the second half of the nineties, heroin has become less relevant, since cocaine problems now represent a significant proportion of recorded drug problems. Problems caused by amphetamines and other illegally traded drugs are quite irrelevant.

The information obtained from population surveys on problem heroin use is not considered to be very reliable, and very little data is obtained by indirect methods. At the beginning of the nineties, local estimations were carried out in Barcelona and Madrid using the capture-recapture method and thus annual prevalence figures were achieved for the period 1990-1993 and for population aged 15-54: 7.2-11.0/1000 in Barcelona and 14.1/1000 in Madrid.

Currently, the GDNPD is performing national estimations using the indirect methods proposed by the EMCDDA within the context of the harmonization of a European indicator. For the period 1999-2001 some estimations have been carried out for Spain with demographic and treatment multiplicative methods. In order to obtain the estimation with the demographic method the number of opiates (o cocaine) consumers entering treatment for the first time by drug dependence in a given year was multiplied by the number of years of opiates (or cocaine) consumption of those entering treatment for these dugs, for the first o consecutive times, whether it was the first treatment or not.

In order to get the estimation by the treatment multiplicative method, the number of clients entering treatment for drugs dependence that consumed opiates in a given year was divided by the proportion of clients entering treatment for opiates dependency in 1996 that had get in touch with centres that had notified it to the National Plan on Drugs during the 12 previous months to the treatment admission (26,2%).

The results obtained with the application of these methods are shown on the table 2.3.1, where it can be seen clearly that the number of problem opiates users is decreasing and, at the same time, the number of problem cocaine users is increasing.

Table 2.3.1 Prevalence of problematic use of opiates or cocaine according to the demographic and the treatment multiplicative methods. Spain, 1999-2001

		TM Opiates	DM Opiates	DM Cocaine	DM Opiates+cocaine	Combined methods Opiates+cocaine
1999	Number	149244	116657-189927	41993-72302	158650-262229	187470-217779
	Rate per 10000 people 15-64 years	5,34	4,17-6,8	1,5-2,59	5,68-9,38	6,71-7,79
	Rate per 10000 people	3,65	2,86-4,65	1,03-1,77	3,88-6,42	4,59-5,33
2000	Number	144198	99585-156680	41639-73293	141224-229973	182498-214152
	Rate per 10000 people 15-64 years	5,16	3,56-5,61	1,49-2,62	5,05-8,23	6,53-7,66
	Rate per 10000 people	3,53	2,44-3,84	1,02-1,79	3,46-5,63	4,47-5,24
2001	Number	137107	95733-145970	49038-86250	144771-232220	182775-219987
	Rate per 10000 people 15-64 years	4,91	3,43-5,22	1,75-3,09	5,18-8,31	6,54-7,87
	Rate per 10000 people	3,36	2,34-3,57	1,2-2,11	3,54-5,69	4,47-5,39

TM: Treatment Multiplier Method; DM: Demographic method

It must be remembered that many limitations were found when applying these methods, and therefore the results must be interpreted cautiously. As it is showed, the demographic method provides lower figures than the treatment multiplicative one for the prevalence of opiates use. In fact, the demographic method could be affected by bias that caused a lower estimation of the prevalence. A decrease in the number of patients starting their first treatment will prevent to fulfil the adoption of the method of stable population. However, the estimation of a high confidence interval for this method, considering the average age of use of which is doubled, for clients entering treatment for the first time in their lives, believable figures that go beyond the estimated figure with the multiplicative method.

The demographic method has many critics and, in fact, it is not accepted as a valid method among others proposed by the EMCDDA. But in Spain it is not possible to apply an alternative method for cocaine use, as it is not available at the present time an adequate treatment multiplicative method. The application of heroin multiplicative provides low figures, hardly reliable, especially when the multiplicative bias are known.

On the other hand, the treatment multiplicative method has two biases that probably act in an opposite way. First, the multiplicative could be underestimated because the ratio of consumers starting treatment might have increased since 1996, due mainly to a wider offer of methadone treatments. Secondly, the mentioned ratio was obtained in a sample of clients collected in the centres when entering treatment, and those people had high probability to start another treatment during the 12 previous months than

other consumers found in the streets. It is very difficult to know which of the two bias is more important and, so that, how both affect to the final prevalence estimation.

The social-demographic profile of heroin users with which we are already familiar remains unchanged. In 2001 84.4% were male, average age was 32.8, and most of heroin users entering treatment had low education, unemployment rate of over 50%, considerable involvement in illegal activities, arrests and frequent spells in prison. The use of this drug is concentrated in urban areas.

Currently, most heroin users prefer to smoke this drug or alternatively use the intranasal route (sniffers). In 2001, 67,4% of those clients in treatment for heroin addiction were smokers and 4,6% were sniffers. The proportion of intravenous drug users varies significantly from one geographical area to another, this percentage being quite low in the South-Western part of the country, and topping 50% in the North-east.

Heroin users also frequently consume cocaine, sometimes mixed with heroin. In fact, in 1996, 29.5% had consumed this mixture in the previous month to treatment. This phenomenon is especially relevant in the south of Spain. Likewise, heroin users frequently drink alcohol and consume other opiates, cannabis and especially all benzodiazepine.

The discrepancy between the relatively high level of cocaine use and the extremely low rate of associated health problems has been one of the most debated aspects connected with problems related to illegal drug use. In Spain, this discrepancy prevailed over a long period, despite the fact that, in the eighties, problems were expected to increase, in the same way as they had in the United States. Nevertheless, the framework has changed since 1995 and medical attention and the number of emergency cases connected with this drug have increased. In 2001, cocaine use was the cause of 19% of the cases entering treatment for abuse or addiction to drugs (34% among first treatment demands), and cocaine was the drug most mentioned among hospital emergency services for acute reaction to drugs (44.4% of episodes).

There is a lack of information about the specific problems of cocaine users who seek medical attention in Spain. In 1994, the most frequent symptoms of episodes treated in emergency services were anxiety, mydriasis, syncope, tachycardia, dyspnoea, confusion or coma, nervous or mental disorders, chest pain and palpitations. Most episodes occurred in persons who had either injected or smoked cocaine, but did not require admittance to hospital. Currently, however, this situation may have changed.

With regard to the relationship between cocaine and road traffic accidents, a recent study indicates that in Spain this drug is frequently detected (7.4%) in people dying in road traffic accidents, often in combination with alcohol.

3.- HEALTH CONSEQUENCES

3.1. Drug treatment demand

When analysing data connected to this indicator, it must be borne in mind that its development could have been influenced by the number and problems of the users, as well as by the supply and use of treatment facilities, which have increased significantly over the last decade.

In 2001, 49,376 admissions for drug treatment were registered (excluding treatments for tobacco and alcohol), compared to 49,487 in 2000 and 51,191 in 1999. This decrease or stabilization breaks the rising tendency observed between 1987 and 1998, and it can be attributed mainly to the impact of long-term treatments (Program of substitute opiates) that reduce the rotation of users through the different assistance services.

The number of centres reporting such figures rose from 414 in 1994 to 478 in 1998 and 492 in 2001.

The overall rate of admissions in 2001 was 123,9 per hundred thousand inhabitants (271,3/100000 among people aged 15-39 years old). These rates showed significant variations between the different Autonomous Communities, moving from the highest rates in the Canary Islands (349,7/100000) to the lowest in Navarra (23,0/100000).

As in previous years, in 2001, most admissions to treatment were due to heroin (68,3%), although cocaine is starting to be present in an important number of cases (19,0%), mainly among those clients entering treatment for the first time. The ratio of treatments for other psychoactive substances was low: cannabis (7,4%), opiates different than heroin (2,4%), hipnosedatives (1%), ecstasy (0,7%), amphetamines (0,5%), hallucinogens (0,2%), and volatile substances (0,1%). Three of each four treatments for opiates different than heroin (890) were attributed to methadone use or dependence and 66 to codeine. Hipnosedatives responsible of most treatments were benzodiazepines, and, among them the alprazolam (Trankimazin^{R}). Among amphetamines, the substance that caused more treatments was sulphate of amphetamine, and among hallucinogens LSD. Nevertheless, the importance of the different drugs depends on whether there has been previous treatment. In fact, if considering only the cases without previous treatment, the importance of drugs such as cocaine (34%) or cannabis (16,9%) is increasing, while heroin is decreasing (42,4%).

On one hand, even though heroin remains as the main substance used by clients seeking treatment due to psychoactive substances, from 1996 on the ascending trend observed since 1987 took the opposite direction. The number of admissions for treatment due to this drug began to descend slowly, moving from 9,434 in 1987 to 40,007 in 1995, 46,635 in 1996, 44,089 in 1997, 43,598 in 1998, 36,731 in 1999, and 33,702 in 2001. If an analysis is made of the stratified data according to whether or not previous treatment has been received, it can be observed that the number of clients treated previously for problems deriving from this drug has almost stabilized. There have been drastic reductions in the number of persons seeking treatment for the first time in their lives, moving from 20,017 admissions in 1992 to 11,867 in 1998, 10,309 in 1999, 8,151 in 2000, and 7,461 in 2001.

On the other hand, the number of clients entering treatment due to cocaine use stabilized. Nevertheless, an important increase had been noticed until 1999, moving

from 2,980 admissions in 1996 to 4,647 in 1997, 6,154 in 1998, 8,977 in 1999. After that year, some stabilization has been observed (8,522 in 2000, and 9,367 in 2001). This increase was more significant among those clients entering treatment for the first time for this drug (for whom the number of treatments has risen from 932 in 1992 to 4,174 in 1998, 6,126 in 1999, 5,499 in 2000, and 5,977 in 2001) than among those clients who had been admitted on previous occasions. In 2001, 19% of the admissions to treatment were for abuse of or dependence on this drug, this figure being 34% among those clients entering treatment for the first time.

The number of admissions to treatment due to cannabis has increased 1,6 times between 1996 and 2001, because of the increasing of the clients treated for their first time in life. The number of clients in treatment due to hypnosedatives has increased as well, mainly at the expense of those clients entering treatment for the first time. In the same period the number of admissions has slightly increased while the number of people admitted for amphetamines or hallucinogens has remained stable.

Most people (84.7%) entering treatment during 2001 were men. The highest proportion of males was observed among those clients receiving treatment for cannabis (90,1%) or volatile inhalants (93,3%), and the lowest proportion was among those clients in treatment for hypnotic substances or sedatives (56,0%). The average age of those clients in treatment was 31,5 (29,0 in cases with no previous treatment and 32,8 in those previously treated). The average age was observed in those clients entering treatment for phenylethylamyine derivatives (age 21.4) and the highest was observed among those clients entering treatment for hypnotic drugs and sedatives (age 34.5). Most of those clients in treatment (79,9%) had been educated up to intermediate or lower levels. The education level showed important differences according to the main drug of admission to treatment. With regard to the work situation, many of those admitted to treatment were unemployed (45,4%), the proportion of unemployed being greater for those cases with previous treatment (51.0%) than for those admitted clients entering treatment for the first time (36,6%). The unemployed rate also shows important differences depending on the main drug for which treatment is sought, the highest figures corresponding to heroin (52.6%).

The average age to start using the main drug was 20.8 years for the combination of all the cases captured for the indicator. Important differences were observed in the average age to start using drugs, depending on the admission to treatment. The average earliest initiation age corresponding to those clients entering treatment for volatile substances (age 15.7), cannabis (age 16.4), or derivatives of phenylethylamines (age 17.9) and the highest initiation age corresponding to those clients entering treatment for hypnotic substances or sedatives (aged 26.9).

Pulmonar (smoking or inhaling in aluminium foil or cigarettes or pipes) was the main administration route among those clients in treatment for heroin abuse or dependence in 2001, although there is still a considerable number of clients who continue using the parenteral administration route. Among the cases previously treated for this drug, 26,1% used the parenteral route and 65.0% smoked the drug, whilst among those who had not received previous treatment, these percentages were 17,5% and 74.1% respectively. Significant differences were observed in the heroin administration route among the different regions, but in general the pulmonar route predominated in most parts of Spain, except in a group of regions in the North-east (Catalonia, Balearic Islands, Aragon, Navarra, Cantabria, Rioja and the Basque Country). Among those admitted for treatment for cocaine, the predominating main administration route was intranasal (sniffed), slight use being made of the parenteral route. In fact, the proportion

of intravenous drug users was 9,1% in cases of previous treatment and 1,6% in cases with no previous treatment. Since 1991, time when the Treatment Indicator started to gather data on the main route of administration of the drug motivating the treatment, a significant evolution has been observed in the main administration route of heroin in the overall area of the State. This evolution has occurred both in cases treated previously, and also in cases with no previous treatment, where parenteral use dropped from 50.3% in 1991 to 21.8% in 1998, 19.6% in 1999, and 17,5% in 2001, although, over the last few years, the reduction rate appears to have reduced. This drop affects all the regions. Parenteral use has been mainly replaced by the smoked route ("smoking chinos", "smoking in chinos" or "smoking in silver paper").

Among those clients entering treatment for cocaine in 2001, the main administration route was sniffing (69,4%), next smoking (25,1%) and injected (4,1%). Examining data related to the proportion of those treated for cocaine that use mainly each administration route, the conclusion is that between 1991 and 2001 the sniffing route has increased, the injecting route has decreased and the smoking route has remained stable. In fact, the proportion of those clients entering treatment for the first time for cocaine consumption using sniffing route went from 55,4% in 1991 to 75,2% in 2001; in the case of the injecting route from 19,2% to 1,6%, and in the smoking route from 24,4% to 21,9%.

In order to understand the evolution of the cocaine treatments it is important to notice not only the evolution proportion using each administration route but also the evolution of the absolute number of clients in treatment using each route. There is a very high increase of the clients in treatment for cocaine between 1991 and 1999 due to the increasing number of consumers by sniffing route that rise from 315 in 1991 to 4777 in 1999 and 4413 in 2001.

These data suggest also that, in spite of the stability of the clients in treatment who smoked cocaine, an epidemic of the problematic use of crack (smoked cocaine) is been developed in Spain. In fact, between 1991 and 2001 treatments due to crack were multiplied by 12,2 rising from 188 to 2296 cases per year. However, the increase of the clients in treatment for crack would be hidden by the simultaneous and higher increase of those clients in treatment who sniff cocaine. Then, between 1991 and 2001 the clients in treatment by sniffing cocaine were multiplied by 16, while the clients in treatment for crack for 12,2. It is unknown in what extent the rising of problems for crack is due to the influence of heroin consumers or ex-consumers. Although treatments for crack take place mainly among people that have not consume heroin in the 30 previous days to recruitment, it is unknown if those people are consuming methadone at the present time or are heroin ex consumers. Anyway, there is a positive association between the proportion of treatment for crack in different Autonomous Communities and the one for smoked heroin. A certain caution must be keeping in mind when considering these data because it has been observed that consumers and professionals often use terms as "to inhale" which meaning in terms of administration route is not univocal; sometimes (or somebody) is referred to the smoked route (administration of gases or vapours with bronchopulmonary absorption) and another times to the sniffing route (powder administration with nasal pharynx absorption).

More than half (56,9%) of those clients entering treatment in 2001 had never used the intravenous route (non-intravenous drug users), 19,5% had used the intravenous route at some time in their lives but not in the year prior to admission for treatment (ex-intravenous drug users) and 23,5% had used the intravenous route in the last year (current intravenous drug users). Among those clients entering treatment for heroin,

these proportions were 43,7%, 25,2% and 30,1% respectively. With respect to those clients entering treatment for other drugs, only a significant proportion of intravenous drug users at some time (current or ex intravenous drug users) figure among those clients in treatment for opiates other than heroin (67,1%). For the remaining drugs, the proportion of intravenous drug users is very low.

Apart from the main drug, those clients entering treatment frequently use other drugs. The validity and reliability of this information, however, may not be too accurate. Among those clients entering treatment for heroin in 2001 the most widely used secondary drugs were cocaine (71.9%), cannabis (35.8%), hypnotic substances or sedatives (19.8%) and alcohol (25.1%). Among those clients entering treatment for cocaine, heroin was used as a secondary drug in 12,2% of the cases. Other secondary drugs frequently used were alcohol (63.4%), cannabis (47.5%), and MDMA and similar (11.3%).

Of all those clients entering treatment for psychoactive substances during 2001, 60.2% reported that they had been previously treated for the main drug, compared to 62.1% in 2000, 58.9% in 1999, 62.1% in 1988, 62.1% in 1997, 56.9% in 1996, 47.5% in 1994 and 43.9% in 1992. The proportion of cases treated previously was higher among those clients in treatment for heroin (73.7%) than among those clients in treatment for cocaine (32.5%).

With regard to the HIV serologic status of those clients entering treatment, in the first place it must be stressed that the proportion of clients entering treatment with an unknown serologic status with respect to HIV is very high (39,2%), reaching 57,1% among those admitted for treatment for the first time, so their results should be used cautiously, bearing in mind that the prevalence of infection due to HIV (positive) which are detailed below, are minimum prevalence figures (at least that percentage is infected). The highest infection prevalence due to HIV was found among those clients entering treatment for opiates other than heroin (21.5%) and for heroin (18.1%) and the lowest among those clients entering treatment for volatile substances (0.0%), phenylethylamine derivatives (0.6%) or cannabis (1.7%). The prevalence is much higher among persons with previous treatment than among those admitted for treatment for the first time. For example, figures for heroin are 20.1% among those treated previously and 11% among those treated for the first time.

Among current injectors (people who had injected in the 12 previous months to treatment) the proportion of those with unknown HIV condition is lower (25.5%) than among non-injecting drug users. For this reason, prevalence figures can be considered excluding the denominator unknown (that probably overestimate the real prevalence). In this way, it can be observed that in the year 2001 33.7% of the current drug injectors was HIV positive (34.6% of those previously treated and a 28.8% of those treated for the first time). Among current injectors, those who have consumed recently opiates (including clients in treatment for opiates and for other drugs with mention to opiates use in the 30 days previous to treatment) showed a higher HIV+ prevalence than those that had not consumed (34.1% vs. 24,7%). On the other hand, women that had injected recently had higher HIV+ prevalence than men (40.2% vs. 32.7%, respectively). At the same time, older injectors had higher infection prevalence than younger ones. During the last years, HIV infection prevalence among injectors has slightly decreased, dropping from 37.1% in 1996 to 33.7% in 2001. This decrease affects both men and women, and it is less significant among injectors older than 34 years old (dropping from a 48.9% to 45.1%) than among those younger than that age. In fact, among

injectors from 25-34 years old has dropped from a 39,3% to 30.5% and among the population younger than 25 years old from 20.3% to 14.7%.

3.2. Drug-related mortality

3.2.1. Drug-related deaths

For several years the use of illegal drugs (mainly injected heroin) has been one of the main death causes among young people living in large Spanish cities. AIDS and the acute reaction experienced after taking drugs are the two death main causes among opiates or cocaine users, however at present deaths due to AIDS are more numerous than those caused by acute reaction.

Since 1983 Spain had a specific registry that collects deaths due to acute reaction to drugs in different geographical areas. Also, in 1999 and 2000 an estimation of the number of deaths due to acute reaction to drugs for Spain was carried out calculating from the specific registry the level of under estimation of the General Mortality Registry.

Mortality indicator for acute reaction to psychoactive substances carried out by the National Plan on Drugs (Specific Registry)

This indicator collects information on deaths with judicial intervention where the direct and main cause is an acute adverse reaction after a non-medical and deliberate use of psychoactive substances (except alcohol and tobacco) in the population aged 15-49 years old. It is called acute reaction and not “overdose” because it is not always possible to assure that the death cause is a pharmacological overdose. Actually, in these deaths there could be implied several physic-pathological mechanisms that go beyond the concept of pharmacological overdose. Sometimes even death could happen due to a complication caused from withdrawal symptoms. For example, a death due to convulsions developed during barbiturate abstinence symptoms in a habitual consumer of these substances.

The value of the indicator in each monitored area is estimated through the number of deaths that follow the mentioned definition registered annually by the Autonomous Communities after consulting the forensic and toxicological sources that provide information in this area.

A case is chosen and included in the registry if it fulfils any of the four following requirements of inclusion:

1. Evidences of recent use of psychoactive drugs. Those evidences could be as follows:
   - Clinic evidences of acute intoxication due to psychoactive substances immediately before death registered in any document (hospital report, medical history, etc.).
   - Physical external signs of recent administration of psychoactive substances (recent injections, psychoactive substance remains in mouth, nostril, stomach, etc, smell of solvent in hair, breath and clothes, etc.).
   - Presence of psychoactive substances or tools to consume them in the death place (syringe or other injecting tools, aluminium paper, pipe, tablet can, glue or empty spray cans, lighter spare, plastic bags to inhale, etc.).

   - ?? Recent use (7 days before death) told by family members o detected by a forensic in a recent assistance or expert report related to the dead person.
2. Positive toxicological analysis for any registered substance.
3. Pathological findings of the autopsy, compatible with death due to recent use of any psychoactive substance.
4. Forensic diagnosis of death for acute reaction to any psychoactive substance.

According to the initial definition, the following types of death are excluded:

1. Deaths where there is neither judicial intervention nor forensic report about their causes with written evidence of the results. However if no toxicological analyses have been carried out, it is not an exclusion reason, although results availability of those analyses is highly recommended.
2. Deaths not related to psychoactive substances consumption. However deaths caused by pathologies complicated with recent consumption of psychoactive substances are not excluded if inclusion criteria are fulfilled.
3. Deaths indirectly related with registered psychoactive substances; so, those deaths where the psychoactive drug consumption has been a concurrent element but not the death main cause. For this reason, death caused by the following motives are excluded:
   a. Infectious pathologies transmitted because of drugs use (HIV, endocarditis, hepatitis, septicaemia, tetanus, etc.).
   b. Homicide, even if dead was under the influence of psychoactive substances or it has happened during activities related to drug use or trafficking. Deaths by homicide through use of psychoactive substances are excluded as well.
   c. Any accident (in the workplace, domestic, traffic, etc.), suffered by people under psychoactive substances effects, except deaths caused directly by poisoning or acute intoxication due to any of these substances.
   d. Any suicide (hanging, falling, drowning, by firearm, etc), in people under psychoactive substances effects, except those deaths caused directly by poisoning or acute intoxication with these substances.
   e. Deaths caused by exposure or non-deliberate consumption of psychoactive substances.
   f. Deaths caused by acute reactions to medicines or psychoactive pharmaceutical products correctly prescribed and administered.
   g. Deaths caused by a chronic disease related to alcohol consumption and deaths caused exclusively by acute ethylic intoxication (drunkenness).

In 2001 there were 496 deaths caused by acute reaction after using psychoactive substances in 119 administrative areas, with a population of 19.800.071 inhabitants (49% of the Spanish population). Deaths in most cases are notified by the Anatomic Forensic Institutes, although in some cases notification is received from Forensic Surgeons grouped within other entities (Forensic Clinics) or, on exceptional occasions, from single forensic surgeons. The complementary data on toxicology are provided mainly by the National Institute of Toxicology (Departments of Seville, Madrid, Barcelona and Tenerife), but also by other institutions.

The quality of the information has improved during the last years. In fact, the proportion of cases with available toxicological results was 65.9% in 1993, 82.1% in 1995, 88.1% in 1998, 97.7% in 2000 and 96.6% in 2001.

The number of deaths for acute reaction to opiates or cocaine increased continuously between 1983 and 1991, and followed a decreasing trend from then on. In 2000-2001

there are stabilization signs. The number of deaths due to overdose in five large Spanish cities (Madrid, Barcelona, Valencia, Zaragoza, and Bilbao) dropped from 553 in 1991 to 373 in 1995, 267 in 1988, 254 in 1999, 241 in 2000, and 245 in 2001. The mortality trend also dropped in other areas monitored on a continuous basis from 1991 onwards, although the fact that many of these were small areas causes an important inter-annual fluctuation in the number of deaths due to the chance effect. In this sense, Palma de Mallorca is an exception and mortality trend during the last decade has been increasing (22 deaths in 1991, 37 in 1995, 42 in 1999, 47 in 2000 and 41 in 2001).

As in previous years, in 2001 significant differences have been detected in the mortality rate among the various areas monitored, corresponding in general the higher rates to areas where mainly injected heroin is consumed, such as Palma de Mallorca (9,5 deaths/100.000 inhabitants) or Barcelona (5,9 deaths/100,000 inhabitants). In the rest of the monitored areas, rates were lower than 3,5/100.000. It is probable that those differences would be attributed to the use of injecting route as the main route of administration of heroin in Northern Spain and Balearic Islands.

Among the group of deaths in 2001, 85.5% were male. The average age of the dead was 33.9 years. 52.3% showed recent injecting signs and 46.5% were VIH positive, although the proportion of cases with unknown figures for this variable was very high (58%).

The possibility of being able to rely on toxicological analyses for all deaths due to unnatural causes would be a welcome asset, including deaths by intoxication or acute reaction to any type of substance. However, in some cases this information is unavailable. Most of the cases with available toxicological analyses were positive to opiates (86.8%), 53.5% to cocaine, 52.7% to benzodiazepines, 51.7% to cocaine, 35.3% to alcohol, 18.7% to cannabis. The remaining substances had a presence lower than 5%.

In 43 deaths (8.7%) only opiates were detected and in 207 (41.7%) opiates were detected and not cocaine. On the other hand, 16 deaths were reported (3.2%) with cocaine exclusively detected in toxicological analysis and (7.9%) where cocaine was detected and not opiates. The difference between the two last ones was 5.3. That figure could not represents adequately the real contribution of heroin and cocaine to the mortality in Spain because an important and unknown proportion of deaths caused by cocaine might not be investigated by judges and forensic scientists.

Although cannabis was detected in a relatively high ratio of deaths, nothing can lead to think that it has contributed to death. In fact, during 2001 no death was registered for acute reaction to drugs where cannabis was detected exclusively. In contrast, there were two deaths where MDMA or other feniletilamines were detected, although in one case there was evidence of suicide. Also, a death was registered where amphetamines were exclusively detected and another where just volatile substances were detected.

The ratio of deaths due to acute reaction to drugs in which opiates or their metabolites (mainly attributed to heroin consumption) are found has decreased slowly since 1983. In the same way, the ratio of deaths where opiates were detected exclusively has decreased marked, dropping from 21,6% during 1983-1989 to 9,1% in 1998-2001. Also, the ratio of deaths where opiates and not cocaine were detected has decreased slightly dropping from 43,7% during 1983-1989 to 38,8% in 1998-2001. On the other hand, the average age of the deaths where opiates are involved has increased progressively going from 25,1 years old in 1983 to 33,8 years old in 2001. Methadone

presence has been increased during the last years in cases of deaths where opiates and cocaine were detected. In fact, in 1996 methadone was detected in 15.8% of deaths with opiates detection and in 2001 this figure was 40.1%.

Contrary to opiates, the ratio of deaths due to acute reaction to drugs with cocaine or its metabolites detection has highly increased since 1983, especially between 1995 and 1999. The increase is related to cases where just cocaine was detected (going from 0.6% during 1983-1989 to 4.1% in 1998-2001) and cases where cocaine and not opiates were detected (going from 1.2% during 1983-1989 to 7.5% in 1998-2001). Combining data of opiates and cocaine, it can be observed that during last decade the ratio between number of positive deaths to opiates and negative to cocaine and number of positive deaths to cocaine and negative to opiates has decreased, dropping from 37.7 in 1983-1989 to 5.1 in 1998-2001.

During the last years, it has also increased the ratio of deaths with benzodiacepines o their metabolites detection (29.7% in 1987, 43.8% in 1996 and 52.7% in 2001), and the ratio with cannabis detection (from 6.5% in 1996 to 18.7% in 2001). On the contrary, there is no a clear trend in the case of amphetamines and ecstasy.

Also, the proportion of deaths due to acute reaction to drugs with recent signs of injecting determined by a forensic has gone from 89.6% in 1996 to 75.3% in 1999, and 55.2% in 2001, although this indicator validity is not very high. Another indicator that can show the HIV/AIDS epidemic among injectors is the prevalence evolution of infection by HIV/AIDS among deaths due to acute reaction to opiates or cocaine (most of them injectors). That prevalence shows a descendant trend between 1996 and 2000, going from 52.3% in 1996 to 48.1% in 1999, and 47.1% in 2000, but in 2001 increased again (49.2%). However these figures could be affected by variations in the indicator coverage and in the proportion of deaths to whom the test is carried out. In Madrid, where those factors are considered more stable, they showed a continuous decrease between 1988 and 2001, dropping from 76% in 1988 to 48% in 1996 and 42% in 2001.

Estimation of the number of deaths related to drug use in Spain (General Mortality Registry)

The EMCDDA defines deaths related to drugs as those caused directly by drug consumption, pointing out that those deaths happen usually after substance use. Also, the EMCDDA just shows deaths related to typical drug abuse consumption as opiates, cocaine, amphetamines, cannabis and hallucinogens, excluding tobacco, alcohol and psychoactive medicines. The EMCDDA expert group for this indicator has recommended that in the future these deaths would be drawn from the General Mortality Registry (GRM) in all EU member states. For this reason, an estimation of the number of deaths related to drugs in Spain is showed below, using the General Registry, but correcting its underestimation.

In spite of the EMCDDA recommendations, a research carried out in Spain related to the period 1984-1993 showed that it was inadequate to estimate mortality directly linked to drugs from Mortality Statistics based on the causes drawn from the General Mortality Registry because those statistics underestimate mortality. In fact, during 1984-93 the General Registry showed only 1285 deaths related to drugs among the population aged 15-49 years belonging to six Spanish cities while mortality indicator of the National Plan on Drugs (NPD) showed 3491 (2,7 times more). This problem of adjusting was attributed to the fact that usually deaths directly related to drugs and other external causes are neither registered in the General Registry nor codified

adequately. Those deaths need a study and a judge and forensic report in order to determine their causes but often definitive results of the medical-legal study are not shown in BED and are useless to correct the initial cause of death included in this document. As a consequence, it is necessary to recuperate the information of the medical-legal study before codifying it in order to include in the appropriate section and to avoid underestimation in the General Registry.

In order to evaluate if the situation was the same in 1999-2000, a new evaluation has been carried out comparing number of deaths directly linked to drugs registered by General Registry of Mortality and the ones showed by the mortality indicator of the National Plan on Drugs. In this occasion the study was referred to a wider area composed of 4 autonomous communities (Madrid, Murcia, País Vasco, and Galicia) and 11 cities (Badajoz, Barcelona, Cáceres, Las Palmas de Gran Canaria, Palma de Mallorca, Pamplona, Ponferrada, Sevilla, Valencia, Valladolid y Zaragoza). Data on the deaths in those areas were requested to the National Institute of Statistics that made an ad hoc tabulation. Results indicate that the situation has improved but the Registry is still underestimating to a certain extend the deaths directly linked to drugs. In fact, in 1999 the GRM (selecting codes of death cause proposed by the EMCDDA) registered in that area 274 deaths in people aged 15-49 and mortality indicator of the National Plan on Drugs 446 (1,63 times more). In 2000 figures were 284 y 413 deaths, respectively, which means that the NPD indicator registered 1,45 times more deaths.

Multiplying corrector rates of under-notification of the General Registry of Mortality calculated for number of deaths directly linked to drugs for overall Spain extracted from GRM (http://www.ine.es/inebase/), it can be obtained a estimation of the number of total deaths directly linked to drugs in Spain (Table 3.2.1).

Table 3.2.1. Estimation of deaths directly linked to drug use. Spain, 1999-2000

		All ages		15-49 years old	
		1999	2000	1999	2000
Selection A	Nº of deaths GRM	609	604	588	576
	Corrector index of underestimation	1,628	1,454	1,628	1,454
	Nº of deaths estimated	991	878	957	838
	Deaths per 100000 inhabitants	2,43	2,15	4,46	3,90
	Proportional Mortality (% of all deaths)	0,27	0,24	3,91	3,44
Selection B	Nº of deaths GRM	808	763	777	717
	Corrector index of underestimation	1,158	1,211	1,158	1,211
	Nº of deaths estimated	936	924	900	868
	Deaths per 100000 inhabitants	2,29	2,26	4,19	4,05
	Proportional Mortality (% of all deaths)	0,25	0,26	3,68	3,57

Notes:

Selection A is proposed by the EMCCDA and includes the following codes ICD-10: F11-F12, F14-F16, F19, X41, X42, X61, X62, Y11 e Y12.
Selection B includes all codes of selection A plus X49 Proportional Mortality=(deaths related to drugs/related to all causes)*100.
Populations to calculate those rates were provided by the 2001 Population Census (www.ine.es/censo2001/)

When selection of codes proposed by the EMCDDA is used (selection A), the number of estimated deaths in all ages is 991 in 1999 and 878 in 2000. If another selection is chosen (selection B), that use besides the codes proposed by EMCDDA the code X49 (Accidental poisoning or exposure to other chemical products and harmful substances and non specified ones) it is possible to obtain slightly different estimations not too different from the ones mentioned (936 in 1999 and 924 in 2000). The second selection is justified to collect non specific "overdoses", that in Spain are quite numerous. In any case, it has to be remembered that none of estimations carried out include deaths related to drugs not admitted or registered by doctors in the official certificate of deaths or drugs that are not investigated by forensic and judges. These deaths could be very important as in the case of drugs such as cocaine.

3.2.2. Mortality and causes of death in drug users, trends

In Spain, there is little information available on the mortality rate (for any cause) of drug users. Among the published articles a few refer to opiate consumers (heroin) and come from Catalonia. These studies from Barcelona indicate that the annual mortality rate in opiate users was less than 1.5% in the mid-eighties, and that it increased, due mostly to deaths caused by AIDS and overdose, reaching figures between 3% and 5% at the beginning of the nineties. This means that the mortality of this population was 20-30 times higher than the general population of the same age and sex. From 1995 onwards, it is very probable that the mortality rate will have gone down within the

Spanish user groups, as a result of the progress made in the control of HIV infection and the treatment received by this type of patient. Also due to the increased number of opiate substitution programmes and harm reduction programmes in the country. In fact, between 1994 and 1997 the annual mortality rate among intravenous drug users in Barcelona descended abruptly.

A recent study over a cohort of 5049 heroin users (most drug injectors) recruited at outpatient treatment centres in Barcelona between 1992 and 1997, and followed until December 1999 (23048 persons-years of observation), shows the following relevant data: the direct standardised mortality rate (using distribution of Barcelona general population by age as population-type) went from 5,8 per 100 persons-years of observation in 1992 to 1.6% in 1999. The direct standardised mortality rate during the whole period of follow up (1992-1999) was higher for men (4.0%) than for women (3.5%); however the standardised mortality ratio (SMR) -which compare the observed number of deaths in the cohort with the expected number of deaths according the mortality rates of the Barcelona general population of the same age- was twice higher among females (36,3) than among males (18,8). The most frequent causes of death of heroin users in the whole period of follow-up were AIDS (38.4% of all deaths) and overdoses (34.7%).

3.3. Drug-related infectious diseases

Since the second half of the eighties, AIDS and HIV infections have become one of the major health problems associated with the drug use in Spain. According to the National AIDS Registry, up to 31 December 2002, 65025 cases of AIDS related to intravenous drug use had been registered in Spain, representing 64.4% of all the cases of AIDS diagnosed up to that time. Among the 2437 cases diagnosed in 2001, the proportion attributable to parenteral drug use is lower (52.1%), being slightly more elevated in men (53.9%) than in women (45.5%). The proportion of AIDS cases that were infected due to intravenous drug use has decreased during the last decade, going from 69.6% in 1990 to 52.1% in 2002 . It is very important to keep in mind that AIDS registration is accumulative and that notification undergoes certain delays, and therefore these figures may be subsequently modified.

The AIDS cases related to injected drugs diagnosed annually, is descending, after a maximum point was reached in the year 1994. In fact, the number of new cases diagnosed, (correction having made after the notification delay period had elapsed), was 4,997 cases in 1994, 4,288 in 1996, 2,099 in 1988, 1,408 in 2000 and 1,268 in 2001 and 1,270 in 2002. This decrease reflects the combination of improvements that have been made in the fight against AIDS in drug users (maintenance treatments with methadone, prevention of injecting risk behaviours, early diagnosis, new anti retroviral treatments, etc) and giving up the injection as the main heroin administration route. On the other hand, the current stabilization of the AIDS incidence in levels still high seems to indicate that the impact of the new anti retroviral treatments has reach the highest top and that it is necessary to activate the preventive interventions to avoid new infections.

Nevertheless, the biggest drop took place in 1996 and 1997, when highly efficient anti-retroviral therapies were expanded. The average age of AIDS cases related to intravenous drug use has increased progressively during the last years, from 26.5 years in 1985 to 29 years in 1990, 31.8 years in 1995, 35.5 years in 2000 and 36.6 years in 2002.

The most common AIDS infection source is intravenous drug use in all the Autonomous Communities. But the average annual incidence rate in the period 1998-2001 was not homogeneous, from 47.9 cases per million habitants in Madrid to 9.3 cases/100000 in Cantabria. Apart from Madrid, the Autonomous Communities with higher rates were Baleares (38/1000000), Murcia (33.4/1000000), and La Rioja (32.5/1000000).

There are few studies that reflect clearly the evolution of the infection prevalence for VIH in drug injectors. Most of the studies are precise or referred to very small samples. Recently infection data have been published in people that have been carried out the serologic test HIV in ten centres of sexual transmission diseases and/o diagnosis of VIH located in nine different cities. The number of analysed who were drug injectors has decreased extremely, dropping from 830 in 1992 to 85 in 2001; while in the same period the infection prevalence for HIV among drug injectors passed from 38,4% to 23,5%. It is necessary to keep in mind that the infection figures in people that agree voluntarily to take the test underestimate the real prevalence because usually they don't include people that already know that they are infected. However, they can be sensitive to detect temporary changes in the transmission of the HIV.

On the other hand, the treatment demand indicator shows that in the last years the infection prevalence for VIH among the recent injectors (they had been injected in the 12 previous months to the admission to treatment) has descended slightly, passing from 37,1% in 1996 to 33,7% in 2001. This decrease affects men as well as women, and it is less important among injectors older than 34 years old (where it passed from 48,9% to 45,1%) than among those aged 25-34 years (it passed from 39,3% to 30,5%) and those younger than 25 years (it passed from 20,3% to 14,7%). Also, the 2001 data indicate that women that had injected recently had higher prevalence of HIV+ than men (40,2% and 32,7%, respectively). Nevertheless, when analysing these data it is necessary to consider that among 25% and 30% of the injectors entering treatment the HIV prevalence was ignored.

When analysing the data coming from the National Registry of AIDS it is necessary to remember that this registry counts only the new cases diagnosed in every period and not the new infections for the HIV virus (HIV). The AIDS usually is a late consequence of the HIV infection. Therefore, the data of this registry cannot reflect the current incidence of new HIV infections. In this sense, some Autonomous Communities have systems to register the new HIV infections (incidence registries). The data of these systems indicate that up to December 2001, in the Navarra-La Rioja area (826,000 habitants) the new infections cumulative rate since the beginning of the epidemic was 480 cases every 100,000 inhabitants. 27% of the diagnostic belongs to women and 63% of the cases were injecting drug users. The highest incidence rates were reached in 1991 (49,4/100,000), since then it dropped, being 8/100000 in 2001. Nevertheless this descent was very fast until 1996, and from then some stabilization or slow descent signs are observed. Due to this drop, Spanish rates have come closer to that of other European countries, when at the early nineties Spain had rates much higher. New infections caused by sexual transmission have decreased much slower than those caused by injecting drug use, being in 2001, the first higher than the second. In 2000-2001 the proportion of drug injectors over the overall of new infected was 27% in Navarra, and 56% in La Rioja.

Simulations done up to the year 2000 with mathematical models allow to estimate that the HIV transmission among injectors had taken place abruptly in the eighties (reaching the highest incidence between 1984 and 1987). Since then the incidence would have

dropped progressively, although more slowly during the last years. In the last years some new HIV infections have occurred but available data does not indicate important incidence increases. Nevertheless, the prevalence of HIV infection continues to be high among intravenous drug users and risk conducts (sharing injection material or maintaining sexual relationships with no protection), especially among those HIV negative or those who are not aware of their serological status.

Recently among drug injectors who do share used syringes a high prevalence has been detected caused by sharing in an indirect way other injection materials, like drug prepared in used syringes (front/backloading), recipients where used syringes were placed, and filters or liquids to wash syringes that have been in contact with used syringes.

3.4. Other drug-related morbidity

Non-fatal drug emergencies

In 2001 the Emergencies Indicator recorded a total of 2,145 emergency episodes due to acute reaction to psychoactive substances in 12 Autonomous Communities, the collection of this information having been limited to one week selected randomly from each month.

It refers to urgencies in whose clinical history there are doctor's terms that allow to data collector to relate it with non-therapeutic consumption of some psychoactive substances. In this sense, data probably have validity problems because the collector must often take a decision based on limited, ambiguous or imprecise information. In fact, in an important proportion of emergency episodes the collector doesn't find enough elements in the clinical history to decide whether it is or not of an emergency directly related with the use of psychoactive substances. Also, doctors probably use uneven approaches when relating or not an emergency episode with a concrete drug, and the collectors explain in a different way the terms that the doctors use to refer to this relationship. For this reason this indicator has been modified starting from 2003.

To avoid making mistakes in data interpretation it is necessary to point out also that up to 1995 this indicator collected all direct emergencies or indirectly related with opiates use or cocaine during the whole year; this definition changed at the beginning of 1996 collecting just directly emergency episodes related to the use a week of every month. Also, the spatial covering has been unstable in the time. In consequence, the coverage data on the number of emergency episodes are not comparable with those of previous years without carrying out an itemized study. The characteristics of the emergency episodes can be compared taking certain cautions.

In 2001 the substances most frequently mentioned in emergency episodes were cocaine (44.4% of total episodes), followed by alcohol (33.8%) –in spite of it was only collected when mentioning besides another drugs-, heroin (33.5%), hypnotic substances or sedatives (32%) and opiates other than heroin or unspecified opiates (17.4%). Apart from the not specified benzodiazepines, hypnosedatives more mentioned in the clinical history are : alprazolam (trankimazin$_R$), cloracepato dipotásico, and lorazepam. The most mentioned opiate different than heroin was methadone. It is necessary to point out that during 2001 there were 28 urgencies in which gammahidroxibutirato was mentioned (GHB or “liquid ecstasy”) (1,3% of all the emergency episodes for acute reaction to drugs). All these emergency episodes took

place in the city of Barcelona. Besides GHB, in most of them also other drugs such as alcohol (50%), MDMA (28,6%) or cocaine (17,9%) were mentioned.

It must be taken into account that reference related to the number of mentions is made in the case history regarding the use of these drugs, which does not mean that the emergency episode has been caused by or is connected with the use of the said drugs. With regard to 1997 and 2001 a significant and continuous drop is observed in the number of heroin mentions (61.4% in 1996, 52.6% in 1997, 40.5% in 2000 and 33.5% in 2001). Between 1997 and 1999 a significant increase in cocaine mentions has been observed (30.0% in 1997, 37.2% in 1998, and 48.7% in 1999), but in 2000 the trend changed and began to decrease 45.3% in 2000 and 44.4% in 2001). Starting from 1999 heroin has made way to cocaine as the drug more frequently mentioned in emergency episodes. Even, in 2001 the mentions of alcohol- in spite of only registering when there is a simultaneous consumption of other drugs - overcome those of heroin.

In the last years other changes have also taken place in drugs mentioned in emergencies that could be explained, among other factors, due to a higher tendency to the poly drug use. The hipnosedatives mention has passed from 25,7% in 1996 to 32% in 2001, the mention of cannabis from 7,4% to 19,1%, the one of ecstasy from 1,6% to 5,2%, and that of amphetamines from 3,1% to 4,6%.

When analysing the previous data it is necessary to consider only mentions of use of these drugs in the clinical history, and not those related to emergency episodes caused for (or be related with) their use. However, when considering just the drugs that the doctor relates with the emergency episode, the scenery is similar, being he substances most frequently related to emergency episodes: cocaine (40.5%), heroin (29.2%), hypnotic substances and sedatives (29.2%), and alcohol (29%). When interpreting data, it must be considered that a single emergency episode could be connected to several psychoactive substances use. Data analysis for the period 1997-2001 shows the same trends that can be observed for the substances mentioned.

Regarding the most frequent administration route of the mentioned substances, it must be taken into account that this item has a significant proportion of unknown values, and therefore the results should be seen with considerable caution. In those episodes when heroin was mentioned, the pulmonary (43.3%) and parenteral (42.7%) were the principal routes used by a higher proportion of users and in episodes with mention of cocaine, the routes were, pulmonar (47.8%), intranasal (32.1%) and parenteral (21.1%). During the period 1996-2001 in episodes with mention of heroin the use of injecting route has dropped (62.1% in 1996, 54.6% in 2000 and 42.7% in 2001) and the pulmonar route has increased (36.7% in 1996, 44.2% in 2000 and 43.3% in 2001). In the episodes with mention of cocaine, it is also observed a trend to decrease the use of this drug quickly for injecting route (50.4% in 1996) and to increase their use for pulmonar one (28.0% in 1996).

In 2001, most persons who received emergency care related to drug use were males (72.9%), but it is shown a slight decrease (78.6% in 1996). Somewhat smaller proportion than for the mortality (85.5%) and the treatment (84.7%) indicators. The largest proportion of females was in the episodes in which hypnotic or sedatives were mentioned (34.9%).

The average age of all clients receiving attention for emergency episodes due to acute reaction to psychoactive substances was 29.8 years. It had increased during the period 1996-2001 (27,8 years in 1996, 30,3 years in 2000 and 29,8 years in 2001).

Clients receiving care for phenylethylamine derivatives had the lowest average age (23.2 years), amphetamines (24.4 years) and hallucinogens (24.6 years). Most of emergency episodes were resolved with medical discharge (79.1%), without important changes to point out during these years.

4.- SOCIAL AND LEGAL CORRELATES AND CONSEQUENCES

4.1. Social problems

No information available.

4.2. Drug offences and drug-related crime

During the last years, the number of people arrested for drug trafficking has risen slightly, from 17.380 (2001) to 17.430 (2002), after an important increase between 1999 and 2000 (13.430 in 1999 and 17.067 in 2000). 7.75% of the total arrested people in Spain were due to drug trafficking.

In Spain drug use or drug possession for personal use does not lead to detention because this behaviour is not defined as a crime. Possession for drug trafficking lies within the criminal offence of drug trafficking.

Table 4.2.1. Arrested for drug trafficking

	1998	1999	2000	2001	2002
Spanish	10.651	10.554	12.244	12.380	11.837
Foreigners	3.276	2.840	4.793	4.963	5.551
Not available	40	36	30	37	42
TOTAL	**13.967**	**13.430**	**17.067**	**17.380**	**17.430**
% of foreigners / totals	23,46%	21,15%	28,08%	28,56%	31,85%

Table 4.2.2. Arrested for drug trafficking per drugs

	1998	1999	2000	2001	2002
Opiates	2.436	1.961	2.243	1.914	1.214
Cocaine	3.675	3.918	5.377	5.372	5.633
Cannabis	6.853	6.465	7.518	8.408	9.042
Hallucinogens and psychotropic substances	783	800	1.617	1.686	1.541
TOTAL	**13.747**	**13.144**	**16.755**	**17.380**	**17.430**

According to the Organic Law 1/1992, administrative sanctions are imposed when using or having drugs under some concurring circumstances. There is an important and progressive increase of the sanctions imposed in accordance with this Law, which

shows a higher supply/demand of cannabis and cocaine users and less for synthetic drugs. The sanctions for use or possession for consumption of heroin have decreased almost 50% between 2001 and 2002, which seems to confirm the demand reduction trend.

Table 4.2.3. Reported according to the Organic Law 1/1992

	1998	1999	2000	2001	2002
Spanish	64.554	73.153	77.105	104.740	111.731
Foreigners	3.080	3.399	4.183	7.480	10.096
Not available	43	12	14	49	7
TOTAL	**67.677**	**76.564**	**81.302**	**112.269**	**121.834**
% of foreigners / totals	4,55%	4,44%	5,15%	6,66%	8,29%

Table 4.2.4. Reported according to the Organic Law 1/1992 per drug

	1998	1999	2000	2001	2002
Opiates	11.321	9.910	8.089	11.145	5.916
Cocaine	10.151	13.802	11.422	16.196	25.905
Cannabis	42.472	48.991	57.395	78.629	81.949
Hallucinogens and psychotropic substances	3.715	3.842	4.390	6.300	8.064
TOTAL	**67.659**	**76.545**	**81.296**	**112.270**	**121.834**

4.3. Social and economic costs of drug consumption

No information available.

5.- DRUG MARKETS

5.1. Availability and supply

Access to the different drugs is set by the increment of the demand and the progressive social acceptance of the substances; circumstances that cause any supply increase which drug users easily accept. This effect is especially evident for drugs like hashish and synthetic drugs; and less evident for cocaine.

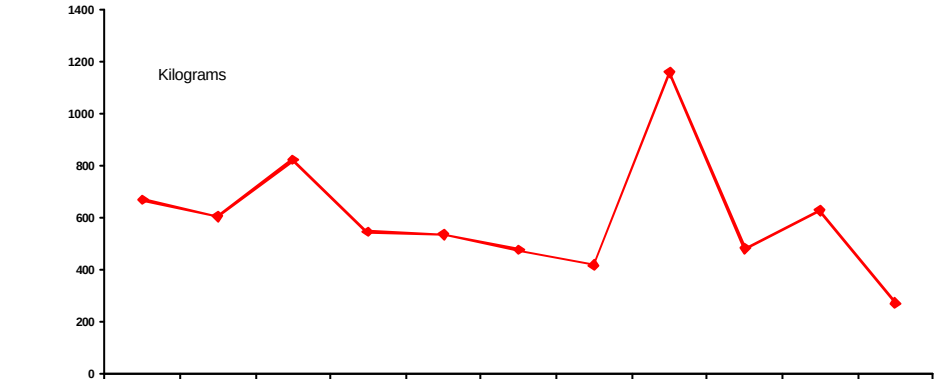
Heroin follows the opposite trend because of the lack of social acceptance that causes a decrease of the declared consumption and, therefore, smallest availability of the substance. In fact, it is observed that organizations dedicated to the distribution of heroin are restructuring toward other more demanded substances.

The hashish seized in Spain comes from the north of Africa, the cocaine from Colombia, the heroin from Turkey and the synthetic drugs from the north of Europe, Holland and Belgium, although an important percentage, about 50%, has an unknown origin.

5. 2. Seizures

Figures on **heroin** show a decreasing trend well-matched with the decreasing data about consumption.

Figure 5.2.1. Evolution of heroin seizures in Spain, 1992-2002.



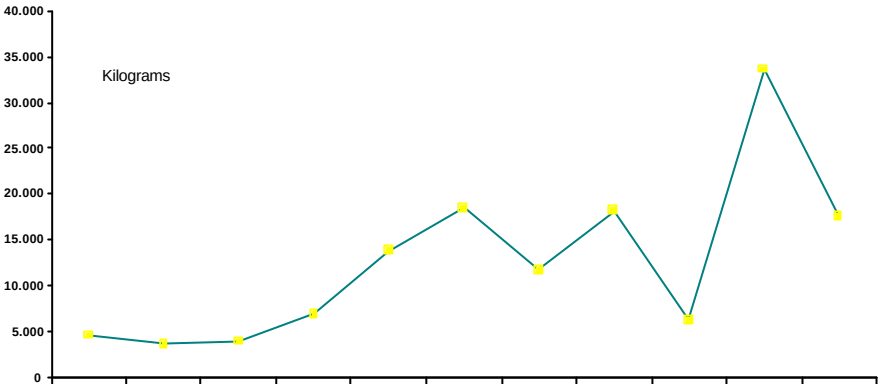
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Heroine	672	604	824	546	537	479	418	1.159	485	631	275

Notice: The quantities corresponding to the year 2001 are provisional.

SOURCE: Ministry of the Central Interior.Unidad of Criminal Intelligence

The graphics about synthetic **cocaine** figures show a characteristic drawing of 'mountain teeth' that can be interpreted as the representation of an adjustment process between the modus operandi and the institutional reaction; in accordance with it, when Law Enforcement Agencies increase their effectiveness against the organizations, they change their modus operandi, which means a decrease in the numbers of seizures until Law Enforcement Agencies react and increase their seizures capacity.

Figure 5.2.2. Evolution of cocaine seizures in Spain, 1992-2002.

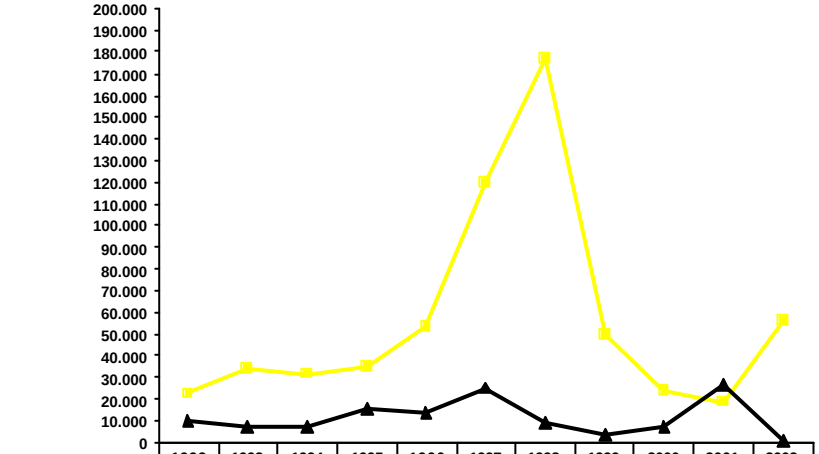


	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Cocaine	4.454	3.541	3.899	6.897	13.742	18.418	11.687	18.111	6165	33.680	17.617

SOURCE: Ministry of Interior.Unit of Criminal Intelligence

It is possible to detect a clear tendency of the seized **LSD** evolution during 1992-2002 (Figure 5.2.3.), although there is an increasing tendency if using number of seizures as indicator.

Figure 5.2.3. Evolution of speed and LSD seizures in Spain, 1992-2002.



	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Speed (grams)	22.785	34.221	31.736	35.038	53.412	119.584	176.958	49.537	23.412	18.685	55.642
LSD (units)	9.662	7.060	7.213	15.437	13.373	25.368	9.068	3.353	7.542	26.535	893

SOURCE: Ministry of the Interior. Central Unit of Criminal Intelligence

Figures on hashish show an upward line that can be interpreted as a sharp increase of the supply above the confiscating capacity of Law Enforcement Agencies, based on an increase in the demand. The same trend can be figured out from the seized synthetic drugs, although in this case the curve is more marked due to the lower starting point, and increase in the demand for this substance.

5.3. Price / Purity

Heroin

During the last five years, prices per dose remained between 9.20 and 9.50 Euros, with an increase in the year 2000 of 10.22 Euros, it is necessary to mention that the large seizures performed in 1999 that could have affected the prices of the following year. Doses purity show an upward curve from 24% in 1998 to 26% in 2001, with a decrease of 22% in 2003.

The heroin price in grams has dropped constantly from 73.55 Euros in 1998 to 63.85 in 2002, with a slight recovery of more than 1 Euro in 2003. The average purity of heroin, sold in grams, has stayed in 34% during 2001 and 2002, to decrease until 32% in 2003.

The wholesale prices remain sensibly constant in the fringe from 78 to 80 Euros for kilo, which indicates price modifications in lower levels. The wholesale heroin average purity shows a slight decreasing trend, from 63.5% in 2001 to 61% in 2003.

Cocaine

During the last five years, the price of cocaine dose has increased from 11.94 Euros in 1998 to 13.61 in 2001, dropping in 2002 and returning to the 2001 level in 2003. The dose purity has increased from 39% in 1998 to 44% in 2000 and 2001, dropping, afterwards, to 43% in 2002 and to 40% in 2003.

The prices of gram show a decrease from 1998 to 2000, to increase in 2001, dropping in 2002 and increasing in 2003 to higher levels than those observed in 1998 (61.85 Euros by gram). The cocaine purity in grams shows a continuous drop since 1999, with a 1% increase in 2003.

According to the price of the cocaine in kilos, figures show very light *"mountain teeth"*, while the purity shows a descent that stops in 2003, with a 2% increase.

The final situation for the first semester of 2003 is that the price of the gram of cocaine, obtained in dose, has experienced an 11.3% increase; this increase, obtained in grams, has been 10.4% and obtained in kilos has been of 0.88%.

Hashish

The average price of hashish in grams keeps constant between 3.85 and 4.01 Euros in 1998, which seems to indicate a constant supply of substance, capable to satisfying the demand without causing a prices drop. The hashish price in kilos shows the same trend, this time located between 1.47 and 1.53 Euros.

Ecstasy

The price of ecstasy for units has experienced a continuous decrease from 14.05 Euros in 1998 to 11.24 in 2002 and 10.70 in 2003.

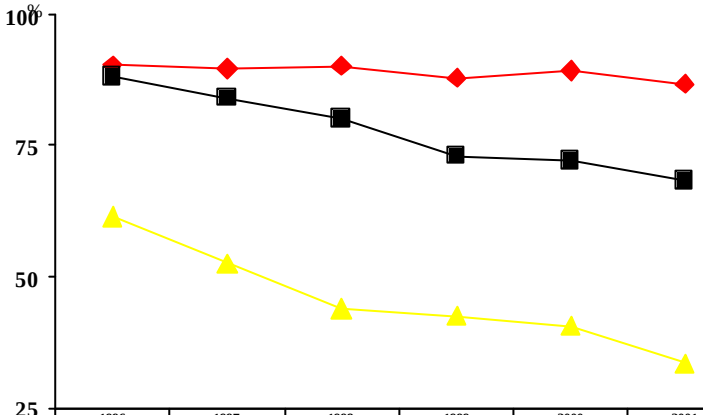
6.- TRENDS PER DRUG

a) Heroin/opiates

As mentioned, surveys do not allow us to obtain a clear picture of the prevalence and trends of opiate use in Spain, although we do have indicators describing the trends in the problems associated with the use of these drugs.

Heroin is still responsible for most of the problems related with drug use detected in Spain, although in the last years its importance has decreased. In 2001, 68.3% of admissions to treatment were caused by heroin, and the consumption of this substance was mentioned in 33,5% of the episodes by acute reaction to psychoactive substances. Also, in 86.8% of the RASUPSI deaths with toxicological analysis were detected opiates or their metabolites mainly due to heroin use (Figure 6.1).

Figure 6.1. Proportion of clients entering treatment, emergency episodes and deaths connected with heroin use. Spain, 1996-2001.



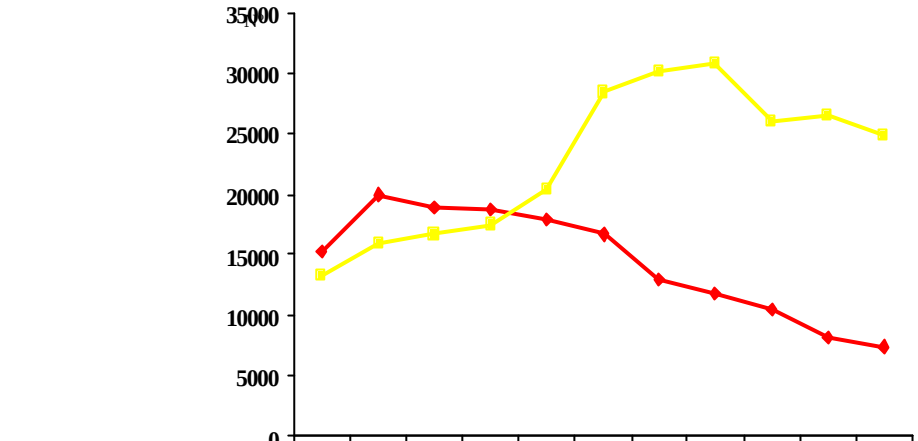
	1996	1997	1998	1999	2000	2001
Deaths (*)	90,4	89,8	90,1	88	89,4	86,8
Clients entering treatment (**))	88,2	84,1	80,2	73,1	72,2	68,3
Emergency episodes (***)	61,5	52,6	43,9	42,5	40,5	33,5

(*) Deaths in with detected heroin or its metabolites in the toxicological analysis.
(**) Clients entering treatment by abuse or dependence of heroin.
(***) Emergency episodes with mention of heroin.
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Treatment, Urgencies and Mortality Indicators

All the indicators show a decreasing trend with regards to the problems related with heroin use.

The number of admissions to treatment for heroin keeps decreasing. Since 1996 when the highest figure was registered, the number of treatments for heroin has decreased considerably (From 46635 in 1996 to 33702 in 2001). In this evolution, surely, it has probably some influence the expansion of maintenance treatments with methadone that take out of circulation many consumers that use to begin treatments repeatedly. If the cases with previous treatment are examined, it is observed that their number increased up to 1998, starting to descend from then. This descent continues in 2001, although it is very slow. On the other hand, the descent of the treatments for the first time in the life began in 1992 and it has been much faster (16647 in 1996 and 7461 in 2001) (Figure 6.2).

Figure 6.2. Evolution of the number of clients in treatment by abuse or dependence of heroin in Spain 1991-2001.

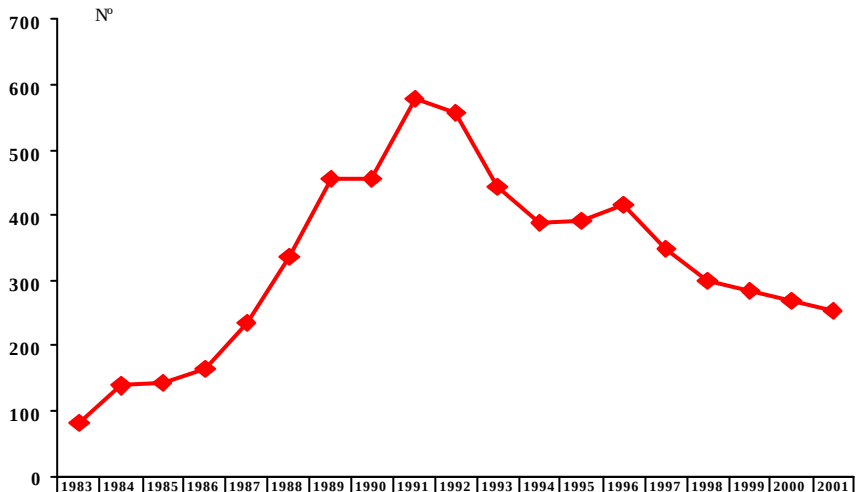


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Clients in treatment first time in life	15277	20017	18977	18770	17878	16647	12993	11867	10473	8151	7461
Clients with previous treatment	13296	15956	16703	17526	20369	28382	30173	30756	26031	26412	24844

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment

The number of deaths for acute reaction to opiates or cocaine in the six large cities (Barcelona, Bilbao, Madrid, Seville, Valencia and Zaragoza) showed a continuous increasing between 1983 and 1991, followed by a decrease, being 557 in 1992 and 252 in 2001 (Figure 6.3). The same trend can be seen in a group of 17 monitored areas from 1996 covering a population of 18.500.000 inhabitants (Figure 6.4). The proportion where opiates metabolites are found in these deaths (due to heroin's consumption) has decreased in a slight and continuous way since 1983 (Figure 6.1).

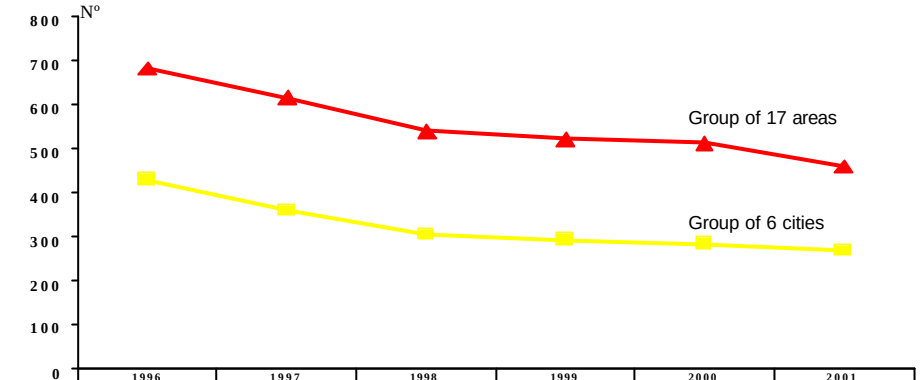
Figure 6.3. Evolution of the deaths for acute reaction after the use of opiate or cocaine in six large Spanish cities. 1983-2001.



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Six cities*	82	139	143	163	234	337	455	455	579	557	442	388	392	415	349	299	285	270	252

(*) The deaths correspond to the group of six cities (Barcelona, Bilbao, Madrid, Seville Valencia and Zaragoza).
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Mortality

Figure 6.4. Evolution of the deaths for acute reaction after the use of psychoactive substances in Spain. 1996-2001.



	1996	1997	1998	1999	2000	2001
Group of 6 cities	430	358	305	291	284	267
Area group	681	615	541	522	512	458

Group of 6 cities: Barcelona, Bilbao, Madrid, Seville, Valencia and Zaragoza.

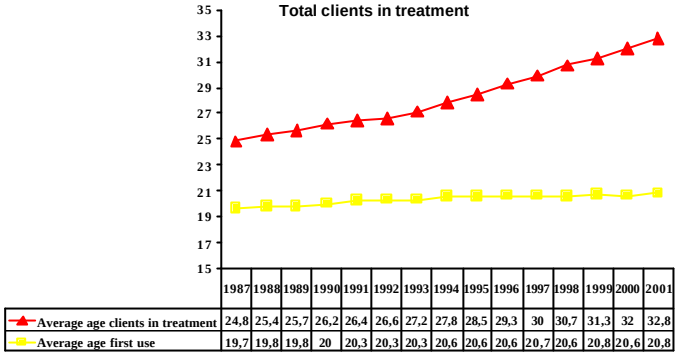
Area group: Galicia, Basque Country, Region of Murcia, Badajoz, Cáceres, Barcelona, Las Palmas de Gran Canaria, Granada, Málaga, Seville, Madrid, Palm of Mallorca, Pamplona, Ponferrada, Valladolid, Valencia and Zaragoza (18.500.000 of inhabitants).

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Mortality.

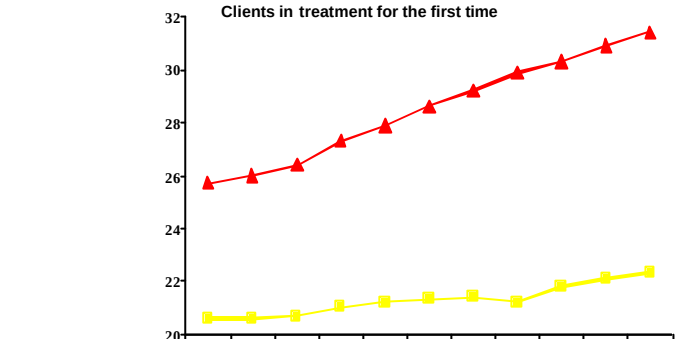
The proportion of emergency episodes for acute reaction to drugs where heroin use is mentioned has decreased, dropping from 61.5% in 1996 to 33.5% in 2001 (Figure 6.1). Heroin has been replaced by cocaine as the most mentioned drug in emergency episodes from 1999.

The average age of opiates consumers provided by the indicator treatment and the indicator mortality keeps rising (Figure 6.5 and 6.6). Also, from the beginning of the 90s the average age to start using heroin use, mainly among those clients entering treatment for this drug for the first time in their life, has increased progressively going from 20,6 years in 1991 to 22,3 in 2001 (Figure 6.5).

Figure 6.5. Evolution of the average age of clients entering treatment and of the average age of starting use among the clients in treatment for heroin in Spain, 1987-2001.



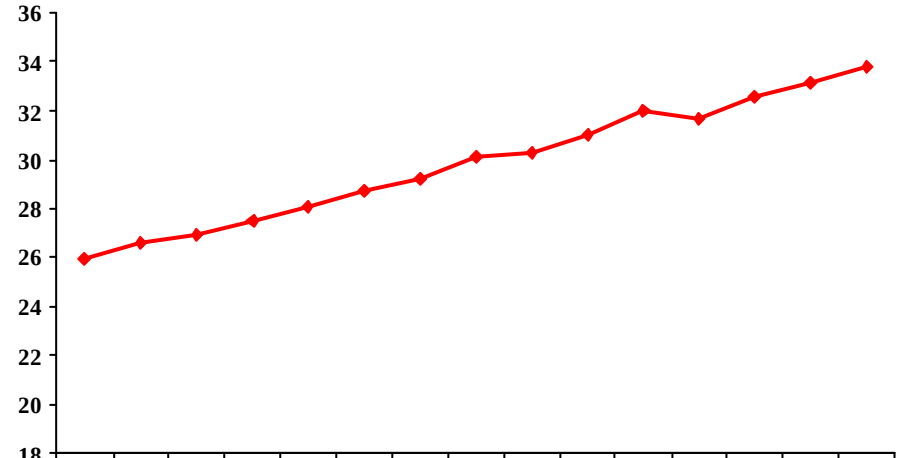
	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Average age clients in treatment	24,8	25,4	25,7	26,2	26,4	26,6	27,2	27,8	28,5	29,3	30	30,7	31,3	32	32,8
Average age first use	19,7	19,8	19,8	20	20,3	20,3	20,3	20,6	20,6	20,6	20,7	20,6	20,8	20,6	20,8



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Average age first treatment	25,7	26	26,4	27,3	27,9	28,6	29,2	29,9	30,3	30,9	31,4
Average age first use	20,6	20,6	20,7	21	21,2	21,3	21,4	21,2	21,8	22,1	22,3

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA)
Key Indicator Treatment.

Figure 6.6. Average age of deaths for acute reaction to drugs with detection of opiate or its metabolites. Spain, 1987-2001.



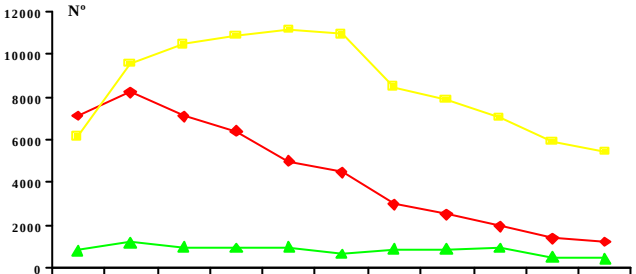
	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
	25,9	26,6	26,9	27,5	28,1	28,7	29,2	30,1	30,3	31	32	31,7	32,6	33,1	33,8

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Mortality

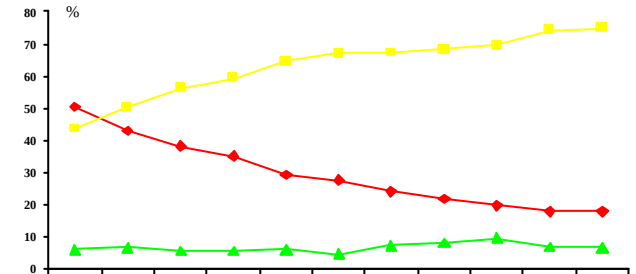
Since 1991, there has been an important decrease of the injecting administration route to consume heroin. In fact, the proportion of clients in treatment for heroin that consumes this drug mainly through injecting route passed from 74.7% in 1991 to 22.9% in 2001 among those previously treated, and from 50.3% to 17.5% among the clients treated for the first time in the life (Figure 6.7). In one decade, the number clients treated for injected heroine has reduced 5.6 times. The injecting administration route has been substituted mainly by the pulmonar route (smoked heroin) increasing from 43.4% in 1991 to 74.9% in 2001. The itemized analysis by Autonomous Community confirms this trend. In 1991 most of the Communities presented high proportion (>60%) injecting heroin use among the treated for the first time in the life, being only low this proportion in some Communities, as Canary Islands and Andalusia.

Between 1993 and 1995 a descent of the use of the injection took place in most of the Autonomous Communities, mainly in the south, and between 1997 and 2001 this decrease was stable. In 2001, eleven Communities were below 20% regarding the proportion of heroin use through injection, and three were only above 40%: Aragon (46,7%), Cantabria (42,2%) and Balearic Islands (40,5%) (Figure 6.8 and 6.9).

Figure 6.7. Distribution of the clients admitted to treatment for the first time in the life for abuse or dependence of heroin, according to the main administration route. (Absolute numbers and percentages) Spain, 1991-2001.



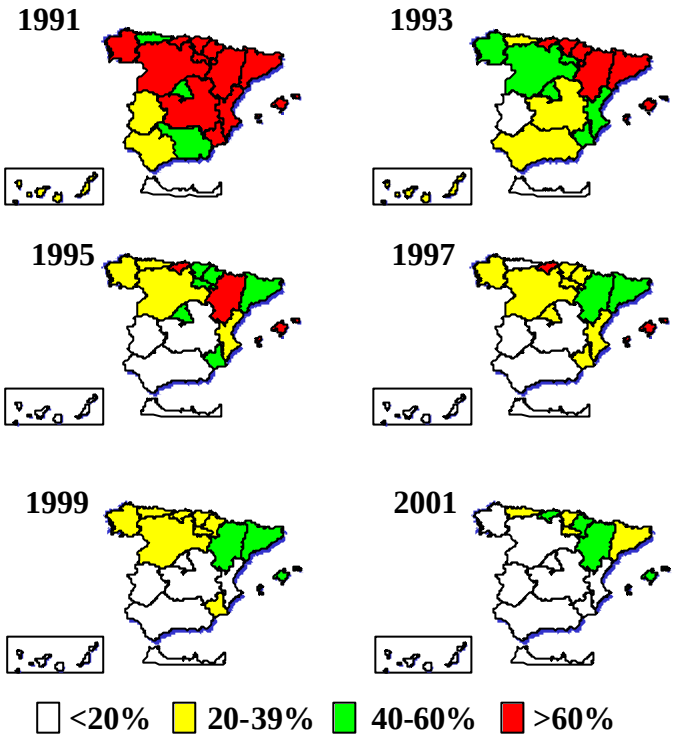
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Injected	7164	8232	7129	6435	5033	4488	3011	2518	1969	1414	1276
Lung	6188	9585	10493	10873	11161	10934	8487	7884	7033	5917	5461
Esnifada	822	1219	995	978	1028	696	887	910	968	532	471



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Injected	50,3	42,9	38,1	35	29,1	27,5	23,8	21,8	19,4	17,7	17,5
Lung	43,4	50	56,1	59,2	64,5	67	67,2	68,3	69,3	74,1	74,9
Esnifada	5,8	6,4	5,3	5,3	5,9	4,3	7	7,9	9,5	6,7	6,5

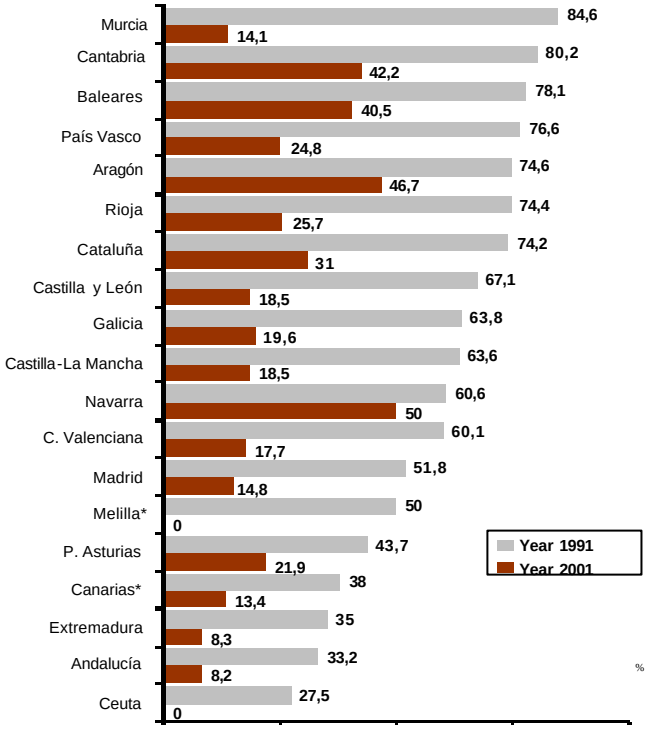
SOURCE: GDNPD. Spanish Montoring Centre for Drugs and Drug Addiction (SMCDDA).
Key Indicator Treatment.

Figure 6.8. Proportion of first treatment of clients admitted to heroin treatment for who injected this drug in Spain, 1991-2001.



SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

Figure 6.9. Proportion clients entering the first time in the life by abuse or dependence of heroin with parenteral route main administration. Spain, 1991-2001.

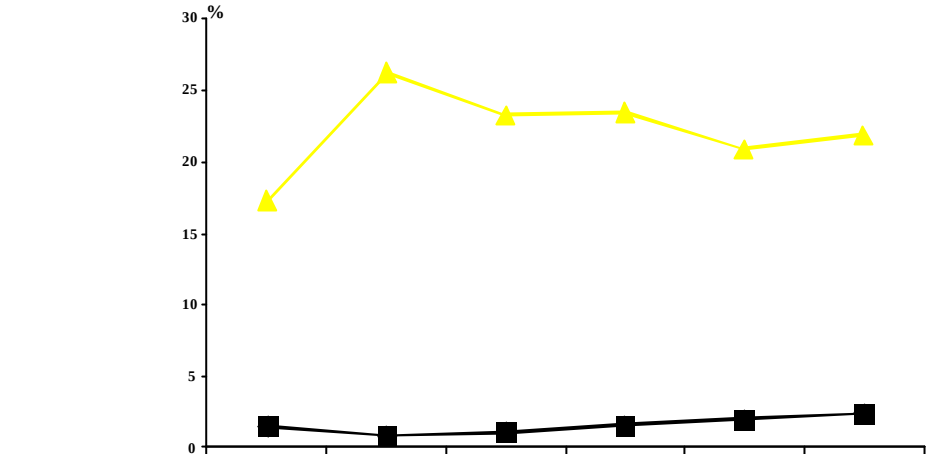


NOTICE: (*) In the CA of Canarias and in the city Melilla the data of 1992 are presented instead of those of 1991, well because in 1991 they were not picked up (Melilla) or because they were not comparable with the later years.
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCCDA). Key Indicator Treatment.

In 2001, the opiates different than heroin were the fourth group of substances as for number of treatments for drugs abuse or dependence. Of the 1186 admissions to treatment for these substances, 890 (75%) were due to methadone, and out of them, 731 corresponded to clients that had already been treated previously because of the same substance. It is possible that many of these admissions are related to heroin ex-consumers that began a maintenance treatment with methadone and now carry out a treatment to stop consuming this substance; so that, evolution of these treatments depends mainly on notifications, and the data should be interpreted cautiously. The second most mentioned opiate different than heroine as for the number of treatments was codeine and its derivates with 66 (5.6%). Other opiates frequently mentioned were: other specified opiates (1.1%), synthetic unspecified opiates (1.0%), buprenorfine (0.7%), fentanilo and similar (0.5%), and tramadol (0.5%).

Admissions to treatment due to these substances have increased since the indicator is operative, passing from 105 treatments in 1987 to 500 in 1996 and 1186 in 2001 (Figure 6.10). The increase has taken place mainly in the cases with previous treatment (Figure 6.11), what seems to confirm that this increase depends mainly on the notifications.

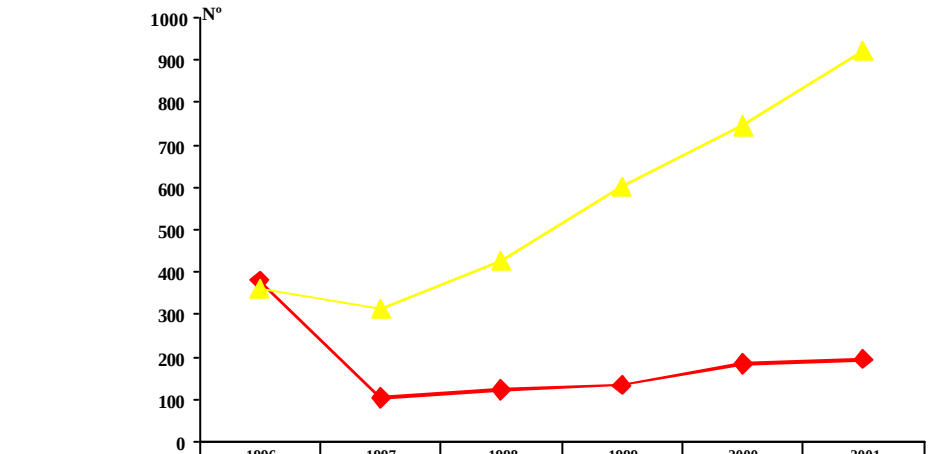
Figure 6.10. Evolution of the proportion of admissions to treatment and emergency services in connection with the use of other opiates different than heroin in Spain, 1996-2001.



	1996	1997	1998	1999	2000	2001
Clients admitted to treatment **	1,5	0,8	1,1	1,6	2	2,4
Emergency episodes ***	17,3	26,2	23,3	23,4	20,9	21,9

(**) Admitted to treatment by abuse or dependence of other opiate different than heroin.
(***) Emergency episodes with mention of other opiate different from the heroin.
SOURCE: GDNPD. Spanish Montoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment and Urgencies.

Figure 6.11. Admissions to treatment for abuse or dependence of other opiates different than heroin (absolute numbers). Spain, 1996-2001.



	1996	1997	1998	1999	2000	2001
Clients entering treatment first time in life	382	104	124	135	184	195
With previous treatment	363	314	429	601	745	923

(*) Makes reference to other opiate different than heroin.
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

The proportion of emergency episodes for acute reaction to drugs where opiates different than heroin are mentioned has passed from17.3% in 1996 to 26.2% in 1997, decreasing slightly after, being 21.9% in 2001 (Figure 6.10). The opiate different to heroin most mentioned in the clinical histories of emergency episodes was methadone.

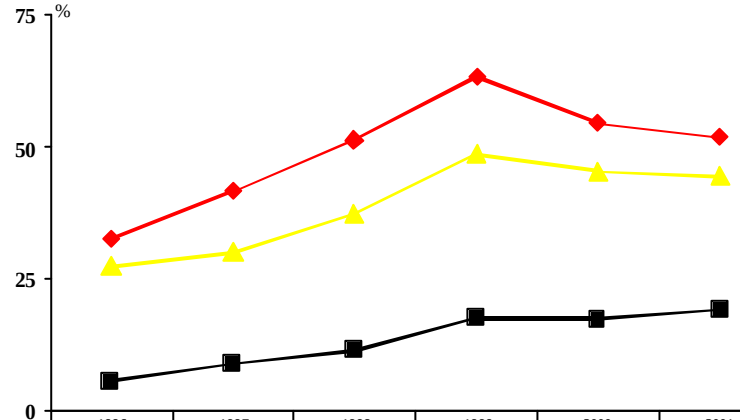
Lastly, available information about toxicological analysis of deaths for acute reaction to drugs doesn't allow separating the heroin metabolites from the metabolites of other opiates clearly.

b) Cocaine/crack

Surveys show an increase of the cocaine use prevalence in the general population (aged 15-64 years) and among 14-18 years-old students. Among 15-64 years-old population, prevalence consumption in the last 12 months increased from 1.5% in 1997 to 2,6% in 2001. On the other hand, among students aged 14-18 the prevalence was 1.7% in 1994, 2.6% in 1996, 4.1% in 1998, 4.0% in 2000, and 6.0% in 2002.

During the last years, an important proportion of the problems detected by the indicators are due to cocaine (Table 6.1). In 2001, 19% (9367) of the clients admitted to treatment were due to abuse or dependence of this substance, and in 44.4% of the episodes for acute reaction after the use of psychoactive substances cocaine was mentioned. Also, it was detected cocaine or their metabolites in 51.7% of the deaths RASUPSI with available toxicological analysis. These percentages, except in the case of the emergencies, are still quite smaller than those corresponding to heroin (Figure 6.12). In 2001, 39 deaths were registered (8.3%) in whose toxicological analysis cocaine and not opiates was detected. Out of them, in 21 (4.6%) cocaine exclusively was detected, in 5 only cocaine and alcohol, and in the rest cocaine and other combinations of drugs. The proportion of deaths where only cocaine was detected in 1983-89 was below a 1%.

Figure 6.12. Proportion of clients entering treatment, emergency episodes and deaths connected with cocaine use. Spain, 1996-2001.



	1996	1997	1998	1999	2000	2001
Deaths (*)	32,7	41,4	51,2	63,3	54,4	51,7
Clients admitted to treatment (**)	5,6	8,9	11,3	17,5	17,2	19
Emergency episodes (***)	27,4	30	37,2	48,7	45,3	44,4

(*) Deaths detected cocaine or its metabolites in the toxicological analysis.
(**) Admitted to treatment by abuse or dependence of cocaine.
(***) Emergency episodes with cocaine mention.
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment, Urgencies and Mortality.

Table 6.1 Treatment and emergency cases related to cocaine

	Year	%	Basis of calculation(n)
Treatment for abuse or dependency (% of treatments due to cocaine use)[a]	1996	5,6	52890
	1997	8,9	52440
	1998	11,3	54338
	1999	17,5	50279
	2000	17,2	49487
	2001	19,0	49376
Treatments for the first time in life for drug abuse or dependency (% of treatments due to cocaine use)[a]	1996	9,1	20855
	1997	16,7	18729
	1998	21,6	19341
	1999	30,9	19426
	2000	32,1	17135
	2001	34,0	17591
Emergency episodes due to acute reaction (% cases in which cocaine is mentioned)[b]	1996	27,4	2585
	1997	30,0	1933
	1998	37,9	2099
	1999	49,2	1743
	2000	45,3	2328
	2001	44,4	2145
[c]			
Deaths due to acute reaction (% cases in which cocaine is detected)	1996	26,6	349
	1997	37,6	255
	1998	56,4	236
	1999	60,9	281
	2000	53,0	251
	2001	54,1	246

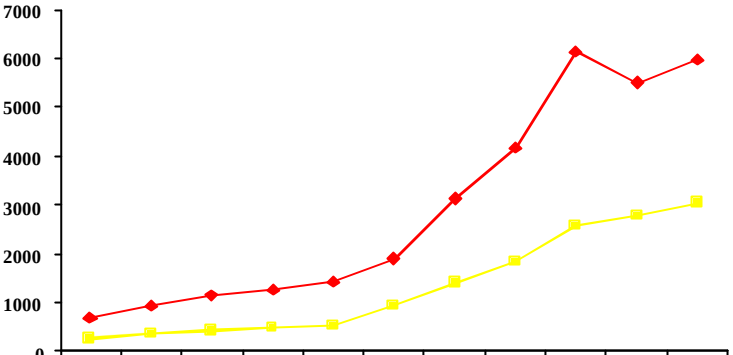
a: Admitted for treatment as a result of psychoactive substances abuse or dependency (Spain). Treatments repeated within the same year and the same region have been eliminated. Coverage is virtually total.
b: Emergency episodes resulting from acute reaction to psychoactive substances. Data gathered in the main hospital emergency services in various monitored areas.
c: Deaths as a result of acute reactions to psychoactive substances. Data gathered in five major cities (Madrid, Barcelona, Valencia, Seville and Bilbao) in which toxicological analysis are available.

SOURCE: Treatment, Emergencies and Mortality indicators from the National Plan on Drugs.

In 2000-2001, although problems related to cocaine have increased, the upward trend observed during the previous years in the three indicators has stopped.

The number of treatments for this drug increased between 1991and 1999, mainly starting from 1995. In the year 2000, however, certain decrease was noticed. In 2001 the number of treatments has increased again, but without exceeding the 1999 levels. It can be said, therefore that the increase of the treatments for cocaine slows down (Figure 6.12). If the cases without a previous treatment due to this drug are analysed, it is observed as well that the cases increased between 1991 and 1999, descended in 2000, and increased in 2001 again, reaching almost the 1999 levels (around 6000 admissions). On the other hand, the cases with previous treatment have continued increasing progressively from 1991, although in the last two years this increase slowed down (Figure 6.13).

Figure 6.13. Evolution of the number of clients in treatment for abuse or dependence of cocaine in Spain 1991-2001.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Clients in treatment first time in life	681	932	1146	1265	1415	1892	3129	4174	6126	5499	5977
Clients with previous treatment	262	367	431	491	516	932	1402	1838	2576	2773	3046

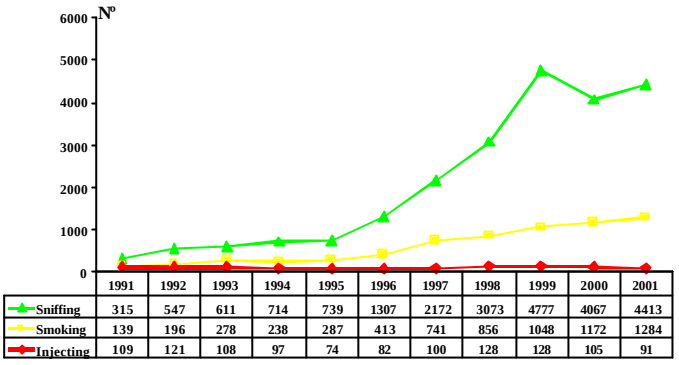
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

Between 1996 and 1999 there was an important increase of episodes for acute reaction to psychoactive substances in which clinical history cocaine is mentioned, passing from 26.1% in 1996 to 48.7% in 1999. In the last two years a certain decrease of the cocaine mentions has noticed (45.3% in 2000 and 44.4% in 2001) (Figure 6.12). Starting from 1999, cocaine is the drug more mentioned in emergency services by acute reaction to drugs, before heroin (Figure 6.13A). However, this change took place several years ago in cities such Madrid and Barcelona.

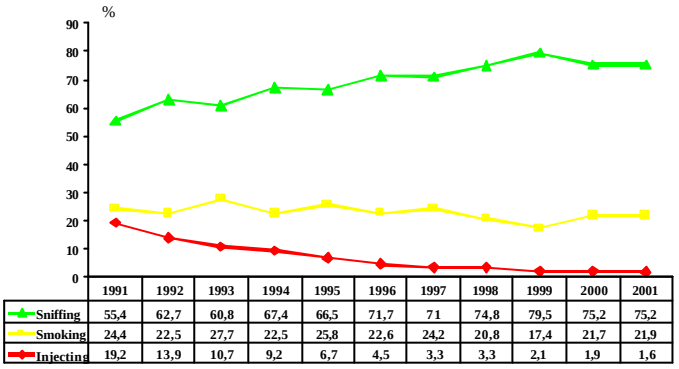
The proportion of deaths RASUPSI with detected cocaine or its metabolites has experienced a growing trend, especially starting from 1996; however, in the last two years it has also descended (Figure 6.12).

The gradual withdrawal of the parenteral administration route and their substitution for other routes is also taking place in treatments for cocaine. The proportion of clients in treatment for the first time that consumed cocaine mainly injected passed from 19,2% in 1991 to 1,6% in 2001 (Figure 6.14). The spectacular increase of the number of treatments for cocaine has been due mainly to the increasing number of consumers by intranasal route that went from 315 in 1991 to 4413 in 2001 (Figure 6.14).

Figure 6.14. Distribution of the clients in treatment for the first time in the life for abuse or dependence of cocaine according to the main road of administration. (Absolute numbers and percentages) Spain, 1991-2001.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Sniffing	315	547	611	714	739	1307	2172	3073	4777	4067	4413
Smoking	139	196	278	238	287	413	741	856	1048	1172	1284
Injecting	109	121	108	97	74	82	100	128	128	105	91



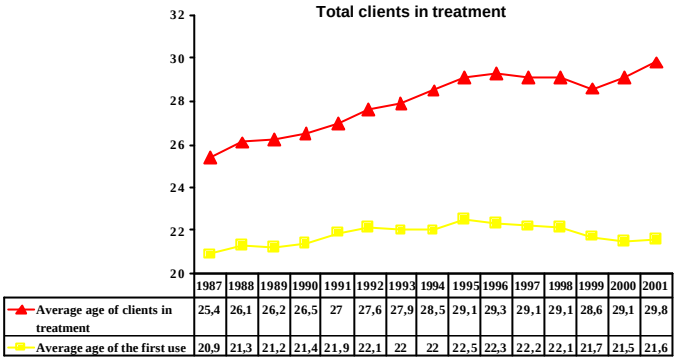
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Sniffing	55,4	62,7	60,8	67,4	66,5	71,7	71	74,8	79,5	75,2	75,2
Smoking	24,4	22,5	27,7	22,5	25,8	22,6	24,2	20,8	17,4	21,7	21,9
Injecting	19,2	13,9	10,7	9,2	6,7	4,5	3,3	3,3	2,1	1,9	1,6

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

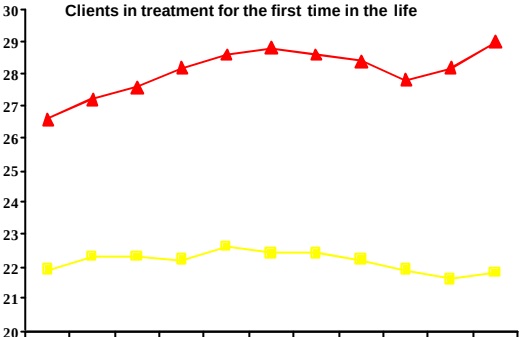
Between 1991 and 2001, the treatments for crack multiplied by 12.2 going from 188 to 2296 annual cases, and the proportion of emergency episodes by acute reaction to drugs with crack mention passed from 4.3% in 1991 to 12.3% in 2001. The same trends can be shown among clients in treatment for the first time in the life for cocaine (Figure 6.14). The increase of problems caused by crack would be hidden by the simultaneous increase of the problems by sniffing cocaine. Between 1991 and 2001, the clients in treatment for sniffing cocaine multiplied for 16, growing faster than the clients in treatment for crack. It is ignored how the increase of problems for crack is due to the influence of the heroin consumers or ex-consumers. Although the treatments for crack are followed mainly by clients that have not used heroin in the 30 previous days to the admission to treatment, it is not known if these people are methadone consumers or heroin ex-consumers. Anyway, a positive association has been observed among the proportion of treatments for crack in the different Autonomous Communities and the proportion of treatments for smoked heroin.

The average age of the clients in treatment for cocaine has increased again since 2000, after some years of stabilization or slight decrease. The same thing has happened with the average age to start in the consumption of the clients in treatment for cocaine (Figure 6.15). On the other hand, the average age of the deaths where cocaine is detected has increased in a progressive way in the last years (Figure 6.16).

Figure 6.15. Evolution of the average age of admission to treatment and the average age of the first use among the clients in treatment for cocaine in Spain, 1987-2001.



	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Average age of clients in treatment	25,4	26,1	26,2	26,5	27	27,6	27,9	28,5	29,1	29,3	29,1	29,1	28,6	29,1	29,8
Average age of the first use	20,9	21,3	21,2	21,4	21,9	22,1	22	22	22,5	22,3	22,2	22,1	21,7	21,5	21,6



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001
Average age of clients in treatment	26,6	27,2	27,6	28,2	28,6	28,8	28,6	28,4	27,8	28,2	29
Average age of the first use	21,9	22,3	22,3	22,2	22,6	22,4	22,4	22,2	21,9	21,6	21,8

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

Cocaine use among heroin users is also rising. According to the National Plan on Drug treatment indicator, the proportion of heroin users under treatment who had also taken cocaine in the month prior to treatment rose from 42.8% in 1987, 51.3% in 1991, 58.4% in 1996, 68.2% in 1998, 73.1% in 1999, 69.5% in 2000 to 71.9% in 2001.

c) Cannabis

Cannabis is the illegal substance most commonly used in Spain.

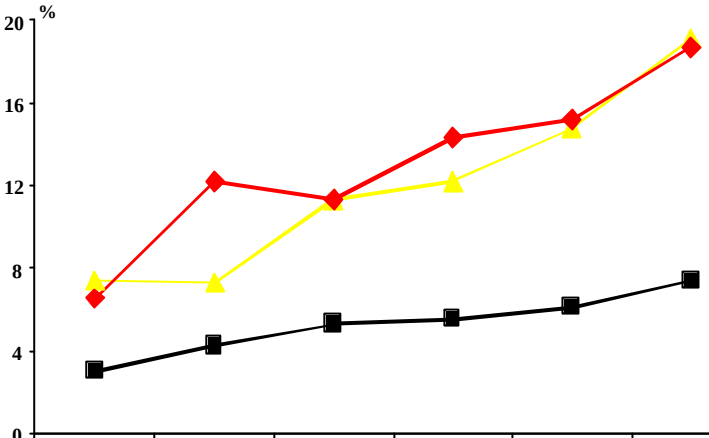
According to the 2001 General Population Survey on Drugs, 24.4% of the Spaniards aged between 15-64 had tried cannabis at least once in their lifetime (19.5 % in 1999 and 21.7% in 1997), 9.9% had tried it during the preceding year (6.8% in 1999 and 7.5% en 1997), and 6.5% in the preceding month (4.2% in 1999 y 4% in 1997). Also, daily consumption prevalence increased from 0.9% in 1997 to 1.6% in 2001.

In the School Survey on Drugs Use, targeted at students aged 14 to 18 years old, the prevalence of cannabis use in the preceding year rose from 18.1% in 1994 to 23.2% in 1996, 25.1% in 1998, 26.8% in 2000, and 32.4% in 2002. In parallel a drop has been observed in the negative attitudes towards the drug (perceived risk of consumption and disapproval of its use). The proportion of students that perceives enough or many problems before habitual cannabis consumption (weekly or more frequent) passed from 85.3% in 1994 to 75.5% in 2002. A certain increase of the consumption intensity is also appreciated. In 2002 the daily average of cannabis consumption (related to the

days with consumption) among 14-18 year-old students was 3.3 joints. This quantity increased in one unit ("joint") with respect to the year 2000.

Despite its widespread use, cannabis continues to have only limited –albeit growing– public health repercussions (Figure 6.16).

Figure 6.16. Evolution of the proportion of admissions to treatment, emergency services and mortality in connection with the cannabis use in Spain, 1996-2001.

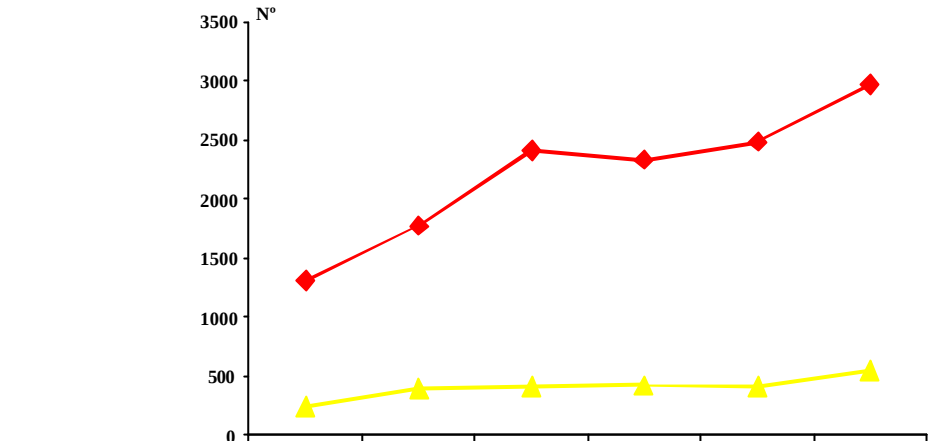


	1996	1997	1998	1999	2000	2001
Clients admitted to treatment (**)	3	4,2	5,3	5,5	6,1	7,4
Emergency episodes (***)	7,4	7,3	11,3	12,2	14,8	19,1
Deaths (*)	6,5	12,2	11,3	14,3	15,2	18,7

(*) Deaths with hipnosedatives or its metabolites detecting in the toxicological analysis.
(**) Clients admitted to treatment by abuse or hipnosedatives dependence.
(**) Emergency episodes with hipnosedatives mention.
SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment, Urgencies and Mortality.

During the last years the number of treatments for cannabis has increased, passing from 1613 in 1996 to 3674 in 2001 (multiplying by 2.3). In a parallel way, it has also increased the proportion of clients in treatment for cannabis considering the total number of treated for psychoactive substances, going up from 3% in 1996 to 7.4% in 2001 (Figure 6.17). The average age of the clients in treatment for cannabis abuse is relatively stable. However, a certain decrease of the average age of first use is detected (Figure 6.18).

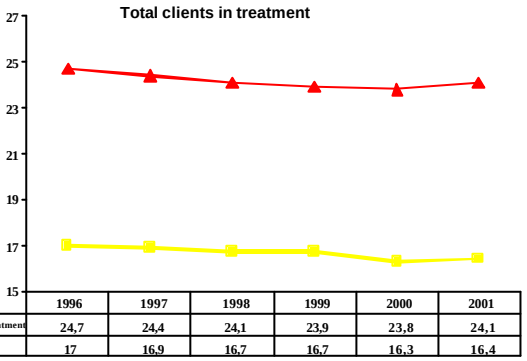
Figure 6.17. Admissions to treatment for abuse or cannabis dependence (absolute numbers). Spain, 1996-2001.



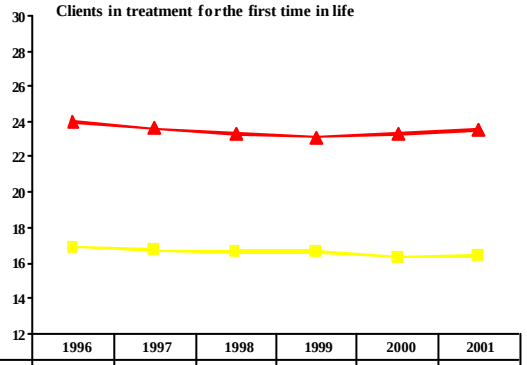
	1996	1997	1998	1999	2000	2001
Clients in treatment first time in life	1300	1768	2412	2335	2487	2966
Clients with previous treatment	230	387	407	418	408	540

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

Figure 6.18. Evolution of the average age of clients in treatment and of the average age of the first use among the clients in treatment for cannabis in Spain, 1996-2001.



	1996	1997	1998	1999	2000	2001
Average age of clients in treatment	24,7	24,4	24,1	23,9	23,8	24,1
Average age of the first use	17	16,9	16,7	16,7	16,3	16,4



	1996	1997	1998	1999	2000	2001
Average age of clients in treatment	24	23,6	23,3	23,1	23,3	23,5
Average age of the first use	16,9	16,7	16,6	16,6	16,3	16,4

SOURCE: GDNPD. Spanish Monitoring for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

The number of times that cannabis is mentioned in emergency episodes for acute drug reaction is also rising (7.4% in 1996 and 19.1% in 2001) (Figure 6.16). But it is difficult to determine the extent to which cannabis is responsible for the episodes as in most cases patients have probably also taken other drugs, particularly cocaine.

The proportion of deaths for acute reaction to drugs where cannabis is detected has also increased considerably, passing from 6.5% in 1996 to 18.7% in 2001 (Figure 6.16). Anyway, there are not evidences that this substance contributes to these deaths. In fact, in 2001 there was not any death of this type where cannabis was detected exclusively.

d) Synthetic drugs (Amphetamine, ecstasy, LSD, other/new)

Amphetamine and ecstasy

In the early eighties restrictions were imposed on the sale of medicines including amphetamines which were used to improve the intellectual performance or avoid fatigue, as a result its use decreased. However, in the late eighties the recreational use of amphetamines (generally in the form of amphetamine sulphate or dexamphetamine) and derivatives of methylenedioximethamphetamine (MDMA or ecstasy) sold on the underground market. Their use became widespread after 1992. Nowadays the use of amphetamines and ecstasy is currently increasing after a stabilisation or decline.

For Spaniards aged 15-64 years old, the annual prevalence of ecstasy use was 1.3% in 1995, 0.9% in 1997, 0.8% in 1999 and 1.8% in 2001. Of amphetamine/speed was 1.1% in 1995, 0.9% in 1997, 0.7% in 1999 and 1.2% in 2001.

No clear trend is shown among school student aged 14 to 18 for the prevalence of amphetamine/speed and ecstasy use. The prevalence of amphetamine/speed use in the previous year has gone from 3.3% in 1994 to 4.1% in 1996, 3.8% in 1998, 3.1% in 2000 and 3.7% in 2002; ecstasy use has gone from 3.0% in 1994, to 3.9% in 1996, 2.5% in 1998, 4.6% in 2000, and 4.1% in 2002.

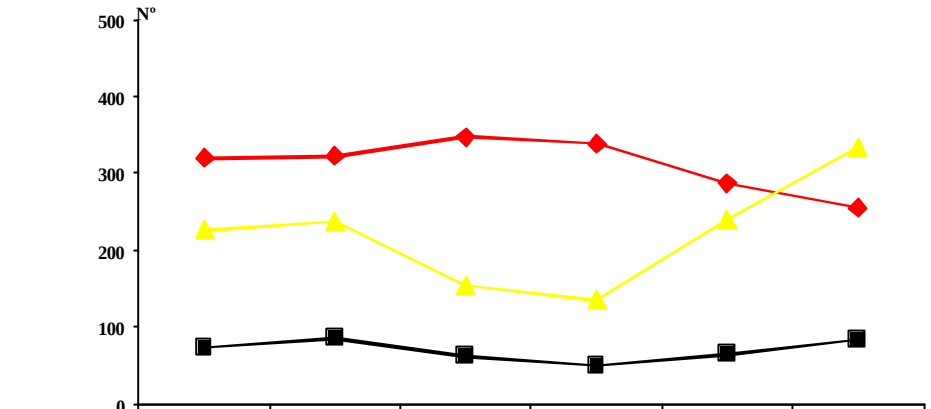
In Spain the impact of amphetamines, and ecstasy on public health is slight, in particular when it is compared with tobacco, alcohol, heroin or cocaine.

In 2001 ecstasy or amphetamines use was mentioned in less than 9.4% of the emergency episodes resulting from acute drug reactions, and in many cases in conjunction with other drugs such as alcohol, cocaine, cannabis or hallucinogens. As regards admissions for treatment in Spain, in 2001 amphetamines and ecstasy together accounted for just 1.2% of treatment for drug abuse/dependency (2.6% of first-time treatment). Lastly, they were found to be present in less than 4.9% of deaths from acute drug reactions, and in most cases they were found together with other drugs such as heroin, cocaine or alcohol. One of the more controversial issues is the role ecstasy and amphetamine consumption play in traffic accidents. There is some evidence that their role is slight. In this sense, a study carried out by the National Toxicological Institute in 2002, in 1441 died drivers in Spain due to traffic accidents, amphetamines were only found in 0.5% and ecstasy in 0.4%, in some cases together with other drugs, mainly alcohol and cocaine.

The evolution of the treatments for ecstasy or amphetamines abuse or dependence in the period 1996-2001 was uneven, with a trend to increase in the case of the ecstasy

(226 treatments in 1996 and 335 in 2001) and to descent in the case of the amphetamines (319 treatments in 1996, 347 in 1998 and 255 in 2001) (Figure 6.19).

Figure 6.19. Evolution of the number of clients in treatment for abuse or dependence of amphetamines, ecstasy and hallucinogens in Spain, 1996-2001.

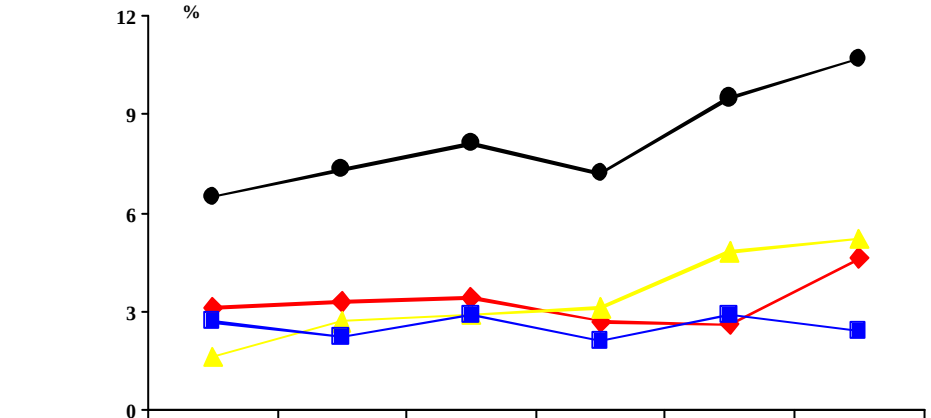


	1996	1997	1998	1999	2000	2001
Amphetamines	319	323	347	339	288	255
Ecstasy	226	237	154	135	240	335
Hallucinogens	74	85	62	50	64	83

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Treatment.

In the last years the proportion of emergencies episodes with ecstasy mention has increased (passing from 1.6% in 1996 to 5.2% in 2001) or with amphetamines (3.1% in 1996 and 4.6% in 2001) (Figure 6.20) In the same period the annual proportion of deaths by acute reaction to drugs with detection of MDMA or similar was located between 0% and 1.8%, and the proportion with amphetamines detection between 2% and 9%, but in none of the two cases a clear trend could be appreciated.

Figure 6.20. Evolution of the proportion of emergency episodes with mention of ecstasy, amphetamines or hallucinogens. Spain, 1996-2001.



	1996	1997	1998	1999	2000	2001
Amphetamines	3,1	3,3	3,4	2,7	2,6	4,6
Ecstasy	1,6	2,7	2,9	3,1	4,8	5,2
Hallucinogens	2,7	2,2	2,9	2,1	2,9	2,4
Anyone of three	6,5	7,3	8,1	7,2	9,5	10,7

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Key Indicator Urgencies.

LSD and other hallucinogens

In the last years the consumption of LSD and hallucinogens have descended or remained stable. Among the general population aged 15-64 years old, the LSD and other hallucinogens prevalence has remained relatively stable (0.9% in 1997, 0.6% in 1999, 0.7% in 2001). On the other hand, among students aged 14-18 years old has reduced (going from 4.0% in 1994 to 5.3% in 1996, 4.1% in 1998, 3.7% in 2000, and 3.1% in 2002).

In the last years the problems detected in Spain connected with hallucinogens use have remained relatively stable. In the period 1996-2001 the volume of treatments for hallucinogens stayed relatively constant, varying between 50 and 85 cases per year (Figure 6.19). In 2001 hallucinogens were mentioned in 2.4% of the emergency episodes by acute reaction to drugs and in no death for acute reaction to drugs. It is necessary to keep in mind that the effects of the LSD are mainly emotional and perceptive, so that the appearance of physical complications is very strange. Most of the detected problems are psycho-pathologic, generally psychotic crisis or panic attacks. In the period 1996-2001, the proportion of emergency episodes for acute reaction to drugs with mention of hallucinogens remained stable, between 2% and 3% (Figure 6.20).

GHB and ketamine

The evolution of the use of these substances is not so known because up to now the General Population School Surveys on Drugs do not individualized them.

In Barcelona there were 104 cases of intoxication attributed to the GHB seen in a period of 15 months in the emergency services (3,1% of all the toxicological emergencies seen). Besides GHB, the great majority had consumed ethanol (73%) and other drugs of illegal trade (86%), mainly amphetamines, cocaine, cannabis and ketamine. They generally went to urgencies during weekends (90%) and early mornings. The main sign in all the cases was the decrease of the level of conscience (16% arrived in deep non-reactive coma with a punctuation of 3 in the scale of Glasgow). All recovered soon, completely and without apparent sequels. On the other hand, in 2001 the indicator urgencies of the Spanish Monitoring Centre of Drugs registered 28 urgencies with mention of GHB, all them in the city of Barcelona, and 5 with mention of ketamine (0,2%).

7. DISCUSSION

7.1. Consistency between indicators

All drug related indicators (treatment demand for abuse/dependency, emergencies and mortality directly linked to drug use) provide highly consistent trends. In fact, in section 6 (trends per drug) the following ideas are highlighted:

- The decrease on heroin problems and the increase of those due to cocaine are clearly detected by all three indicators.
- The three indicators detect the decrease in the use of parenteral administration route for heroin and cocaine and the parallel increase of the smoking route to consume these dugs.
- Likewise the three indicators show an increase of the problems related to hipnosedatives and cannabis use, although according to the mortality indicator the cannabis increase could be more related to polidrug use than to a relevant cannabis presence in deaths.
- Regarding the problems related to ecstasy or amphetamines use, the situation is not so clear, although both indicators treatment and emergencies show a slight increasing trend of the problems related to ecstasy use.

Results showed by the General Population Survey and the School Survey are compatible with the evolution of supply indicators. Both surveys show a clear increase of cocaine and cannabis use, which fits the increase on the number of seizures and on the quantities seized of these substances. Moreover, the apparent decrease of heroin use in the surveys (despite they are not a very useful tool for this purpose) fits the decreasing trend in the number of seizures and amount of heroin seized.

Also there is a high level of consistency between the evolution of the use prevalence for different drugs and the evolution of drug related problems. But in this case it might be a coincidence because situations with a high drug use prevalence can be compatible with low levels of drug related problems (due to use and starting problems are out of phase, low problematic patterns of use or another factors).

7.2. Methodological limitations and data quality

Several authors have described the restrictions of the General Population Survey and School Survey to measure drug use prevalence. It is considered that they can underestimate use prevalence. Nevertheless, the fact that the questions on drug use in the Spanish surveys are made through a self-administered questionnaire can contribute to reduce this problem. Moreover, the size of the sample in both surveys allows obtaining precise prevalence estimations at national level (narrow interval of confidence). Finally, questionnaires show some limitations that may be corrected in the future. For example, there are no individual questions about hypnotic or sedatives use with medical prescription or about GBH or ketamine use.

Regarding the treatment demand indicator coverage is general and the validity of information is high. However there are some problems: for example it is possible to have problems in classifying the administration route as pulmonary or intranasal when the term “to inhale” appears which is ambiguous regarding the way of how the substance is absorbed (nasal mucus or broncho-pulmonary mucus). Nevertheless, some changes introduced in 2003 in the information collection record will reduce this problem. Besides, comparison among Autonomous Communities using the rate of

clients entering treatment in 100.000 inhabitants is still very problematic because there are still disagreements in applying the selection criteria among Autonomous Communities.

Regarding the mortality indicator, the Mortality Specific Registry based on forensics and toxicology laboratories shows high quality data that is very useful to measure temporal trends, geographic differences and characteristics of the deaths directly linked to drug use. The main problem is that these data just refer to the half population of the country. The Mortality General Registry is still underestimating mortality directly linked to drugs and in a different grade depending on the geographical area. However, the underestimation index of this Registry for these deaths has been calculated recently and also it has been possible to make estimations on the number of deaths per year due to acute reaction to drugs in Spain. In the future, efforts will be made in order to improve coding of deaths related to drugs in the General Registry.

Also, in Barcelona there is a wide cohort of opiates users to study mortality. The results provided are of a high quality and consistent with the evolution of the number of deaths directly linked to drugs. Cohorts in other geographical areas and new cocaine users cohorts will be tried to establish.

Regarding the emergencies indicator there are more restrictions. This indicator can be used as alert system of emergent problems related to drug use. However, except in the city of Barcelona, information is collected with some delay and it is not referred to the whole period (it is only collected one week per month), so that the information is devalued. Besides, the instability of the coverage prevents the use of absolute figures as an indicator of drugs problems evolution, except in determined areas. However it is possible to use proportions in order to study trends of features of these problems. Finally, until 2003 when a new definition was introduced, it was very difficult for information collectors to decide whether some cases were related to drug use.

PART 3

DEMAND REDUCTION INTERVENTIONS

8.- STRATEGIES IN DEMAND REDUCTION AT NATIONAL LEVEL

8.1. Major strategies and activities

The main strategy carried out in Spain during 2002 has been on the fulfillment of objectives and goals mentioned in the National Strategy on Drugs 2000-2008.

In this framework, prevention activities are considered the cornerstone in demand reduction area especially the promotion and implementation of prevention programmes in the school and the family as well as some prevention programmes developed in recreational places.

In this context, some Regional Strategy on Drugs have been approved (Andalucia, Cantabria) taking as a reference the National Strategy on Drugs that shows the prevention as a main area of intervention.

Regarding school programmes, it is important to highlight in 2002 the campaign "Sinesio" that has widespread in order to sensitise the school community about the importance to develop prevention programmes besides to inform about the resources to carry them out.

There are also several prevention programmes regularly applied at schools in Spain whose results have been evaluated on 2002 such as "The adventure of Life" and "Ordago".

Finally, prevention in recreational setting is been well developed with two types of programmes: alternative leisure programmes supported by the GDNPD and the Autonomous Communities and harm reduction programmes such as pill testing programmes developed by some NGO that are working at the same time in issuing guidelines for recreational settings that assure leisure quality.

8.2. Approaches and new developments

During 2002, some programmes directed to young people in general have started such as information programmes focused on information about drugs and alternative leisure made through web pages (www.sindrogas.es; www.osasunekintza.org).

Within investigation and training priorities determined in the National Strategy on Drugs the National Institute of Research and Training on Drugs started working as a member of the GDNPD.

In fact, on October 2002, took place the First Conference of the National Institute on Drugs Research and Training, where 30 participants were involved.

The Institute acts as an instrument of promoting and improving the quality of the programmes in this matter.

9.- PREVENTION

Since the approval of the National Drugs Strategy, some Autonomous Communities have elaborated their own Action Plans taking as reference the mentioned National Strategy. In 2002, the II Plan on Drugs 2002-2007 of Andalucia and the Regional Strategy on Drugs 2002-2004 of Cantabria were approved. In both cases prevention is showed as a main area of intervention, in the case of Andalucia, focusing especially on new use patterns.

At national level it has been renewed the Collaboration Agreement among the Ministry of Education and Culture, Health and Consumption and National Plan on Drugs for the promotion of the Health in the School. During 2002 the main activities were:

- The transfer of the program "Building Health" ("Construyendo Salud") to the following Autonomous Communities: Balearic, Murcia, Castilla-Leon and Cantabria has been completed. Coordinators of this program have been trained in these Autonomous Communities.

- The training program is provided on-line through the Ministry of Education and Culture network; it is scheduled to finish in 2003.

- REEPS: For the first time the official announcement is made through the following Autonomous Communities: Catalonia, Navarre, Valencia, Aragon and Asturias. A total of 86 centres have been included in the network. A Spanish centre of this network has been involved in the European project "Young Mind", focused on the prevention of alcohol use through Internet (Finland, Sweden and Spain).

At Autonomous level the collaboration with other Institutions is usual, especially in the school prevention where coordination structures already exist in most of the Autonomous Communities. It is also frequent the coordination with Youth Services, Social Affairs, trade unions and employer organizations to start specific programmes directed to the different areas: community, labour, school...

The budget assigned to prevention in 2002 was 29.659.766€ (amount related to 14 Autonomous Communities and Cities of a total of 19). 18.2% of the global drugs budget is assigned to prevention, which implies a 3% increase with respect to the year 2001.

9.1. School programmes

The implementation continues through structured programmes that include training teaching staff and educational materials to apply in the classroom. In many cases these programmes are applied in the tutorship sessions.

The collaboration between the Drugs and Education Departments is still strengthening as well as the efforts to generalize, systematize and homologate the school programmes. In this way, five Autonomous Communities report about control systems of prevention school programmes, and four of them about Joint Committees Education-Drugs to control the programmes implemented in the schools. It is necessary to emphasize the starting of an official system to confirm and to homologate training prevention programmes run by the Plan of Drugs and the Education Department of Castile-Leon that it is used as a quality filter for programmes.

13 Autonomous Communities have reported information, these programmes coverage is wider than the 2001 one, reaching 593.751 students that shows an important effort of the Autonomous Communities to achieve the goals of the National Strategy.

Regarding spreading strategies of the school prevention, the Government Delegation for the National Plan on Drugs has started twice the School Prevention Campaign "Sinesio". During 2002, the campaign reached 525 schools and 51.509 participants. Its objective is to sensitise the scholar community about the importance to develop prevention programmes besides to inform about the resources to carry them out. Brochures that bring together all school programmes had carried out by 5 Autonomous Communities.

Several prevention programmes have been applying regularly in Spain at schools. Two of most spread are "The adventure of life" and "Ordago".

A high spreading means a previous checking of the program results; for this reason, the NGO responsible of the two programmes has made an effort to evaluate not only the process, as it was made previously, but also the results, that will be available on 2003.

Results evaluation of the school program "The Adventure of the Life"

During the academic year 2001-2002, this program was evaluated for the third time since 1989 when it was started in the Basque Autonomous Community.

This evaluation was carried out simultaneously in Basque Country and nine of the Latin American countries where the Program has been implemented.

The evaluation design is the following one: Post-test evaluation with non equivalent control group and survey with a self-completed questionnaire by the Treatment Group and the Control Group after the program implementation to the first one during three consecutive years. Besides, an intentional sample of educators implied in the development of the programmes is interviewed.

Results evaluation of the school program "Ordago"

All centres, educators and students that participate in the Program "Ordago" in the Autonomous Community of Valencia during the year 2001/2002 form the sample studied in the evaluation. So, there are 815 education centres, 5.783 educators and 142.773 students implied. In order to choose both sample, the criteria has been as follows:

a) Survey directed to educators:
A survey was made to the educators through a self completed questionnaire carried out by a representative sample, stratified according criteria as: province, public/private joining of the centre, cycle and course, etc. The questionnaire is formed by 50 items that collect variables related to the considered objectives.

The questionnaire has been shared in three parts:

- Identification data: municipality, type of centre, age, sex, etc.
- Educational and prevention function: educators' attitudes.
- Program dynamism.

b) Survey directed to the students:
In order to know the students experience, the chosen method has been as well the self-completed questionnaire by a representative sample of the students, stratified according to the same criteria than the educators. The questionnaire directed to the students is formed by 22 items regarding their perception of dynamics and the program "Ordago" effectiveness.

Results will be available in 2003.

9.2. Youth programmes outside school

All those programmes targeted at young people are implemented outside the schools for instance at leisure places. According to this definition the leisure spaces programmes would be included here, although they will be explained in the specific section for these programmes.

These programmes have different objectives, activities and elements, targeted population, application methods etc.

Perhaps the main difference is found depending on the targeted group: they can be targeted at young people in general o to especially vulnerable groups. Their have various objectives and most of the times appear combined: to provide information on drugs, social sensitisation, to reduce risks associated to use, to promote alternative activities, to encourage integration and participation in the community, to promote the development of activities and personal resources.

Programmes directed to young people at risk:

The activity in this field seems to be particularly wider than the activity collected through several information systems (cards SMCDDA, idea prevention, EDDRA). During 2002, the Government Delegation for the National Plan on Drugs supported a research on prevention programmes for young people at risk in Spain. 41 programmes have been collected: 19 selective, 4 indicated and 14 mixed.

In EDDRA, during 2002, 4 programmes directed to young people at risk were included. The selection was made from 18 programmes included in the database of Idea Prevention. They are as follows:

- Program for Immigrant young people "Paco Natera".
- Hirsuta. Preventive program in support of teenagers and their families.
- Program of socio-labour activities for drug use prevention. Norte Joven
- Sport program of children and young immigrants' integration. Ambits-Esport.

Programmes directed to young people in general:

Despite that there are many different initiatives, here two are focused on:

- Youth clubs and associations: they follow objective to promote the youth participation and the association, to prevent social exclusion, to promote a healthy leisure activities with education activities. An example of this program is "Community School of Health" of the Autonomous Community Castilla-La Mancha.

- Sensitisation and information programmes focused on information about drugs which is made through different methods: web pages such as http://www.sindrogas.es; http://www.osasunekintza.org), travelling expositions such as "de que van las drogas de que van los jóvenes", radio programmes, contests, etc.

9.3. Family and childhood

Regarding family and first childhood prevention, there are no changes from last years. Policy makers still define the family as a basic environment for prevention but programmes spreading have many difficulties. Parents workshops are the most spread way and there are many supporting materials to develop them (program VALER, prevention of drug use in the family ambit (NGO Fundación de Ayuda a la Drogadicción- FAD), program Protego, etc).

There is no new information regarding family programmes different than the one collected in the previous report.

As regards to research projects and evaluation results during 2002 there were efforts to improve the quality of the programmes. The Government Delegation for the National Plan on Drugs supported the research and later the publication of "Familiar intervention in the prevention of drug dependencies", as well as the Guide to evaluate the familiar prevention programmes, written by the same authors.

It has been carried out the evaluation of the families' section of the program "Building Health" that is been applied in Spain since the year 2000 as a complement of the same school program. The evaluation results are collected in EDDRA questionnaire because this program is going to be included in the database soon.

As regard to research projects directed to evaluate the results of the Familiar prevention programmes, the National Institute on Drugs Research and Training (INIFD) has supported the project "Family training for the prevention of drug addictions. Introduction and results" of the Autonomous University of Barcelona.

9.4. Prevention in recreational settings

The National Strategy on Drugs mentions as a priority the prevention at recreational settings. This is also showed in different Autonomous Plans on Drugs. There are two types of program:

- Alternative leisure programmes that suggest leisure activities for weekends (daytime and nigh time).
- Harm reduction programmes in recreational settings.

Alternative leisure programmes: This is getting more and more developed work line in Spain, supported by the Autonomous Communities and the Government Delegation for the National Plan on Drugs.

In the official announcement to support alternative leisure projects in municipalities belonging to FEMP (Federación Española de Municipios y Provincias) 27 projects have been supported during 2002 with an amount of 1.500.000€.

These types of programmes are promoted in all Autonomous Communities.

Besides sector Drugs, the Ministry of Social Affairs start for the period 2000-2002 the program “nets for free time” that support alternative leisure programmes directed to young people focusing on information, communitarian dynamism, youth participation and harm reduction associated to drugs use.

Harm reduction programmes in recreational settings

Pill testing: there is no a specific regulation regarding this issue. In Spain, the consumption is not punishable by Law but the consumption in the public spaces can lead to an administrative penalty.

The only legal measures that can be applied to nigh time places are the risk prevention measures that take into account basic heath aspects (capacity, noise, heath conditions...)

However there is a certain agreement between professionals regarding some items that assure the leisure quality:

- Training for people in charge to sell alcoholic drinks in order to get a responsible sale.
- Training for security staff.
- Elaboration of behaves protocols in view of emergencies.
- Security measures at the leisure places

There are some NGO working in guidelines for recreational setting such as Energy Control and Controla Club which results have been published in 2003.

10.- REDUCTION OF DRUG RELATED HARM

The National Strategy on Drugs, 2000-2008, foresees the implementation of interventions directed towards the reduction of drug-related harm on drug users, third parties and the society as a whole. These measures are provided throughout the country with special attention to those areas where the negative effects of the consumption of drugs are more evident.

The Strategy refers to some objectives identified in the field of harm reduction to be achieved by the year 2003 with the co-operation of the Central Government and the Autonomous and Municipal Plans on drugs. In this sense, all Public Administrations have been working together during the last years since the National Strategy was approved.

These objectives are the following:

- To ensure that most of the drug dependent population has access to harm reduction programmes.
- To start up harm reduction programmes associated with drug consumption, particularly syringe exchange programmes, safe sex and consumption with less risk.
- To establish strategies from the Autonomous Plans on Drugs and AIDS and the Official Pharmaceutical Association in order to develop harm reduction programmes in the pharmacy offices.
- To carry out programmes for the introduction of systematic vaccination to drug addicts population related to tetanus, hepatitis B as well as antitubercular quimo-prophylaxis. Whenever possible, these programmes would be extended to families.
- To introduce health education programmes aimed at reducing the harm caused by the consumption of alcohol, tobacco and other drugs among the general population. In particular harm reduction programmes associated to the consumption of alcohol connected with traffic accidents and violence are carried out.
- To improve the quality of the treatment programmes with agonist implemented in the assistant network belonging to the National Health System.
- To diversify the harm reduction programmes available in the prisons using different initiatives such as extending syringe exchange programmes.

Harm reduction programmes have been expanded during the last years in terms of the interventions offered and its geographical coverage.

The Government Delegation for the National Plan on Drugs, in accordance with the decision taken by the Inter-autonomic Commission (a co-operation mechanism that involves the Central Government and the Autonomous Communities and Cities) has set up a Technical Committee on harm reduction, that has met three times up to now.

It was suggested that the Committee would focus on the elaboration of recommendations of good practices in the field of harm reduction. During the meetings, the Committee members focus on priorities, new trends and harm reduction and future perspectives.

Harm reduction programmes focus on injecting drug users in order to prevent the transmission of diseases. In Spain exposure to infected blood linked to needle sharing is the main cause for the transmission of HIV.

The staff working in harm reduction programmes have different professional backgrounds, according to a multidisciplinary approach. They are doctors, nurses, psychologists, social workers…The number of people working in these programmes has not been quantified.

These programmes are basically mobile units (buses or vans with qualified staff that provide services to drug users in those place where they meet) and social emergency centres to where drug users go to seek these services.

10.1. Description of interventions

Data included below (related to 2002) come from the information provided by 15 out of 19 Autonomous Communities and Cities.

Out reach work in recreational settings

Prevention of infectious diseases is an important element. Injecting drug users tend to modify their risk conducts that can lead to the transmission of AIDS and other blood borne diseases if they are provided with information and advice as well as with the instruments needed to develop more hygienic behaviours. Therefore, in Spain those interventions aimed at reaching massively injecting drug users are promoted in order to make them change their risky practices towards their health and that of others.

Harm reduction programmes provide information and advice to promote low risk behaviour and help towards their own care.

Table 10.1.1. Harm reduction programmes

Resources	Number of interventions	Users
Social emergency centres	20	14.665
Mobile units	33	8.295
Pharmacies	492	1.526
Other	123	9.830

These programmes include socio-sanitary services that offer preventive-educational interventions, sterile material, emergency care and assistance to a target population build upon injecting drug users who do not enter into the assistance circuits.

Syringe exchange programmes also have to be mentioned.

Table 10.1.2. Syringe exchange programmes

Location	nº	Users	Activities
Social emergency centres	12	4.539	257.834
Mobile units	26	2.206	1.676.500
Pharmacies	831	47	339.876
Other	207	9.025	2.208.351
TOTAL	**1.076**	**15.817**	**4.482.561**

Prevention of drug related overdoses

Users Rooms / Safe Injection Rooms

The safe injection rooms which implementation is known by the EMCDDA are still in action.

10.2. Standards and evaluations

Nothing to report in addition to information provided in previous years.

11.- TREATMENT

11.1 "Drug-free" treatment and health care at national level

The objectives and definitions of these programmes have already been provided in previous reports. Nevertheless it can be mentioned that drug-free treatment refer to those programmes that seek abstinence and provide multidisciplinary assistance co-ordinating several strategies.

Admission to treatment is free, provided that the clients enter treatment on voluntary basis.

Organisation and delivery of drug-free treatment services is done by the Autonomous Communities and Cities although some co-ordination criteria are established.

The geographical distribution of drug-free programmes is included below.

Table 11.1.1. Geographical distribution of drug free programmes

Autonomous Communities and Cities	Outpatient centres		Hospital units		Therapeutic communities	
	Nº centres	Nº users	Nº centres	Nº users	Nº centres	Nº users
Andalucía	109	11.152	3	453	17	1.122
Aragón	26	1.091	1	127	2	141
Asturias	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Baleares	n.a.	n.a.	n.a.	n.a	n.a.	n.a.
Canarias	30	9.307	2	370	4	477
Cantabria	3	373	1	26	1	46
Castilla-La Mancha	9	1.126	6	96	16	355
Castilla y León	51	1.297	3	230	9	796
Cataluña	53	5.901	10	772	14	468
Extremadura	15	1.147	1	53	6	245
Galicia	38	3.106	5	393	4	438
Madrid	31	8.903	3	328	12	763
Murcia	9	1.068	1	48	2	78
Navarra	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
País Vasco	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
La Rioja	6	386	1	38	1	25
Valencia	56	8.244	5	472	8	229
Ceuta	1	144	0	23	0	2
Melilla	1	57	0	0	0	0
TOTAL	**438**	**54.138**	**42**	**3.649**	**96**	**5.185**

n.a. = not available

Table 11.1.2. Drug free programmes

	Nº of devices and centres		Nº of places		Nº of users (non alcoholic)
Outpatient centres	438				54.138
Detoxification hospital units	42		164		3.649
Therapeutic communities	Public	Private with public funding	Public	Private with public funding	5.185
	29	67	847	1.807	
	TOTAL 96		**TOTAL 2.654**		

11.2 Substitution and maintenance programmes

As already mentioned in previous national reports, these programmes are regulated in the Royal Decree 75/1990, of January 19, amended by the Royal Decree of 5/1996, of January 15.

For inclusion in the treatment programmes it is requested an opiate dependence diagnostic instead of having undergone another treatment modality or suffering from a serious health problem or being HIV infected.

The geographical distribution of methadone maintenance programmes is included below (Table 11.2.1).

Table 11.2.1. Prescribing and/or dispensing methadone devices

CCAA	Nº centres	Nº users
Andalucía	623	19.834
Aragón	81	2.343
Asturias	n.a.	n.a.
Baleares	n.a.	n.a.
Canarias	24	7.311
Cantabria	15	1.250
Castilla-La Mancha	219	2.850
Castilla y León	58	4.907
Cataluña	248	8.949
Extremadura	25	1.986
Galicia	22	12.304
Madrid	39	9.267
Murcia	31	3.104
Navarra	n.a.	n.a.
País Vasco	n.a.	n.a.
La Rioja	4	494
Valencia	78	6.654
Ceuta	3	464
Melilla	1	216
Total	**1.471**	**78.882**

n.a. = not available

Table 11.2.2. Treatment programmes with opiate antagonists

		Nº of programmes	Nº of users
Methadone programmes	Prescribing programmes	168	78.882
	Dispensing programmes	1.037	
	Prescribing and dispensing programmes	266	
	TOTAL	1.471	
Buprenorphine programmes		1	

11.3. After-care and re-integration

Data collected for 2002 include data of 12 Autonomous Communities and 2 Autonomous Cities (Table 11.3.1).

It is observed an increase in data related to training and employment programmes, although data of 2002 and 2001 are not totally comparable. (To be noted that 5 Autonomous Communities have not provided data for 2002).

The number of training programmes' users in 2002 (14.260) is equal to that in all Autonomous Communities in 2001. There is also a development in training aimed to prepare employment searching (9266 students) and training courses in professional activities.

The number of drug users (4500) who obtained a job through the different employment programmes has also increased. In this respect, it is relevant to say that two of these programmes provided most jobs: artisan workshops and special employment programmes supported by the European Social Fund.

Table 11.3.1. Social reintegration programmes. Type, number of programmes and resources and number of users. Spain, 2002

	Number of programmes and/or centres	Number of users
Therapeutic centres with activities and/or programmes	208	
Activities and/or programmes centres (without treatment)	62	
Residential treatment centres with programmes (therapeutic communities)	79	
Housing	94	1801
Training programmes	834	14.260
Employment programmes	822	4500

SOURCE: Government Delegation for the National Plan on Drugs with data provided by 14 Autonomous Communities and Cities and the City Council of Madrid.

12.- INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

12.1. Assistance to drug users in prisons

Abstinence oriented treatments

Detoxification programmes are offered to everyone entering prison that is diagnosed as active drug user and has not been included in methadone treatments. During 2002, 3.481 drug dependent inmates were included in detoxification programmes offered in the 66 prisons managed by the State General Administration (Penitentiary Institutions General Directorate - Ministry of Interior). The prevalence-day was 0.15% of the penitentiary population.

During 2002, 6.362 inmates were treated in drug free programmes:

- Drug free programmes in ambulatory regime. Inmates receiving treatment live together with the rest of the penitentiary population and use the general facilities of the prison. During 2002, 3.801 inmates in 66 penitentiary centres were included in these programmes. The prevalence-day of the penitentiary population was 3,48%.
- Drug free programmes in specific therapeutic areas. These programmes are developed in specific module of the centre and can be a day centre or a therapeutic module where inmates stay over night. During 2002, 2.295 inmates of 19 penitentiary centres received treatment under the therapeutic model, with a prevalence-day of 2,44% of the penitentiary population. Under the day centre model, 266 interns of 6 penitentiary centres received treatment, with a prevalence day of the penitentiary population's 0,13%.

Substitution treatment

These treatments have been carried out in the penitentiary settings since 1992, being extended to all prisons in 1998. The wide spread of substitution treatment is explained by its high efficiency, and especially for its proven effectiveness to prevent HIV infections.

During 2002, 21.819 inmates of 66 penitentiary centres received treatment with methadone with a prevalence-day of 19,43%.

Harm reduction measures

In all penitentiary centres preventive and health education programmes have been developed. Among other subjects, basic information has been provided on the sanitary, legal and social aspects of the consumption of drugs and the motivation for the inclusion in therapeutic programmes.

These programmes are not only targeted at drug dependent inmates but also to inmates likely to begin using drugs inside the prison, such as those in prison for the first time and the younger inmates.

12.459 inmates, from all penitentiary centres managed by the State General Administration, have benefited from these programmes in 2002.

These programmes are particularly relevant because of the frequent and serious health problems these people suffer, since quite often many of them are only reached by the health system on entering prison.

The following preventive activities are carried out:

- Health promotion strategies (from health policies to social and physical interventions).
- Sanitary education for disease carriers.
- Vaccination against hepatitis B.
- Hepatitis treatments.
- Implementation of the program for tuberculosis prevention and control.
- Psychological and sanitary support groups for HIV inmates and inmates that carry out risk behaviour.

Because of the high infection risks for VIH, hepatitis B virus and hepatitis C virus in the penitentiary population and since the highest infection rates are among long term intravenous drug users inmates who carry out risk practices, preventive policies focused on these populations have been reinforced.

During 2002, 27 penitentiary centres implemented syringes exchange programmes and 12.970 syringes were distributed. These experiences have shown that these programmes can be reproduced in the penitentiary environment, without causing distortions neither direct problems.

Community links

Pre-release, units and release

The monitoring and control of inmates on parole is carried out by the social services of the prisons. The Treatment Council elaborates an individual program for monitoring of those on parole that will be implemented by the penitentiary social services in collaboration with the community devices including their families. Also, the Judge of Penitentiary Surveillance (*Juez de Vigilancia Penitenciaria)* can impose the observance of behaviour rules, such as the submission to treatment for drug dependency. Among the causes that will mean the repeal of this freedom is the neglect of the imposed behaviour rules, the repeal supposes re-entering prison.

The prisons Treatment Council, after the emission of a favourable and individualized social reintegration report, can suggest the Judge of Penitentiary Surveillance to advancement the probation period under the above -mentioned conditions.

During 2002, 6.276 inmates were derived to community devices. Most of the derivations referred to inmates that were already free (on parole, probation or after rendering sentences).

Also, the Spanish penitentiaries include social reintegration centres managed by penitentiary staff and dependent units outside the penitentiary centres run by non-governmental organizations, both devices are offered to inmates classified in third degree (open regime).

Therapeutic communities for offenders outside the prisons

The Penitentiary Regulation regulates the following treatments for drug dependent inmates outside the prisons:

- Ambulatory treatment in the community thanks to the inmates daily outings.
- Programmes carried out in out off prisons services through leaves.
- The possibility to undergo treatment in out off prisons services thanks to the provisions on open regime.

- The possibility for drug dependent inmates to serve their sentence boarded in public or private therapeutic communities.
- The possibility to subject the conditional freedom to undergo treatment.

During 2002, 6.276 inmates were diverted from prisons to treatment:
- 1.194 were diverted to external ambulatory centres.
- 4.052 were diverted to external methadone programmes.
- 491 were diverted to external therapeutic communities.
- 539 were diverted to other resources.

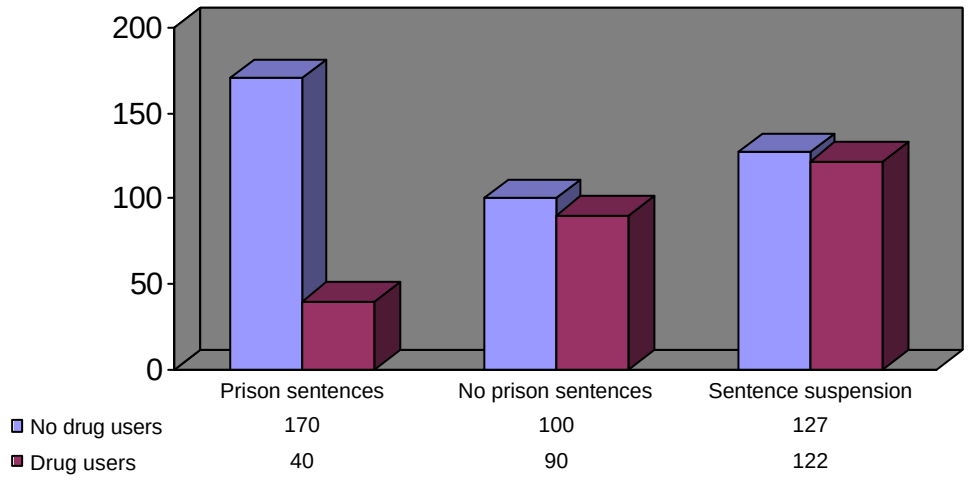
Involvement of community health structures
The definition of the objectives of the interventions as well as the coordination of the resources and the implementation and monitoring of the performances, are carried out within the Group to Care for Drug Dependents (Grupo de Atención a Drogodependientes). This multidisciplinary team is the operative space in which prisons professionals, Not Governmental Organizations and other extra-penitentiary entities participate. All 66 prisons managed by the State General Administration have these units.

12.2. Alternatives to prison for drug dependent offenders

During 2002, the courts ordered the Penitentiary Social Services mediation in 252 drugs users entering treatment.

These data mean an underestimation of the real number of drug dependent offenders rendering alternatives to prison sentences, since the Penitentiary Social Services do not cover all alternatives to prison sentences. Moreover, these social services do not cover Cataluña Courts since all penitentiary competences have been transferred to this Autonomous Community.

Figure 12.2.1. Alternative compliance to prison reported by penitentiary social services. Spain, 2002



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SOURCE: Government Delegation for the National Plan on Drugs with data reported by the Autonomous Organization of Penitentiary works. Cataluña is not included since the Autonomous Community has all competences in this matter transferred.

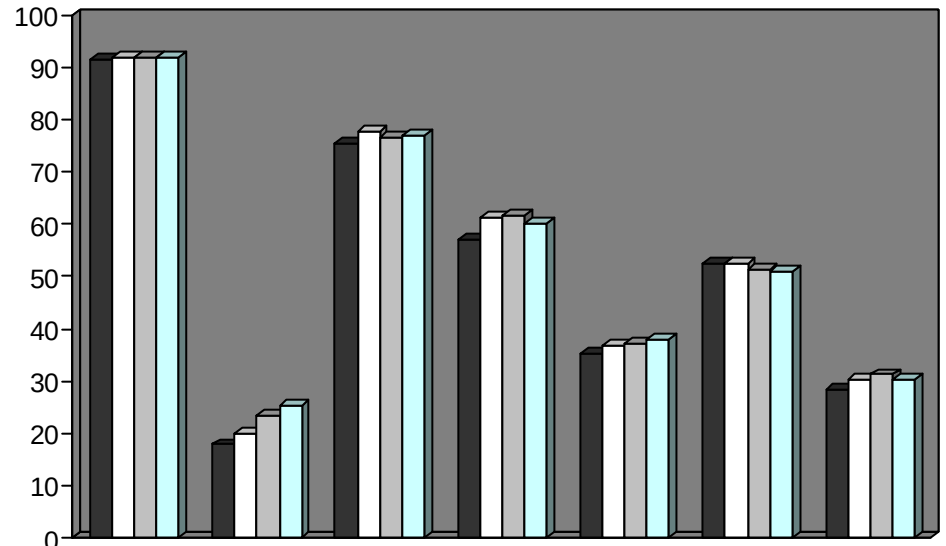
12.3. Evolution and training

Statistics

Statistics on the penitentiary population. Source: Penitentiary Institutions General Directorate.

The penitentiary population is mainly masculine, with an increasing percentage of foreigners and recidivist. Also, it shows a gradual aging process that relates with the recidivism variable.

Figure 12.3.1. Evolution of the penitentiary population profile. Spain 1999-2002



	Men	Foreigners	Sentenced	Recidivist*	Age: 31-40*	C. Property*	C. Public Health*
1999	91,5	17,87	75,5	56,9	35,3	52,4	28,5
2000	91,9	19,93	77,8	61,2	36,9	52,56	30,2
2001	91,79	23,32	76,59	61,79	37,29	51,39	31,29
2002	91,9	25,4	76,8	60,3	38,1	50,87	30,5

*Percentages on sentenced population.
SOURCE: Government Delegation for the National plan on Drugs with the penitentiary statistics provided by the Ministry of Interior.

The last 1.000 entrances in prisons that took place in January 2002 show the same profile that in previous years.

Statistical: prevalence of diseases linked to drug consumption. Source: Sanitary Registries of Penitentiary Health.

- VIH prevalence: 12,8% of the penitentiary population's total.
- Hepatitis C prevalence: 38,2% of the penitentiary population's total.
- Prevalence of inmates under treatment with antiretroviral: 7,0% of the penitentiary population.
- Tuberculosis prevalence: 0,3% of the penitentiary population was under treatment.

Statistics: therapeutic services in prison. Source: the Deputy Direction of Penitentiary Health provides annually data on inmates admitted to treatment under the therapeutic modality. The data collection is carried out through a questionnaire answered by all the penitentiary centres.

Statistics: Use of psychoactive substances. Source: study on drugs use and associated variables. Deputy Direction of Penitentiary Health, 2000.

77,2% of people that enter in prison took psychoactive substances in the month prior to their entrance. One of the characteristics that define these drug users on entering prison is the polidrug use.

21,9 of people entering prison were using drugs by parenteral route in the previous month.

Training

Training for professional. Training courses are offered to all civil servants when starting to work and later on updating courses are organized periodically. During 2002, the Penitentiary Institutions General Directorate has provided training activities on prevention and treatment on centralized basis attended by 1.158 professionals.

Training for inmates. Training for drug dependent inmates tend to achieve their social integration, and therefore focus on harm reduction and social reintegration. The therapeutic alternatives should not be isolated as treatment program, but integrated together with performances that include training and education. Academic education together with pre-labour and labour training courses are offered.

During 2002, 7.342 inmates attended training courses and 988 attended social-labour oriented courses. It is estimated that 50% of these students were drug dependent.

13.- QUALITY ASSURANCE

The National Strategy on Drugs 2000-2008 refers to the creation of the National Institute on Drugs Research and Training (INIFD) with in the Government Delegation.

In October, 2002, took place the First Conference of the National Institute of Research and Training on Drugs. In this event 30 participants were involved.

The main tasks of the Institute are the following:

- To define guidelines and priorities
- To coordinate and promote, through the signing of Covenants, programmes and public activities developed by the different administrations.
- To act as a advisory body
- To act as a communication body and as a body of technic scientific exchange
- To develop programmes of national interest
- To know the economic resources of the State for research and training on drugs.

Also, the Institute priorities lie within the following areas:

- Alcohol abuse among young people during the week-ends
- Evaluation of Techniques of treatment quality rendered to the drug dependent
- Psycho-stimulants. Damages for the use and the abuse in recreational environment
- Features of the consumption prevention in the family environment

Nowadays all public administrations with competences in drug issues have a special interest to assure the quality. In this sense efforts have been devoted to create tools (practical medical guidelines, quality management handbook, evaluation) and to start mechanisms in order to assure them.

Some Autonomous Communities have started programmes and systems to guarantee quality. Those activities cover a wide range of possibilities: Cantabria applies the certification ISO 9002 to every process and resources in its Autonomous Plan, Andalucia has certified with ISO its program management processes, Galicia has started to introduce the model EFQM in its Plan, Valencia has developed tools to evaluate the perceived quality, etc.

Besides, an important number of NGO have started as well systems of quality management in their resources.

PART 4

SELECTED ISSUES

14.- EVALUATION OF DRUGS NATIONAL STRATEGIES

14.1. Existence of evaluation

During the past years we have seen how private management techniques have been adopted by national administrations and by the international community. Due to internal and external elements, the decision making process has evolved and policy makers are now aware of the key role played by the evaluation when talking of public policies.

Due to the scarcity of public resources, public administrations have had to rationalise its decision making processes and improve the productiveness of the public sector. These elements together with the growing complexity of the public policies, imply that the evaluation is seeing as an useful tool.

In this sense, Spain is part of this movement, and the Spanish Drugs National Strategy approved by the Government in December 1999 foresees its evaluation, in line with the documents drawn up by the 20th United Nations General Assembly Special Session on the world drug problem and the documents discussed at about that time within the European Union.

Evaluation is a key point for the National Drugs Strategy, which not only refers to it when setting the general frame but also includes a special chapter on this topic linked to information systems. The Strategy foresees a midterm evaluation in 2003 and a final one in 2008.

14.2. Methodology of evaluation

The Spanish Drugs National Strategy is built on three areas of intervention, drug demand reduction, drug supply control and international cooperation, and for each of which measurable targets are identified. Also in some cases dates on which they should have been achieved are included.

The Strategy declares that it should define and establish mechanisms and instruments that enable to understand and study the progress achieved in meeting the targets and goals set up. Therefore an evaluation mechanism will be established, on the one hand, to allow for the early detection of any possible deviation and the inclusion of corrective measures to guarantee the efficacy and effectiveness of the own Strategy and, on the other, to allow for it adaptation to new needs that might arise.

The fact that the Strategy foresees its evaluation can be related with the national situation during the last decades. When the Strategy was approved the Spanish national drug co-ordination unit, the Government Delegation for the National Plan on Drugs, had been working since 1985. At that time the drug issue had been in the Spanish political agenda for the last years since it was in 1978 when the Government decided upon the need to adopt structured and co-ordinated actions in view to address the drugs problem.

Since that moment the Government Delegation for the National Plan on Drugs has co-ordinated and promoted drug policies implemented by other public administrations and the civil society, having played the Autonomous Communities and Cities a key role in this field for the last years.

The next cornerstone was the approval of the Spanish Drugs National Strategy in December 1999, 14 years after the establishment of the Government Delegation, at a time when it was felt the need to reconsider the whole situation, taking into account the changes that had happened during the last years.

In this sense, when drafting the Strategy the consensus of all interested parties was sought. Therefore, now there are many actors involved in the fulfilment of the targets set up in 1999 since Spain is a decentralised country and the Autonomous Communities and Cities play an important role for achieving the goals regarding drug demand reduction, since all the competences in fields such as education or health have been transferred by the Central Government.

The Strategy stresses the role drug prevention has to play but it also pays attention to other working areas as harm reduction and treatment and social reintegration.

For the section on drug demand reduction not only targets but also indicators are identified in the Strategy. An assessment of the Spanish situation prior to 1999 was carried out so that the level of fulfilment of the goals could be measured in 2003 and 2008, taken into account that when drafting the Strategy not all data needed for this exercise was available. Therefore some new information collection mechanisms have been developed with the assistance of the Spanish Monitoring Centre on Drugs, the Monitoring Centres established within the Autonomous Communities and some municipalities.

The next turning points, as already mentioned, are 2003 and 2008, dates in which a midterm and a final evaluation are to be carried out. At present, the midterm evaluation is being performed by the Government Delegation for the National Plan on Drugs. It is therefore an internal evaluation with the advantages and drawbacks this exercise has, taken into account the complex network of interests that interacts when performing the evaluation.

Insight knowledge of the system is guaranteed since the people performing the evaluation have a long expertise in the drug field and the independence of the evaluation is achieved due to the wide spectrum of the data gathered.

In order to perform the evaluation, the experts have to rely on data from different sources such as other Ministerial Departments, the Autonomous Communities or the surveys carried out by the Government Delegation for the National Plan on Drugs on regular basis…

When choosing in house staff working for the organisation or outsiders it is important to consider which way will be easier to gather the information. Internal evaluators can have a broader knowledge of the structures and the communication mechanisms but this information can be obtained by the external evaluators if they find the support and collaboration they need.

Another advantage that can be mentioned is that the evaluation report produced by in house staff tends to be of more use than that drawn up by external consultants since they are familiar with the organisation. On the other hand they might tend to justify the deviations and are less willing to make observations or suggest changes that can be seen as an threat to the organisation.

The external evaluations provide a more objective and reliable view since they are not involved in the processes but they run the risk of trying to satisfy the client providing results as good as expected.

Therefore a dilemma is faced in terms of choosing between the ability to obtain information and understanding of the situation or the objectivity and the professionalism when assessing the situation.

Having said this, a few words can be devoted to the evaluation exercise itself. The evaluation is intended to improve the effectiveness and the efficiency of the public policies since it is the task of the public administrations not only to put implement public policies, in line with demands of the citizens, but also to measure the quantity and the quality of the services provided.

Given that the evaluation can be defined as the systematic application of social research procedures to asses the design, the implementation and the usefulness of all public policies, different types of evaluation can be considered. It can assess the conceptualisation and design of the policy, its implementation, its impact or its efficiency.

As for the indicators used to evaluate public policies, different kind of indicators tend to be used such as the effectiveness indicators, activity indicators and efficiency indicators. Therefore, information on the level of compliance with the policy objectives or on relation between the resources invested on a certain policy and the outputs produced will be obtained.

It is also important to mention that when building up the indicators some conditions have to be met in terms of its validity, reliability, coverage of all objectives and reasonable data gathering costs.

Some conclusions can be drawn:

- The evaluation must be understood by the addressee.
- The evaluation must be available when it can be useful.
- The evaluation must deal with the networks of interests, that can be conflicting.
- It must be known before hand how the evaluation results will be used (internal report, communication to the policy makers, public diffusion…).

Most indicators mentioned in the Strategy are quantitative indicators that can be measured. Particularly in the section on demand reduction, the Strategy includes quantitative indicators referred mainly to the year 2003. But the fulfilment of the indicators lies within the competences of each Autonomic Plan on Drugs, due to the transfer of competences from the Central Government to the Autonomous Communities.

The co-ordination mechanisms involving the Government Delegation for the National Plan on Drugs and the Autonomic Plans on Drugs have considered the evaluation foreseen in the Strategy and they have had access to the evaluation of the Autonomic Plans on Drugs (Planes Autonómicos de Drogas) carried out by the Faculty of Sociology of the University of Granada in January 2003.

The study was conceived as an evaluation – diagnostic and focused on all the programmes implemented in the field of drug demand reduction in order to provide an insight on how they are implemented and on the results, also attention was paid to the co-ordination mechanisms between the Public Administrations involved.

The main advantage of this type of evaluation is the wide range of information collected from the different information sources. It can be considered a comprehensive evaluation that takes into account all the areas that make up the Autonomic Plans on Drugs (prevention, treatment, social reintegration, training, research, institutional co-ordination and budget).

The study intended to provide an in-depth analysis of the present reality of each Autonomous Community and City (Comunidad y Ciudad Autónoma) that will provide descriptive information on problems, challenges, strengths and weaknesses on individual basis.

The procedure followed included five steps:

- Analysis and development of a data base with the information gathered from the annual reports of the Autonomous Communities and other data sources.

- Design of a questionnaire that covered all the elements not included in the previous phase that was sent to the Autonomic Plans on Drugs.

- Analysis of the information provided in the questionnaires and establishment of an inventory of the activities implemented by the Autonomic Plans on Drugs.

- Semi-structured interviews with staff of the Autonomic Plans on Drugs in order to improve and broaden the information collected through the questionnaires.

- Analysis of the all the information collected.

The study is structured in two main sections. First, it provides information on the national situation and then it focuses in each of the 19 Autonomous Communities and Cities.

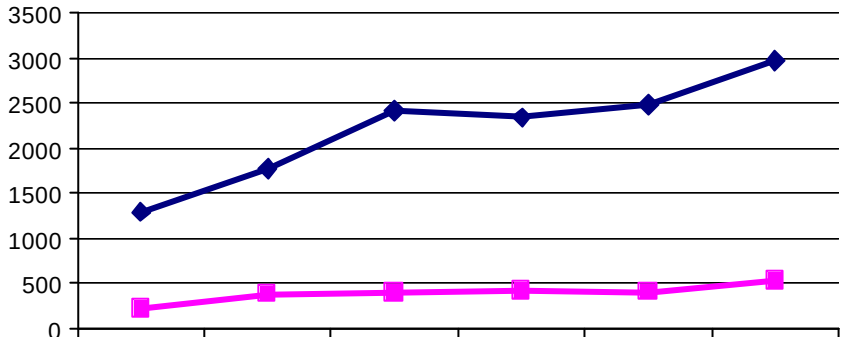
15.- CANNABIS PROBLEMS IN CONTEXT: UNDERSTANDING INCREASED TREATMENT DEMAND

15.1. Demand for treatment for cannabis uses

In 2001 cannabis was the third drug as regard the number of admissions to treatment (3674), behind heroin and cocaine, representing 7,4% of all the admissions to treatment. This proportion increases up to 16,9% if only users treated for the first time in their life are considered.

In the last years the number of treatments have increased considerably for cannabis, from 1613 in 1996 to 3674 in 2001 (multiplying for 2.3) (Figure 15.1.1). In a parallel way proportion of users treated for cannabis has also increased over the total of users treated by psychoactive substances, rising from 3% in 1996 to 7.4% in 2001.

Figure 15.1.1. Admissions to treatment for abuse or cannabis dependence (absolute numbers). Spain, 1996-2001.

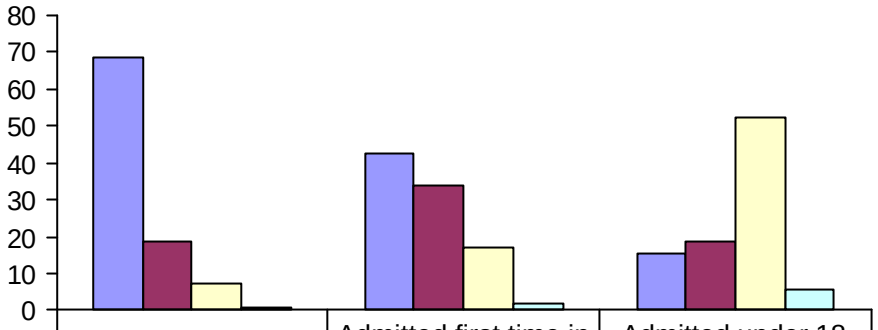


	1996	1997	1998	1999	2000	2001
New clients seeking treatment	1300	1768	2412	2335	2487	2966
Clients previously treated	230	387	407	418	408	540

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Treatment Demand Indicator (TDI)

Clients in treatment for abuse or cannabis dependence in 2001 were quite young (average age: 24.1 years old). In fact, 52.4% of the 1174 treatments for abuse or dependence of drugs communicated about clients under 18_s were due to cannabis (Figure 15.1.2), proportion that reached 62.1% in the case of those under 15_s. The average age of these clients remained relatively stabilized between 1996 and 2001. (Figure 15.1.3).

Figure 15.1.2 Ratio of clients in treatment by abuse or dependence of psychoactive substances in Spain, 2001



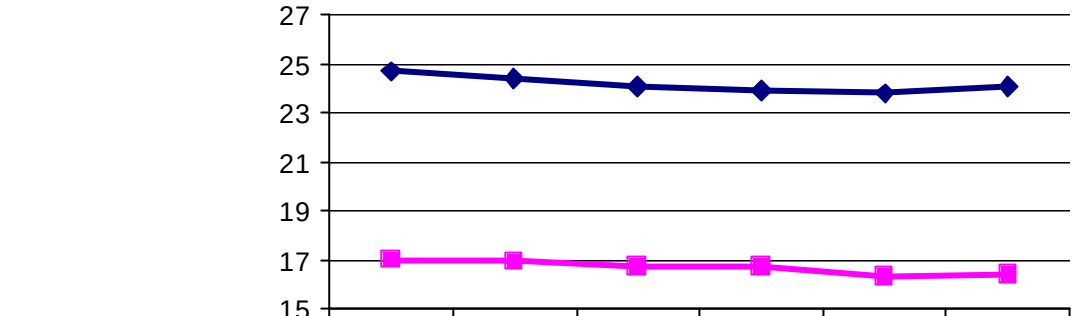
	All the admissions	Admitted first time in life	Admitted under 18 years (*)
Heroin	68,3	42,4	15,4
Cocaine	19	34	18,4
Cannabis	7,4	16,9	52,4
MDMA or derived	0,7	1,6	5,4

Number of admissions	49376	17591	1174
(*) All the cases admitted to treatment younger than 18 years old			

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Treatment Demand Indicator (TDI)

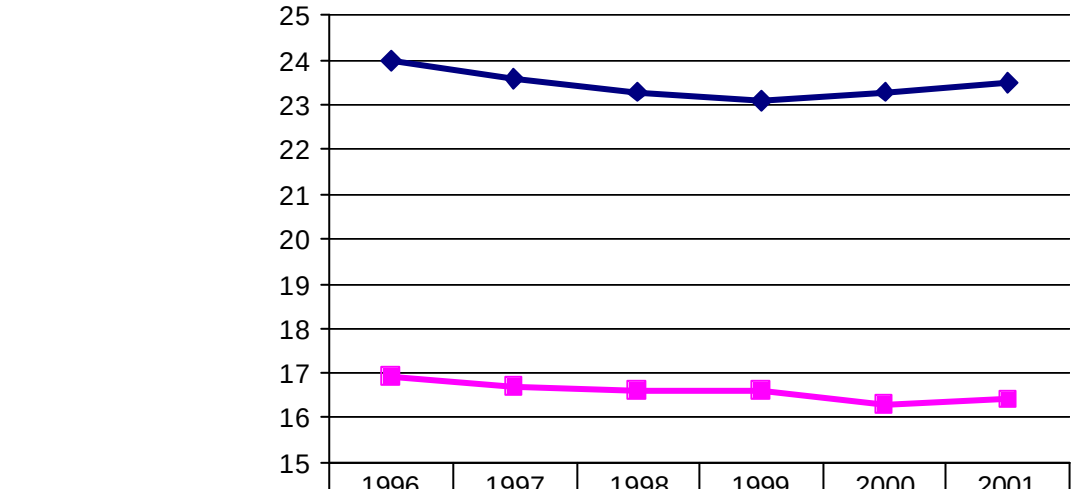
Figure 15.1.3. Evolution of the average age at admission to treatment and average age at first use among clients in treatment for cannabis in Spain, 1996-2001

Total clients in treatment



	1996	1997	1998	1999	2000	2001
Average age at treatment admission	24,7	24,4	24,1	23,9	23,8	24,1
Average age at first use	17	16,9	16,7	16,7	16,3	16,4

Clients in treatment for the first time in the life



	1996	1997	1998	1999	2000	2001
Average age at treatment admission	24	23,6	23,3	23,1	23,3	23,5
Average age at first use	16,9	16,7	16,6	16,6	16,3	16,4

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addictions (SMCDDA). Treatment Demand Indicator (TDI)

The clients entering treatment for cannabis in 2001 were mainly males (90.1%), and they had, in relation to the clients in treatment for other illegal drugs, a relatively high level of education (68% had secondary or higher education), and a relatively low level of unemployment (25.5% were unemployed). They had started to consume cannabis at a very early age (16.4 years old); the age of initiation was in fact the lowest of the clients in treatment for any other illegal drug.

Also, in the last years a certain decrease of the average starting age is shown in the use, changing from 17 years in 1996 to 16,4 years in 2001. The most consumed product was the resin of the plant (hashish) blended with tobacco. However, cannabis was often notified without specifying as main product of consumption (73.3% of the clients in treatment), in 21.7%, resin of the plant (hashish) and in 4.6% the plant crushed (marijuana). The main or habitual cannabis administration route was smoking (97.6%), although in 2.2% the administration route was oral route, and other routes.

The most common secondary drugs used by clients in treatment for cannabis during 30 days before their admission to treatment were alcohol (58%) and cocaine (42.8%). The injecting drug use was not very frequent: 4.7% had injected drugs at some time in the life and 1% during the previous month to treatment admission. Most of them (75.1%) ignored their situation related HIV, but at least a 1.7% were HIV+ (Table 15.1.1).

Table 15.1.1. General characteristics of the clients in treatment for abuse or dependence of psychoactive substances, according to main substance of use (Percentages and averages), Spain 2001

	Heroin	Other opiates (0)	Cocaine	Amphetamines	MDMA and derivatives	Hipnosedantives	Cannabis	Hallucinogens	Volatile substances	Others (1)
Number of treatment admissions notified clients	33702	1186	9367	255	335	491	3674	83	30	253
Admitted to some previous treatment (%):										
- Yes	76,9	82,6	33,8	29,1	15,0	36,2	15,4	14,8	28,6	30,3
- No	23,1	17,4	66,2	70,9	85,0	63,8	84,6	85,2	71,4	69,7
Average age (years)	32,82	33,89	29,82	25,00	21,43	34,47	24,13	26,00	22,93	31,66
Sex (%):										
- Men	84,4	77,8	86,6	77,6	80,6	56,0	90,1	83,1	93,3	81,0
- Women	15,6	22,2	13,4	22,4	19,4	44,0	9,9	16,9	6,7	19,0
Maximum level of studies (%):										
- Without studies	14,3	9,9	6,3	3,6	4,0	11,3	5,0	11,0	20,7	19,2
- Primary 1st cycle	38,8	40,1	29,0	28,6	23,5	36,1	26,6	29,3	41,4	31,0
- Primary 2nd cycle	30,6	30,9	36,3	39,3	41,9	25,5	38,4	30,5	24,1	27,1
- Secondary	13,8	15,9	23,6	22,2	27,5	21,1	24,0	25,6	10,3	15,3
- Medium or superior degrees	2,5	3,1	4,8	6,3	3,1	6,1	6,0	3,7	3,4	7,4
Main labour situation (%):										
- Working	31,3	42,6	58,5	48,8	45,3	29,7	45,7	39,5	17,2	34,7
- Unemployed without previous job	8,8	4,6	4,2	6,9	7,0	7,3	5,6	3,7	24,1	5,1
- Unemployed with previous work	43,8	33,7	26,7	20,7	20,7	32,6	19,9	27,2	20,7	24,6
- Others	16,1	19,1	10,6	23,6	27,1	30,4	28,8	29,6	37,9	35,6
Beginning age to consume (years):	20,84	25,07	21,61	18,32	17,95	26,93	16,40	19,68	15,74	21,94
Main administration route(%):										
- Oral	1,0	84,2	,9	66,5	95,1	95,1	2,2	76,9	3,6	33,2
- Smoked	24,9	3,0	10,1	2,0	1,5	2,5	96,7	6,4	14,3	25,7
- Inhaled	42,5	4,4	15,0	2,4	,0	,8	,9	12,8	82,1	8,4
- Sniffed	4,6	1,1	69,4	25,3	2,1	,4	,2	,0	,0	24,8
- Injected	24,2	5,7	4,1	3,3	,0	,4	,0	3,8	,0	3,7
- Others	2,9	1,5	,4	,4	1,2	,8	,1	,0	,0	4,2
Other drugs consumed during 30 previous days (%) (**):										
- Heroin	,0	19,5	12,2	4,5	2,3	12,6	6,4	1,7	21,7	5,0
- Other opiates	10,1	,0	1,5	2,5	,4	8,3	,6	,0	,0	1,0
- Cocaine	71,9	35,1	,0	44,4	49,6	29,1	42,8	47,5	21,7	20,0
- Amphetamines	1,8	1,3	7,4	,0	12,8	2,4	9,0	11,9	4,3	3,0
- MDMA and derivates	1,0	,7	11,3	16,7	,0	2,0	12,9	11,9	8,7	3,0
- Hypnotic and sedatives	19,8	19,9	6,9	7,6	2,7	,0	3,9	,0	8,7	4,0
- Cannabis	35,8	33,8	47,5	61,6	64,0	31,9	,0	67,8	65,2	47,0
- Hallucinogens	1,3	,2	4,4	11,1	5,0	2,8	8,2	,0	8,7	4,0
- Volatile substances	,1	,0	,2	1,5	,4	,8	,5	,0	,0	,0
- Alcohol	25,1	29,7	63,4	49,0	46,9	49,2	58,0	33,9	43,5	61,0
- Other substances	16,2	30,0	18,7	17,2	14,3	29,5	23,0	32,2	21,7	,0
Time from last injection (%):										
- Less than 30 days	22,8	13,4	5,3	6,3	1,0	2,5	1,0	1,7	,0	2,5
- 1 month – 1 year	8,3	12,9	2,5	2,7	2,0	3,9	,5	6,9	,0	5,4
- 1 – 4 years	12,6	28,4	2,4	,9	1,3	6,5	1,3	5,2	4,2	3,4
- 5 years or more	12,6	12,4	3,3	1,8	,7	6,0	1,9	1,7	4,2	4,4
- Never	43,7	32,9	86,5	88,4	95,0	81,1	95,3	84,5	91,7	84,3
Serologic situation in front of the VIH (%):										
- Positive	18,1	21,5	3,5	2,0	,6	10,2	1,7	8,4	,0	2,0
- Negative (analysis last 6 months)	23,9	18,5	21,1	15,7	11,0	19,3	9,1	21,7	16,7	22,5
- Negative (without date analysis)	28,0	27,0	20,3	12,5	13,1	16,3	14,1	18,1	10,0	11,5
- Without analysis or unknown result	30,1	33,0	55,1	69,8	75,2	54,2	75,1	51,8	73,3	64,0

(**) The percentages are calculated on the number of cases with information on some of the four drugs secondary collections.
(0) In this group it has been included the metadona and other opiate ones given the small number of cases notified for each category.
(1) In this group the rest of the psychoactive substances has been included that don't correspond to the given other categories the small number of cases notified for each category.

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs and Drug Addictions (SMCDDA). Treatment Demand Indicator (TDI)

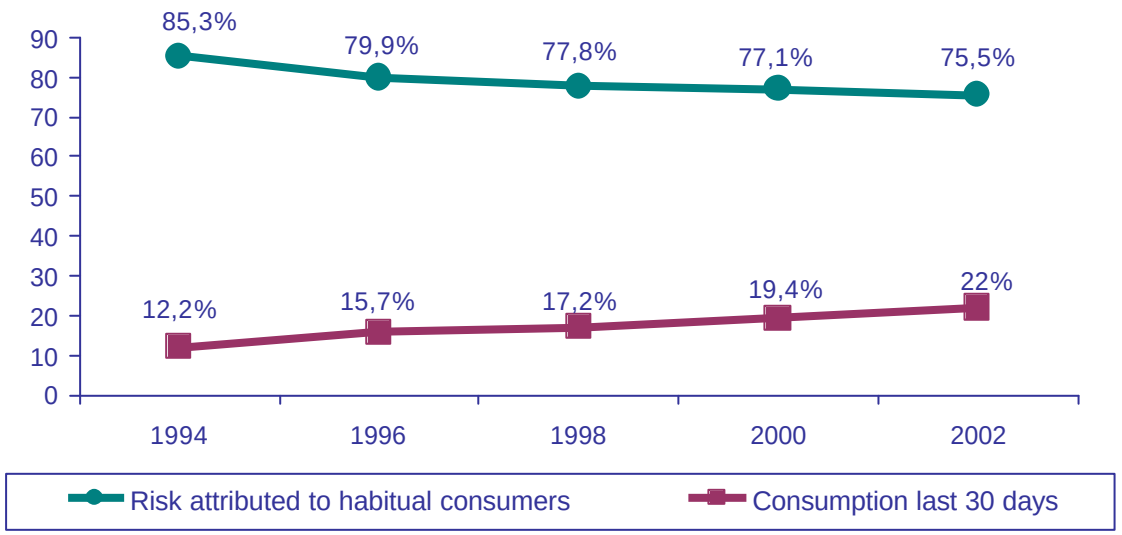
Cannabis use during the 30 days previous to the treatment is frequently mentioned among those clients treated by abuse or dependence of other drugs as hallucinogens (67.8%), volatile inhalant (65.2%), MDMA and derivatives (64%), amphetamines (61.6%), cocaine (47.5%), heroin (35.8%), opiates different to heroine (33.8%).

Most of the clients in treatment for cannabis in 2001 (84.6%) had not been treated previously for this main drug, being one of the drugs with more proportion of patient in these circumstances.

15.2. Prevalence of problematic cannabis uses and patterns of problems

As it has been pointed out in the previous sections, cannabis is the most common used illegal drug in Spain, especially among young people, and is spreading in the last years. This spreading has been come with a continuous decreasing of the perception of risk of this substance (Figure 15.2.1) and it has been created around it a culture that emphasize its qualities and its harmlessness, which probably helped it. The own consumers point out (EED2002)(2), several negative effects associated to cannabis use and, as it has been mentioned before, the treatment demanded for cannabis is increasing considerably.

Figures 15.2.1. Evolution of the associate risk (ratio of students that think that their behaviour can cause many problems) and prevalence of cannabis use. Spain, 1994-2002.



SOURCE: Surveys on Drugs to School Population 1994-2002. Spanish Monitoring Centre for Drugs and Drug Addictions (SMCDDA).

It is not easy to define what it is understood by problematic use of cannabis. As stated below, some data on prevalence of frequent or intense consumption in Spain are shown from the General Population Survey on Drugs of 2001 targeted at the population aged from 15 to 64 years and of the School Survey on Drugs of 2002 targeted at the students aged from 14 to 18 years. It is necessary to mention that the term " problem " is very wide and therefore it should not be limited to physical or sanitary problems but

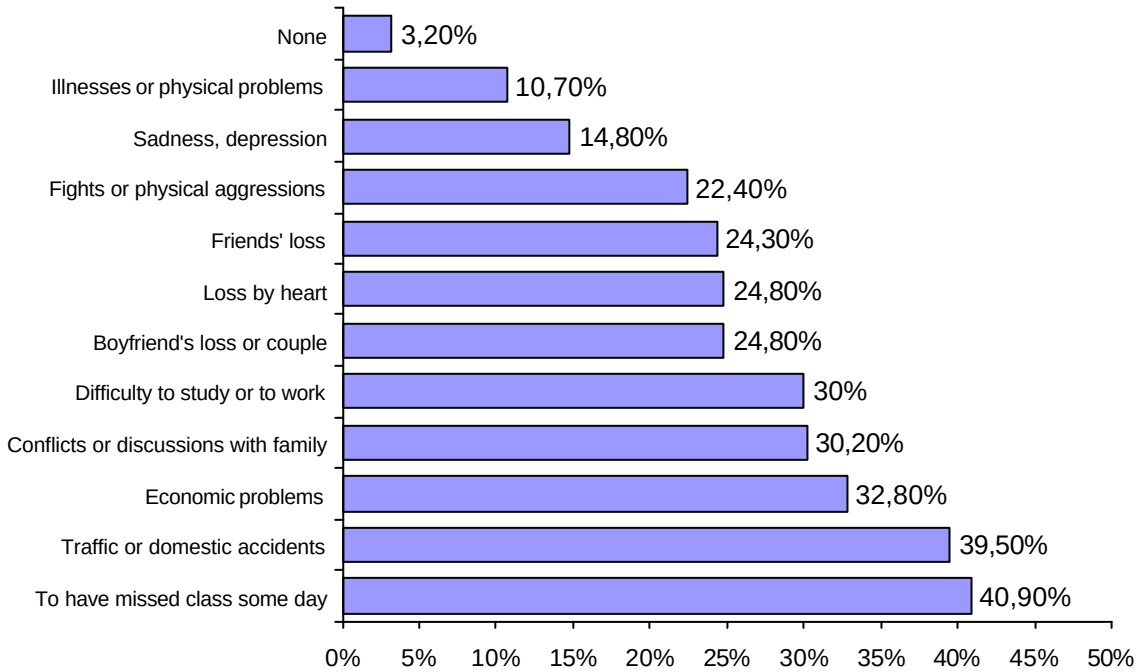
also include problems that affect to the social, family and personal life of the individuals, as well as to situations that can derive in their own risk and the other ones as, for example, the traffic accidents.

During 2001, 1.6% of the Spaniards aged 15 to 64 years old declared to have smoked cannabis daily during the last 12 months, and 4.4% every week. Most of the daily consumers were men (2.7% against a 0.6% of the women). Among the youths the daily use was more extended, above 3% in the group aged 20-29 years old.

In 2002, among the students aged 14-18 years, daily or almost daily use (20 days or more in the last 30 days) reaches similar figures (3.6%), and overcomes a 5% starting from the 17 years old. Also in this case the cannabis use is more frequent among boys than among girls. In this group the use is very intense since the average number of joints consumed per day (alone or shared with other people) is 5,6 joints (average of 4 joints/day).

Besides, the cannabis consumers recognize negative effects derived from consumption. In 2002 those effects more mentioned by students aged 14-18 years old with high consumption of cannabis were (Figure 15.2.2): truancy, traffic or domestic accidents, economic problems, conflicts and discussions with their relatives and difficulties for studying or working (all of them mentioned by 30% of those interviewed). Also it is necessary to highlight that only 3.2% of these consumers declare not to suffer negative consequences.

Figure 15.2.2. Ratio of students aged 14 - 18 years old consuming cannabis during 20 days or more in the last 30 days, who suffered negative effects as consequence of their use. Spain 2002



In other studies carried out in the recreational framework, the habitual consumers recognize difficulties to stop using cannabis, even higher than for other illegal drugs.

Also, it is also frequent the mention or detection of cannabis in emergency services and deaths for acute reaction to psychoactive substances. Although the meaning of the presence of cannabis in these cases is unknown, it seems that this substance rarely contributes to deaths for acute reaction to drugs. In fact, in 2001 there were any deaths of this type in which cannabis exclusively would be detected. In the case of emergency services the situation changes. The doctors related somehow (sometimes together with other drugs) 16,9% of the episodes for acute reaction to drugs with cannabis, being the fourth drug, after cocaine, heroin and hypno-sedatives, that caused higher number of emergencies. As for the treatment, in the emergencies files, the most mentioned cannabis types were: cannabis without specifying, resin and plant. The ratio of emergency services for acute reaction to drugs mentioning cannabis rose up from 7,4% in 1996 to 19,1% in 2001, and the ratio of deaths by acute reaction to drugs in which it was detected went from a 6,5% in 1996 to 18,7% in 2001.

15.3. Specific interventions for problematic cannabis uses

Preventive or harm reduction interventions targeted to problematic cannabis users specifically have not been detected in Spain. However there are some interventions targeted to problem users of recreational drugs who take cannabis among other drugs.

16.- CO-MORBIDITY

16.1. Main diagnoses, prevalence

a) The most common types of mental disorders diagnosed among drug users
No information available during 2002. The impression among professionals is that mood, anxiety and personality disorders are suffered frequently by Spanish drug users.

b) Estimated rates of prevalence of concurrent mental health disorders among illegal drug users
No information available during 2002.

c) Prevalence in different sub-populations
The lifetime prevalence of drug dependence (including alcohol and other psychoactive substances except for tobacco) was 37.8% in a sample of 82 out-patients diagnosed of schizophrenia. Drug-dependent patients, in comparison with the rest of the sample, had more family and legal problems as measured by the Addiction Severity Index. The prevalence of drug dependence for the different substances was: alcohol 29.3%, cannabis 24.4%, cocaine 11%, and opioids 9.8%. Moreover, 68.3% presented with current nicotine dependence.

A sample of methadone-maintained opioid-dependent patients (*n* = 150) was assessed using the Spanish version of the Psychiatric Research Interview for Substance and Mental disorders (PRISM) to make DSM-IV diagnoses. The more frequent current axis I disorders found were: social phobia (6%), major depression (5%), and substance-induced affective disorder (4%). The more frequent axis II disorders detected were borderline personality disorder (7%) and antisocial personality disorder (6%).

In a group of female drug-dependent patients (n = 103) hospitalised in a closed addiction unit for detoxification treatment, the prevalence of borderline and antisocial personality disorders was 13.5%, and 5.7%, respectively. The International Personality Disorder Examination was used to make personality diagnosis.

d) Results from studies about drug-related risk behaviour among mentally ill drug users
No information available during 2002.

16.2. Impact of co-morbidity on services and staff

a) Research and practice reports from different drug service types
No information available during 2002.

b) Professional qualifications in mental health
There are two systems devoted to mental health problems. We named them “the mental health system” and “the drug dependencies system”.

Doctors who work in the mental health system are psychiatrists. The majority has obtained the title as specialist through a 4-year residency training in a Psychiatry service. They entered to the psychiatry training after to pass a selective national exam.

These doctors usually keep relationships with hospital services along their professional practice. In this system, there are psychologists specialised in psychosocial treatment or clinical psychopathology. Quite a lot of psychologists specialised in clinical

psychopathology make diagnosis of mental disorders of axis I. Likewise, other psychologists are specialised in assessment and treatment of cognoscitive or personality disorders.

Until 2001, a few doctors who worked in the drug dependencies system were specialists in Psychiatry or Internal Medicine, and the majority was general practitioners. During 2002, quite a lot of general practitioners have obtained the title as specialist in Psychiatry, after to pass and exam and to demonstrate, by means of the curriculum, clinical experience with mental disorders non-substance related. These new psychiatrists barely are related with hospital psychiatry services. Almost all drug dependencies resources have at least a psychologist. But this professional usually is not trained in the diagnosis of mental disorders non-substance related.

c) Training needs of staff

A lot of psychiatry services do not treat substance use disorders with the exception of alcoholism. Moreover, training in drug addictions is optional for residents in psychiatry. Only a few residents choose a 3- or 4-month stay in a drug addiction unit. Psychiatrists are trained in the differential diagnosis between primary mental disorders and substance-induced disorders. Their main training need is the assessment and treatment of addictions. This lack of training is subsequent frequently to do not consider substance-use disorders as genuine mental disorders.

In the other hand, the majority of doctors who work in the drug dependencies system have not received a systematic psychiatric training. They manage drug-dependent patients with this lack of training, but with a deep experience in the relationship with antisocial and other DSM-IV cluster B personality disorders. Doctors from drug dependence treatment resources are very receptive to training in diagnosis of any kind of mental disorders. Psychologists from this system are less interested in the co-morbidity approach to addictions. Frequently, a psychologist leads the mental health management of drug-dependent patients.

16.3 Service-provision

a) General problems in the treatment of drug users with mental disorders

The main problem is non-detection of concomitant non-addictive mental disorders. Depression or anxiety can be considered always as inherent symptoms of the intoxication-withdrawal cycle. A frequent mistake is the exclusion of depression, because the patient develops frequently violent or antisocial behaviours. Bipolar disorders almost never are detected and, subsequently, almost never are rightly treated.

Conversely, there is a tendency to administer psychopharmacologic medications in an indiscriminate way. The causes of this practice are the short time available for each visit, the good client acceptance of ‘chemical solutions’, and the pressure from the industry to extend the use of its products.

Another important problem is the existence of the two parallel, independent, non-coordinated systems for treating people diagnosed of mental disorders. This assistance structure is not a problem for patients without co-morbidity or with non-severe concomitant disorders, because they are easily placed in the more appropriate system.

Patients with severe co-morbid disorders frequently remain out of the structure assistance. These patients suffer characteristically a schizophrenic or bipolar psychotic disorder and a severe polysubstance use disorder. The mental health system send them to the drug dependencies system, because the use of illegal substances. And the drug dependencies system refused them because their resources are not prepared to guarantee the security of patients with delusions, hallucinations or agitation.

b) Legal provisions for treatment of mentally disturbed drug users
There are not specific legal provisions for this type of drug users. They must go to addiction treatment centres because their substance use disorder. From these centres patients can be referred to specialised psychiatric services if they need. Likewise, they must to go to a psychiatric emergency service if they suffer an acute mental problem.

In accordance with legal provisions, the two systems should keep close relationships in order to provide high quality assistance to patients. But, the separated model even exists in the structure of Spanish administrations.

c) Policy of referral of clients by drugs services to specialised mental health services
Substance-dependent patients to illegal drugs usually start their treatment process in the drug dependent system and their referral to the other system is very infrequent. However, a patient treated in the non-substance use system is more easily referred to the addiction system if a patient develops a very severe addiction disorder or to illegal drugs.

The cause of referring patients from the drug dependence system to the mental health system is mainly the indication of hospitalisation in a psychiatric ward. The drug dependence system has not availability of resources where a patient could be adequately assisted, if he need hospitalisation because severe psychotic or mood disorders.

There is also a problem in regard to the referral to a day hospital of drug-dependent patients who suffer schizophrenia or other usually chronic psychosis. The staff of drug dependence resources attempt this referral, but patients are frequently refused because the substance dependence diagnosis.

d) Cooperation between treatment services
Close cooperation between systems is not habitual. Frequently, patients are treated in a parallel way, but not in an integrated way. Staff of addiction centres tries that doctors from mental health system visit periodically drug-dependent psychotic patients. In this way, the hospitalisation in a psychiatric ward, when a patient need it, is easily and quickly got. For this reason, some patients are assisted simultaneously in the two systems.

e) Availability and access to treatment, treatment provision and outcomes
Specialised mental health services are available for mentally disturbed drug users. The problem is the access to these services. Frequently, the staff from these centres designed exclusion criteria that are opposed to legal treatment provisions. Among these exclusion criteria are illegal substance use disorders. The reason is to avoid the extension of addictive disorders or antisocial attitudes to patients treated in the mental health system. The final outcome is the separation between systems.

16.4. Examples of best practices and recommendations for future policy

a) Which policies and/or interventions have shown positive effects
The implementation of specific resources for treating co-morbidity has began in some Spanish regions. During 2002 a 'Unit of Dual Pathology for Alcoholic Patients' started its activity in Catalonia. This in-patient resource has 20 beds and is aimed to treat acute problems. The inclusion criteria are: 'a severe mental disorder, plus an alcohol use disorder plus, a behaviour disorder or a clinic situation difficult to manage'. A similar dual pathology unit for drug-dependent patients also exists in Catalonia. In Cantabria there is Therapeutic Community for patients who need a residential treatment during several months due to co-morbidity.

These kinds of resources solve the drug-dependence system needs of patient contention. This is its main advantage. Its main drawback is the strengthening of the separated model between systems.

b) Which methodological limitations there are to evaluation and research

- The use of systematic assessment instruments

Doctors and psychologists should to use systematic assessment instruments in order to avoid assessment bias. This method avoids non-detection of depression and suicide risk on patients with borderline or antisocial personality disorders.

- The distinction between primary and substance-induced mental disorders

Clinicians make the distinction between primary and substance-induced mental disorders with a high diagnostic uncertainty in a lot of cases. Assessment after 1-or 2-week abstinence periods is not easy because patients continue using substances and frequently they refused hospitalisation in a close addiction unit. Moreover, periodic urinalysis is necessary in order to identify the substances the patient is using. Urinalysis is not sufficiently used as a tool for the diagnosis.

The Spanish version of the Psychiatric Research Interview for Substance and Mental disorders (PRISM) can help clinicians to improve their diagnostics. This is an important issue, because the mental health system staff co-operates easily in the therapeutic process when co-morbidity is due to a primary mental disorder instead a substance-induced disorder.

- The pharmacological treatment of substance-induced mental disorders

Efficacy studies are performed with patients diagnosed of primary mental disorders, but not with drug-dependent patients with substance-induced mental disorders. In consequence, we know antidepressants, for example, are efficacious for primary depression, but we are not sure if antidepressants reduce substance-induced depression.

Nowadays, there are a wide variety of attitudes among Spanish doctors in regards to treatment of substance-induced disorders. Some doctors recommend antidepressants even for depressive symptoms associated to abstinence. Other doctors barely recommend antidepressants, because they consider that this practice frequently interferes with addiction treatment.

c) How can responses to co-morbidity be improved
Firstly, we need to know the rates of prevalence of concurrent mental health disorders among clinical samples in Spain. These data are necessary for clinicians and health

managers. Doctors and psychologists should be sensitised about diagnosis bias and the frequency of non-accidental overdoses.

The approach of the staff from the two systems must be fostered. The title of specialist in Psychiatry obtained but quite a lot of general practitioners surely favours more close relationships. The approach could be useful for removing barriers and exclusion criteria.

Lastly, it is urgent to give a response to patients out of the two systems. The implementation of specific resources for hospitalisation of severe mental-disturbed drug users is now tried as a response to this problem.

d) What are current political or professional discussion issues with regard to co-morbidity

Professionals are very worried about co-morbidity. They think the frequency of drug dependence, as a complication of non-substance use mental disorders, is increasing. Likewise, psychotic, mood and anxiety symptoms are now a main treatment objective for doctors who treat drug-dependent patients. This attitude could be due to the extension of psycho-stimulant dependence and pharmaceutical laboratory policies. Previously, when the AIDS epidemic associated to heroin dependence happened in Spain, infectious diseases, but not mental complications, was a main concern for doctors.

e) What should be future policy directions for providing adequate services to illicit drug users with mental health problems

There are two possibilities:

- the integration of the two systems in a only mental health system
- the implementation of an self-sufficient drug dependence system

The integration of the two systems is the ideal solution. It is a cost-effective policy that guarantees the best treatment, because professionals would be trained in co-morbidity. But integration is a long-term objective; unfortunately, it is not realistic to think this change will happen in the next future.

The implementation of a self-sufficient drug dependence system will cover patient needs at the present. This policy must not be an obstacle for a progressive approach of both the mental health and the drug dependence systems.

REFERENCES

BIBLIOGRAPHY

Arbex Sánchez, Carmen. 2002 “Menores y consumos de drogas: Guía de intervención”. Asociación de Técnicos para el Desarrollo de Programas Sociales. 117. Madrid.

Gamella JF. Drogas: la lógica de lo endovenoso. *Claves de Razón Práctica*. Número 18, diciembre 1991, pp: 72-80.

Gamella JF. The spread of intravenous drug use and AIDS in a neighborhood in Spain. *Medical Anthropology Quaterly* 1994; 8: 131-160.

Lacoste JA. ¿Está cambiando la vía de administración de la heroína? *Med Clín (Barc)* 1992; 99: 517.

Recio Adrados JL. Las drogas en la España de hoy. Encuesta Nacional sobre Drogas 1997-98. Madrid: Editorial Complutense, 2001

Álvaro E, Vegue M. Situación actual de los tratamientos con metadona en prisión. Revista Española de Sanidad Penitenciaria 2000; 2: 77-82.

Brugué Q, Gomá R y Subirats J. Exclusión Social y Drogas. Sociedad y Drogas, una perspectiva de 15 años. Madrid, FAD, 2002.

Calafat, A; Juan, M; June 2001. The legitimating of cannabis in the Spanish society . Proyecto Hombre nº 38,. 27-38.

Camí J, Rodríguez ME. Cocaína: la epidemia que viene. *Med Clin (Barc)* 1988, 91: 71-76.

Camí J, Farré M. Éxtasis la droga de la ruta del bakalao. *Med Clín (Barc)* 1996; 106: 711-716.

Castilla J, De la Fuente L. Evolución del número de personas infectadas por el VIH y de los casos de Sida. España, 1980-1998. *Med Clín (Bar)* (en prensa).

Fernández Hermida, J.R.; Secades Villa, R. 2002. “Intervención familiar en la prevención de Drogodependencias”. Madrid.

Gamella JF, Álvarez-Roldán A. Drogas de síntesis en España. *Patrones y tendencias de adquisición y consumo.* Madrid: Delegación del Gobierno para el Plan Nacional sobre Drogas, Ministerio del Interior, 1997.

Prada C, Álvarez FJ. MDMA o éxtasis: aspectos farmacológicos, toxicológicos o clínicos. *Med Clín (Barc)* 1996; 107: 549-555.

Alvarez-Requejo A, Suelves JM, Brugal MT, Correa JF. Monitoring treatment demand for drug abuse in Spain: Perspective over a decade. *Eur Addict Res* 1999; 5: 179-184.

Agencia Antidroga. Comunidad de Madrid. Memoria 1999. Madrid: Consejería de Sanidad, 2000.

Agencia Antidroga. Comunidad de Madrid. Memoria 2001. Madrid: Consejería de Sanidad, 2002.

Arias Horcajadas F, Sánchez Romero S, Padin Calo JJ. (2002) Relevance of drug use in clinical manifestations of schizophrenia. Actas Esp. Psiquiatr. 30, 65-73.

Astals M, Torrens M, Domingo-Salvany A, Vázquez JM, Tato J, Castillo C. (2002) Comorbidity in opioid addicts in methadone maintenance treatment: preliminary results. 5th Conference of the European Opiate Addiction Treatment Association, Abstracts p. 34.

Bañuls E, Gil L, Trujols A, Tejero A, Ribalta E, Nicolás M, Batlle F, Pérez de los Cobos J. (2002) A TCI-based cluster-analytic classification of female drug-dependent inpatients. Drug Alcohol Depend. 66 (Suppl. 1), S-10.

Barrio G, De la Fuente L, Camí J. El consumo de drogas en España y su posición en el contexto europeo. *Med Clín (Barc)* 1993; 101: 344-355.

Barrio G, López-Gigosos R, De la Fuente L, Rodríguez-Artalejo R. Patrones de uso de cocaína en un grupo de consumidores de esta droga que no consumen heroína captados fuera de los servicios asistenciales. *Med Clín (Barc)* 1997; 109: 364-369.

Barrio G, Saavedra P, De la Fuente L, Royuela L and the Spanish Group for the Study of the Purity of Seized Drugs. Purity of cocaine seized in Spain, 1985-1993: variations by weight, province and year of seizure. *Forensic Sci Int* 1997; 85: 15-28.

Barrio G, Bravo MJ, De la Fuente L, Royuela L.)Está extendiéndose en España el consumo de crack en grupos que no consumen heroína? *Med Clín (Barc)* 1999: 113; 676-677.

Barrio G, Rodríguez MA, De la Fuente L, Royuela L y Grupo de Trabajo para el Estudio de las Urgencias por Psicoestimulantes. Urgencias en consumidores de cocaína: primeras evidencias de complicaciones agudas por consumo de crack. *Med Clín (Barc)* 1998; 111: 49-55.

Barrio G, De la Fuente L, Royuela L, Díaz A, Rodríguez-Artalejo F and the Spanish Group for the Study of the Route of Drug Administration. Cocaine use among heroin users in Spain: the diffusion of crack and cocaine smoking. *J Epidemiol Community Health* 1998; 52; 172-180.

Bravo MJ, Barrio G, De la Fuente L, Royuela L, Colomo C, y Grupo de Trabajo de Médicos del Mundo para la Monitorización del VIH y las Prácticas de Riesgo en Inyectores de Drogas. Evolución de la prevalencia de Infección por VIH y de prácticas de riesgo de inyección entre inyectores de drogas infectados o no por el VIH de tres ciudades españolas. *Rev Clín Esp* 2000; 200 (en prensa).

Brugal MT, Villalbí JR, Torralba L, Valverde JL, Tortosa MT. Epidemiología de la reacción aguda adversa a drogas en Barcelona, 1983-1992: análisis de la mortalidad. *Med Clín (Barc)* 1995; 105: 401-405.

Brugal MT, Domingo-Salvany A, Maguire A, Caylà JA, Villalbí JR, Hartnoll R. A small area analysis estimating prevalence of addiction to opioids in Barcelona, 1993. *J Epidemiol Community Health* 1999; 53: 488-494.

Caballero PJ, Dorado S, Brusint B, Jerez B, Medina M. Vigilancia epidemiológica de la intoxicación aguda 1997 (Estudio de 1.140 casos del área sur de la Comunidad de Madrid). *Rev Clín Esp* 1999; 424-430.

Calafat, A; Fernández, C; Becoña, E.; Gil, E.; Juan M.; you Toast, M.A. I Use and cannabis users in leisure. Monography cannabis, Addictions, vol12, supplement 20, 2000. 197-230.

Circular sobre Política global de actuación en materia de drogas en Instituciones Penitenciarias (5/95 IP).

De la Fuente L, Barrio G, Vicente J, Bravo MJ, Lardelli P. Intravenous administration among heroin users having treatment in Spain. *Int J Epidemiol* 1994; 23: 805-811.

De la Fuente L, Barrio G, Vicente J, Bravo MJ, Santacreu J. The impact of drug related deaths on mortality among young adults in Madrid. *Am J Public Health* 1995; 85: 102-105.

De la Fuente L, Saavedra P, Barrio G, Royuela L, Vicente J and Spanish Group for the Study of the Purity of Seized Drugs. Temporal and geographic variations in the characteristics of heroin seized in Spain and their relation with the route of administration. *Drug Alcohol Depend* 1996; 40: 185-194.

De la Fuente de Hoz L, Rodríguez Arenas MA, Vicente Orta J, Barrio Anta G. Epidemiología del consumo de drogas de diseño en España. *Med Clín (Barc)* 1997; 108: 54-61.

De la Fuente L, Lardelli P, Barrio G, Vicente J, Luna JD. Declining prevalence of injection as main route of administration among heroin users treated in Spain, 1991-1993. *Eur J Public Health* 1997; 7: 421-426.

De la Fuente L, Barrio G, Royuela L, Bravo MJ and the Spanish Group for the Study of the Route of Heroin Administration. The transition from injecting to smoking heroin in three Spanish cities. *Addiction* 1997; 92: 1749-1763.

De la Fuente L, Barrio G, Bravo MJ, Royuela L. Heroin smoking by Achasing the dragon@: its evolution in Spain. *Addiction* 1998; 93: 444-446

Del Rio MC, Álvarez FJ. Presence of illegal drugs in drivers involved in fatal road traffic accidents in Spain. Drug Alcohol dependence 2000; 57:177-182.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Informe nº 1 Observatorio Español Sobre Drogas. Madrid. Ministerio del Interior, 1998.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Plan Nacional sobre Drogas. Actuar es posible. Servicios Sociales y Drogodependencias. Madrid: Ministerio del Interior, 1998.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Informe nº 3 Observatorio Español Sobre Drogas: Ministerio del Interior, 2000.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Estrategia Nacional sobre Drogas 2000-2008. Madrid: Ministerio del Interior, 2000.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Informe nº4. Observatorio Español sobre Drogas. Madrid, Ministerio del Interior, 2001.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Informe nº5. Observatorio Español sobre Drogas. Madrid: Ministerio del Interior, 2002.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Salir de marcha y consumo de drogas. Madrid: Ministerio del Interior, 2002.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Encuesta Domiciliaria sobre Drogas del año 2001. Madrid: Ministerio del Interior, 2002 (Policopia. Varios informes).

Delegación del Gobierno para el Plan Nacional sobre Drogas. Indicadores de tratamiento, urgencias y mortalidad. Informe año 2001. Madrid: Ministerio del Interior, 2002 (Policopia).

Delegación del Gobierno para el Plan Nacional sobre Drogas. Encuesta sobre drogas a la población escolar 2000. Madrid: Ministerio del Interior, 2002 (Policopia. Varios informes).

Delegación del Gobierno para el Plan Nacional sobre Drogas. Informe estratégico sobre represión del tráfico ilegal de drogas. Madrid, 2002.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Plan Nacional sobre Drogas. Memoria 2001. Madrid: Ministerio del Interior, 2003.

Delegación del Gobierno para el Plan Nacional sobre Drogas. Encuesta sobre drogas a la población escolar 2002. Madrid: Ministerio del Interior, 2003 (Policopia. Varios informes).

Díaz A, Barruti M, Doncel C. *Les línies de l'èxit? Naturalesa i extensió del consum de cocaïna a Barcelona.* Barcelona: ICESB-Ajuntament de Barcelona, 1992.

Domingo A, Antó JM, Camí J. Epidemiological surveillance of opioid-related episodes in an emergency room of Barcelona, Spain (1979-1989). *Br J Addict* 1991; 86: 1459-1466.

Domingo-Salvany A, Hartnoll R, Antó JM. Opiate and cocaine consumers attending Barcelona emergency rooms: a one year survey (1989). *Addiction* 1993; 88: 1247-1256.

Domingo-Salvany A, Hartnoll RL, Maguire A, Brugal MT, Albertín P, Caylà JA, *et al.* Analytical considerations in the use of capture-recapture to estimate prevalence: case studies of the estimation of opiate use in the Metropolitan Area of Barcelona, Spain. *Am J Epidemiol* 1998; 148: 732-740.

Domingo-Salvany A, Correa JF, Izarzugaza I. Estimación de la prevalencia de consumo de opiáceos en dos áreas geográficas. Aplicación del método de captura-recaptura. XIX Reunión Científica de la SEE. Murcia 17-19 octubre 2001.

Espinosa G, Miró O, Nogué S, To-Figueras J, Sánchez M, Coll-Vinent B. Intoxicación por éxtasis líquido: estudio de 22 casos. *Med Clín (Barc)* 2001; 117:56-58.

Fundación Secretariado General Gitano. Grupos étnicos minoritarios y consumo de drogas. Madrid, 2002.

Gamella JF, Álvarez-Roldán A, Romo N. La Afiesta@ y el Aéxtasis@. Drogas de síntesis y nuevas culturas juveniles. *Revista de Estudios de Juventud* 1997b; 40: 17-36.

Hernández-Aguado I, Aviñó MJ, González-Aracil J *et al*. Human Inmunodeficiency virus (HIV) infection in parenteral drug users: evolution of the epidemic over 10 years. *Int J Epidemiol* 1999; 28: 335-340.

Instituto de Salud Carlos III. Vigilancia del Sida en España. Situación a 30 de junio de 2001. Registro Nacional de Sida. Madrid: Ministerio de Sanidad y Consumo, 2001.

Lacoste JA, Valverde E, González JM, Chavernas S, De la Cruz A, Marín C et al. Cambio en los hábitos de administración de la heroína y la cocaína. Estudio comparativo entre 1990 y 1991. *Adicciones* 1993; 5: 339-347.

Lora-Tamayo C, Tena T, Rodríguez A. Amphetamine derivative related deaths. *Forensic Sci Int* 1997; 85: 149-157.

Martínez JM, Del Río MC, López N, Álvarez FJ. Illegal drug-using trends students in a Spanish University in the last decade (1984-1994). *Subst Use Misuse* 1999; 34: 1281-1297.

Miró O, Nogué S; Espinosa G, To-Figueras J, Sánchez M. Trends in illicit drug emergencies: the emerging rol of gamma-hydroxibutyrate. *Toxicol Clin Toxicol* 2002; 40(2): 129-135.

Muga R et al. Mortalidad en una cohorte de usuarios de drogas por vía intravenosa antes de la introducción de la terapia VIH potente. Med Clin (Barc) 1999; 112: 721-725.

Ortí RM, Domingo-Salvany A, Muñoz A, McFarlane D, Suelves JM, Antó JM. Mortality trends in a cohort of opiate addicts, Catalonia, Spain. *Int J Epidemiol* 1996; 25: 545-553.

Rodés A, Vall M, Casabona J, Nuez M, Rabella M, Mitrani L. Prevalencia de infección por el virus de la inmunodeficiencia humana y de los comportamientos asociados a su transmisión entre usuarios por vía parenteral seleccionados en la calle. *Med Clín (Barc)* 1998; 111: 372-377.

Rodríguez-Arenas MA, Barrio G, De la Fuente L, Vicente J y Grupo de Trabajo para el Estudio de las Urgencias por Psicoestimulantes. Urgencias relacionadas con el consumo de drogas de diseño, alucinógenos y anfetaminas atendidas en 15 hospitales españoles durante 1994. *Rev Clín Esp* 1997; 197: 804-809.

San L, Tato J, Torrens M, Castillo C; Farré M, Camí J. Flunitrazepam comsumption among heroin addicts admitted for in-patient detoxification. *Drug alcohol Depend* 1993; 281-286.

Sánchez J, Rodríguez B, De la Fuente L, Barrio G, Vicente J, Roca J et al. Opiates or cocaine: mortality from acute reactions in six major Spanish cities. *J Epidemiol Community Health* 1995; 49: 54-60.

Sánchez-Carbonell J, Brigos B, Camí J. Evolución de una muestra de heroinómanos dos años después del inicio del tratamiento (proyecto EMETYST). *Med Clín (Barc)* 1989; 92: 135-39.

Secretaría del Plan Nacional sobre el Sida. VIH y sida en España. Situación epidemiológica 2001. Madrid: Ministerio de Sanidad y Consumo, 2002.

Secretaría del Plan Nacional sobre el Sida. Infección por VIH y sida. España. Plan Multisectorial 2001-2005. Madrid: Ministerio de Sanidad y Consumo, 2002.

Sopelana P, Carrascosa C, García-Benito P. Evolución de la prevalencia de infección por VIH-1 en drogodependientes de la Comunidad de Madrid (1985-1996). *Med Clín (Barc)* 1998; 11: 257-258.

Torralba L, Brugal MT, Villalbí JR, Tortosa MT, Toribio A, Valverde JL. Mortality due to acute adverse drug reactions: opiates and cocaine in Barcelona, 1989-93. *Addiction* 1996; 91: 419-426.

Torrens M, San L, Peri JM, Ollé JM. Cocaine abuse among heroin addicts in Spain. *Drug Alcohol Depend* 1991; 27: 29-34.

Villalbi JR, Brugal MT. Sobre la epidemia de heroína, su impacto, su contexto y las políticas sanitarias. Med Clin (Barc) 1999, 112: 736-737

UNAD (Unión Española de Asociaciones y Entidades de Atención al Drogodependiente). Aunando esfuerzos nº 69. Madrid, 2002.

DATA BASES/SOFTWARE/INTERNET ADDRESSES

- Arbex Sánchez, Carmen. 2002 “Menores y consumos de drogas: Guía de intervención”. Asociación de Técnicos para el Desarrollo de Programas Sociales. 117. Madrid. http://www.mir.es/pnd/publica/pdf/menoresyconsumos.pdf

- General Registry of Mortality http://www.ine.es/inebase/

- Páginas institucionales de Delegación del Gobierno para el Plan Nacional sobre Drogas:
  - http://www.mir.es/pnd/index.htm
  - http://www.sindrogas.es

- Asociación de Expertos para la Promoción y Divulgación de la Salud Mental de la Comunidad Autónoma Vasca. http://www.osasunekintza.org

ANNEXES

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ANNEX 3. LIST OF ABBREVIATIONS USED IN THE TEXT

AIDS	Acquired Immune Deficiency Syndrome
CCAA	Autonomous Communities
EMCDDA	European Monitoring Centre for Drug and Drug Addiction
EU	European Union
FEMP	Federación Española de Municipios y Provincias
GDNPD	Government Delegation for the National Plan on Drugs
GRM	General Registry of Mortality
HIV / VIH	Human Immuno-deficiency Virus
INIFD	Instituto Nacional de Investigación y Formación sobre Drogas
SMCDDA	Spanish Monitoring Centre for Drugs and Drug Addiction
TDI	Treatment Demand Indicator