European Monitoring Centre for Drugs and Drug Addiction

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, POLITICA SOCIAL E IGUALDAD
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2010 NATIONAL REPORT (2009 data) TO THE EMCDDA
by the Reitox National Focal Point

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

REITOX

CONTENT TABLE

The present report on the drug situation in Spain in 2009 has been elaborated by the Spanish Focal Point, the Government Delegation of National Plan on Drugs (DGPNSD), in accordance with the established guidelines by the European Observatory on Drugs and Drug Addiction as part of the contract REITOX.

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

With regard to the legal framework, in the year 2009 several dispositions of interest were approved and published on diverse aspects referring to the phenomena of drugs.

Special mention must first of all be made of the *Council of Ministers Resolution of January 23, 2009* issued in passage of the 2009-2016 National Strategy on Drugs (published in the Spanish Official Gazette on February 13, 2009 in accordance with the resolution of the Government Delegation for the National Plan on Drugs of February 2nd).

As far as the control of psychotropic substances is concerned, special note must be made of the passage of *Order SAS/1916/2009 of July 8th, by virtue of which the substance 1-benzylpiperazine (BZP) was included in Annex I to Royal Decree 2829/1997 of October 6th governing the manufacture, distribution, prescription and dispensing of psychotropic substances and preparations.*

Within the scope of the control of substances catalogued as drug precursors, special mention must be made of new *Law 4/2009 of June 15th governing control of drug precursors*, revoking the regimen established until that time under Law 3/1996 of January 10th.

It is important to highligh the collaborating and coordinating effort carried out within all scopes related to drugs and drug addiction with the aim of reaching a consensus regarding a 2009-2012 Plan of Action for carrying out the new National Strategy approved in January 2009 and which entered into effect that same year, which entailed, in turn, a major effort of coordinating all the stakeholders and sectors involved. The 2009-2012 Plan of Action is a document which the Interautonomic Commission has adopted, including the actions which will be carried out for the purpose of accomplishing the objectives set under the Strategy by the year 2016.

Also still in force is the 2007-2010 Cocaine-Combating Program. The Government Delegation started up the implementation of this Program during the first quarter of 2007. From that time up to the end of 2009, more than 300 programs have been started, with the participation of Autonomous Communities, NGO's and Research Units. Over these nearly three years, more than fifteen million euros have been allocated to starting up and carrying out these programs.

In 2009, the results of the latest 2007-2008 Nationwide Survey on Alcohol and Drugs in Spain (Home Survey on overall population within the 15-64 age range) have also been presented. A total of 23,715 people were surveyed. The questionnaire shows some changes compared to previous years aimed at converging with the model proposed by the European Drug and Drug Addiction Monitoring System.

The main conclusions reached based on the analysis of this Survey are:

- The data shows a positive trend, with a reduction in the use of tobacco, alcohol and cannabis for all frequencies of use.
- Although powder cocaine use has stabilized, the continuity in use has dropped to a major degree.
- Polydrug use is revealed, once again, to be a constant among illegal drug consumers.
- The perception of the risk has increased. Outstanding are the greater perceived risk concerning daily and weekend alcohol consumption, occasional cannabis use and, due to its relevance, occasional cocaine use.
- For the first time, the perceived availability of drugs has decreased after several years of continuous growth.

Regarding prevention, according to the information provided by the Autonomous Communities, there are 101 structured programs[1] now being put into practice in Spain. Some of these programs are quite widely extended and are being used in more than just one Autonomous Community. The Spanish Government Delegation for the National Plan on Drugs has held the 8th edition of the *"The Secret to a Good Life"* school contest, reaching 100,000 students from 1,450 schools. Also, the Ministry of the Interior also carries out drug prevention activities at schools: the *Strategic Police Response Plan to Retail Traffic and Drug Use at schools and in the areas around schools and*, in collaboration with the Ministry of Education, the *Master Plan for improving peaceful living and safety at school.*

One of the regular lines of intervention within the community scope in Spain, in addition to other measures already included under other headings (family programs, in-situ training …) are the alternative leisure time activities programs.

Finally, the top priority selective prevention groups are families and the under age or young consumers who drop out of the educational system or who have disputes with the law, immigrants and recreational drug consumers in night-time leisure spaces.

About problem drug use, it should be stressed that another way of assessing problem drug use is by means of adding screening tools into the surveys for the purpose of achieving an overall view of the population with regard to the use of certain substances. In the 2009 Home Survey on Alcohol and Drugs in Spain, the AUDIT scale was added for the purpose of assessing at-risk or harmful drinking among Spain's population. The results are currently in the data mining and analysis stage.

On the other hand, In Spain, the implementation, management and evaluation of the resources and programs for providing care for drug users come under the authority of the Autonomous Communities and Autonomous Cities, as does providing help and counseling for the families of these individuals.

In general, the main objective of these plans is to reduce the morbimortality and the health and social problems related most directly to drug abuse.

Thus, in the care provided for drug-dependent individuals, the priorities include heightening the quality of the services provided by the treatment centres, developing effective treatment programs, providing care for those drug-dependent individuals who have special problems and further expanding and diversifying the care offer.

Over the past 20 years, AIDS and HIV infection have been one of the main health problems associated with drug use in Spain. Data presented in this report are available from different sources of information which, as a whole, aids toward understanding the evolution of this phenomenon as well as the current situation.

On the scope of responses to health correlates and consequences, drug users are provided with care in Spain at public and publicly-funded centres managed directly by the Autonomous Government Communities or by NGO's.The harm reduction programs are carried out mainly at social emergency centres, mobile units, pharmacies and in controlled use rooms (safe injection).

There are numerous programs for exchanging and dispensing needles, as well as sanitary kits (in addition to a needle, these kits also usually include liquid disinfectant, condoms, etc.) which are handed out both in outreach programs and at more institutionalized centres and resources. A total of approximately 3,422,000 needles and/or sanitary kits have been handed out nationwide in Spain in 2008.

Care is provided for psychiatric co-morbidity at both the drug dependence care centres and at the mental health centres. In 2008, the Autonomous Community Administrations have reported there being 105 dual disorder care program, having provided are for 9,985 drug-dependent patients with psychiatric co-morbidity.

Besides all of the Autonomous Communities and Autonomous Cities are carrying out activities in collaboration mostly with the Ministry of the Interior for the purpose of preventing or reducing the number of traffic accidents and their consequences, particularly as far as their relationship with drinking and other drugs is concerned. One of these activities worthy of special mention are the awareness heightening campaigns targeting young people and adolescents, measures in the media, preparing and handing out educational materials, etc.Driver blood alcohol content checks have been stepped up, carried out by the Civil Guard Traffic Division (Ministry of the Interior).

Regarding social reintegration, the 2009-2016 National Drug Strategy includes as one of its general objectives that of facilitating the reintegration into society of the individuals in the process of rehabilitation by means of integral training and employment preparation and insertion programs.

The Spanish Government Delegation for the National Plan on Drugs, being aware of these problems, is supporting different activities aimed at encouraging this goal being accomplished, by way of the calls for applications it is making for granting aid to the non-profit organizations

In the drug markets area, the decline of cocaine and hashish seized in Spain suggests the use of new routes while production and distribution of ecstasy doesn't present significant changes. As for the heroin most of the seized heroin is of the "brown sugar" and the same routes continue being used. Concerning the prices can be observed a rise on the resale dealer market in hashish resin over the last nine years while a downward trend has been detected in the wholesale market. Same trends are showed for Marijuana.

This year the mandatory Selected Issue is on the subject of "History, methods and implementation of national treatment guidelines". In this chapter, it is traced the evolution of the treatment guidelines in Spain along the history, with special mention to the existing guidelines.

Finally, the report shows the voluntary Selected Issue referring to “Cost of drug-related treatment in Spain”. The economic resources for treatment come mainly from the Autonomic Plans on Drugs and to a lesser extent from local governments. A significant sum of money is transferred from the Central Government to the Autonomic Plans on Drugs.

This report can not show data regarding expenditures of treatment to drug users for pathologies associated to drug use. It has been done a bibliographic research of existing studies on the costs analysis and economic evaluations in the scope of drug dependencies treatment in Spain.

Besides, the studies on illegal drugs in Spain from 2005 to 2010 are analyzed in those national and international journals considered more relevant in specific field of drug addictions.

Part A:

NEW DEVELOPMENTS AND TRENDS

INTRODUCTION

Firstly, an understanding as to how Spain's territory is divided from a political standpoint is necessary. The territory is divided into 17 Autonomous Communities and two Autonomous Cities. An Autonomous Community is a territorial entity which, within the constitutional laws of Spain and in accordance with a division of powers between the Central Government and the Autonomous Communities as governed under Spain's Constitution is vested with legislative autonomy and executive powers, as well as the power of self-government by means of its own representatives.

This territorial distribution also has a bearing on drug policy, given that the Autonomous Communities and even the smaller Municipal Governments are vested with certain authorities concerning this matter. This leads to the coordination-related aspect being indispensable and of utmost importance. The territorial coordination is carried out through an administrative organization which includes:

- Sectorial Conference (political scope): Chair person: the Minister of Health and Social Policy. Composition, members of the Central Government and those responsible for the drug policy of the Autonomous Communities and Autonomous Cities.

- Interautonomic Commission (management scope): Chair person: Government Delegate for the National Drug Plan. Composition, those responsible for the Autonomous Community Drug Plans.

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

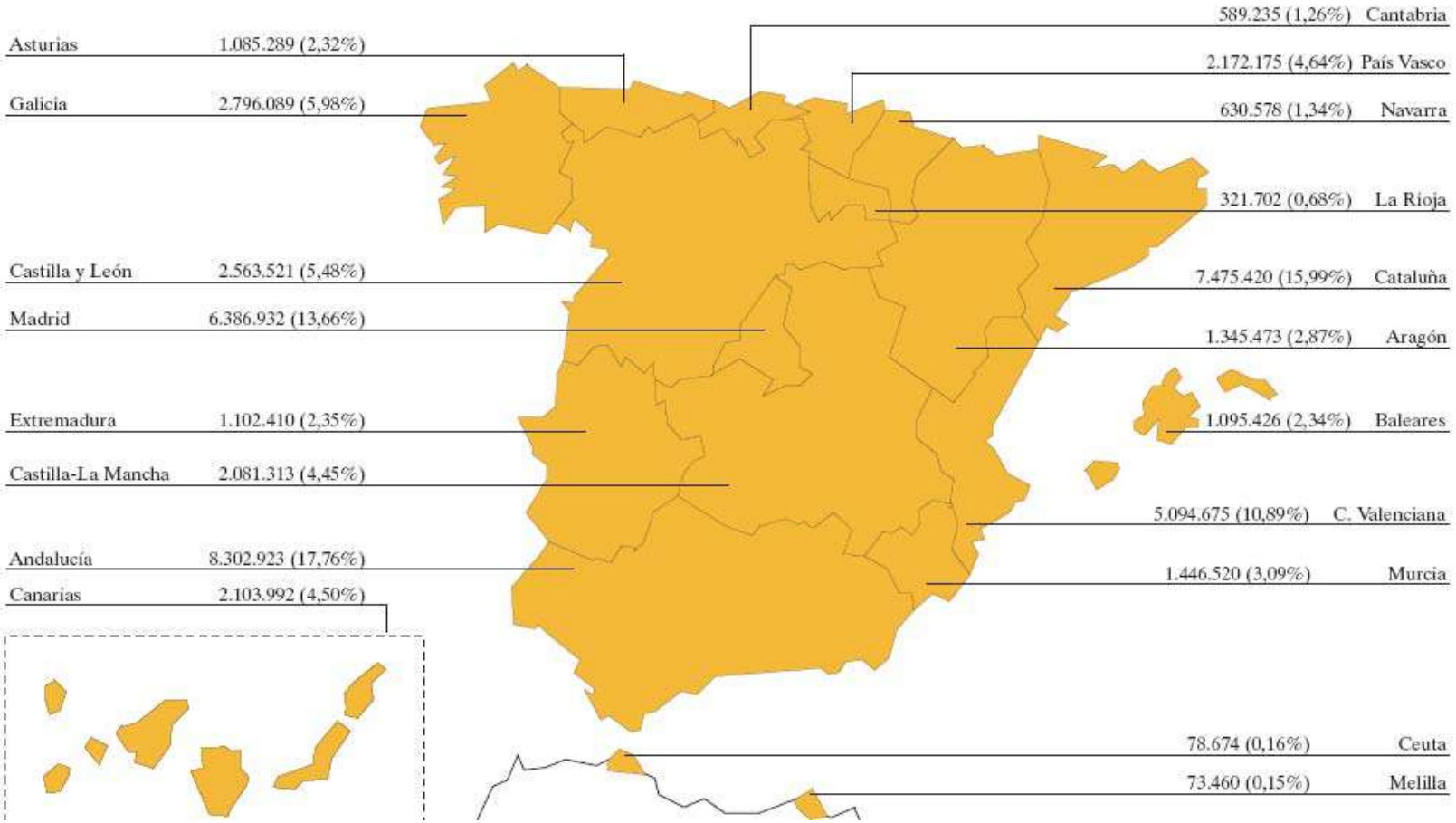
On the other hand, the year 2009, to which this report refers, marked the end of the period throughout which the 2000-2008 National Strategy on Drugs and its second 2005-2008 Plan of Action had been in effect. Within this context, a new Strategy (previously mentioned in the respective report for 2008) was prepared to remain in effect throughout the 2009-2016 period. This new Strategy will be set into operation by way of two individual four-year Plans of Action.

In 2009, the 2009-2012 Plan of Action, which will be dealt with at greater length at a further point herein, was fully prepared and presented.

The general information concerning the 2000-2008 National Strategy on Drugs, the interim evaluation of the 2000-2008 National Strategy and the 2005-2008 Plan of Action, which went out of effect in 2008, is included in Structured Questionnaire 32 submitted to the EMCDDA in 2006.

Also in 2009 the results of the Home Survey on Alcohol and Drugs in Spain have been publicized, which is conducted nationwide among the population within the 15-64 age range who are living in households within the framework of an ongoing series of surveys which have been being conducted on a biennial basis since 1995.

Figure 1.1. Spain: Population by Autonomous Communities and Autonomous Cities and Percentage of the Total Population



Note: Spain's total population in 2009 is estimated at 46,745,807 inhabitants. The map above shows the population by Autonomous Communities and Autonomous Cities, as well as the percentages over the total population.

LEGAL FRAMEWORK

As far as the regulatory activities are concerned, several provisions of law of interest concerning different aspects related to the drug phenomenon have been passed and published in Spain in 2009.

Special mention must first of all be made of the *Council of Ministers Resolution of January 23, 2009* issued in passage of the 2009-2016 National Strategy on Drugs (published in the Spanish Official Gazette on February 13, 2009 in accordance with the resolution of the Government Delegation for the National Plan on Drugs of February 2nd).

According to the aforementioned Resolution, the new Strategy is for the following end purposes: On one hand, to update the National Plan on Drugs by guiding, promoting and coordinating the different measures on the subject of drugs and drug addictions which are being carried out in Spain within the 2009-2016 period and, on the other hand, to serve as a framework of reference for setting up the necessary coordination, collaboration and cooperation among the different government agencies and non-governmental organizations devoted to the drug addiction phenomenon.

The content of the new National Strategy on Drugs - which is included as an addendum to the aforementioned Resolution - is divided into six (6) major sections (introduction; current status; guiding principles and overall objectives; coordination; fields of action; and evaluation), which refer both to reducing the demand for these substances (this being one aspect in which prevention plays a crucial role), and to controlling the supply thereof, also including international cooperation in these two fields.

As far as the control of psychotropic substances is concerned, special note must be made of the passage of *Order SAS/1916/2009 of July 8th, by virtue of which the substance 1-benzylpiperazine (BZP) was included in Annex I to Royal Decree 2829/1997 of October 6th governing the manufacture, distribution, prescription and dispensing of psychotropic substances and preparations.*

This regulatory standard serves to render actual compliance in Spain with *European Council Decision 2008/206/JAI of March 3, 2008*, in which the aforementioned substance is defined as a new psychotropic substance which must therefore be subject to the control measures and to the criminal penalties for which provision is made under the national legislation in force on this subject in accordance with the obligations undertaken by virtue of the 1971 United Nations Convention on Psychotropic Substances.

Within the scope of the control of substances catalogued as drug precursors, special mention must be made of new *Law 4/2009 of June 15th governing control of drug precursors*, revoking the regimen established until that time under Law 3/1996 of January 10th.

The new rule of law is warranted - essentially - on the grounds of the need of adapting Spain's domestic standards as regards the subject of the *European Parliament and Council Regulations 273/2004 of February 11th on drug precursors, European Council Regulation 111/2005 of December 22, 2004 setting forth rules for monitoring drug precursor trading among the Community and non-EU countries and European Commission Regulation 1277/2005 of July 27th setting forth standards for the enforcement of the two aforementioned Regulations*.

Although the aforesaid EU regulations are of a mandatory nature in all their elements and are directly applicable in the member States, these EU rules of law however order each member State to determine the regimen of penalties applicable to the violations of such Regulations as well as to adopt the measures necessary to guarantee the applying thereof, also requiring that the penalties for which provision is made be effective, proportional and deterrent.

This new law renders appropriate compliance with the aforementioned EU provisions. Thus, it governs the existence of a *General Registry of Catalogued Chemical Substance Operators* (attributing authority over the same to the Ministry of the Interior) and of a *Registry of Foreign Trade Operators of Catalogued Chemical Substances* (attributing authority over the same to the Ministry of Economy and Finance), which shall be sole nationwide registries. And, similarly, the law vests the Ministry of the Interior with the authority over granting the business permits to these operators for carrying out transactions within the EU, and to the Ministry of Economy and Finance the authority for granting the business permits when carrying out transactions outside of the EU is involved.

Lastly, regarding the subject of penalties, the most important new aspects entailed in the new legal standard worthy of note are both the substantial lowering of the amount of the fines and of the length of time throughout which the business permit is suspended, as well as the shortening of the time periods under the statute of limitations of the different offences for which provision is made thereunder.

Of major importance is the reform carried out this year (2009) on the regime governing the powers of Spain's jurisdiction over trying cases concerning the violations of law entailing illegal toxic drug dealing committed by citizens of Spain or foreigners outside of the national territory by means of the amendment of Article 23.4 of the Judiciary Power Act, which takes place with *Act 1/2009 of November 3rd supplementary to the Law reforming the procedural legislation for the implementation of the new Judiciary Office, thus amending Judiciary Act 6/1985 of July 1st.*

In fact, according to the aforementioned reform - in keeping with an initiative of the Spain's Congress of Deputies - the province of Spain's Courts over trying the aforesaid offences committed outside of the territory of Spain - save that which may be stipulated under the international treaties and agreements signed by Spain - is conditioned to the substantiation of those allegedly responsible being in Spain or there being victims who are Spanish nationals, or rather that proof be found as to any relevant link connecting to Spain and, in any case, no proceedings having been filed in another competent country or within an International Court entailing any actual investigation and prosecuting of the same punishable acts.

Regarding preventing toxic drug use and the harmful consequences thereof on many social areas, special mention must be made of three rules of law of a regulatory nature enacted during this year.

The first is *Royal Decree 641/2009 of April 17th, by virtue of which the doping control processes and the authorized analysis laboratories are governed and by way of which supplementary measures for preventing doping and safeguarding health in sports are set forth.* By way thereof*, Act 7/2006 of November 21st for safeguarding health and combating doping in sports* is further expanded upon in part.

Other aspects dealt with under this Royal Decree - in further expansion upon the aforesaid law, include the following as worthy of special mention: that of establishing the general regulatory framework within which the list of substances and methods

prohibited in sports falls (province over the approval thereof being attributed to the Office of the President of the National Sports Council); the regulation of a set of positive measures for preventing doping; determining the procedure for granting the permits for therapeutic use which allow using prohibited substances or methods; and the setting out of different provisions applicable to conducting the doping control checks (laboratories, actual conducting of the checks and taking of samples, etc…).

The second aspect is related to the field of highway safety, with the passage of *Royal Decree 818/2009 of May 8th, by virtue of which approval was rendered of the General Driver Regulations.* As the Regulation in force until that time had set forth in the past (approved by Royal Decree 772/1997 of May 30th), which has been revoked, one of the requirements for obtaining a driver's license or permit included under the new Regulation still requires meeting the requirements regarding the required psycho-physical aptitudes in each case in relation to the class of permit or licenses for which application is being made.

To this end, the legal obligation is also expanded upon in the regulation as to submitting to the psycho-physical aptitude tests, the diseases and defects related to the disorders having to do with substance use (alcohol and/or toxic drugs being expressly included among the same) which shall be causes for refusal or placing limitations for being granted or renewing a driver's license or permit are similarly stipulated in detail in Section 11 of Annex IV.

Lastly, the third aspect which must also be taken into account in the field of air safety is the passage of *Royal Decree 1516/2009 of October 2nd, by virtue of which EU air traffic controller licensing is governed.*

Under this provision, in addition to the requirements of the medical certificates necessary for obtaining and keeping this license are regulated, specifically set forth thereunder is the obligation applicable to the providers of air navigation services and to the training providers of preventing the controllers or student controllers from performing their duties when reasonable indications exist as to diminished psycho-physical capacity or when they are under the effects of some psychoactive substance, alcohol or any medication, which might prevent them from performing the duties to which the license refers in a proper, safe manner.

To conclude this review of the new aspects which have come to bear in the Central Government legislation, mention must be made in the organizational field of the reform carried out by virtue of *Royal Decree 640/2009 of April 17th enacted in further expansion of Royal Decree 542/2009 of April 7th, by virtue of which the ministerial departments were restructured and in amendment of Royal Decree 438/2008 of April 14th,* by virtue of which approval was rendered of the basic organizational structure of the ministerial departments, according to which the Government Delegation for the National Plan on Drugs was thereby assigned - with Directorate-General ranking- to the Office of the Secretary General of Social Policy and Consumer Affairs), subsequently being set forth the specific authorities concerning the subject of drugs of this Secretariat General, and those of the Government Delegation proper under Articles 11.1 and 14, respectively, of *Royal Decree 1041/2009 of June 29th, by virtue of which the basic organizational structure of the Ministry of Health and Social Policy was further expanded upon and amendment made of Royal Decree 438/2008 of April 14th by virtue of which approval was rendered of the basic organization structure of the ministerial departments.*

Within an exclusively Autonomous Community-related scope, the most outstanding regulatory activities having taken place in 2009 are related to the reforms of Articles 15

and 48 of *Law 20/1985 of July 25th on prevention and care with regard to potentially addictive substances* of the Autonomous Community of Catalonia; as well as of Articles 20, 26 and 41 of *Law 5/2002 of June 27th on Drug Addictions and Other Addictive Disorders* of the Autonomous Community of Madrid.

In the first case, the most important aspect of the reform has to do with the prohibition of the promotion - and advertising in any media - of alcoholic beverages in establishments, shops and other spaces authorized for the supply or use thereof which is done by means of promotional offers, prizes, drawings, etc… which are advertised under names such as "open bar", "buy one, get one free", "get three from the price of one" or any other similar thereto.

In the second case, that most worthy of special note is the reform revolving around the regulation of the inspection and control regime of the sociosanitary establishments providing care for drug addicts, of the minimum requirements these centres must meet - whether public or private - in order to be able to carry out their activities, as well as the starting up of the activities thereof being subject to being notified within the time frame of 30 business days.

In conclusion of this review, mention must be made- in the field of the international regulatory activities of a bilateral nature - of two provisions of law of importance for the cooperation for combating illegal toxic drug traffic and the laundering of the money resulting from the same. Firstly, the *Convention between the Kingdom of Spain and the Republic of Turkey on the subject of cooperation in the fight against delinquency made <ad referendum> in Istanbul on April 5, 2009* (to enter into effect on December 1, 2009); and, secondly,, the *Agreement between the Kingdom of Spain and the Government of the Republic of Albania on Cooperation and Mutual Assistance Concerning Customs-Related Matters made in Tirana on May 20, 2009* (to enter into effect on November 7, 2009).

NATIONAL ACTION PLAN, STRATEGY, EVALUATION AND COORDINATION

To be highlighted, first of all, under this heading is the collaborating and coordinating effort carried out within all scopes related to drugs and drug addiction with the aim of reaching a consensus regarding a 2009-2012 Plan of Action for carrying out the new National Strategy approved in January 2009 and which entered into effect that same year, which entailed, in turn, a major effort of coordinating all the stakeholders and sectors involved. The 2009-2012 Plan of Action is a document which the Interautonomic Commission has adopted, including the actions which will be carried out for the purpose of accomplishing the objectives set under the Strategy by the year 2016.

This Plan of Action highlighting the public health dimension as a social component of drug policies, is a firm commitment to improving the interventions and guaranteeing their quality through the activity coordinated among all of the administrations, which have, in turn, the indispensable collaboration of the non-governmental organizations to get the measures included under this Plan under way.

After the Strategy entered into effect, the Government Delegation for the National Plan on Drugs promoted a process for the drafting of the first Plan of Action. In this process, which took place over the first three months of 2009, those social entities and

administrations which had collaborated in drafting the Strategy also collaborated in this process, that is to say: the Drug Plans of the Autonomous Communities and Autonomous Cities, the non-governmental organizations in this sector, experts in the different fields of intervention in drug addictions, scientific societies and different agencies of the Central Government administrations.

This Plan has been designed in synch, with regard to its structure, with the 2009-2012 European Union Action Plan and, with regard to its contents, with the Plans of Action of the Autonomous Communities, the international plans and those of the EU member states. It is also the result of the evaluation of the previous 2005-2008 Plan of Action.

The main characteristics of this Plan are:

- Carrying out the 2009-2016 National Strategy on Drugs.
- Representative of all sectors of the National Plan on Drugs.
- Respectful of the authorities of all the administrations.
- Integrating all areas.
- Based on the current situation and adaptable to new scenarios.
- Possible and continuously assessable.
- Result of the evaluation of the previous 2000-2008 Strategy.

The Plan is structured into six (6) areas: coordination, demand reduction, supply reduction, improving knowledge, training and international cooperation. These areas include 14 objectives coinciding with those included in the 2009-2016 Strategy, which are divided, in turn, into 68 actions. The Plan also includes the description of the stakeholders involved in getting the Plan under way and the indicators for evaluating each one of the actions.

The area of on which importance is placed is that of "demand reduction", divided into three sections (prevention, risk reduction and harm reduction and care and social integration), totalling practically 53% of all of the actions, and within this area, the majority of the actions are preventive, totalling 25% of all of the actions included under the Plan, followed by the actions related to "care and social integration", totalling 19.11% of all actions.

Worthy of highlighting under this prevention-related heading are the actions aimed at heightening the awareness and informing the different sectors of society concerning the risks to which using drugs may lead, as well as the emphasis placed on all that which has to do with prevention in the educational and school environments. Notwithstanding this emphasis on reducing the demand, it has been attempted to endow the Plan as a whole with balance in all areas, as well as to take into account the most recent knowledge regarding the trends in drug use, the modes of use and the profiles of drug consumers. Likewise, in keeping with that for which provision is made under the Strategy, the need is stressed of developing programs - whether of a preventive, care or social integration-related type - the effectiveness of which is backed by scientific evidence.

On the other hand, the work related to the final evaluation of the previous 2000-2008 National Strategy on Drug has been carried out satisfactorily throughout 2009, the final report being anticipated to be presented during the first half of 2010.

In 2009, the Central Government's investment (through the Government Delegation for the National Plan on Drugs) devoted to carrying out the 2009-2012 Plan of Action, kicking off the new 2009-2016 Strategy entering into effect and the first of the two in

which it is being carried out, is estimated at around 24,000,000 euros. This sum has been used to fund some 400 measures encompassing all areas of intervention of the Plan of Action: coordination, demand reduction (prevention, risk reduction and harm reduction, care and social integration), supply reduction, improving the basic and applied scientific knowledge, training and international cooperation.

As far as the coordinating and collaborating bodies regarding which the need thereof has been previously stated, the calls from the different coordinating bodies, both from the Sectorial Conference between the Central Government and the Autonomous Communities and from the Interautonomic Commissions, which held three meetings in 2009, have continued to be frequent. The National Commission for the Prevention and Treatment of Drug Addictions in the Work Environment also held meetings, having met twice in 2009.

Apart from the above, the Government Delegation has continued along its line of collaborating and working more closely with the Joint Congress-Senate Commission for the Study of the Drug Problem. On the part of the Ministry of Health and Social Policy, in addition to different appearances throughout 2009 concerning general and circumstantial drug policy, it has presented the 2009-2012 Plan of Action before said Commission.

Under this heading of strategies and policies, mention must be made of the continuing of the activity started up the year before which is mentioned in the respective Report, of the Institutional Drug Use-Related Health Policies Committee, with representatives from all the Autonomous Communities, within the framework of the Pact for Health presented before the Congress of Deputies Health and Consumer Affairs Commission and approved by all of the parliamentary groups in 2008, with physical meetings an virtual work via e-room to accomplish political commitments on the part of all the components within their attributed authorities.

Also still in force is the 2007-2010 Cocaine-Combating Program. The Government Delegation started up the implementation of this Program during the first quarter of 2007. From that time up to the end of 2009, more than 300 programs have been started, with the participation of Autonomous Communities, NGO's and Research Units. Over these nearly three years, more than fifteen million euros have been allocated to starting up and carrying out these programs.

This Program's objective encompasses several actions aimed at carrying out informative campaigns regarding cocaine, informative measures targeting parents, conveying information to young people and providing information to the society as a whole, to further strengthen the prevention programs in both the educational and workplace environments, to promote the active involvement of the companies in the leisure time entertainment sector and to promote measures for heightening the awareness as to the risks involved in using cocaine.

This Cocaine Combating Program, regarding which information has been provided in previous years, is structured into four areas of intervention (coordination, demand reduction, international cooperation and supply control) and marks 8 operating objectives and 33 specific actions.

In 2009, the results of the latest 2007-2008 Nationwide Survey on Alcohol and Drugs in Spain (Home survey on overall population within the 15-64 age range) have also been presented. A total of 23,715 people were surveyed. The questionnaire shows some changes compared to previous years aimed at converging with the model proposed by the European Drug and Drug Addiction Monitoring System. The field work was done

from November 2007 to March 2008. No surveys were conducted during the month of January so as to avoid the influence of the holidays on the questions concerning drug use within the past 30 days.

The main conclusions reached based on the analysis of this Survey are:

- The data shows a **positive trend**, with a reduction in the use of tobacco, alcohol and cannabis for all frequencies of use.

- Although powder **cocaine use** has stabilized, the **continuity in use** has dropped to a major degree (i.e. in 1997, 47.1% had used cocaine sometime in their life and had also done so within the past twelve months. In the 2007-2008 Survey, this percentage had dropped down to 37.5%.)

- **Polydrug use** is revealed, once again, to be a constant among illegal drug consumers.

- **The perception of the risk** has increased. Outstanding are the greater perceived risk concerning daily and weekend alcohol consumption, occasional cannabis use and, due to its relevance, occasional cocaine use.

- **For the first time, the perceived availability** of drugs has decreased after several years of continuous growth.

In the area of prevention, special mention must be made of the campaigns conducted, both by the Central Government (Government Delegation for the National Plan on Drugs) and by the Autonomous Communities. All that which has to do with the prevention area is explained in greater detail in the respective section of this report.

The Government Delegation has continued the "Bike Tour" campaign begun in 2008. In November 2009, 5,000 people took part in this event, consisting of a bike tour of the city of Madrid with the main objective of promoting a healthy life, avoiding taking doping substances and using alternative means of moving about town. "Enjoy yourself and get moving …. all on your own power!" is the slogan of this project to which some major Spanish companies as well as the Municipal Government of Madrid have joined in to support.

The Government Delegation for the National Plan on Drugs, in collaboration with the Cantabrian Department of Health and Social Services, organized a Symposium in July 2009, totalling 10 classroom hours on "Drugs: Other Views" as part of the Menéndez Pelayo International University summer courses.

Also noteworthy is the presentation of the fourth Government Delegation for the National Plan on Drugs Clinical Commission Report devoted to a review of Cannabis, presented during the last quarter of 2009, yet another in the series prepared in 2006, 2007 and 2008 respectively on cannabis, alcohol and cocaine.

Within the Autonomous Community scope, all of the Autonomous Communities has regional strategies dealing with the subject of drug addictions. Thus:

The Autonomous Community Drug Addiction Strategies and Plans.

1. **2002-2007 Andalusian Plan on Drugs and Addictions**. Autonomous Government of Andalusia. Department of Social services. Currently in the process of preparing Plan III for the 2010-2016 period.

2. **2005-2008 Autonomous Community Plan on Drug Addictions and other Addictive Behaviours. Aragon.**

3. **Creating a Future: Strategies for Improving the Situation of Drug Addictions in Asturias (2002).** Government of the Principality of Asturias. Department of Health and Healthcare Services. A draft exists of the new 2010-2016 Principality of Asturias Plan on Drugs.

4. **2007-2011 Balearic Island Plan of Action in Drug Addictions and Other Addictions.** Balearic Island Government. Department of Health and Consumer Affairs. Directorate General of Public Health and Participation. Drug Addiction Coordinating Centre. (2007).

5. **III Canary Island Plan on Drugs: 2010-2017**. Autonomous Government of the Canary Islands. Department of Health and Consumer Affairs. Directorate General of Drug Addiction Care.

6. **2009-2013 Cantabrian Drug Strategy.** Government of Cantabria. Department of Health and Social Services. Directorate General of Public Health. Drug Addiction Service.

7. **2006-2010 Castile-La Mancha Alcoholism and Drug Addiction Plan.** Autonomous Government of Castile-La Mancha. Department of Health. Directorate General of Sociosanitary Planning and Care (2006).

8. **VI Castile and Leon Regional Plan on Drugs: 2009-2013.** Autonomous Government of Castile and Leon. Department of Family and Equality of Opportunities. Regional Drug Commission.

9. **White Paper on Prevention in Catalonia: Drug Use and Associated Problems.** Autonomous Government of Catalonia. Health Department. Directorate General of Public Health. Subdirectorate General of Drug Addictions (2008).

10. **2006-2010 Strategic Plan on Drug Addictions and other Addictive Disorders in the Autonomous Community of Valencia.** Autonomous Community of Valencia. Department of Health. Directorate General of Drug Addictions.

11. **2008-2012 Integral Plan on Drug Addictions and other Addictive Behaviours.** Autonomous Government of Extremadura. Department of Health and Consumer Affairs. Technical Secretariat on Drug Addictions.

12. **2007-2009 Galician Plan on Drugs.** Autonomous Government of Galicia. Department of Health. Galician Health Service. Subdirectorate General of Mental Health and Drug Addictions.

13. **2006-2009 Autonomous Community of Madrid Anti-drug Agency Strategy Plan**. Autonomous Community of Madrid Department of Health and Consumer Affairs.

14. **2007-2010 Regional Plan on Drugs**. Region of Murcia. Department of Health. Autonomous Community Office of the Secretary for Citizen Assistance, Health Planning and Drug Addictions.

15. **Rioja Plan on Drug Addictions and Other Addictions**. La Rioja (1998, biennial evaluation).

16. **Autonomous Community of Navarre Plan on Drug Addictions**. Autonomous Community Government of Navarre. Department of Health.

17. **V Autonomous Community of Euskadi Plan on Drug Addictions: 2004-2008.** Autonomous Government of the Basque Country. Department of Housing and Social services. Vitoria-Gasteiz (2006).

The requirement of adopting municipal plans on drug addictions on the part of the municipal governments (City Councils) may be reflected in the Regional Drug Addiction Laws. These municipal Plans must be in keeping with the different Autonomous Community Plans on Drugs, which coordinate their objectives, in turn, with the National Plan on Drugs. There are already more than two hundred Municipal Plans, and a large majority of Spain's municipalities of over 50,000 inhabitants have their own Municipal Plan on Drugs.

Lastly, with regard to the initiatives of civil society concerning the subject of drug addictions, special mention must be made of the work done by the Forum: "Society and Drugs", formed in 2005 and currently totalling more than 50 participating entities. Its objective is to create a platform for relations between the Ministry and civil entities representing the family, youth and the media which will make it possible to imbue the civil society with more of a leading role and greater participative capacity in the commitment of all to reduce drug use.

Over the years it has been functioning, the Forum has set up three Working Groups: Youth, Family and the Media. In this regard, special mention must be made of the continuity of the work being done by these Society and Drugs Forum Groups, which continued their work and their scheduled meetings in 2009 so as to be able to present their proposals at the fifth Forum Plenary meeting to be held in February 2010. In February 2009, the fourth plenary meeting of the Forum was also held.

Apart from the above, worthy of special note are the frequent contacts and overall work done with the Non-Governmental Organizations operating in this sector. Along this main line of coordination in 2009, a total of 11 programs carried out by NGO's within the action "4. Promote the coordination and cooperation of the Government Delegation for the National Plan on Drugs with civil society" has been funded.

ECONOMIC ANALYSIS

As has been pointed out in the Introduction to this chapter, the 17 Autonomous Communities and the two Autonomous Cities (Ceuta and Melilla) which comprise the State of Spain have highly important competences regarding the prevention of drug addictions, assisting drug consumers and their social reinsertion. These competences are reflected in the budgeting allocated to these matters, so that in order to ascertain the economic resources invested in carrying out the drug policies, one must avail both of the information furnished by the Central Government Administration and that provided by the Autonomous Government Administrations.

In addition to the above, there must consider municipal budgeting allocated to carrying out the Municipal Plans on Drug Addictions of a local scope, with their widely-varying budgeting allocations, which, in some cases, such as that of the most populated cities (Madrid, Barcelona, etc.) amount some very large sums. Nevertheless, it is not possible to provide even an approximate figure of the total of all these budgets.

Nor are provided the figures for the expenditures made for health care provided to drug users for reasons other than habit-breaking treatments, but related to disorders associated with cocaine use (including different infectious diseases such as AIDS, hepatitis, etc.) reflected in following, given that, as a result of the authorities over health care having been transferred from the Central Government to the Autonomous Communities, it is highly difficult to itemize that part of the health care spending allocated to diseases directly related to drug use with the total expenditure invested in health care in general.

With all of the exceptions set out hereinabove, a number of items of data are provided in following for the **year 2008**, the last year for which complete, final figures are available.

The Central Government, through the different Ministerial Departments, has invested budgeting totalling 133,412,805 euros, a total of 18,455,000 euros of which are from the Fund of Goods Confiscated for Illegal Drug Traffic and Related Offences. This Fund has been operating since 1996 and is supplied from the cash monies and the goods confiscated as a result of final, unappealable judgment in proceedings for drug trafficking and other related offences.

Of the aforementioned 133,412,805 euros of the different Ministries, the Ministry of Health and Consumer Affairs (currently the Ministry of Health and Social Policy) transferred the sum of 28,294,020 euros to the Autonomous Communities and Autonomous Cities for this amount to be managed directly by the same.

In addition to this amount, the Autonomous Government Administrations have invested a total of 296,601,275 euros charged to their own budgets, thus meaning that they have availed of a total of 324,895,295 euros for carrying out programs and activities related to the prevention, care, social reinsertion and research in drug addictions.

In all, then, the Central Government Administration and the Autonomous Communities and Autonomous Cities invested a total of **430,014,080 euros** in **2008.**

Regarding the distribution of the aforementioned monetary sums, a estimate can be made with regard to the budgeting managed by the Autonomous Communities and Autonomous Cities, in other words, the above-mentioned 324,895,295 euros, which, in round numbers is as follows:

- Prevention: 56.6 million euros (17.44%)
- Social services, health care and social reinsertion: 249.5 million euros (76.81%).
- Research, documentation and publications: 6.1 million euros (1.88%).
- Institutional coordination: 12.5 million euros (3.87%).

DRUG USE IN THE GENERAL POPULATION (BASED ON PROBABILISTIC SAMPLE)

In 2009, a further Home Survey on Alcohol and Drugs in Spain was conducted as has been being done on a biennial basis since 1995 within the framework of the National Plan on Drugs, targeting the population within the 15-64 age range living in family households. The population residing in institutions (military quarters, convents, penitentiaries, student or elderly living facilities, etc.), collective establishments (hotels, rooming houses, etc. and the homeless population therefore being outside of the sampling frame.

The sample size was 20,109 in 2009 (in prior surveys, the sample ranged from 9,000 to 14,000), with overrepresentation of the 15-39 age group. A sampling was done by conglomerates in several stages (census sections, households and individuals within the household). The questionnaire used consisted of two parts: one for administering by means of a face-to-face interview (which included all the questions, except those concerning alcohol and drug use); and another for self-administering using paper and pen (questions on drug use). The field work was done between the months of November 2009 and May 2010. No surveys were conducted in January, so as to avoid the influence of the Christmas holidays on the questions regarding use during the past 30 days. The response rate on the sample initially selected was 50.1%. The non-responses were distributed as follows: household refusals, including not opening the door and refusal of anyone in the household being surveyed (22.0%), nobody home (14.6%), refusals of the person selected (7.8%), person selected not at home (5.5%).

In the analysis, the data was weighted by Autonomous Communities, age and gender for reinstating the proportionality of the sample. All of the calculations were made by not including in the numerator and denominator those subjects with unknown values for the variables entailed in each cross tabulation.

Extent of Drug Use

In 2009, the psychoactive substances most widespread among Spain's population within the 15-64 age range were alcohol and tobacco. Among the drugs illegally sold, the most widespread were cannabis and cocaine, with prevalences over the last 12 months of over 2% (10.6% for cannabis; 2.6% for cocaine) and ecstasy with a prevalence of 0.8% over the last 12 months. The consumptions of other illegally sold drugs showed lower prevalences of use. The prevalence of use of prescription or non-prescription tranquilizers (5.5%) and sleeping pills (3.6%) over the past 12 months was surpassed only by alcohol, tobacco and cannabis (Tables 2.1 to 2.4).

Table 2.1. Prevalence of drug use at some time in life among Spain's population within the 15-64 age range (%). Spain, 1995-2009.

	1995	1997	1999	2001	2003	2005	2007	2009
Tobacco	*	69.7	64.9	68.4	68.9	69.5	68.5	**75.0**
Alcohol	*	90.6	87.3	89.0	88.6	93.7	88	**94.2**
Cannabis	14.5	22.9	19.6	23.8	29.0	28.6	27.3	**32.1**
Ecstasy	2.0	2.5	2.4	4.0	4.6	4.4	4.3	**4.9**
Hallucinogens	2.1	2.9	1.9	2.8	3.0	3.4	3.8	**3.7**
Amphetamines/speed	2.3	2.7	2.2	2.9	3.2	3.4	3.8	**3.7**
Powdered cocaine	3.4	3.4	3.1	4.8	5.9	7.0	8	**10.2**
Crack	0.3	0.4	0.4	0.5	0.5	0.6	1.8	**0.9**
General cocaine	*	*	*	*	*	*	8.3	**10.2**
Heroin	0.8	0.6	0.5	0.6	0.9	0.7	0.8	**0.6**
Volatile inhalants	0.7	0.8	0.6	0.8	1.0	0.8	1.1	**0.6**
Tranquilizers with or without prescription	*	*	*	*	*	7	13.0	**11**
Sleeping pills with or without prescription	*	*	*	*	*	4.6	6.0	**6.3**
Hypnosedatives with or without prescription	*	*	*	*	*	8.7	15.4	**13.4**

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009

Table 2.2. Prevalence of drug use over the past 12 months among Spain's population within the 15-64 age range (%). Spain, 1995-2009

	1995	1997	1999	2001	2003	2005	2007	2009
Tobacco	*	46.8	44.7	46.0	47.8	42.4	41.7	**42.8**
Alcohol	68.5	78.5	75.2	78.1	76.6	76.7	72.9	**78.7**
Cannabis	7.5	7.7	7.0	9.2	11.3	11.2	10.1	**10.6**
Ecstasy	1.3	0.9	0.8	1.8	1.4	1.2	1.1	**0.8**
Hallucinogens	0.8	0.9	0.6	0.7	0.6	0.7	0.6	**0.5**
Amphetamines/speed	1.0	0.9	0.7	1.1	0.8	1.0	0.9	**0.6**
Powdered cocaine	1.8	1.6	1.6	2.5	2.7	3.0	3.0	**2.6**
Crack	0.1	0.1	0.2	0.1	0.1	0.2	0.5	**0.1**
General cocaine	*	*	*	*	*	*	3.1	**2.7**
Heroin	0.5	0.2	0.1	0.1	0.1	0.1	0.1	**0.1**
Volatile inhalants	0.1	0.2	0.1	0.1	0.1	0.1	0.1	**0.0**
Tranquilizers with or without prescription	*	*	*	*	*	3.9	6.9	**5.5**
Tranquilizers without prescription	**	2.0	2.0	2.5	2.5	0.9	0.9	**1.6**
Sleeping pills with or without prescription	*	*	*	*	*	2.7	3.8	**3.6**
Sleeping pills without prescription	**	1.2	1.3	1.6	1.6	0.8	0.8	**1.1**
Hypnosedatives with or without prescription	*	*	*	*	*	5.1	8.6	**7.1**
Hypnosedatives without prescription	**	2.3	2.3	2.8	3.1	1.2	1.3	**1.9**

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

** Non available data.

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009

Table 2.3. Prevalence of drug use over the past 30 days among Spain's population with the 15-64 age range (%). Spain, 1997-2009.

	1997	1999	2001	2003	2005	2007	2009
Tobacco	42.9	40.1	41.4	42.9	38.4	38.8	**39.4**
Alcohol	64.0	61.8	63.7	64.1	64.6	60	**63.3**
Cannabis	4.6	4.5	6.4	7.6	8.7	7.2	**7.6**
Ecstasy	0.3	0.2	0.8	0.4	0.6	0.6	**0.4**
Hallucinogens	0.2	0.2	0.2	0.2	0.2	0.1	**0.2**
Amphetamines/speed	0.2	0.3	0.6	0.2	0.4	0.3	**0.3**
Powdered cocaine	0.9	0.9	1.3	1.1	1.6	1.6	**1.2**
Crack	0.0	0.1	0.0	0.0	0.1	0.3	**0.1**
General cocaine	*	*	*	*	*	*	**1.3**
Heroin	0.1	0.0	0.0	0.0	0.1	0.0	**0.1**
Volatile inhalants	0.1	0.0	0.1	0.0	0.1	0.0	**0.0**
Tranquilizers with or without prescription	*	*	*	*	2.7	4.7	**4.0**
Sleeping pills with or without prescription	*	*	*	*	2.0	2.5	**2.7**
Hypnosedatives with or without prescription	*	*	*	*	3.7	5.9	**5.2**

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997-2009

Table 2.4. Prevalence of daily drug use among Spain's population within the 15-64 age range (%). Spain, 1997-2009

	1997	1999	2001	2003	2005	2007	2009
Tobacco	34.9	33.6	35.7	36.7	32.8	29.6	**31.8**
Alcohol	12.7	13.7	15.7	14.1	14.9	10.2	**11**
Cannabis	0.7	0.8	1.5	1.5	2.0	1.6	**2**
Tranquilizers with or without prescription	*	*	*	*	1.7	2.6	**2.3**
Sleeping pills with or without prescription	*	*	*	*	1.1	1.1	**1.4**
Hypnosedatives with or without prescription	*	*	*	*	2.1	3.1	**2.7**

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997-2009

Average age at first use

In 2009, the average age at which use of the different substances was first started remained stable in comparison to the previous years, although it did vary substantially according to the type of drug. The drugs which were consumed, on the average, at an earlier age were those legally sold, such as tobacco (average age 16.5 years) and alcoholic beverages (16.7 years). The illegal drug which began being used at an earlier age was cannabis (18.6 years). To the contrary, those which began being used later were the hypnosedatives (tranquilizers and/or sleeping pills), at age 34.5. The use of the rest of the drugs was begun on the average between 19 and 22 years of age (Table 2.5) (Figure 2.1).

Table 2.5. Average age at which the different substances are first started being used among the population within the 15-64 age range. Spain, 1995-2009

	1995	1997	1999	2001	2003	2005	2007	2009
Tobacco	15.9	16.6	16.7	16.5	16.5	16.4	16.5	**16.5**
Alcoholic beverages	**	16.8	16.9	16.9	16.7	16.7	16.8	**16.7**
Cannabis	18.3	18.9	18.7	18.5	18.5	18.3	18.6	**18.6**
Powdered cocaine	21.4	21.3	21.8	20.4	20.9	20.6	20.9	**20.9**
Heroin	20.3	20.1	19	20.7	22	20.2	21.7	**22.9**
Amphetamines	19.2	19.4	19.2	18.8	19.6	19.2	19.7	**20.1**
Hallucinogens	19.3	19	19.3	18.9	19.9	19	19.9	**19.7**
Volatile inhalants	17.7	19	18.1	17.5	17.5	17.8	19.7	**19.2**
Crack	21.8	20.6	20.1	19.6	20.1	20.8	21.4	**23.1**
Ecstasy	21.1	20	20.7	20.2	20.3	20.1	20.8	**20.5**
Hypnosedatives[(1)] with or without prescription	*	*	*	*	*	**	33.8	**34.5**
Hypnosedatives[(1)] without prescription	35.2	28.7	29.2	29.5	30	29.8	29.1	**29.5**

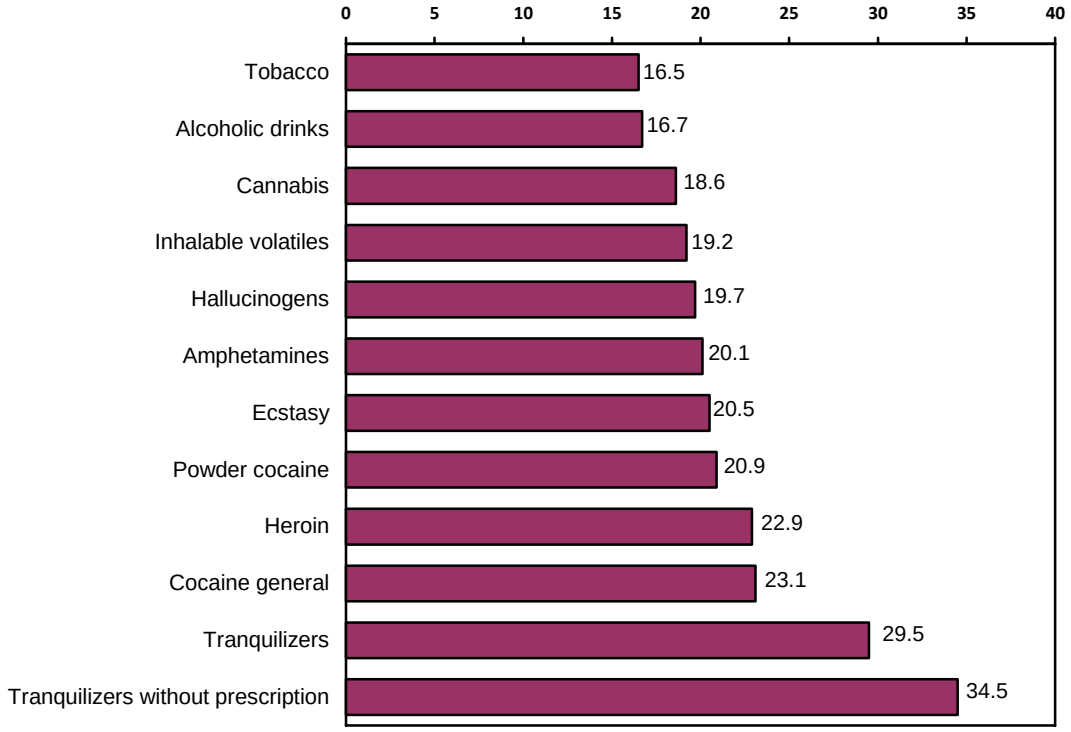
[(1)] Trannquilizers and/or sleeping pills

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

** Non available data.

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009

Figure 2.1. Average ages at which the different psychoactive drugs are first started being used among Spain's population within the 15-64 age range. Spain 2009.



Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009

Differences in drug use by gender

Except in the case of hypnosedatives (tranquilizers and/or sleeping pills), in 2009 in Spain, the use of drugs among the population within the 15-64 age range was more widespread to quite a much higher degree among males than among females, especially in the case of illegally sold drugs, where the prevalence among males was several times higher than among females. (Tables 2.6-7). As regards use over the past 12 months, the differences in the use of cannabis (14.8% males and 6.2% females) and of powdered cocaine (4.2% in males and 1% in females) stand out (Table 2.6).

As far as legally sold drugs are concerned, the prevalence of use is also greater among males. For example, the prevalence of alcoholic beverage consumption during the past 30 days was 74% among males and 52.2% among females, tobacco having been smoked by 44.7% of the males and 34% of the females among the population with in the 15-64 age group (Table 2.7).

There are, however, some types or patterns of use for certain psychoactive substances (daily tobacco smoking, at-risk drinking of alcoholic beverages and alcohol poisoning, to name a few) in which the prevalences of use among females in certain age groups has been increasing considerably in recent times, the differences in prevalences of use between males and females thus having decreased and the ratio among some age groups even having reversed, as will be discussed at a further point herein.

Table 2.6. Prevalences of drug use over the last 12 months among the population within the 15-64 age range, by gender (%). Spain, 1995-2009

	1995		1997		1999		2001		2003		2005		2007		2009	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Tobacco	*	*	55.0	38.7	50.3	39.2	51.5	40.5	53.0	42.6	47.2	37.5	46.0	37.6	48.4	37.0
Alcohol	79.3	58.0	86.4	70.5	83.2	67.2	85.2	70.9	84.5	68.4	84.0	69.2	80.4	66.4	84.4	72.7
Cannabis	10.7	4.4	10.7	4.7	9.6	4.3	13.0	5.5	16.2	6.3	15.7	6.6	13.6	6.6	14.8	6.2
Ecstasy	1.9	0.7	1.2	0.5	1.2	0.5	2.8	0.7	2.0	0.8	1.8	0.6	1.6	0.5	1.4	0.3
Hallucinogens	1.1	0.4	1.4	0.4	0.8	0.4	1.2	0.2	0.9	0.3	1.1	0.4	0.9	0.3	0.7	0.2
Amphetamines/ speed	1.3	0.7	1.4	0.4	1.0	0.4	1.6	0.6	1.1	0.5	1.4	0.5	1.3	0.3	1.0	0.3
Powdered cocaine	2.7	1.0	2.6	0.6	2.3	0.8	3.8	1.3	4.1	1.2	4.6	1.3	4.4	1.5	4.2	1.0
Crack	0.2	0.0	0.2	0.0	0.4	0.0	0.2	0.0	0.2	0.0	0.3	0.0	0.7	0.1	0.2	0.1
General cocaine	*	*	*	*	*	*	*	*	*	*	*	*	4.7	1.6	4.2	1.0
Heroin	0.8	0.3	0.4	0.1	0.2	0.0	0.2	0.0	0.2	0.1	0.2	0.1	0.1	0.0	0.1	0.0
Inhalants	0.2	0.1	0.3	0.0	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.1	0.3	0.1	0.0	0,0
Tranquilizers with or without prescription	*	*	*	*	*	*	*	*	*	*	2.6	5.2	4.7	9.1	3.4	7,6
Tranquilizers without prescription	**	**	**	**	1.9	2.2	2.2	2.8	2.4	2.7	0.8	1.0	1.0	0.9	1.5	1,7
Sleeping pills with or without prescription	*	*	*	*	*	*	*	*	*	*	2.0	3.5	2.8	4.3	2.6	4,6
Sleeping pills without prescription	**	**	**	**	1.4	1.2	1.4	1.8	1.7	1.4	0.7	0.9	0.6	0.8	1.1	1,0
Hypnosedatives with or without prescription	*	*	*	*	*	*	*	*	*	*	3.5	6.7	6.8	11.5	4.6	9,3
Hypnosedatives without prescription	**	**	**	**	2.3	2.4	2.5	3.1	2.9	3.3	1.1	1.3	1.2	1.4	1.9	1,9

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

** Non available data.

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009

Table 2.7. Prevalences of drug use over the past 30 days among the population within the 15-64 age range, by gender (%). Spain, 1997-2009.

	1997		1999		2001		2003		2005		2007		2009	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Tobacco	51.4	34.4	45.0	35.2	46.5	36.3	47.9	37.9	43.1	33.6	42.6	34.7	44.7	34.0
Alcohol	75.8	52.1	74.4	49.1	76.4	50.9	75.8	52.1	76.0	52.9	71.4	49.0	74.0	52.2
Cannabis	6.7	2.5	6.2	2.8	9.4	3.4	11.3	3.9	12.5	4.7	10.0	4.2	11.0	4.0
Ecstasy	0.5	0.1	0.3	0.2	1.3	0.3	0.5	0.2	0.9	0.3	0.6	0.2	0.5	0.2
Hallucinogens	0.3	0.1	0.3	0.1	0.4	0.1	0.3	0.1	0.4	0.1	0.1	0.0	0.2	0.1
Amphetamines/ Speed	0.4	0.1	0.4	0.2	0.9	0.2	0.4	0.1	0.6	0.2	0.4	0.1	0.4	0.2
Powdered cocaine	1.5	0.2	1.3	0.4	2.2	0.5	1.6	0.5	2.5	0.7	2.5	0.8	2.0	0.4
Crack	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.5	0.1	0.1	0.0
General cocaine	*	*	*	*	*	*	*	*	*	*	2.5	0.8	2.0	0.4
Heroin	0.2	0.1	0.1	0.0	0.1	0.0	0.0	0.1	0.1	0.0	0.1	0.0	0.1	0.0
Inhalants	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0
Tranquilizers with or without prescription	*	*	*	*	*	*	*	*	1.7	3.7	3.3	6.3	2.4	5.7
Sleeping pills with or without prescription	*	*	*	*	*	*	*	*	1.3	2.8	2.0	3.0	1.9	3.5
Hypnosedatives with or without prescription	*	*	*	*	*	*	*	*	2.3	5.1	4.3	7.6	3.2	7.0

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997-2009

Differences in drug use by age

In 2009, the consumers of psychoactive substances were, except in the case of tranquilizers or sleeping pills, mainly young people within he 15-34 age range (Tables 2.8-10), regarding both legal and illegal drugs. Thus, for example, the prevalence of use over the past 12 months for cannabis, cocaine and ecstasy were respectively 19.4%, 4.3% and 1.8% among the 15-34 age group; as compared to 4.6%, 1.5% and 0.2% within the 35-64 age range. The prevalences of alcohol and tobacco use are somewhat higher among the 15-34 age range than among the 35-64 age group, with figures over the past 12 months of 80.1% and 45.3% among the 15-34 age range and of 77.7% and 41.1% among the 35-64 age group. Lastly, the 35-64 group consumes a higher percentage of tranquilizers or sleeping pills (13.8% and 8% respectively) than the 15-34 age group (7.1% and 4%).

Table 2.8. Prevalences of drug use at some time in life among the population within the 15-64 age range, by age group (%). Spain, 1995-2009

	1995		1997		1999		2001		2003		2005		2007		2009	
	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64
Tobacco	*	*	72.7	66.9	65.2	64.7	69.4	67.6	69.2	68.7	67.9	70.7	66.6	69.8	**70.1**	**78.3**
Alcohol	*	*	91.4	89.9	87.4	87.2	89.3	88.8	88.9	88.3	93.2	94.1	87.7	88.3	**92.2**	**95.5**
Cannabis	22.9	6.1	32.4	14.4	28.1	12.3	34.3	15.3	39.0	21.0	39.4	20.4	37.5	20.2	**42.4**	**25.2**
Ecstasy	3.5	0.5	4.8	0.4	4.4	0.7	7.7	1.0	8.3	1.6	7.6	1.9	7.2	2.2	**8.4**	**2.6**
Hallucinogens	3.3	0.9	4.7	1.3	2.9	1.0	4.6	1.3	4.7	1.6	5.4	1.9	5.9	2.3	**5.7**	**2.4**
Amphetamines/ Speed	3.7	1.0	4.2	1.3	3.1	1.3	4.6	1.5	4.7	1.9	5.2	2.0	5.6	2.6	**5.7**	**2.4**
Powdered cocaine	5.4	1.4	5.5	1.6	4.7	1.8	7.7	2.4	8.9	3.6	10.4	4.4	11.4	5.5	**13.5**	**7.9**
Crack	0.5	0.1	0.7	0.2	0.6	0.2	0.7	0.3	0.7	0.3	0.7	0.6	2.3	1.5	**0.9**	**0.9**
Heroin	1.4	0.2	0.9	0.3	0.6	0.3	0.7	0.5	0.8	0.9	0.6	0.7	0.6	1.0	**0.4**	**0.6**
Inhalants	1.1	0.3	1.3	0.3	0.9	0.4	1.5	0.2	1.7	0.5	1.2	0.5	1.7	0.8	**1**	**0.4**
Tranquilizers with or without prescription	*	*	*	*	*	*	*	*	*	*	5.1	8.4	8.8	16.0	**7.1**	**13.8**
Sleeping pills with or without prescription	*	*	*	*	*	*	*	*	*	*	2.9	5.8	3.7	7.6	**4.0**	**8.0**

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995- 2009

Table 2.9. Prevalences of drug use over the past 12 months among the population within the 15-64 age range, by age group (%). Spain, 1995-2009

	1995		1997		1999		2001		2003		2005		2007		2009	
	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64
Tobacco	*	*	54.5	39.9	49.5	40.6	52	41.2	52.8	43.8	47.3	38.8	46.2	38.8	45.3	41.1
Alcohol	72.9	64.1	82.5	74.9	79	71.8	81.5	75.2	79.5	74.2	79.4	74.7	76.9	71.1	80.1	77.7
Cannabis	12.7	2.3	14.2	1.8	12.6	2.2	16.7	3.3	20.1	4.2	19.8	4.7	18.9	3.9	19.4	4.6
Ecstasy	2.4	0.1	1.8	0	1.6	0.1	3.7	0.2	2.9	0.1	2.4	0.4	2.4	0.4	1.8	0.2
Hallucinogens	1.3	0.2	1.8	0.1	1.2	0.2	1.3	0.2	1.1	0.2	1.5	0.1	1.4	0.1	1.1	0.1
Amphetamines/ Speed	1.8	0.2	1.8	0.1	1.3	0.2	2.2	0.2	1.6	0.2	1.9	0.3	1.7	0.2	1.4	0.1
Powdered cocaine	3.1	0.5	2.9	0.5	2.8	0.5	4.5	0.9	4.8	0.9	5.2	1.3	5.3	1.3	4.3	1.5
Crack	0.1	0.1	0.2	0.1	0.4	0	0.2	0	0.2	0	0.2	0.1	0.6	0.2	0.2	0.1
Heroin	0.9	0.1	0.4	0.1	0.2	0	0.1	0.1	0.2	0.1	0.2	0.1	0.1	0	0.1	0.1
Inhalants	0.2	0.1	0.4	0	0.1	0.1	0.3	0	0.2	0	0.2	0.1	0.2	0	0.1	0
Tranquilizers with or without prescription	*	*	*	*	*	*	*	*	*	*	2.7	4.8	4.4	8.4	3.1	7.1
Sleeping pills with or without prescription	*	*	*	*	*	*	*	*	*	*	1.5	3.6	1.8	4.6	1.9	4.7
Tranquilizers, without prescription	**	**	**	**	**	**	**	**	**	**	0.7	0.9	1.1	0.8	1.6	1.5
Sleeping pills, without prescription	**	**	**	**	**	**	**	**	**	**	0.6	0.9	0.7	0.7	1.0	1.1

* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

** Non available data.

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009

Table 2.10. Prevalences of drug use over the past 30 days among the population within the 15-64 age range, by age group (%). Spain, 1997-2009.

	1997		1999		2001		2003		2005		2007		2009	
	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64	15-34	35-64
Tobacco	49.6	36.9	43.7	36.9	46.3	37.5	47.2	39.5	42.3	35.5	42.2	36.3	40.9	38.4
Alcohol	66.7	61.6	64.4	59.4	65.7	62.1	65.8	62.7	66.3	63.4	61.7	59.4	63.1	63.3
Cannabis	8.5	1.1	7.9	1.5	11.5	2.3	13.4	2.9	15.4	3.6	13.5	2.8	14.1	3.2
Ecstasy	0.6	0.0	0.5	0.0	1.5	0.2	0.7	0.0	1.1	0.2	0.8	0.2	0.8	0.1
Hallucinogens	0.4	0.0	0.3	0.1	0.4	0.1	0.4	0.0	0.5	0.1	0.2	0.0	0.4	0.0
Amphetamines/ speed	0.5	0.0	0.5	0.1	1.1	0.1	0.4	0.1	0.8	0.1	0.5	0.1	0.7	0.1
Powdered cocaine	1.6	0.2	1.5	0.3	2.4	0.5	1.9	0.4	2.8	0.7	2.9	0.7	2.0	0.7
Crack	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.4	0.2	0.1	0.1
Heroin	0.2	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.0	0.1
Inhalants	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Tranquilizers with or without prescription	*	*	*	*	*	*	*	*	1.6	3.5	2.5	6.2	1.8	5.5
Sleeping pills with or without prescription	*	*	*	*	*	*	*	*	0.8	2.9	1.0	3.6	1.2	3.7

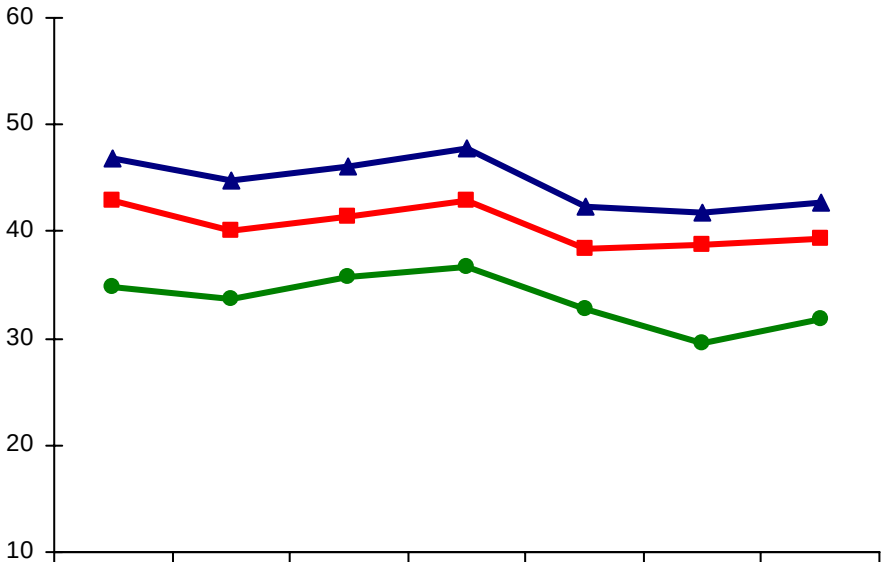
* Item not included in the Home Survey on Alcohol and Drugs questionnaire (EDADES).

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997-2009

Tobacco

In 2009, a total of 42.8% of the population within the 15-64 age range residing in Spain had smoked tobacco over the past 12 months; 39.4% within the last 30 days and 31.8% daily throughout that period. These figures indicate a certain stabilisation of the use during the 2005-2009 period, with drug use levels currently quite similar to those found immediately prior to the national regulation governing smoking entered into effect in December 2005, but lower than the drug use levels (1997-2003) prior to the social debate to which the anti-smoking bill gave rise in Spain.

Figure 2.2. Trend in the prevalence of smoking among Spain's population within the 15-64 age range (%). Spain 1997-2009

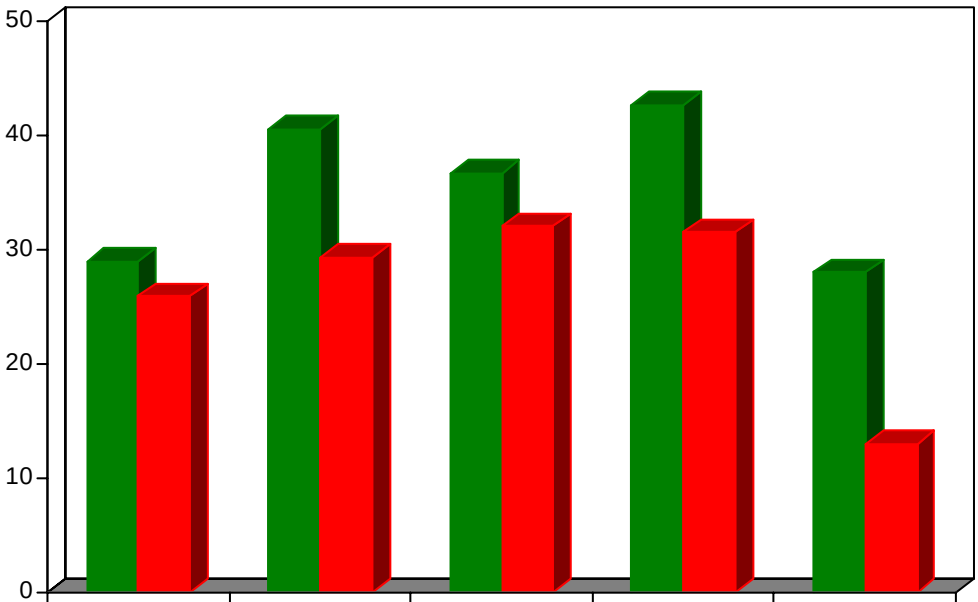


	1997	1999	2001	2003	2005	2007	2009
Last year	46,8	44,7	46	47,8	42,4	41,7	42,8
Last month	42,9	40,1	41,4	42,9	38,4	38,8	39,4
Daily in last 30 days	34,9	33,6	35,7	36,7	32,8	29,6	31,8

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain,1997- 2009

The prevalence of daily use was higher among males than among females (36.2% and 27.2%). By age groups, the highest prevalence was among the males within the 45-54 age group (42.6%), the females ages 55-64 being those having the lowest (13%). Among the youngest age group (ages 15-24), the differences between genders were smaller (29% males and 25.9% females) (Figure 2.3). Among the adolescents ages 15-18, a total of 20.7% of the males and 17.6% of the females smoked daily.

Figure 2.3. Prevalence of daily tobacco use within the last 30 days, by age groups and gender (%). Spain 2009



	15-24	25-34	35-44	45-54	55-64
Male	29	40,5	36,6	42,6	28
Female	25,9	29,3	32	31,5	13

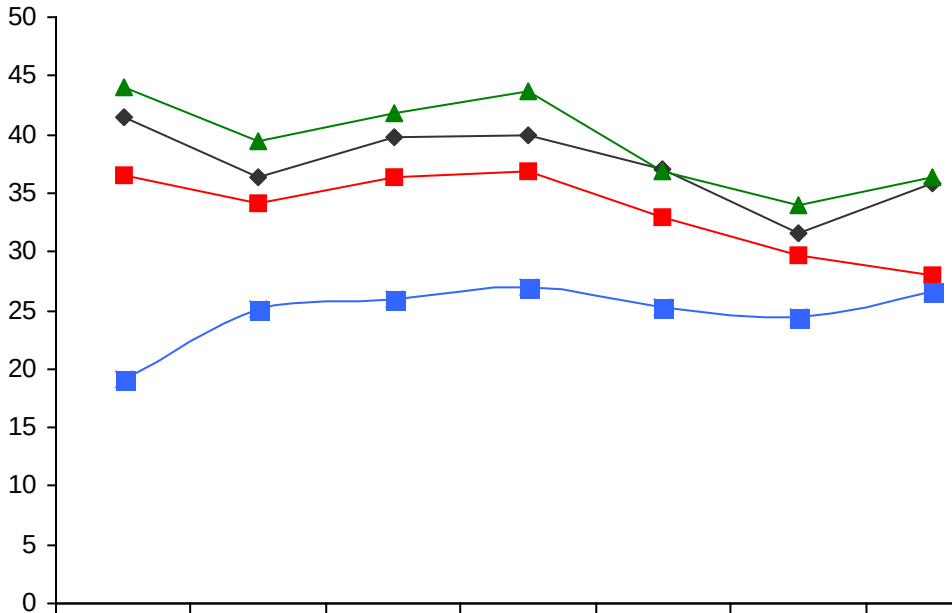
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009

The average number of cigarettes smoked over the last 30 days was 15 cigarettes among the males and 12.4 among the females. In 2009, smoking was being first taken up at 16.5 years of age, precisely as in 2007, remaining quite constant over the course of time. Nevertheless, males are starting smoking at age 16, whilst females are starting one year later. The average age for starting smoking daily was 18.5 years of age.

Ex-smokers, defined as those who had smoked daily throughout some period during their lives who currently no longer smoke, totalled 29.2% of the sample. A total of 25.7% were consolidated ex-smokers who had no smoked for over one year, 3.5% not having smoked for longer than one month, but less than one year.

As far as the time-related trends are concerned, daily use was found to remain relatively stable up until 2003. From 2003 to the end of 2007, the prevalence of daily use dropped among all age groups for both genders, this downward trend continuing for females within the 15-34 age group, slight increases having been found among the different age groups (Figure 2.4). This figure shows how, for the first time, the differences in prevalences by age groups, for both males and females, dropped off to the point of nearly ceasing to exist, this being something which had never occurred in the case of females, in which the 15-34 age group had always show higher prevalences of daily tobacco use than those of the 35-64 age group.

Figure 2.4. Trend in the prevalence of daily tobacco use among the population within the 15-64 age range, by gender and age group. Spain, 1997-2009 (%)



	1997	1999	2001	2003	2005	2007	2009
Male 15-34	41,4	36,3	39,8	40	37,1	31,5	35,9
Female 15-34	36,5	34,2	36,4	36,8	33	29,7	28
Male 35-64	44	39,5	41,8	43,7	36,9	33,9	36,4
Female 35-64	19,1	25,1	25,9	27	25,3	24,4	26,7

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997-2009

Alcohol

The alcohol use in Spanish society is practically universal. Thus, in 2009, a total of 94.2% of the population within the 15-64 age range had consumed alcohol at some time during their lives, 78.7% having admitted to having consumed it during the year immediately prior to being surveyed, 63.3% having done so some time during the month immediately prior to the survey, although solely 11.0% had consumed alcohol daily during that same period.

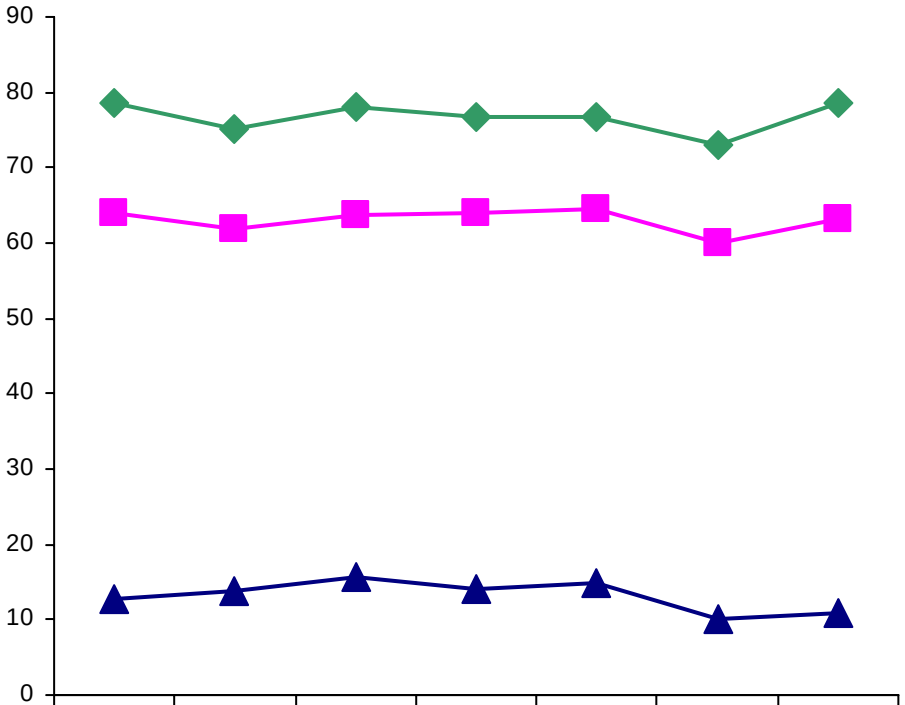
As far as the time-related trends are concerned, up to 2005, a stability was found to exist in the prevalence of alcoholic beverage consumption both on a sporadic basis (some time during their lives), regular (past year) and recent (last 30 days), which broke off slightly in 2007, starting an overall drop in all the indicators which seems to have gone back up slightly in 2009, except for the prevalence of daily use, which has remained stable in comparison to 2005. Nevertheless, the prevalences found in 2009 (with the exception of consumptions at some time in one's life) currently remain at levels quite similar to those found for prior editions of the survey (2005, 2003, 2001 and 1999), as a result of which it will be necessary to await new data to confirm these trends.

Table 2.11. Evolution over time prevalences of alcoholic beverage consumption (%). Population 15-64 years of age. Home Survey on Alcohol and Drugs in Spain. 1995-2009. Spain.

%	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	--	90.6	87.3	89.0	88.6	93.7	88.0	**94.2**
Last 12 months	68.5	78.5	75.2	78.1	76.6	76.7	72.9	**78.7**
Last 30 days	--	64.0	61.8	63.7	64.1	64.6	60.0	**63.3**
Daily last 30 days	--	12.7	13.7	15.7	14.1	14.9	10.2	**11.0**
Never	--	9.4	12.7	11.0	11.4	6.3	12.0	**5.8**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.

Figure 2.5. Evolution over the course of time prevalences alcoholic beverage consumption (%). Population 15-64 years of age. Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.



	1997	1999	2001	2003	2005	2007	2009
Last year	78,5	75,2	78,1	76,6	76,7	72,9	78,7
Last month	64	61,8	63,7	64,1	64,6	60	63,3
Daily last 30 days	12,7	13,7	15,7	14,1	14,9	10,2	11

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain, 1997-2009. Spain.

The prevalence of alcohol consumption is higher among males than among females, generally speaking for all of the drug use indicators considered, although the relative differences increase when referring to more frequent or intensive consumptions, with the exception of cases of alcohol poisoning, which will be discussed further along, in which the difference in prevalence by genders is barely noticeable and is even reversed, the females showing higher prevalences, in some specific age groups.

The data therefore shows that, in 2009, 96.0% of the males surveyed had consumed alcohol at some time during their lifetimes, as compared to 92.3% of the women. A total of 84.4% of the males had consumed alcohol during the year immediately prior to the survey, as compared to the 72.7% of the females; 74.0% of the males having done so during the month immediately prior to being surveyed, as compared to 52.2% of the females. The male/female prevalence ration was 1.04 for the prevalence of use at some time during their lives; 1.16 for the prevalence of annual use; 1.41 for the prevalence of monthly use; 3.3 for the prevalence of daily use throughout the immediately preceding month; 1.9 for annual prevalence of drunkenness; and 2.4 for the prevalence of binge drinking during the month immediately prior to the survey. In relation to the data obtained in earlier editions of this same survey, a general, progressive trend obviously exists for all the indicators, toward a lowering of the male/female ratio of prevalences of use revealing the full incorporation of females into

the different alcoholic beverage consumption patterns, especially among the youngest age groups.

With regard to the age-related differences, the prevalence of use for this past year has been found to be higher among the group of young people within the 15-34 age group (80.1%) than in the 35-64 age group (77.7%), although the difference between these two groups has decreased in comparison to prior editions. On the other hand, unlike what occurred in previous editions of this survey, the prevalence of use over the past month was found to be slightly higher among the 35-64 age group (63.3%) than among the young people 15-34 years of age (63.1%). Similarly, the prevalence of daily use is higher among the population within the 35-64 age group (25.4%) than among the 15-34 age group (5.5%). However, the differences for the younger age group outweigh the others quite remarkably when intensive type consumptions are assessed, such as drunkenness (annual prevalence of 35.2% among the 15-34 age group as compared to 15.0% for the older groups) or for binge drinking (21.7% among the 15-34 age group as compared to 10.3% among the older population).

On making a more detailed evaluation of the data according to the different age groups for each type of use indicator, one finds that for the use over the past year, it is the young people within the 25-34 age group who show a higher prevalence of use (80.5%). With regard to the last 30 days, it is the 25-34 age group (65.0%), the 35-44 age group (64.4%) and the 45-64 age group (64.7%) in which higher prevalences of use are found. Lastly, it is the 55-64 age group (22.1%) that shows a higher prevalence of daily use, which goes to prove the extending pattern of daily use at lunch and dinner among older age groups and the rather much episodic weekend use among the youngest people, as will be discussed at a further point herein.

Table 2.12. Alcohol consumption by age groups in 2009 (% total)

	15 - 24		25 - 34		35 - 44		45 - 54		55 - 64	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Ever in lifetime	90.2	87.4	95.8	93.1	96.5	94.0	98.2	95.1	98.7	90.1
Last year	82.1	76.9	86.6	73.9	84.1	74.9	85.4	73.3	82.6	63.0
Last month	65.2	55.1	76.7	52.6	75.1	53.2	76.2	53.0	74.5	46.3
Daily last 30 days	2.1	0.9	7.9	1.5	15.4	5.1	28.0	8.4	33.7	11.1
Never	9.8	12.6	4.2	6.9	3.5	6.0	1.8	4.9	1.3	9.9

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

In 2009, the average age at which alcohol consumption was first begun was 16.7 years, practically identical to that recorded in 2007, 2005, 2003, 2001, 1999 and 1997 (ranging between 16.7 years and 16.9 years). The first contact with alcoholic beverages is somewhat earlier among the males (15.9 years of age) than among the females (17.6 years of age). However, in addition to the logical earlier age at which alcohol consumption is begun, the lower the age of the age group in question, the analysis of the data by age groups and gender shows the age at which the females are

starting to consume alcohol to be clearly passing that of the males, which reveals the earlier incorporation of the females of the more recent generations into alcohol consumption.

The alcoholic beverage most consumed on weekdays was beer. A total of 20.0% of those surveyed (15-64 years of age) admitted having drunk beer on some weekday from Monday through Thursday, this use being concentrated in the oldest age group (22.4% for the 35-64 age group compared to the 16.5% of the 15-34 age group. Weekday beer drinking is more prevalent among males than among females (29.3% vs. 10.5%) for the general population within the 15-64 age range.

Wine is the second most prevalent beverage consumed on a daily basis on weekdays (16.1%), although this figure, just as in the case of beer, shows a slight reduction compared to the 2007 figures comprising part of an overall downward trend in alcoholic beverage consumption on weekdays, compared to an overall increase in the use on weekends for both the general population within the 15-64 age range as well as for the 15-34 and 35-64 age groups. On weekdays, alcoholic beverage consumption is more prevalent among the 35-64 age group than among the 15-34 age group, except in the case of the mixed drinks and fruit liqueurs. The major difference in prevalence, in favour of the oldest age group, is found for wine cnsumption (22.5% among the 35-64 age group as compared to the 16.4% among the 15-34 age group).

On weekends, the alcoholic beverage most consumed is beer, followed by wine and, close behind, by mixed drinks/long drinks. Table 2.13 clearly shows how alcoholic beverage consumption is generally concentrated for the general population on weekends (the percentage of consumed on weekends is double that consumed on weekdays) although this ratio is higher in the case of the 15-34 age group (3.1) compared to the 35-64 age group (1.7). Compared to 2007, there has been an increase in 2009 of the percentage of beer consumers (37.5% to 41.3%) and of mixed drinks/long drinks (21.9% to 24.4%) on weekends among the general population, whilst those pertaining to this group who consume hard liquors is lower in 2009.

By age groups, the highest weekend use prevalences are found among the 15-34 age group for beer (41.5%) and mixed drinks/long drinks (39.0%) and among the 35-64 age group for beer (41.2%) and wine (35.6%).

Among the 15-34 age group, a slight drop is noted in the prevalence of consumption of all alcoholic beverages on weekdays and a discreet increase in weekend consumption. The prevalence of the use of mixed drinks/long drinks on weekends has risen from 35.3% in 2007 to 39.0% in 2009, that of beer/cider having risen one percentage point during this same period.

In the 35-64 age group, an increase is found to exist, in comparison to 2007, in the prevalence of use of any alcoholic beverage in general on weekends, which however does not tally with a drop in the drop in use of a similar magnitude on weekdays. By types of alcoholic beverages, the prevalences in weekday as well as weekend use of beer/cider and that of mixed drinks/long drinks on weekends have risen, the use of fruit liqueurs both on weekdays and weekends having dropped.

The two major age groups both show very similar prevalences for weekend beer/cider use (41.5% among the 15-34 age group compared to the 41.2% among the 35-64 age group), the prevalences however differing to a major degree for the weekend use of mixed drinks/long drinks (39.0% VS. 14.6%) and the use of wine/champagne on weekdays (6.5% vs. 22.5%).

The use prevalences among the general population within the 15-64 age range are always higher for males than for females, for any of the type of beverages in question (note the minimums in the case of the fruit liqueurs), both on weekdays (2.27) and on weekends (1.41).

Table 2.13. Alcoholic beverage consumption prevalences over the past 30 days, on weekdays and weekends, by age group and beverage type (%). Spain, 2009.

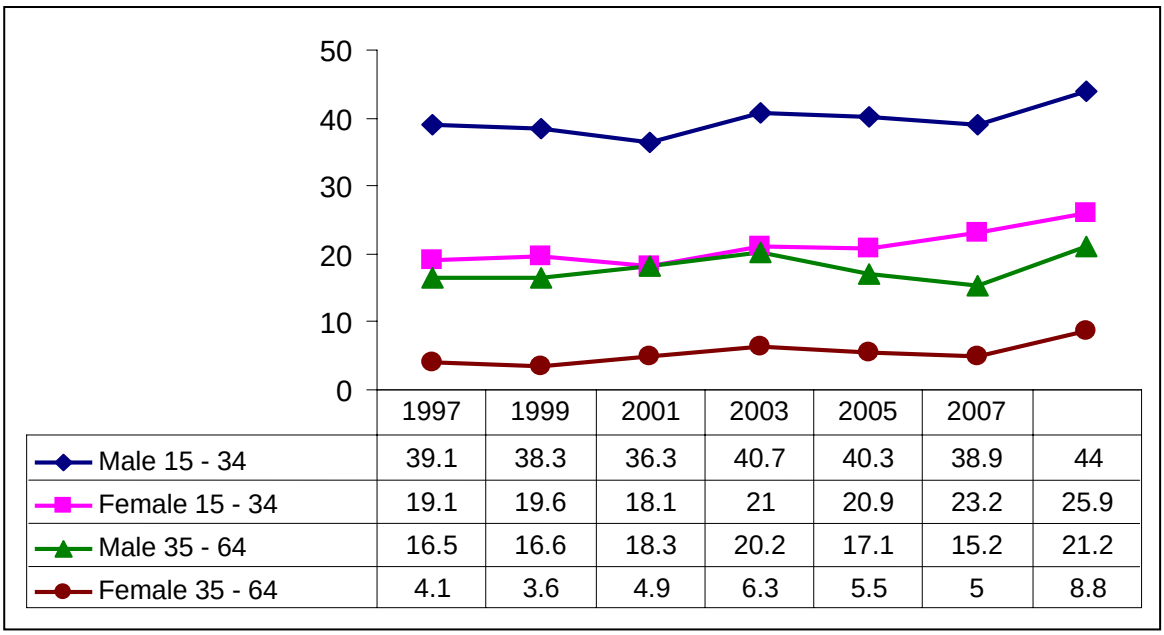
	15-64 age range		15-34 age group		35-64 age group	
	Weekdays	Weekends	Weekdays	Weekends	Weekdays	Weekends
Wine/Champagne	16.1	27.9	6.5	16.4	22.5	35.6
Beer/Cider	20.0	41.3	16.5	41.5	22.4	41.2
Aperitifs/Vermouth	0.8	3.9	0.7	3.1	0.9	4.5
Mixed drinks / Long drinks	1.9	24.4	2.4	39.0	1.7	14.6
Fruit liqueurs	0.6	2.4	0.6	2.9	0.6	2.0
Hard liquor	1.4	4.9	1.2	5.6	1.5	4.4
Any alcoholic beverage	29.0	61.9	19.5	62.1	35.3	61.7

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

With regard to the cases of alcohol poisoning, 23.1% of the population within the 15-64 age range had experienced episodes of drunkenness some time within the past year (18.4% less than 10 times a year and 4.7% having done so 10 or more times during the year). The prevalence of episodes of drunkenness was higher among the males (30.0%) than among the females (15.5%) and among the younger ones within the 15-34 age range (35.2%) than among the older ones within that age group (15.0%). Thus, there has been an almost 4 percentage point rise over 2007 in the percentage of consumers who get drunk, and although the male/female ratio has not changed much (around 2 in both 2007 and 2009), the ratio of the prevalences by age group have indeed undergone a change (15-34 years/ 35-64 years), dropping from around 4 in 2007 to 3 in 2009, thus meaning these two age groups becoming more similar to one another in this type of intensive use.

As regards the evolution over the course of time of the prevalence of episodes of drunkenness by gender and age group, Figure 2.6 shows how, since 2007, the downward trend among males (15-34 and 35-64 age groups) has reversed, and there has been a rise in the respective figures for females within the 35-64 age group which had been dropping since 2003, the upward trend young females had been showing since 2001 being confirmed.

Figure 2.6. Evolution of the prevalence of episodes of drunkenness within the last 12 months among the population within the 15-64 age range, by age groups and genders (%). Spain, 1997-2009



	1997	1999	2001	2003	2005	2007	
Male 15 - 34	39.1	38.3	36.3	40.7	40.3	38.9	44
Female 15 - 34	19.1	19.6	18.1	21	20.9	23.2	25.9
Male 35 - 64	16.5	16.6	18.3	20.2	17.1	15.2	21.2
Female 35 - 64	4.1	3.6	4.9	6.3	5.5	5	8.8

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain, 1997-2009. Spain.

Delving a bit further into the data findings with regard to the intensive type consumptions of alcoholic beverages in 2009, the percentage of at-risk drinkers among the 15-64 age range population was 4.4% in 2009, which is a slightly higher figure than that of 2007 (3.4%), but lower than those found in the 2005, 2003 and 2001 editions. Considered as "at risk drinkers" are the males who consume, on the average, 50 cc or more of pure alcohol per day and the females who consume 30 cc or more.

Special mention must be made of the fact that it is in the 15-24 age group in which the highest prevalences (5.5%) are found, although differing very little with regard to the rest of the age groups, and that this same age group is the only one in which a high prevalence figure has been found among females (6.1%) than among males (5.0%). The prevalences for males and females will even out if the 15-34 age group is considered, and become higher among males in the oldest-aged population (ages 35-64). This data contrasts with the conventionally-accepted idea that the prevalences of use of psychoactive substances are generally much higher among males and more so the more intense or frequent the consumptions. On the other hand, they can somehow be overlapped with the age range in which higher prevalences of binge drinking are found among females, as in detailed at a further point in this chapter, with the upward trend of the prevalences of alcohol poisoning among young females (1ges 15-34) which first started being detected in 2007 and which has been confirmed in 2009.

Lastly, with regard to binge drinking, the percentage of drinkers who drank on binges among the population within the 15-64 age range totalled 14.9% in 2009 (21.0% among males and 8.6% among females), thus meaning an increase of over 2 percentage points compared to the figures found in 2007. The males/females ratio however barely shows any changes in this intensive use indicator for the 15-64 age group (2.7 in 2007 to 2.4 in 2009).

Table 2.14. Prevalence of binge drinking some time in the last 30 days among the population within the 15-64 age range, by gender. Spain. **Home Survey on Alcohol and Drugs in Spain, 2007-2009**

%	Ages 15 - 64	Males	Females
2007	12.6	18.3	6.7
2009	**14.9**	**21.0**	**8.6**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2007-2009

If, instead of taking the general population within the 15-64 age range into consideration, the prevalence of this type of use is studied in those who, having consumed within the past 30 days, admit having gone on a binge some time during this period, the figure amounts to 23.8% (28.7% among males and 16.7% among females), the males/females ratio dropping to 1.7.

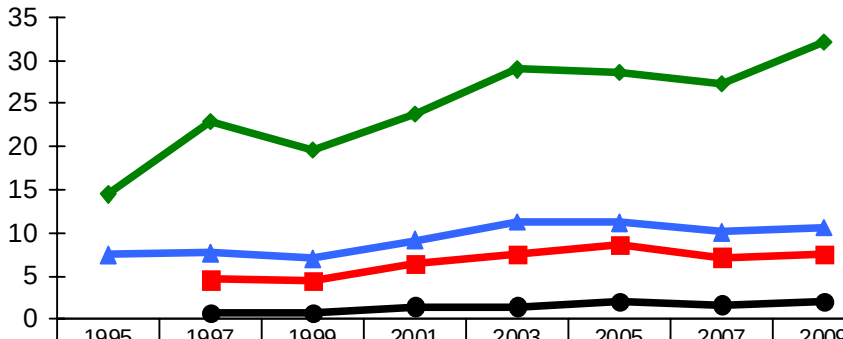
Taking another look at the age 15-64 population, one finds that, generally speaking, among the males, by age groups, it is the age 25-34 group where a higher percentage of those who have gone on a binge within the last 30 days are found. For all the age groups, the highest proportion of binge drinkers go on binges 1-5 days a month. This pattern could be identified with episodic consumptions on the weekends (episodic binge drinking).

Among the females, generally speaking and for all the age groups and all frequency ranges, the percentages are lower than those of the males, and the older the ages of the females surveyed, the lower the percentages become. The highest percentage of women admitting to binge drinking some time within the last 30 days immediately prior to the survey fall within the 15-24 age group (17.9%), despite 82.1% denying having done so.

Cannabis

Cannabis continues to be the illegal drug most consumed in Spain and that which had undergone the greatest increase in its prevalence since 2007. A total of 32.1% of Spain's population states having tried it some time in their lives, 10.6% having done do within the last 12 months, 7.6% within the last 30 days and 2% daily throughout the last 30 days. Despite the highest prevalence of experimental use (ever in lifetime) since a record started being kept having been reached in 2009, the prevalences of all other indicators recorded (except the increases mentioned in comparison to 2007) are remaining relatively stable since 2003.

Figure 2.7. Prevalence of cannabis use among Spain's population within the 15-64 age range (%). Spain 1995-2009



	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	14,5	22,9	19,6	23,8	29	28,6	27,3	32,1
Last 12 months	7,5	7,7	7	9,2	11,3	11,2	10,1	10,6
Last 30 days		4,6	4,5	6,4	7,6	8,7	7,2	7,6
Daily in last 30 days		0,7	0,8	1,5	1,5	2	1,7	2

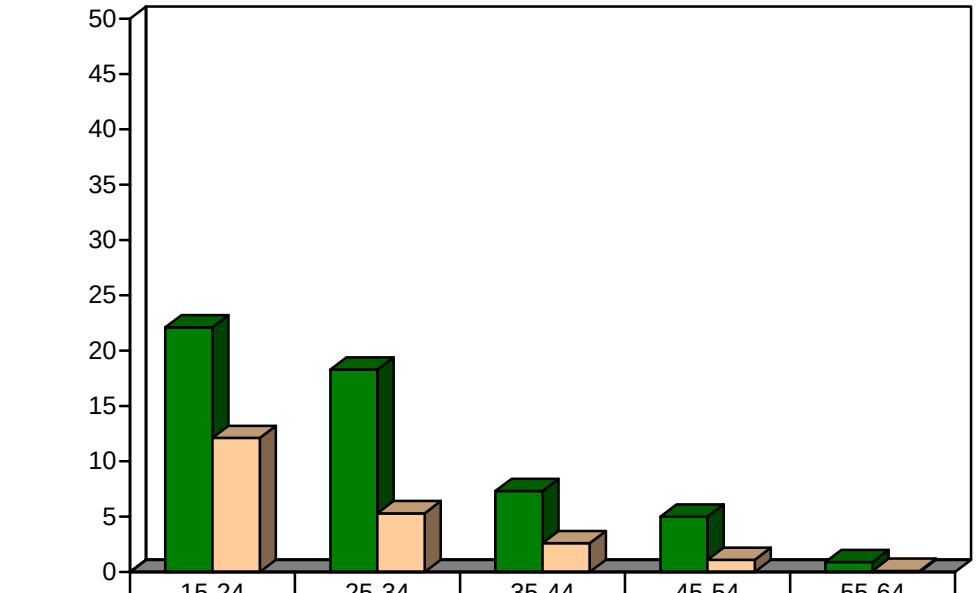
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain, 1995- 2009. Spain.

Use was quite a bit more widespread among males than among females in all age groups and for all the use periods.

The relative differences between genders in cannabis use are quite high for both the use within the last 12 months (14.8% males and 6.2% females) as well as for monthly use (11% males and 4% females) and daily use (3.2% males and 0.9% females).

The highest percentages of cannabis consumers fall within the group of the youngest consumers (ages 15-24), above all among the males (Figure 2.8).

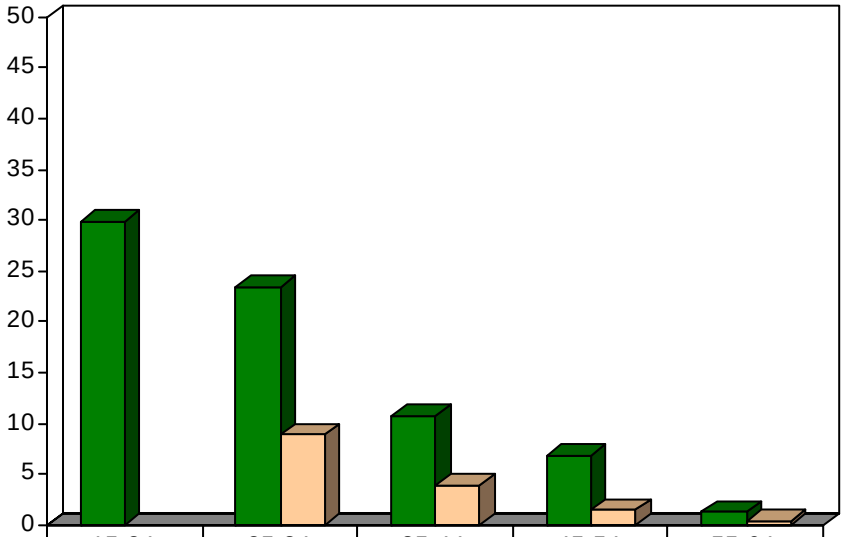
Figure 2.8. Spain 2009. Prevalence of cannabis use within the last 30 days among Spain's population within the 15-64 age range, by gender and ages (%). Spain 2009.



	15-24	25-34	35-44	45-54	55-64
Male	22,1	18,3	7,3	5	0,9
Female	12,1	5,3	2,6	1,1	0,1

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

Figure 2.9 Prevalence of cannabis use within the last 12 months among Spain's population within the 15-64 age range, by gender and ages (%). Spain 2009



	15-24	25-34	35-44	45-54	55-64
Male	29,9	23,4	10,8	6,8	1,3
Female	17.6	8,9	3,9	1,5	0,4

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs**.** Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

The age at which cannabis is consumed for the first time was 18.6 years of age, which is quite similar to the age in previous years (18.6 in 2007 and 18.3 in 2005).

The continuity of cannabis use is not high. In 2009, around one third of those who had tried this drug some time in their lives had also consumed it within the last 12 months, and approximately one fourth had consumed it within the last 30 days. As can be seen by noting the parallelism of the prevalence figures in the different periods, the continuity in use has remained relatively stable as of 1997 (Table 2.15).

Table 2.15. Prevalence and continuity in cannabis use among Spain's population within the 15-64 age range. Spain, 1995-2009

	1995	1997	1999	2001	2003	2005	2007	2009
Prevalence ever in lifetime (%) (A)	14.5	22.9	19.6	23.8	29	28.6	27.3	**32.1**
Prevalence last year(%) (B)	7.5	7.7	7.0	9.2	11.3	11.2	10.1	**10.6**
Prevalence last month (%) (C)		4.6	4.5	6.4	7.6	8.7	7.1	**7.6**
B/A	0.52	0.34	0.36	0.39	0.39	0.39	0.37	**0.33**
C/A		0.20	0.23	0.27	0.26	0.30	0.26	**0.24**

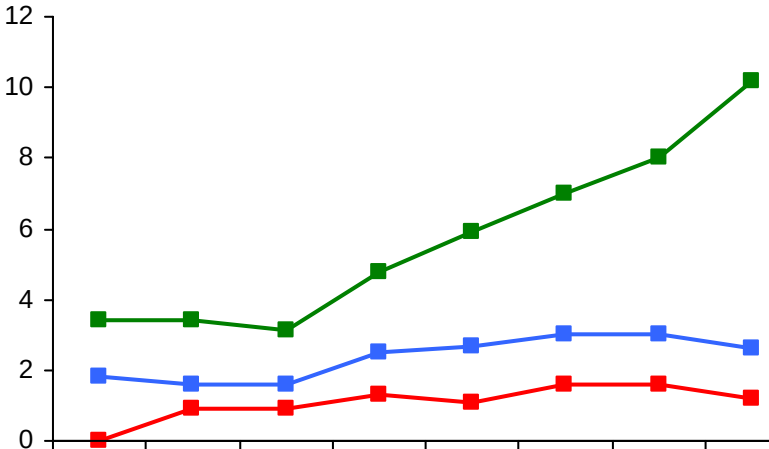
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.

Cocaine

Cocaine is the second illegal psychoactive substance of greatest prevalence use in Spain: 10.2% of the resident population 15-64 years of age has tried it some time in their lives, 2.6% having done so within the last 12 months and 1.2% within the last 30 days.

In regard to the time-related trends, the prevalence of powdered cocaine showed an increase from 1995 to 2005, the percentage of consumers within the last 12 months having risen from 1.8% to 3.0%, respectively, having stabilized at around this figure. Since then, it has shown a drop to the point of reaching 2.6% (Figure 2.10).

Figure 2.10. Evolution of the prevalences of powdered cocaine use among Spain's population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.



	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	3,4	3,4	3,1	4,8	5,9	7	8	10,2
Last year	1,8	1,6	1,6	2,5	2,7	3	3	2,6
Last month	0	0,9	0,9	1,3	1,1	1,6	1,6	1,2

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.

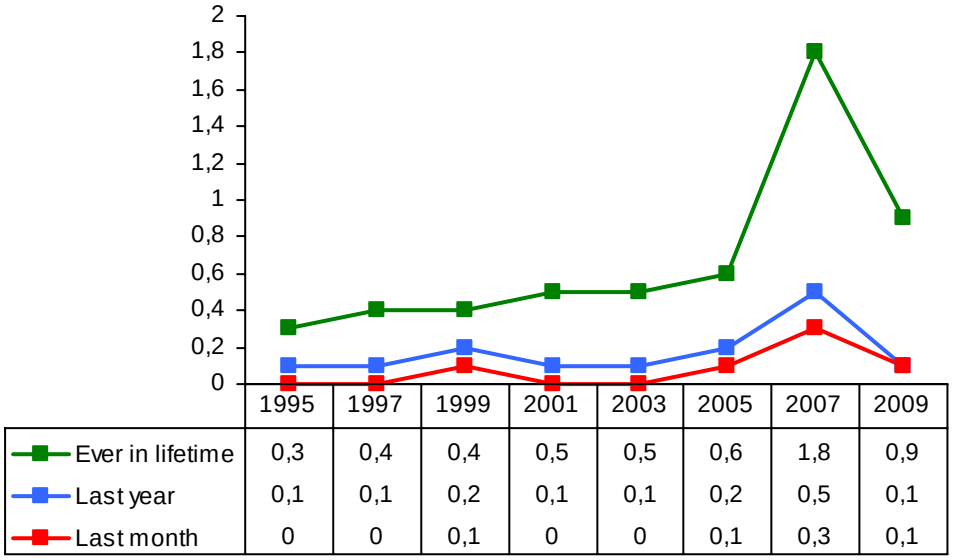
Figure 2.10 clearly shows the increase in cocaine use from 1999 to 2005 for all the indicators used. In 2005, Spain was ranked in one of the top positions in the world ranking of cocaine-consuming countries along with other countries in our environment such as the United Kingdom and Italy and the United States, which also showed a considerable increase in cocaine use for that same time period. It must however be said that Spain started off from higher prevalences than the others, there thus not having been such a glaring increase in use, but rather being a matter of a problem which already existed in 1995 having become more acute.

As of 2007, coinciding with the 2007-2010 Plan for Action Against Cocaine having been gotten under way, an upward break in the use trend and the stabilization of those prevalence figures related to the most problematic consumptions were noted (around 3% for use within the last 12 months and 1.6% for use within the last 30 days) and a drop in 2009 (2.6% for use within the last 12 months and 1.2% for use within the last 30

days). It will be necessary to await future editions of this survey to confirm this downward trend.

Crack use shows a similar panorama. Even with the lower prevalence of use, the evolution over the course of time shows a progressive rise from 1995 to 2007, the year in which this trend reverses, showing a clear drop in 2009, the percentage of consumers within the last 12 months dropping from 0.5% to 0.1% (Figure 2.11).

Figure 2.11. Evolution of the prevalences of crack use among Spain's population within the 15-64 age range. (%). Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

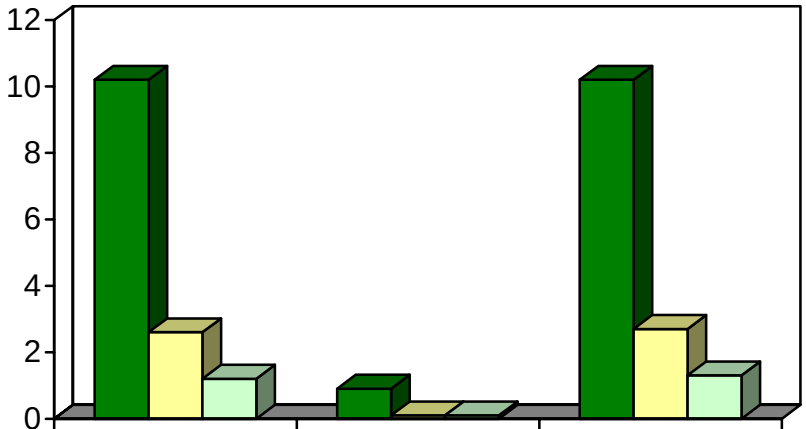


	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	0,3	0,4	0,4	0,5	0,5	0,6	1,8	0,9
Last year	0,1	0,1	0,2	0,1	0,1	0,2	0,5	0,1
Last month	0	0	0,1	0	0	0,1	0,3	0,1

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995- 2009. Spain.

As shown in Figure 2.12, cocaine is consumed mostly in powder form, the prevalence of crack use being very low.

Figure 2.12. Prevalence of cocaine use within the last 12 months, by format (crack or powder) among the population within the 15-64 age range. Home Survey on Alcohol and Drugs in Spain, 2009. Spain

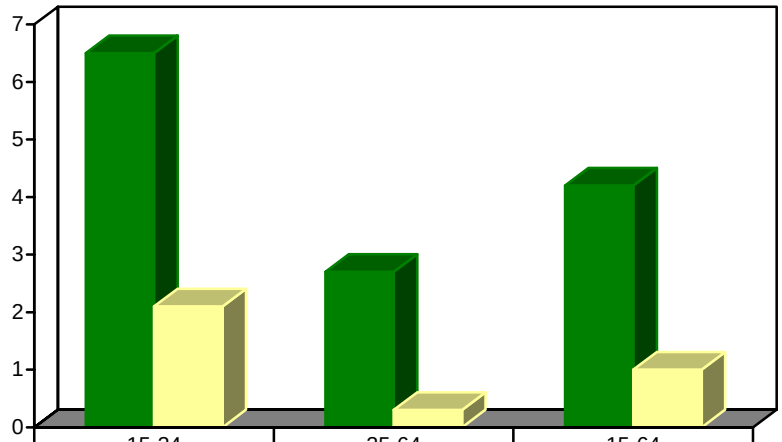


	Cocaine powder	Cocaine base	Cocaine general
Ever in lifetime	10,2	0,9	10,2
Last year	2,6	0,1	2,7
Last month	1,2	0,1	1,3

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

The prevalences of cocaine use are higher among the males than among the females. Specifically, the prevalence of cocaine use within the last 12 months was significantly higher among males (4.2%) than among females (1%). The highest percentages of consumers are found among the males within the 15-34 age group (6.5%) compared to the females (2.1%). (Figure 2.13).

Figure 2.13. Prevalence of cocaine use in general (crack and/or powder) within the last 12 months, by ages and gender. (%) Home Survey on Alcohol and Drugs in Spain, 2009. Spain.



	15-34	35-64	15-64
Male	6,5	2,7	4,2
Female	2,1	0,3	1

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

The average age at which this substance is consumed for the first time remains stable at 20.9 years of age for powered cocaine, being 23.1 years of age for crack, this age having risen by 1.8 years over that recorded in 2007, which was 21.3 years of age.

The continuity in cocaine use is not high. In 2009, around one fourth of those who had tried this drug ever in lifetime had consumed it within the last 12 months, approximately one seventh having consumed it in the last 30 days. As is revealed by the prevalence figures for the different periods, the continuity in use has remarkably decreased in the last few years (Table 2.16).

Table 2.16. Prevalence and continuity in powdered cocaine use among Spain's population within the 15-64 age range. Home Survey on Alcohol and Drugs in Spain 1997-2009. Spain

	1997	1999	2001	2003	2005	2007	2009
Prevalence ever in lifetime (%) (A)	3.4	3.1	4.8	5.9	7	8	**10.2**
Prevalence last year (%) (B)	1.6	1.6	2.5	2.7	3	3	**2.6**
Prevalence last month (%) (C)	0.9	0.9	1.3	1.1	1.6	1.6	**1.2**
B/A	0.47	0.52	0.52	0.46	0.43	0.37	**0.26**
C/A	0.29	0.27	0.19	0.23	0.20	0.15	**0.13**

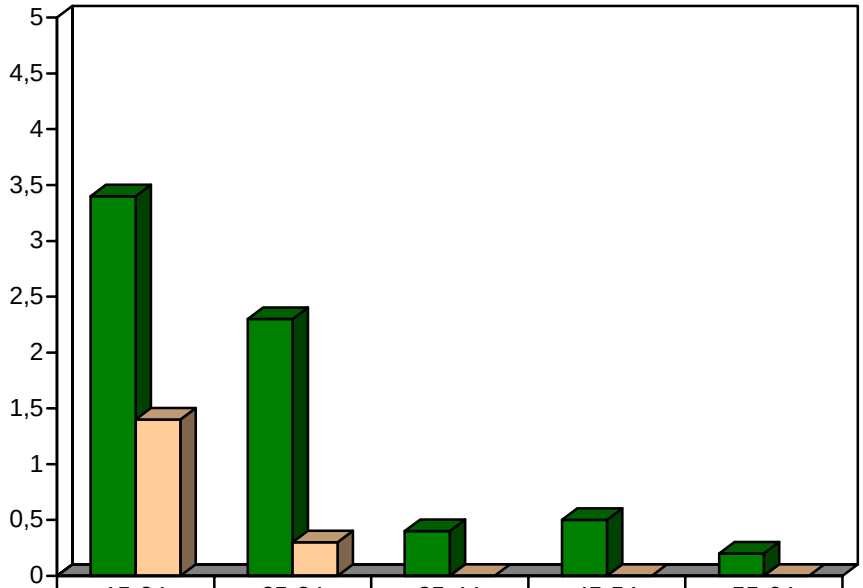
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997- 2009. Spain.

Ecstasy

A total of 4.9% of the population within the 15-64 age range has tried Ecstasy some time in their lives, 0.8% having consumed it within the last 12 months and 0.4% within the last 30 days.

The prevalence of use within the last 12 months was greater among the males (1.4%) than among the females (0.3%), and among the population within the 15-34 age group (1.8%) than among the older-aged population (0.2%) The highest use prevalences were found among the males within the 15-24 age group (Figure 2.14).

Figure 2.14. Prevalence of Ecstasy use over the last 12 months among Spain's population within the 15-64 age range, by gender and age (%). Spain 2009



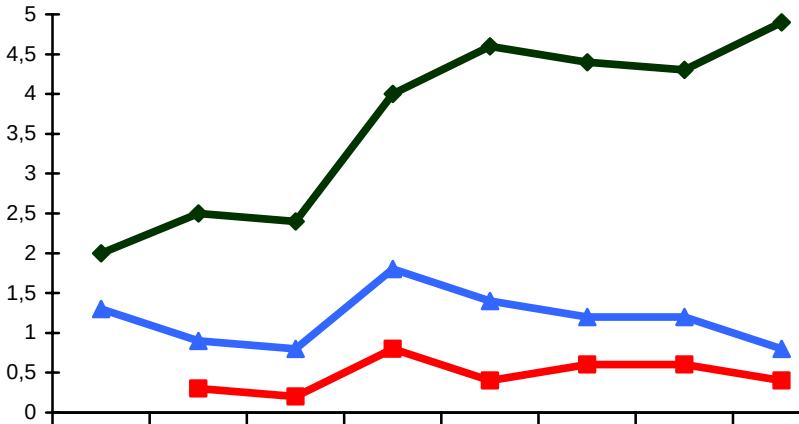
	15-24	25-34	35-44	45-54	55-64
Male	3,4	2,3	0,4	0,5	0,2
Female	1,4	0,3	0	0	0

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

This is a drug consumed very sporadically. In fact, no daily consumers are to be found in this sample. The average age of initial use was 20.5 years of age, which is older than the average age at which use first begins of substances such as tobacco, alcohol, cannabis, hallucinogens or amphetamines.

As far as the evolution of ecstasy use is concerned, a recent stabilization of regular use is noted commencing as of 2003, although the upward trend in experimental use has remained the same since 1999 (Figure 2.15).

Figure 2.15. Evolution of the prevalences of Ecstasy use among Spain's population within the 15-64 age group (%). Spain, 1995-2009



	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	2	2,5	2,4	4	4,6	4,4	4,3	4,9
Last 12 months	1,3	0,9	0,8	1,8	1,4	1,2	1,2	0,8
Last 30 days		0,3	0,2	0,8	0,4	0,6	0,6	0,4

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1996- 2009. Spain

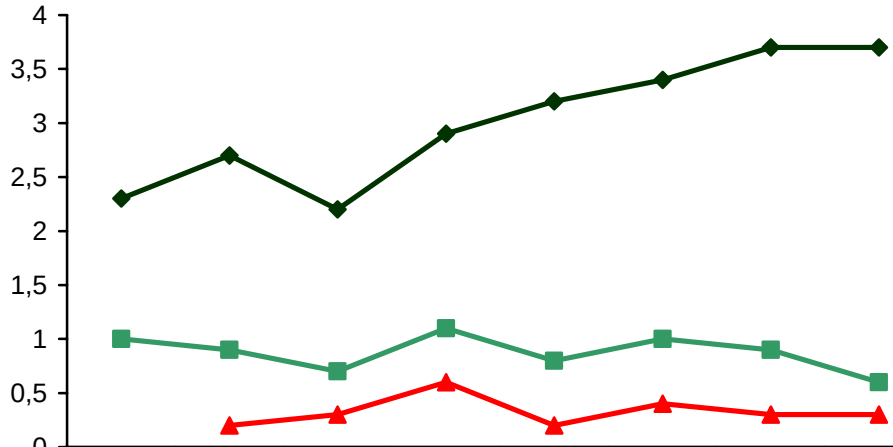
Generally speaking, this is a substance which is consumed mainly experimentally. The consumers are mostly males and young people.

Amphetamines

This group of substances are known by the name of speed, go-ee, whizz, uppers, ice or crystal. In 2009, 3.7% of the population within the 15-64 age range had tried amphetamines some time in their lives, 0.6% having consumed it within the last 12 months and 0.3% within the last 30 days.

Although the low prevalence of use of this substance leads to its values being subject to a high degree of variability in view of minimal changes in their value, the time-related trends over the last 12 months enable us to report their use to apparently been rather stabilized, although, since 2005, a downward trend is noticeable (Figure 2.16).

Figure 2.16. Evolution of the prevalences in amphetamine use among Spain's population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain, 1995- 2009. Spain.

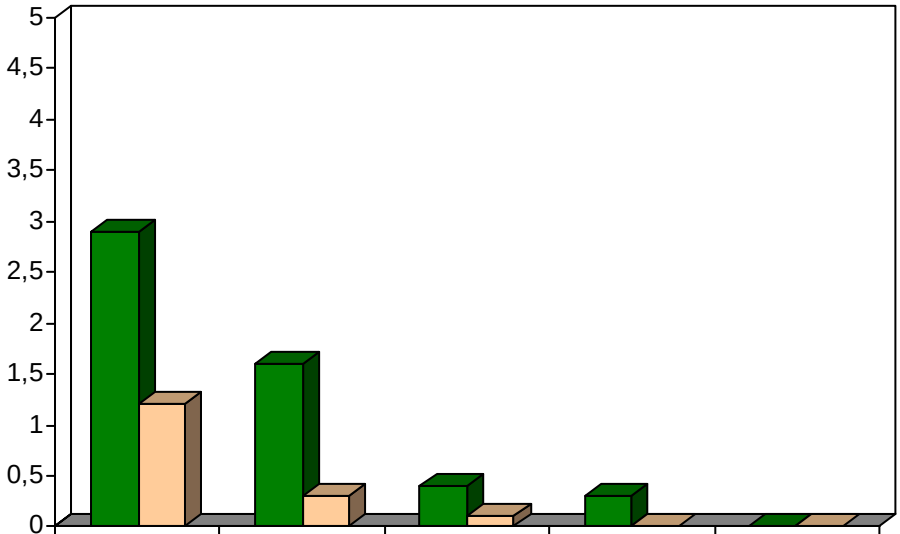


	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	2,3	2,7	2,2	2,9	3,2	3,4	3,7	3,7
Last year	1	0,9	0,7	1,1	0,8	1	0,9	0,6
Last month		0,2	0,3	0,6	0,2	0,4	0,3	0,3

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain, 1995- 2009. Spain.

As in the aforementioned cases, the use was quite a bit more widespread among males than among females and among the 15-34 age group than among the 35-64 age group (Figure 2.17). The average age at which this substance was first consumed was at 20.1 years of age.

Figure 2.17. Prevalence of use of amphetamines in the last 12 months among Spain's population within the 15-64 age range, by gender and age (%). Home Survey on Alcohol and Drugs in Spain, 1997- 2009. Spain.



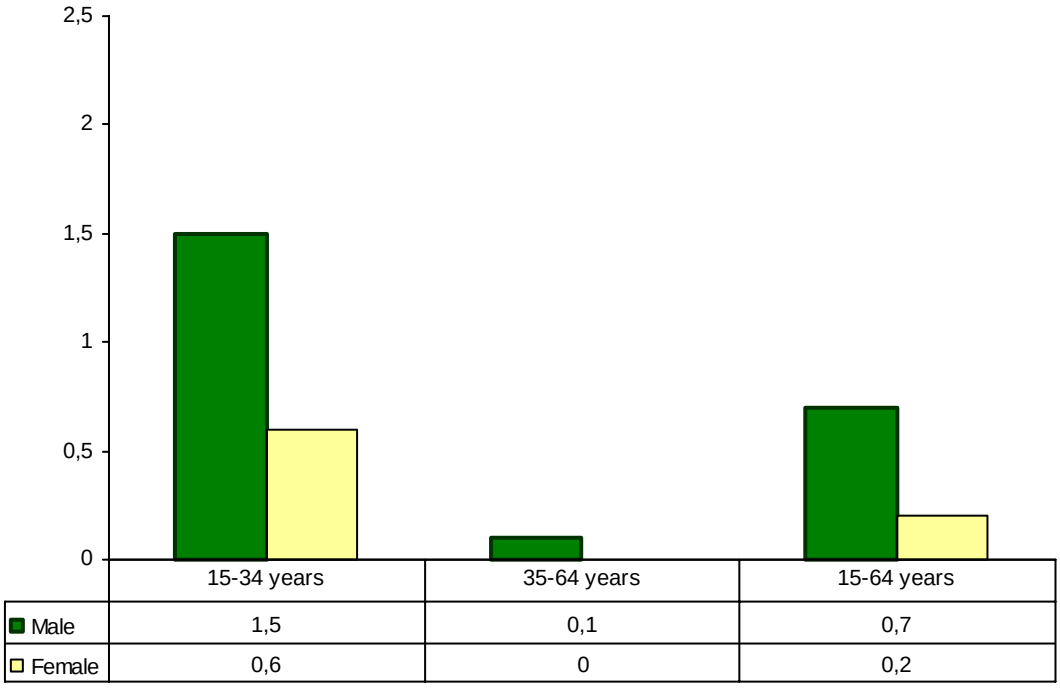
	15-24	25-34	35-44	45-54	55-64
Male	2,9	1,6	0,4	0,3	0
Female	1,2	0,3	0,1	0	0

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain.

Hallucinogens

In 2009, 3.7% of the population within the 15-64 age range had tried hallucinogens some time in their lives, 0.5 having consumed them within the last 12 months and 0.2% within the last 30 days. As in the aforementioned cases, the prevalence of use within the last 12 months was higher among the males (0.7%) than among females (0.2%) and among the 15-34 age group (1.1%) than among the 35-64 age group (0.1%). Figure 2.18 shows how the highest percentage of hallucinogen consumers is among the males within the 15-34 age group.

Figure 2.18. Prevalence of hallucinogen use within the last 12 months, by age and gender (%). Home Survey on Alcohol and Drugs in Spain, 2009. Spain.



	15-34 years	35-64 years	15-64 years
Male	1,5	0,1	0,7
Female	0,6	0	0,2

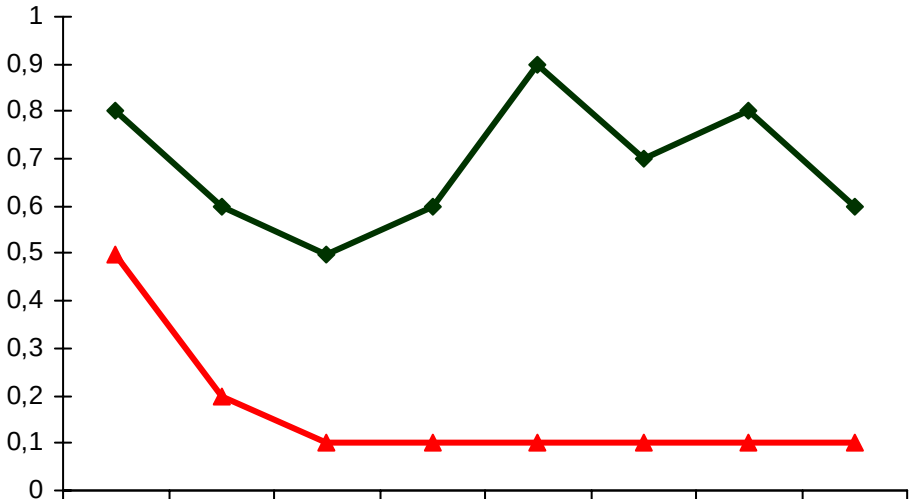
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain

The average age at which use was first started was 19.7 years of age. The trend in use over the past few years has remained relatively stable (prevalence of use in the last 12 months: 0.6% in 1999 and 0.6% in 2007).

Other psychoactive drugs

The lifetime prevalences of volatile inhalants and heroin were lower than those of the aforementioned substances, totalling figures of 0.6% for both substances. On the other hand, the prevalences of use within the last 12 months amounted to 0.1%. It must nevertheless be taken into account that populational surveys have quite a few limitations regarding estimating the prevalence and trends in use of these substances, due to the difficulty involved of including the most problem consumers.

Figure 2.19. Prevalence of heroin use at some time in life and within the last 12 months among Spain's population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain, 1995-2009.



	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	0,8	0,6	0,5	0,6	0,9	0,7	0,8	0,6
Last 12 months	0,5	0,2	0,1	0,1	0,1	0,1	0,1	0,1

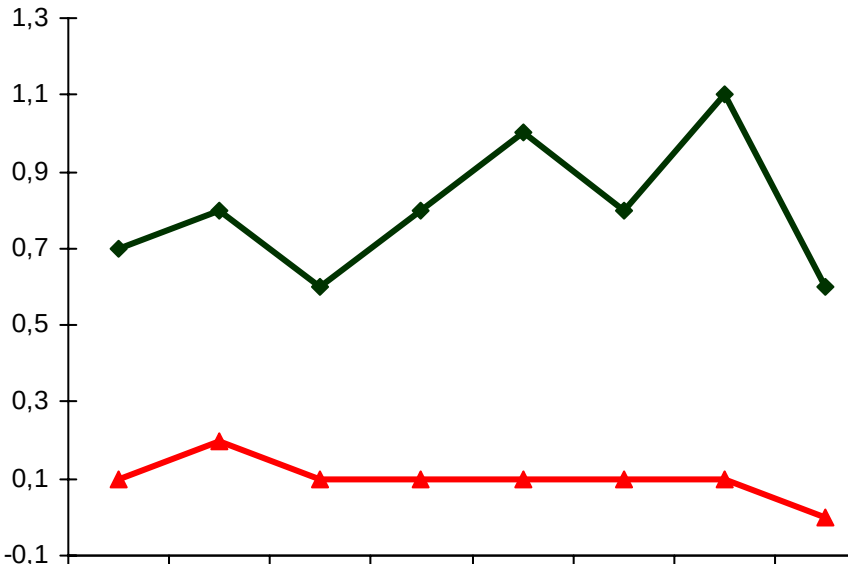
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain1995-2009. Spain.

The average age at which consumed for the first time was 19.2 years of age in the case of volatile inhalants and 22.9 years for heroin.

Lastly, as far as the trends in use are concerned, in the case of heroin, a downward trend in experimenting with this substance since 2003 has been noted (Figure 2.19).

In the case of volatile inhalants, a downward trend is also noted in experimental use over the past few years (Figure 2.20).

Figure 2.20. Prevalence of use of volatile inhalants at some time in life and within the last 12 months among Spain's population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.



	1995	1997	1999	2001	2003	2005	2007	2009
Ever in lifetime	0,7	0,8	0,6	0,8	1	0,8	1,1	0,6
Last 12 months	0,1	0,2	0,1	0,1	0,1	0,1	0,1	0

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1995-2009. Spain.

Hypnosedatives

The Home Survey on Alcohol and Drugs in Spain takes on, on one hand, hypnosedatives in general without making any distinction between whether they are prescription drugs or non-prescription drugs and, on the other hand, includes data on the use of non-prescription hypnosedatives. A record has been kept of the use of prescription and non-prescription hypnosedatives only since 2005, it therefore not being easy to determine any trends in use over the course of time.

Hypnosedatives (prescription and non-prescription)

Hypnosedative use (in general) is calculated by adding together the use of tranquilizers (pills for calming nervousness or anxiety) and/or sleeping pills. It seems more appropriate to consider the group of hypnosedatives in general, given that, in practice, on the definitions used in the survey not specifying the specific pharmacological group to which the pills pertain, but rather the effect sought by consumers (calming anxiety or inducing sleep), those surveyed have probably included substances from a group to which they do not pertain (sleeping pills in the tranquilizers group and vice versa). In 2009, 13.4% of Spain's population within the 15-64 age range admitted having consumed hypnosedatives at some time in their lives (11.0% tranquilizers and 6.3% sleeping pills), revealing, as has been occurring in other previous editions of this survey, a higher prevalence among females (17.0%) than among males (9.9%).

As regards use within the last 12 months, the prevalence of hypnosedative use totals 7.1% (9.3% among females and 4.6% among males), the 55-64 age group being that showing the highest prevalences (11%). The analysis by age groups clearly confirms higher prevalences of use among females, with greater differences in use compared to the males within the 35-64 age group (overall 9.1% prevalence and female/male ratio of 2.1) in comparison to the 15-34 age group (overall prevalence of 4.0%) and female/male ratio of 1.7).

As regards the use within the 30 days immediately prior to the survey, the prevalence of hypnosedative use is 5.2% (7% among the females and 3.2% among the males), once again reaching maximum levels within the 55-64 age group (10.2%). The differences in prevalence of use among females and males also remain at percentages similar to those found for the use within the last 12 months in the 15-34 age group (1.8) and the 35-64 age group (2.2), in favour, as always, of the females.

Lastly, 2.7% of the population acknowledges consuming hypnosedatives daily (4% in females and 1.5% in males), the 55-64 age group being that which shows a greater prevalence of use (6.8%). In this case, the differences in use also remain the same, in favour of the females, among all the age groups in question, as for all of the other indicators assessed.

The age at which use of hypnosedatives is first started is 34.5 years of age (34.3 years of age for the case of tranquilizers and 35.6 years of age for sleeping pills).

In relation to the evolution over the course of time revealed by this indicator, a decrease is seen in the percentage of consumers compared to the 2007 edition, both for use at some time in life as well as for within the last 12 months, last 30 days or daily, although it is still higher than the figures for 2005.

Table 2.17. Evolution over the course of time of both prescription and non-prescription hypnosedative use. Home Survey on Alcohol and Drugs in Spain 2005-2009. Spain

%	2005	2007	2009
Ever lifetime	8.7%	15.4%	**13.4%**
Last year	5.1%	8.6%	**7.1%**
Last month	3.7%	5.9%	**5.2%**
Daily	-	3.1%	**2.7%**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain2005-2009. Spain

Non-prescription hypnosedatives

The prevalences of non-prescription hypnosedative use are logically remaining at much lower levels than those of prescription or non-prescription hypnosedative use. This survey solely records the use for the last 12 months.

In 2009, 1.9% of Spain's population within the 15-64 age range consumed non-prescription hypnosedatives within the last 12 months (1.6% tranquilizers and 1.1% sleeping pills). These consumptions mark an increase in the figures for 2007 (1.3%, 0.9% and 0.7%, respectively).

The greatest prevalences of use are found, unlike what was found for the use or prescription or non-prescription hypnosedatives, among the 35-44 age group (2.2% for the hypnosedatives taken as a whole), among the 25-34 age group (1.8% for tranquilizers) and, once again, among the 35-44 age group (1.3% for sleeping pills).

The age at which non-prescription hypnosedatives are first started being consumed is at 29.5 years of age (28.8 tranquilizers and 30.6 sleeping pills.

No gender-related differences are found in the overall prevalences of use for the entire population as a whole (1.9% among both males and females), but the use is slightly more prevalent among the females in the case of tranquilizers (1.7 compared to .5) and, to the contrary, is more prevalent among the males (1.1% vs. 1.0% in the case of the sleeping pills, although with minimal differences.

The analysis of the consumptions by age groups and genders reveals a clear presence of the males from the 15-34 age group for non-prescription hypnosedative use which is not found for the prescription hypnosedatives.

As regards the evolution over the course of time, despite a discreet rise in the percentage of consumers of non-prescription hypnosedatives commencing as of 2005 apparently being confirmed, the figures are still far below those of 2003. As has previously been mentioned in the REITOX reports from previous years, new questions

having been added concerning the use of prescription or non-prescription hypnosedatives may have had a bearing on those surveyed when giving an answer.

Table 2.18. Evolution over the course of time of non-prescription hypnosedative use. Home Survey on Alcohol and Drugs in Spain, 2003-2009. Spain

%	2003	2005	2007	2009
Last 12 months	3.1	1.2	1.3	**1.9**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain2003-2009. Spain.

Table 2.19. Prevalence (%) Prescription or Non-Prescription Hypnosedatives. Home Survey on Alcohol and Drugs in Spain 2009. Spain.

		Overall	Male	Female	15-34 age group			35-64 age group		
					Overall	Male	Female	Overall	Male	Female
Hypnosedatives (prescription or non-prescription)	**Lifetime**	13.4%	9.9%	17.7%	8.8%	7.0%	10.8%	16.5%	12.0%	21.0%
	Last 12 months	7.1%	4.6%	9.3%	4.0%	3.0%	5.2%	9.1%	5.7%	12.5%
	Last 30 days	5.2%	3.2%	7.0%	2.4%	1.7%	3.2%	7.0%	4.4%	9.7%
Tranquilizers (prescription or non-prescription)	**Lifetime**	11.0%	8.0%	14.2%	7.1%	5.3%	8.9%	13.8%	9.9%	17.7%
	Last 12 months	5.5%	3.4%	7.6%	3.1%	2.0	4.3%	7.1%	4.4%	9.8%
	Last 30 days	4.0%	2.4%	5.7%	1.8%	1.2%	2.5%	5.5%	3.2%	7.7%
Sleeping pills (prescription or non-prescription	**Lifetime**	6.3%	4.8%	**7.9%**	4.0%	3.2%	4.7%	8.0%	5.9%	10.1%
	Last 12 months	3.6%	2.6%	4.6%	1.9%	1.7%	2.2%	4.7%	3.3%	6.2%
	Last 30 days	2.7%	1.9%	3.5%	1.2%	0.9%	1.5%	3.7%	2.5%	4.8%

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain

Table 2.20. Prevalence (%) Non-prescription hypnosedative use. Home Survey on Alcohol and Drugs 2009. Spain..

		Overall	Male	Female	15-34 age group			35-64 age group		
					Overall	Male	Female	Overall	Male	Female
Hypnosedatives (non-prescription)	**Last 12 months**	1.9%	1.9%	1.9%	1.8%	2.1%	1.5%	1.9%	1.7%	2.1%
Tranquilizers (non-prescription)	**Last 12 months**	1.6%	1.5%	1.7%	1.6%	1.9	1.4	1.5%	1.2%	1.9%
Sleeping pills (non-prescription)	**Last 12 months**	1.1%	1.1%	1.0%	1.0%	1.3%	0.8	1.10%	1.1%	1.2%

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009. Spain

Polidrug use

The polydrug use of legal and illegal drugs is a progressively more prevalent use pattern on the scenario of psychoactive substance use in Spain.

The analysis of the number of the substances consumed by those surveyed who acknowledge having consumed any of the substances regarding which they are questioned reveals that, despite approximately half of the consumers consuming solely one substance, the rest (nearly the other half) are involved in polydrug use of 2 or more substances. Thus, within the last 12 months, 49.3% of the population that has reported consuming any of the substances included on the survey, has taken two or more of them, this being a percentage which drops to 43.0% if the use within the last 30 days is taken into consideration.

Table 2.21. Prevalence of use of one single or more psychoactive substances. (%). Home Survey on Alcohol and Drugs in Spain. Spain.

	Last year	Last 30 days
One single substance	50.6	57.0
Two substances	34.8	33.7
Three substances	10.5	7.4
Four substances	2.7	1.3
Five or more substances	1.3	0.6

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 1997- 2009. Spain.

The analysis of the number of substances consumed (in terms of the use within the last 12 months) of the certain substances in particular makes it possible to come to some interesting data on the use profiles. Alcohol is found to be present in most of the poludrug users (values over 90%).

Table 2.22. Prevalence of polydrug use of two or more psychoactive substances by psychoactive substance consumed within the last 12 months. (%). Home Survey on Alcohol and Drugs in Spain 2009. Spain

Substances consumed	Two substances	Three substances	Four substances	Five or more substances
Alcohol	95.7	96.0	98.6	99.1
Tobacco	89.0	91.2	96.9	97.2
Cannabis / Marijuana	4.8	69.0	76.6	95.2
Ecstasy	0	0.6	5.1	58.4
Tranquilizers / Sedatives	6.3	22.3	32.6	29.4
Sleeping pills	3.7	14.3	29.8	26.1
Powdered cocaine	0.4	5.6	51.1	72.4
Base / Crack	0	0.1	1.1	7.3
Speed / Amphetamines	0	0.2	3.8	47.3
Hallucinogens	0	0.3	4.3	30.3
Heroin	0	0.4	0.0	3.6
Inhalants	0	0	0.1	2.2

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 2009. Spain.

Lastly, the study of the cross use of the different substances within the last 12 months provides specific information on the prevalences with which each consumer of a psychoactive substance consumes all the other substances within this same time period, which facilitates associating different groups of drugs for each type of consumer (Table 2.23). A thorough analysis of this table will afford the possibility of detecting specific patterns of use, which is information highly useful for designing interventions adapted to the changing actual situation of the use of psychoactive substances.

Table 2.23. Percentage of consumers of other drugs among the 15-64 age range who have consumed alcohol, tobacco, cannabis, ecstasy, tranquilizers, sleeping pills, hypnosedatives, powdered cocaine, crack, cocaine in general (powdered and/or crack), amphetamines, hallucinogens, heroin or inhalants within the last 12 months. (%). Home Survey on Alcohol and Drugs in Spain 2009.

	Use of the different substances within the last 12 months													
	Alcohol	Tobacco	Cannabis/ marijuana	Ecstasy	Tranquilizers sedatives	Sleeping pills	Hypno-sedatives	Powdered cocaine	Crack	Cocaine in general	Speed/ Amphetamines	Hallucino-gens	Heroin	Inhalants
Alcohol	100.0	85.8	94.6	98.2	70.0	72.2	72.2	97.5	94.1	97.6	99.5	97.2	87.8	100.0
Tobacco	46.9	100.0	86.3	89.1	52.3	47.8	50.8	88.6	88.1	88.3	95.3	91.1	87.8	94.7
Inhalants	0.0	0.1	0.2	2.2	0.2	0.0	0.1	0.7	0.0	0.7	2.9	3.9	0.0	100.0
Speed/ Amphetamines	0.8	1.4	5.2	45.0	1.6	1.7	1.4	15.7	22.7	15.7	100.0	52.2	0.0	66.4
Hallucinogens	0.6	1.0	4.2	26.4	1.5	1.3	1.2	9.5	11.6	9.6	38.4	100.0	8.5	66.3
Heroin	0.1	0.2	0.3	2.6	0.4	0.7	0.3	1.2	6.7	1.2	0.0	1.4	100.0	0.0
Tranquilizers/ Sedatives	4.9	6.7	5.8	10.4	100.0	53.8	76.6	7.8	17.4	8.1	13.9	16.8	30.7	35.0
Sleeping pills	3.3	4.0	4.8	8.8	35.5	100.0	50.6	6.8	8.8	6.9	9.6	10.0	30.7	0.0
Hypnosedatives	6.6	8.5	8.1	14.1	100.0	100.0	100.0	10.8	17.4	11.0	15.8	17.8	30.7	35.0
Cannabis/ Marijuana	12.8	21.3	100.0	91.8	11.2	13.9	11.9	77.6	85.5	77.7	85.6	94.5	44.1	81.1
Ecstasy	1.1	1.7	7.3	100.0	1.6	2.0	1.7	21.3	11.2	20.8	58.6	46.8	27.0	65.2
Powdered cocaine	3.3	5.4	19.2	66.2	3.7	4.9	3.9	100.0	62.0	98.2	63.3	52.4	37.8	61.8
Base/Crack	0.2	0.3	1.0	1.7	0.4	0.3	0.3	3.0	100.0	4.7	4.4	3.1	10.7	0.0
General cocaine	3.3	5.5	19.5	66.2	3.9	5.0	4.1	100.0	100.0	100.0	64.5	54.0	39.0	61.8

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009

Drug injection

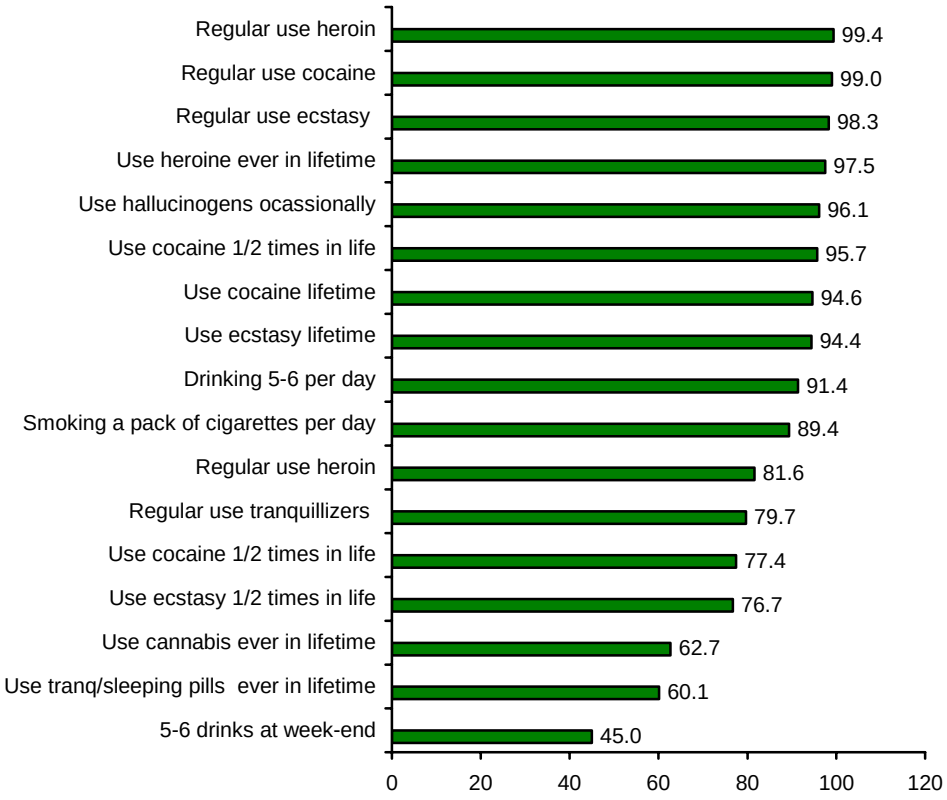
Once again, it must be said that this type of surveys are not a very suitable means of estimating how widespread the drug injection phenomenon maybe. It is however known, by way of other indicators, that this is a rapidly regressing phenomenon. The results of this survey indicate that, in 2009, a total of 0.2% of Spain's population within the 15-64 age range have injected heroin or cocaine (0.5% males and 0.1% females) at some time in their lives, the highest prevalence being found among the 45-54 age group (0.3%).

Perceived risk regarding different drug use behaviours

The perceived risk regarding different behaviours concerning drug use/abuse on the part of the population can be construed as a defence tool, as a greater sense of risk can be a factor safeguarding against use and vice versa.

Of all the types of use considered, the population within the 15-64 age range finds the most dangerous behaviours to be the regular use (weekly or more often) of heroin, cocaine and ecstasy, this being a perception which has remained the same, having gone unchanged, year after year. The situations considered to entail a lesser risk are the use of 5/6 glasses of alcohol on the weekends and consuming tranquilizers/sleeping pills or hashish some time in their lives. Hence, the perception of risk perceived by those surveyed for the use of ecstasy and cocaine at some time in their lives and for the regular use of tranquilizers is relatively low, all showing a percentage below 80%.

Figure 2.21. Percentage of the population within the 15-64 age range who think that each use behaviour can cause quite a few/many problems (%). Spain 2009.



Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. 2009.

Table 2.24. Evolution of the perceived risk regarding different drug use behaviours (% of population within the 15-64 age range who believe that this use behaviour can cause many or quite a few problems). Spain 1997-2009

Category: many or quite a few problems	1997	1999	2001	2003	2005	2007	2009	Difference 2009-2007	Difference 2009-1997
Regular use heroin	99.4	99.6	98.8	99.3	99.3	99.4	**99.4**	0.0	0.0
Use heroin ever in lifetime	97.6	98.5	96.7	97.4	97.9	98.7	**97.5**	-1.2	-0.1
Regular use cocaine	98.5	99.2	97.9	98.5	98.7	98.9	**99.0**	+0.1	+0.5
Use cocaine ever in lifetime	93.5	95.4	93.3	93.1	95.0	95.8	**94.6**	-1.2	+1.1
Try cocaine once or twice	--	--	--	--	--	--	**77.4**	--	--
Regular use ecstasy	98.6	98.9	97.8	98.3	98.7	98.3	**98.3**	0.0	-0.3
Use ecstasy ever in lifetime	92.5	94.6	92.6	92.6	94.4	95.8	**94.4**	-1.4	+1.9
Try ecstasy once or twice	--	--	--	--	--	--	**76.7**	--	--
Regular use hallucinogens	99.1	99.4	98.5	99.1	99.2	97.4	**--**	--	--
Use hallucinogens ever in lifetime	96.0	97.4	95.5	96.3	97.1	--	**96.1**	--	+0.1
Regular use tranquilizers / sleeping pills	81.4	86.8	84.8	85.4	81.8	79.7	**79.7**	0.0	-1.7
Use tranquilizers / sleeping pills ever in lifetime	60.4	70.1	66.7	65.3	62.3	62.2	**60.1**	-2.1	-0.3
Regular use hashish	84.0	87.6	83.1	79.2	80.8	83.0	**81.6**	-1.4	-2.4
Use hashish ever in lifetime	68.9	74.8	67.9	62.0	64.2	68.5	**62.7**	-5.8	-6.2
Try crack one or two times	--	--	--	--	--	--	**95.7**	--	--
Drink 5/6 beers/mixed drinks a day	89.2	90.7	86.1	83.3	87.3	89.2	**91.4**	+2.2	+2.2
Drink 5/6 beers/mixed drinks on weekend	45.6	49.2	44.2	41.8	43.6	46.6	**45.0**	-1.6	-0.6
Smoke pack of cigarettes daily	79.7	82.4	83.6	84.6	87.1	87.1	**89.4**	+2.3	+9.7

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. 1997-2009.

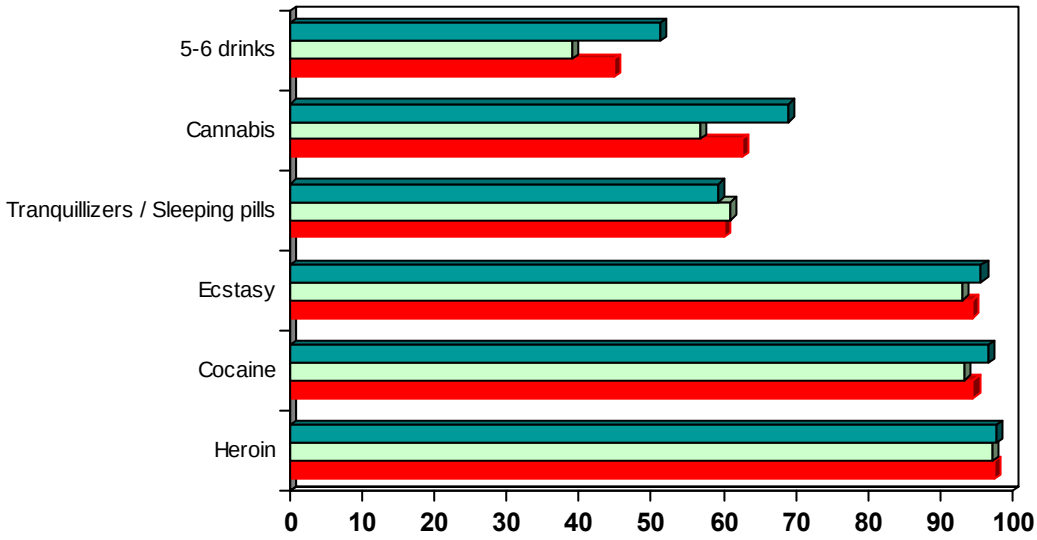
The most important positive trend from 1997 to 2009 is noted on assessing the perception of risk associated with "smoking a pack of cigarettes a day, which has increased by 9.7 percentage points. The perception of risk associated with "drinking 5-6 beers /mixed drinks daily" has increased by 2.2 points, and that of "using cocaine ever in their lifetime" has increased by 1.1 percentage points during this same period.

For other behaviours, the perceived risk either remains the same ("regular use heroin") or decreases, as is the case of "using hashish ever in their lifetime", which has dropped 6.2 percentage points, and "regular use of tranquilizers/sleeping pills" or "regular use of hashish", the associated risk percentages of which dropped by 1.7 and 2.4 percentage points, respectively. The figures for the perception of risk associated to using cannabis, in conjunction with the use prevalences recorded for this substance, point to a their use being "considered normal".

Within the 2007-2009 period, the perception of risk associated with "regular use" of almost all the substances with the exception of "regular use of hashish" (-1.4 points) has either increased or remained the same, a drop also being noted for "use of cannabis ever in their lifetime" (-5.8), tranquilizers/sleeping pills (-2.1), ecstasy (-1.4) and heroin and cocaine (-1.2 points), which indicates a recent decrease in the risk associated with the experimental type of uses in general.

As shown in Figure 2.22, the females show a greater perception of risk associated with use for all the substances with the exception of tranquilizers/sleeping pills, the perceived risk figures for which are higher among the males.

Figure 2.22. Perception of the risk associated with the sporadic use of psychoactive substances (once a month or less), by gender. (%). Spain 2009

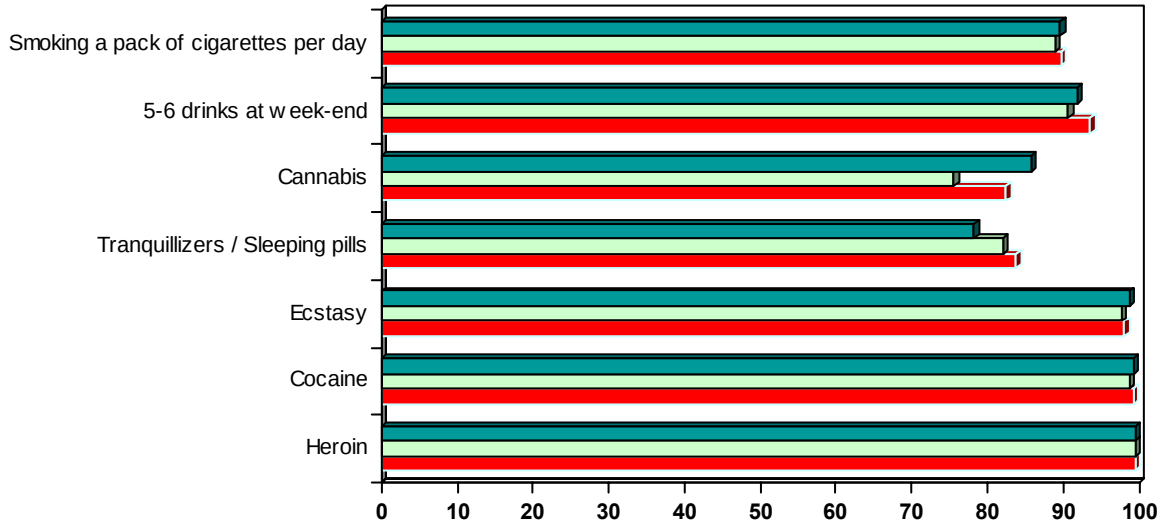


	Heroin	Cocaine	Ecstasy	Tranquillizers / Sleeping pills	Cannabis	5-6 drinks
Female	97,7	96,7	95,7	59,4	68,9	51,3
Male	97,3	93,4	93,2	60,9	56,8	39,1
total	97,5	94,6	94,4	60,1	62,7	45

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. 1997-2009.

In terms of ages, differences are found in the perception of the risk associated with the use of the different substances. Thus, the older age group shows the lowest perception of risk for the sporadic use of tranquilizers/sleeping pills, and the youngest respectively considering the sporadic use of cannabis less dangerous.

Figure 2.23. Perception of the risk associated with the sporadic use of psychoactive substances (once a month or less), by ages. (%). Spain 2009.



	Heroin	Cocaine	Ecstasy	Tranquillizers / Sleeping pills	Cannabis	5-6 drinks at w eek-end	Smoking a pack of cigarettes per
35-64 years	99,5	99,2	98,7	78,2	85,8	91,8	89,6
15-34 years	99,5	98,7	97,7	82	75,6	90,7	88,9
15-18 years	99,5	99,2	98,1	83,7	82,5	93,6	89,7

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. 1997-2009.

Perceived drug availability

Generally speaking, Spain's population considers it easy to gain access to illegally-sold drugs. In 2009, for three illegally-sold substances (cannabis, cocaine and ecstasy) more than 50% of the population considered them to be readily or very readily available within 24 hours. The 25-34 age group is that stating finding them more readily accessible, the older age group (55-64 years of age) being the group stating having more problems getting the different substances.

In Spain, cannabis is the illegal drug considered the easiest to obtain within 24 hours (69.6% of citizens considering it to be readily or very readily available), heroin being that which is less readily accessible (44.7%). Cocaine, ecstasy and LSD are positioned in an intermediate risk perception tranche (56.7%, 51.9% and 48.7%, respectively).

The perceived availability has increased for the five main illegally-sold drugs during the 1995-2009 period. Cannabis is the substance having shown the greatest increase (19.2 percentage points), heroin having been that for which a lesser increase (7.7 percentage points) has been recorded.

Table 2.14. Evolution of the perception of availability of illegal psychoactive drugs (the are readily / very readily available within 24 hours) among the population within the 15-64 age range (%). Spain 1995-2009

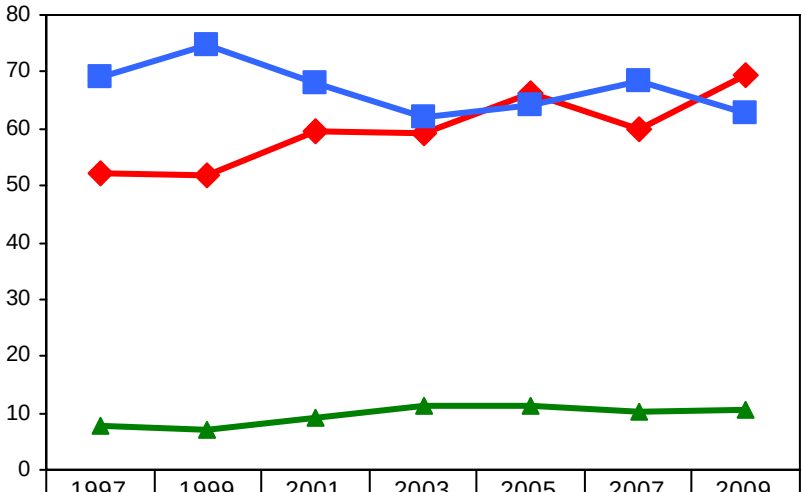
	1995	1997	1999	2001	2003	2005	2007	2009	2007-2009	1997-2009
Hashish/ Marijuana	50.3	52.1	51.8	59.5	59.2	66.2	59.8	**69.6**	**+9.8**	**+19.2**
Ecstasy	41.1	40.9	39.9	48.2	46.1	49.7	43.8	**51.9**	**+7.1**	**+10.8**
Cocaine	39.5	39.2	39.9	46.7	46.5	53.3	43,8	**56.7**	**+7.8**	**+17.2**
Heroin	37.0	36.2	37.2	41.2	39.2	43.4	39.5	**44.7**	**+5.2**	**+7.7**
LSD	37.1	37.0	37.2	42.7	40.0	44.8	40.2	**48.7**	**+8.5**	**+11.6**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 1995-2009. Spain.

If we establish a correlation between prevalence of use, perception of risk associated with use and perceived drug availability, some indications will result providing us with a closer view of the trends in use.

On reviewing the evolution of these three variables for cannabis, cocaine and ecstasy, we find that, for cannabis (Figure 2.24), he perception of the risk decreased and the availability and prevalence of use increased in 2009. In the case of cocaine (Figure 2.25), the prevalence of use decreased in 2009 after experiencing an upward trend for several years, followed by a stabilization, the perception of risk now remaining the same and the perceived availability increasing. As regards ecstasy, Figure 2.26 shows a situation similar to that of cocaine, that is to say, the prevalence of use decreasing, the perception of the risk remaining at figures similar to those of the past few years and the perceived availability increasing.

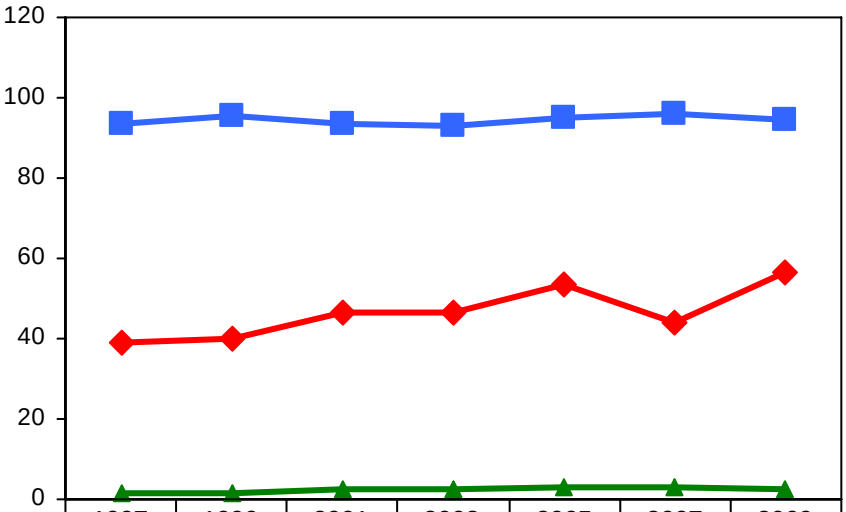
Figure 2.24. Prevalence of cannabis use within the last 12 months, perception of the risk involved in sporadic use (once or less per month) and perceived availability (readily / very readily available within 24 hours) among the population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain 1997-2009.



	1997	1999	2001	2003	2005	2007	2009
Availability	52,1	51,8	59,5	59,2	66,4	59,8	69,6
Risk	68,9	74,8	67,9	62	64,2	68,5	62,7
Prevalence of use	7,7	7	9,2	11,3	11,2	10,1	10,6

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain 1997-2009. Spain.

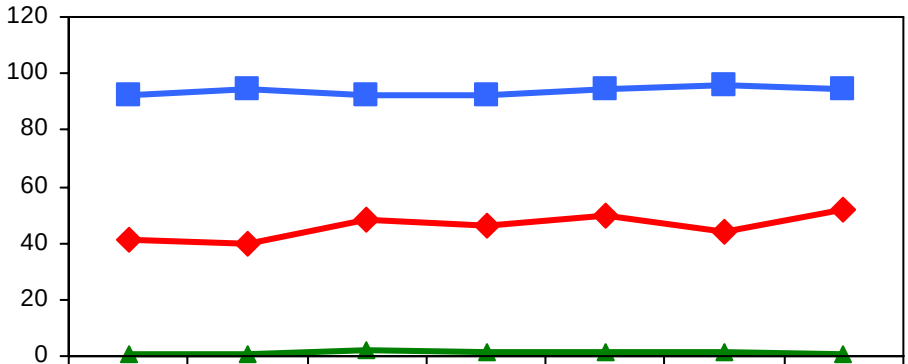
Figure 2.25. Prevalence of powdered cocaine use within the last 12 months, perception of the risk involved in sporadic use and perceived availability among the population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain 1997-2009.



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

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.Home Survey on Alcohol and Drugs in Spain 1997-2009. Spain.

Figure 2.26. Prevalence of ecstasy use within the last 12 months, perception of the risk involved in sporadic use and perceived availability among the population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain 1997-2009.



	1997	1999	2001	2003	2005	2007	2009
Availability	40,9	39,9	48,2	46,1	49,7	43,8	51,9
Risk	92,5	94,6	92,6	92,6	94,4	95,8	94,4
Prevalence of use	0,9	0,8	1,8	1,4	1,2	1,1	0,8

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 1997-2009. Spain.

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

In 2009, almost half of the population (49%) within the 15-64 age range considered the problem of illegal drugs to be "highly important" where they live (district or town). This figure is quite similar to the figure for 2007. Of the other half, 30% considered the use of illegal drugs to be a "somewhat important" problem, the other 20% not considering it to be of any importance at all. (Table 2.15).

The evolution over the course of time of this parameter tells us that the feeling about the importance of the problem of drugs continues to be the same for both the bottom category (totally unimportant) and for the top category (highly important). There not having been any change in the overall opinion concerning drug use during the 1997-2009 period however contrasts with the tremendous change there has been in the drug use scenario both in terms of social visibility, type of associated problems, improvement of citizen safety, different use profiles (use associated with social exclusion has been taken over by uses integrated socially and in recreational environments, etc.)

Table 2.15. Evolution of the importance Spain's population within the 15-64 age range places on the problem of illegal drugs where they live (%). Spain 1997-2009.

	1997	1999	2001	2003	2005	2007	2009	Difference 2007- 2009
Totally unimportant	19.6	22.3	19.1	20.9	14.8	20.5	**20.4**	**- 0.1**
Somewhat important	28.1	32.1	34.3	34.3	27.9	29.7	**30.7**	**+ 1.0**
Highly important	46.4	37.3	39.3	36.3	52.0	49.8	**48.9**	**- 0.9**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 1997-2009. Spain

Of all the situations linked to the problem use of drugs regarding which questions were asked in the survey, those considered by Spain's population in 2009 to be the most frequent and visible in their residential environment were the drug sniffers (10.4%) and the existence of drug dealers (13.5%). Those less visible were the existence of people injecting drugs (2.9%) and finding syringes on the ground (3.8%) (Table 2.16 and Figure 2.27).

Table 2.16. Evolution of the visibility of some illegal drug use-related situations in the close environment (% of the population within the 15-64 age range encountering each situation in the location where they live frequently or very frequently). of some s Home Survey on Alcohol and Drugs in Spain 1995-2009.

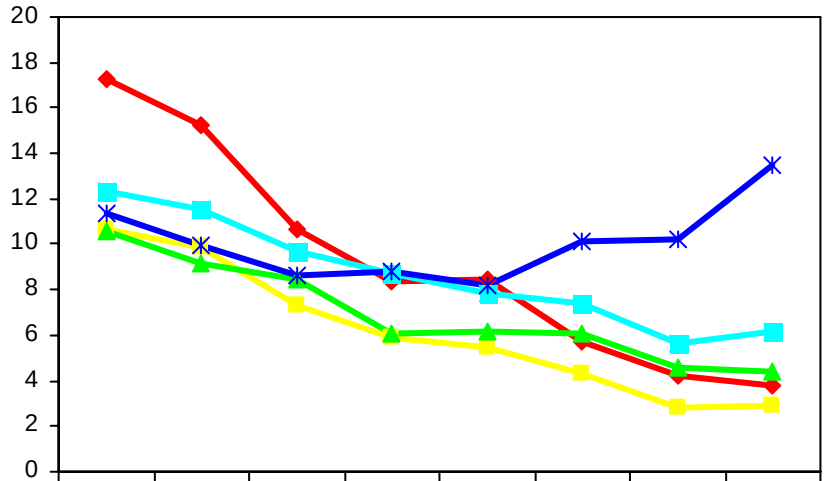
% of population frequently or very frequently finding	1995	1997	1999	2001	2003	2005	2007	2009	Difference 2001-2009
Syringes on ground	17.3	15.2	10.7	8.4	8.5	5.7	4.2	**3.8**	**- 4.6**
People injecting drugs	10.7	9.9	7.3	5.9	5.5	4.3	2.8	**2.9**	**- 3.0**
People smoking drugs	10.6	9.2	8.5	6.1	6.2	6.1	4.6	**4.4**	**- 1.7**
Drugged people lying on the ground	12.3	11.5	9.7	8.7	7.8	7.4	5.6	**6.2**	**- 2.5**
Drug dealers pushing drugs	11.4	10.0	8.6	8.8	8.2	10.1	10.2	**13.5**	**+ 4.7**
People sniffing drugs	--	--	--	--	--	--	11.6	**10.4**	**--**

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 1997-2009. Spain.

For all of the situations set out in the survey, the evolution over the course of time has been clearly favourable. The visibility of the drug use phenomenon (gauged by specific

situations) has significantly decreased since 1995. This decrease has been confirmed in the latest Home Survey on Alcohol and Drugs in Spain, with the exception of the existence of "dealers pushing drugs" which has risen by 3.3 percentage points since 2007 and by 4.7 points since 2001. These results contrast, as mentioned at the beginning of this chapter, with there being no significant change in the opinion of the population with regard to the importance generally placed on the drug use problem.

Figure 2.27. Evolution of the visibility in the close environment of some illegal drug use-related situations (% of the population within the 15-64 age range encountering each situation frequently or very frequently in the location where they live. Spain 1995-2009



	1995	1997	1999	2001	2003	2005	2007	2009
Syringes on the ground	17,3	15,2	10,7	8,4	8,5	5,7	4,2	3,8
People inyecting drugs	10,7	9,9	7,3	5,9	5,5	4,3	2,8	2,9
Drug smokers	10,6	9,2	8,5	6,1	6,2	6,1	4,6	4,4
Drug users fallen	12,3	11,5	9,7	8,7	7,8	7,4	5,6	6,2
Drug dealers	11,4	10	8,6	8,8	8,2	10,1	10,2	13,5

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.Home Survey on Alcohol and Drugs in Spain 1995-2009. Spain

Assessment of the importance of the actions for attempting to solve the problem of illegal drugs

Education in the schools has been being the intervention measure most highly valued by the population within the 15-64 age range for solving the drug-related problem. The second best measure considered is the voluntary treatment of the drug users (availability and accessibility of the treatments) and, thirdly, police and Customs control.

Spanish citizens place little importance on legalizing drugs both as an overall measure for all drugs, which is considered the worst of all (15.6%) and when taken as a specific measure with regard to some substances such as cannabis (29.6%). Nevertheless, despite lesser importance having been placed on the legalization of all drugs by those surveyed compared to 2007, the opinion of the legalization of cannabis has improved

from 2007 to 2009 by 6.2 points, although it is still ranked in the same position among the measures to be assessed.

The publicity campaigns has been considered effective by 77% of those surveyed in 2009, this measure however having shown a drop in importance (dropping by 1.4 percentage points compared to 2007), its former position being taken over by the measure consisting of the enacting of stricter anti-drug laws.

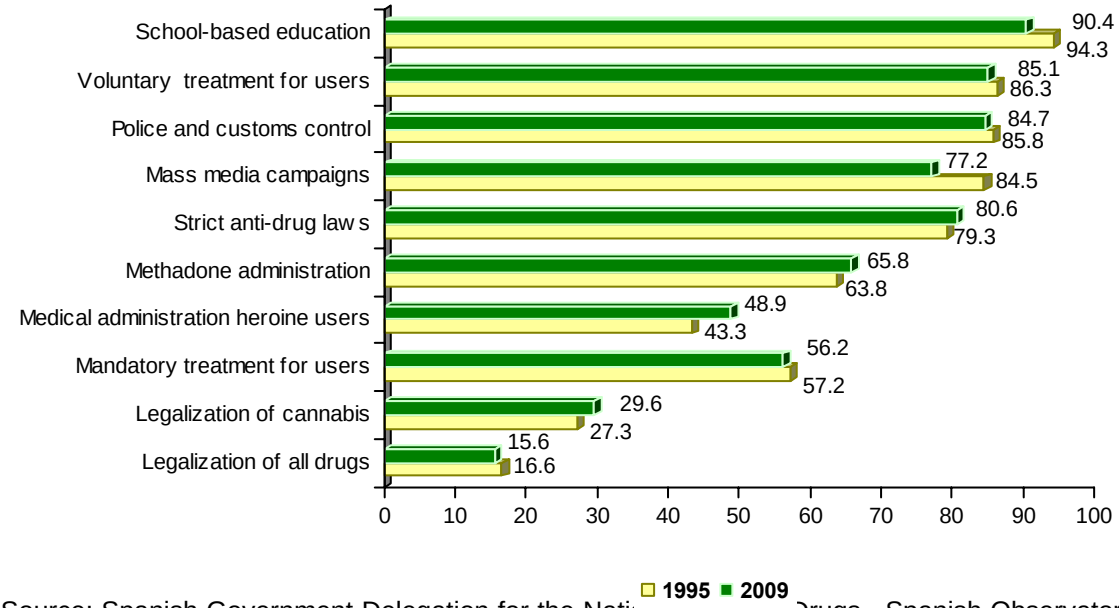
Generally speaking, Spain's population considers the most effective measures to be education/instruction, accessibility to treatment and the police and government control measures.

Table 2.17. Evolution in the assessment of different actions for resolving the problem of drugs among the population within the 15-64 age range (%). Home Survey on Alcohol and Drugs in Spain 1995-2009. Spain

Is highly important for solving the problem	1995	1997	1999	2001	2003	2005	2007	2009
School-based education	94.3	93.1	91.8	89.4	89.5	88.8	90.6	**90.4**
Voluntary treatment for users	86.3	87.1	84.8	81.6	82.7	82.4	83.2	**85.1**
Police and Customs control	85.8	83.7	82.1	80.5	78.8	79.8	83.3	**84.7**
Mass media campaigns	84.5	81.5	79.8	77.6	75.6	77.7	79.1	**77.7**
Strict anti-drug laws	79.3	77	76.9	75.5	73.2	75.3	77.9	**80.6**
Methadone administration	63.8	62.9	67.5	66.6	67.1	68.4	66.8	**65.8**
Mandatory treatments	56.2	57.2	57.9	62.8	59.7	58.2	56.3	**57.2**
Heroin administration	43.3	47.5	53.9	58.2	59.3	59.9	52.8	**48.9**
Legalization of cannabis	27.3	30.2	33.3	38.5	37.1	35.2	23.4	**29.6**
Legalization of all drugs	19.8	21.5	24.6	27.1	23.5	21.4	16.6	**15.6**

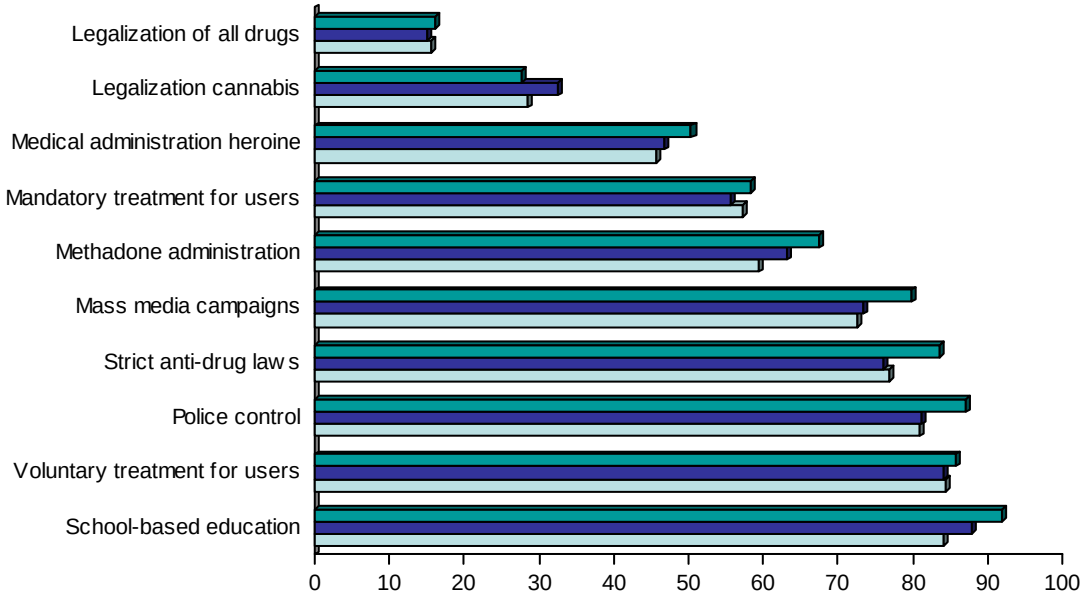
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 1995-2009. Spain.

Figure 2.28. Assessment of different actions for solving the problem of drugs among the population within the 15-64 age range (% considering each action to be highly important). Spain 1995-2009.



Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain 1995-2009. Spain.

Figure 2.29. Assessment of different actions for solving the problem of drugs among Spain's population within the 15-64 age range (by age groups).Home Survey on Alcohol and Drugs in Spain 2009. Spain



	School-based educatio	Voluntary treatmen	Police control	Strict anti-drug laws	Mass media campaig	Methadone administr	Mandatory treatmen	Medical administration	Legalization cannabis	Legalization of all drugs
35-64 years	92	85,7	87,1	83,7	79,8	67,5	58,3	50,4	27,7	16,1
15-34 years	88	84,1	81,1	76,1	73,3	63,2	55,6	46,8	32,5	15
15-18 years	84,1	84,3	80,9	76,8	72,7	59,3	57,3	45,7	28,5	15,5

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs.. Home Survey on Alcohol and Drugs in Spain 2009. Spain.

Conclusions

- From 2007 to 2009, tobacco use has stabilized for all use indicators, showing a slight trend toward increasing. Males continue smoking to a greater extent than females, the prevalences in daily use being found to be nearing one another, by genders, for the 15-34 and 35-64 age groups, and the drop in daily use among females within the 15-34 age range is confirmed.

- Alcohol is the psychoactive substance most consumed by Spain's population. The consumptions remain relatively stable compared to previous years, although showing a slight increase of all the use indicators as compared to 2007. The at risk and intensive consumptions (at risk drinkers, alcohol poisoning and binge drinking are increasing compared to previous years. Alcohol consumption is concentrated during the weekends, beer being the beverage consumed mostly on both weekdays and weekends.

- The prevalence of hypnosedative (prescription or non-prescription) use has decreased compared to the values found in 2007. The prevalence of use is clearly greater among females. The prevalence of use of non-prescription hypnosedatives is logically lower that that of the prescription or non-prescription use and shows a discreet rise since 2005, however not having risen as far as the figures of 2003. The differences in prevalence, by genders, are much smaller in this group than in the case of prescription hypnosedatives, the consumptions even being more prevalent among the group of the younger males.

- The prevalence of cannabis use has increased for experimental use and is showing a slight trend toward increasing for the rest of the use indicators. The youngest males (15-24) show the highest prevalences, with significant differences compared to the females. The age at which use first begins has not undergone any change compared to 2007. A trend is noted toward stabilization or a reduction in the continuity of cannabis use.

- Powdered cocaine continues to be the most prevalent form in which this substance is being consumed. The prevalences in use within the last 12 months and within the last 30 days have dropped, for the first time, in 2009 following an upward stage (1995-2005) and subsequent stabilization (2005-2007). The age at which powdered cocaine is first consumed remains the same, the age for crack rising by nearly two years. Experimentation with powdered cocaine increased in 2009, whilst decreasing considerably in the case of crack. The continuity in cocaine use has decreased remarkably over the past few years..

- Males continue to be the greatest ecstasy consumers. The prevalence of experimental use remains the same, but an upward trend is confirmed in the consumptions within the last 12 months and in the last 30 days. There are no daily consumers on record.

- Amphetamine use has stabilized during the 2007-2009 period, with the exception of the use within the last 12 months, which has dropped.

- The prevalences of hallucinogen use are showing a stable trend, continuing to be higher among males than among females.

- From 2007 to 2009, both heroin and volatile inhalants have remained at low levels of use, A lesser experimental use is noted for both of these substances, although a

very slight increase in the prevalence of use within the last 30 days is noted. The age at which heroin use first starts has increased by 1.2 years compared to 2007.

- In 2009, 50% of the consumers of psychoactive substances in Spain consume two or more substances. Alcohol is present in over 90% of the polydrug uses.

- The population within the 15-64 age range perceives regular heroin, cocaine and ecstasy use as being more dangerous. Sporadic cannabis use, drinking 5-6 beers or mixed drinks on weekends and consuming tranquilizers some time in their lives are the use which the population associated with a lesser risk. In 2009, compared to 2007, the perception of the risk associated with experimental use decreased, whilst the perception of the risk association with regular cocaine use, drinking 5/6 beers or mixed drinks daily and smoking a pack of cigarettes a day increased.

- The perception of illegal drug availability increased within the 2007-2009 period.

- Half of the population considers the drug use phenomenon to be a major problem in their close environment. There is no evidence of any changes in this perception during the 1995-2009 period, this being a fact contrasting with the striking decrease in the social visibility during this same period of most of the behaviours associated with problem drug use.

- The measure most highly valued by the population for preventing drug use and the different problems associated with its use continues to be school-based education. The measure least valued continues to be legalization. The mass media campaigns are less highly valued in 2009 and are given a worse assessment on the part of the youngest population (15-18 years of age). The opinion of the legalization of cannabis has improved compared to 2007 but is still included among the group of least highly valued measures.

UNIVERSAL PREVENTION

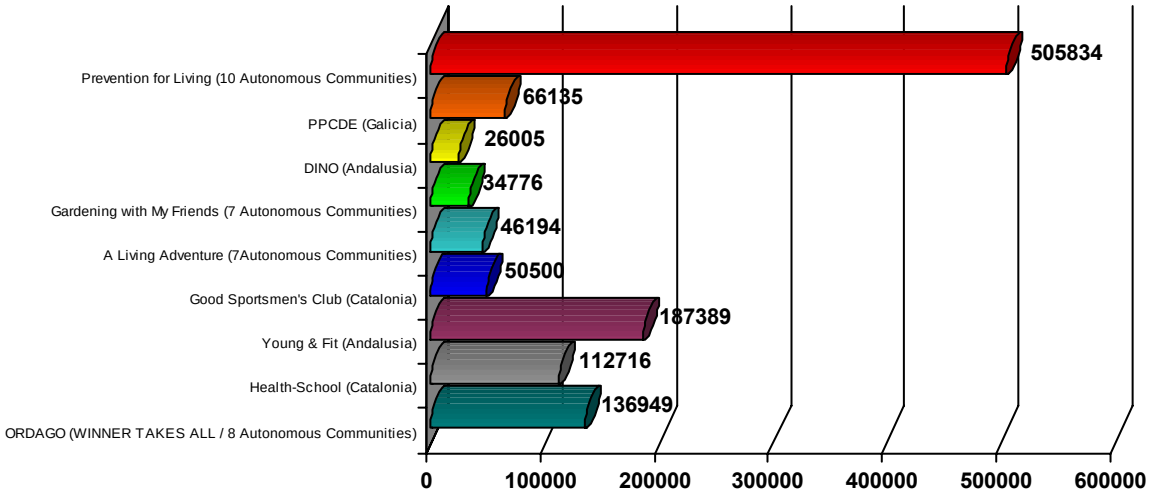
School-based Prevention

There are three types of major prevention measures within the school environment:

- Structured prevention programs put into practice in the classroom
- Periodic special extracurricular activities at schools
- Faculty training

According to the information provided by the Autonomous Communities, there are **101 structured programs**[2] now being put into practice in Spain. Some of these programs are quite widely extended and are being used in more than just one Autonomous Community (See Table: School Programs Most Widely-Extended Throughout Spain below), others are however local programs which are being put into practice at a limited number of schools.

Figure 3.1. School Programs Most Widely-Extended Throughout Spain



The programs offered through the **Autonomous Regional Plans on Drugs** are widely varied, some including more than 15 programs in their portfolios. Others, however, are focusing on one or two. These programs make their way into the schools by way of different channels: sometimes through the Autonomous Regional Plans on Drugs, other times by way of the Local Drug Plans and in yet other cases, it is the NGO's which are offering these programs directly to the schools.

Along with the conventional programs, measures have started being carried out in coordination with the medical centres, consisting of the presence of a professional from these centres at the school whose function it is to provide advice and inform the school children regarding health-related topics, especially drugs and sexuality. Andalusia ("En forma joven" / "Young & Fit") Catalonia ("Salud-Escuela" / "Health-School") and Asturias ("Consulta joven" / "Youth Council") are the three Autonomous Communities offering these programs.

[2] Programs consisting of more than 5 sessions with program implementation manuals.

In 2008, a total of **1,602,821 students and 30,180 teachers from 9,967 schools** have taken part in structured prevention programs.

A great many **periodic special activities for heightening awareness** are still currently being carried out at the schools, such as talks, prevention workshops, theatre performances, film screenings, exhibits, etc. In 2008, **400,000 students from 2,600 schools** took part in these activities.

With regard to getting **extracurricular activities** under way, worthy of special note is Castile and Leon, with their "Sports Schools" or the "You Want to Join? and "Live the Moment?" programs.

The Spanish Government Delegation for the National Plan on Drugs has held the 8th edition of the ***"The Secret to a Good Life"*** school contest, reaching 100,000 students from 1,450 schools. The objective of this context is to convey preventive messages to the children by means of an interactive graphic adventure and the dissemination of the preventive programs at the schools.

The Spanish Government Delegation has funded school programs by way of having called for applications for funding aid, for the Autonomous Communities and the NGO's (617,000 €).

The **Ministry of the Interior** also carries out drug prevention activities at schools. Firstly, the *Strategic Police Response Plan to Retail Traffic and Drug Use at schools and in the areas around schools.* Since the plan started up to December 2009, a total of 17,146 reports have been received; 463 arrests have been made and 329 drug-selling points around schools have been rendered inoperative. Secondly, in collaboration with the Ministry of Education, the *Master Plan for improving peaceful living and safety at school* has been gotten under way, 15,876 periodic special interventions (talks) having been carried out at 8,266 schools focusing mainly on the problems of bullying, the risks of the new technologies, youth gangs and drugs. A total of 4,342 of these activities were talks with students, 9,955 with teachers and 1,579 with representatives from the Parent-Teacher Associations.

Faculty Training

According to the Survey conducted on teachers by the Spanish Government Delegation for the National Plan on Drugs, 30% of the Secondary School faculty teaching the school-leaving certificate level have received some offer of training in preventing drug addictions or Education for Health, 17% of them having taken training on this subject within the last 5 years. Over half of the teachers deal with the subject of drugs in the classroom with their students, although most (72%) do so only occasionally. Teachers are the second source of information on drugs for students, after the media.

According to the information furnished by the **Autonomous Drug Plans**, a total of 13,258 teachers have taken prevention-related training in 2008.

Family Prevention

According to information from the Autonomous Drug Plans, more than **150,000 parents** have taken part in family prevention programs during 2008. Some structured programs have been consolidated, such as "Moneo" (Social Promotion & Development) "Valer" (Family Action) or "Zeus" (Sports and Living). In addition thereto,

there are a great number of less structured programs which are being put into practice at schools or community centres.

The **Spanish Government Delegation for the National Plan on Drugs** has allocated 547,000 € to funding family prevention programs for the Autonomous Communities and the NGO's in this sector.

Community Prevention

One of the regular lines of intervention within the community scope in Spain, in addition to other measures already included under other headings (family programs, in-situ training …) are the **alternative leisure time activities programs**. More than 560,000 adolescents and young people have taken part in alternative leisure time activity programs started by the Autonomous Drug Plans. The Spanish Government Delegation for the National Plan on Drugs avails, on its part, of a specific funding line for projects of this type for the municipal governments. In 2008, a total of 59 programs were funded, amounting to 3,740,000 €, a sum similar to that of previous years.

In the area of **night-time leisure activities**, progressively more actions are being carried out in collaboration with the bar and restaurant trade. For example, the Spanish Government Delegation for the National Plan on Drugs has gotten under way, within the framework of an agreement with the Spanish Hotel, Bar and Restaurant Federation, a *Training program for serving alcoholic beverages responsibly* and for reducing drug-related harm and injuries at leisure time establishments. On the other hand, many Autonomous Communities are carrying out measures such as these (Catalonia, Basque Country, Valencia, Balearic Islands…).

Also customary are the programs for reducing harm to young people carried out by different NGO's (Red Cross Youth Groups, Energy Control…), funded by the Autonomous Community Drug Plans.

Apart from the above, the **Ministry of the Interior** has continued implementing its "Plan for the Prevention of Drug Dealing and Use in Leisure Establishments and Premises", expanded upon in 8 Phases (January 2006-December 2009) with the following results: Arrests: 3,862; Points of sale rendered inoperative: 1,204; Reported drug use/possession: 147,535; Establishments Inspected: 56,638; Establishments Reported: 7,627.

Another group with which work has begun being done over the past few years is the driving school instructors, who are requesting increasingly more support for the Drug Plans for implementing drugs-and-driving prevention programs to broaden the contents included by Spain's Highway Administration.

SELECTIVE PREVENTION IN AT-RISKS GROUPS AND SETTINGS AND INDICATED PREVENTION

The top priority selective prevention groups are families and the under age or young consumers who drop out of the educational system or who have disputes with the law, immigrants and recreational drug consumers in night-time leisure spaces.

In **selective family prevention**, special mention must be made of the "Protego" programs targeting families with problem minors, "Alfil" / "Chess Strategy" and "Bitácora" / "Ship's Log" for parents of children who are drug users, "Limits" for families

with minors who are going through the juvenile court system. In addition to these structured programs, there is a wide-ranging offer of guidance and counselling actions, workshops and mediation for families with drug-related problems.

As regards the work being done with **vulnerable minors**, more than 40,000 minors have taken part in prevention programs of widely-varying types: workshops, guidance and counselling, leisure time alternatives and in-situ education, mainly, although this figure is underestimated because, in many cases, the pertinent information is unavailable. Special mention must be made of programs such as "Odisea" / "Odyssey", offered for workshop school students (academic failure) or "Alternativas" / "Alternatives" (youths reported to the police for possessing or using drugs). Also outstanding is the work with minors at protection or reform centres in Autonomous Communities such as Catalonia or Madrid.

The Spanish Government Delegation for the National Plan on Drugs has allocated 860,000 € to programs to be offered for minors. It has also funded a **research project** on selective prevention at social guarantee centres for the Deusto Drug Dependency Institute: *"Evaluative investigation of the experiences in selective prevention at the Social Guarantee centres of the Autonomous Community of the Basque Country (attached please find a description of the project).*

Prevention programs funded by the Spanish Government Delegation for the National Plan on Drugs for the Autonomous Communities, Municipal Governments and NGO's

The Spanish Government Delegation has allocated **8,572,600 €** for funding prevention projects in Spain through its orders of aid to Autonomous Communities, Municipal Governments and NGO's.

Figure 3.2. Aid to NGO's (2008) by level of intervention

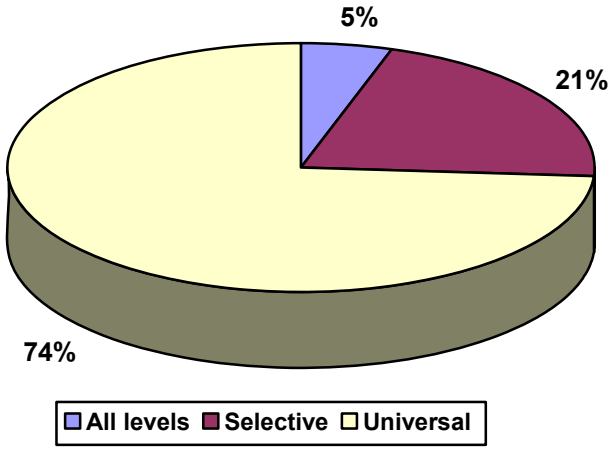
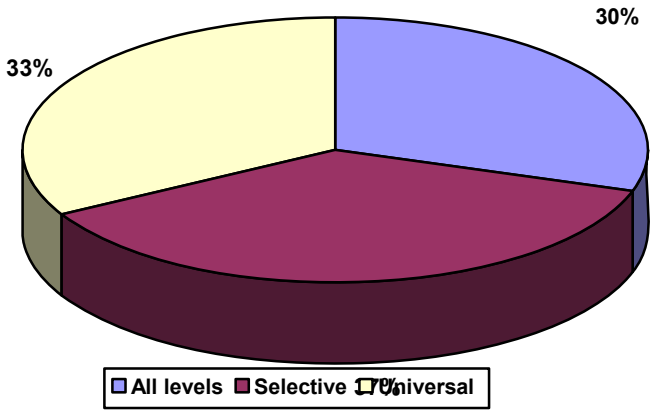


Figure 3.3. Aid to Autonomous Communities (2008) by level of intervention



Research projects on prevention funded by the Spanish Government Delegation for the National Plan on Drugs[3]:

1. **Evaluative research of the experiences in selective prevention at the Social Guarantee centres of the Autonomous Community of the Basque Country (University of Deusto). 57,000 €**
   The objective of this research is to ascertain the protection and risk factors of minors who are attending Social Guarantee centres, that is to say, who have previously experienced academic failure, and to evaluate the effectiveness of different modalities of preventive intervention which are being carried out at these centres. The sample is comprised of 32 of the Social Guarantee centres in the Autonomous Community of the Basque Country. A Solomon-style experimental design will be employed. Thus, the groups will be: Group I Having an overall intervention (specific for drugs + multi-component). Group II Having a specific intervention for drugs (not having any multi-component intervention). Group III Having a multi-component intervention (but no specific drug addiction activities). Group IV: Centres without any interventions of this type.

2. **Preparation of a system for evaluating and enhancing the drug addition prevention and health promotion programs among Galicia's adolescent population; Phase II (University of Santiago de Compostela). 31,800 €.**
   The objective of the project is to develop an evaluation system which will make it possible to regularly follow up on the preventive actions taken on this population and to know the results achieved.

3. **Early prevention of drug abuse: Follow-up study and multi-component intervention. Phase II (University of Santiago de Compostela). 74,055.00 €**
   For the purpose of evaluating the effectiveness of an indicated prevention program offered for children with Attention Deficit/Hyperactivity Disorder, the multi-component being offered for the parents, the school teachers and the children themselves.

[3] These three projects summarized herein will be of a three-year duration.

NATIONAL AND LOCAL MEDIA CAMPAIGNS

Fewer campaigns were found to have been carried out in 2008. The Spanish Government Delegation did not carry out any campaign this year, and only 9 of the 19 Autonomous Communities and Autonomous Cities carried out any campaign. The themes of these campaigns revolved mainly around smoking tobacco and drinking alcoholic beverages, having targeted mainly young people. Some examples are: “Con Alcohol, No Tiene Sentido” / "Drinking Makes No Sense" and ”¡BÚRLALAS! DROGAS NO / "OUTSMART THEM! SAY NO TO DRUGS! (youths of Castile and Leon; "TE INVITAMOS A DECIR NO) VER, OÍR Y ¿HABLAR?" / PLEASE SAY NO! SEE, HEAR AND … SAY? (Youths and families, Andalusia). The media most used have been posters, radio announcements, billboards, e-mail mkt, msm, and t.v. ads.

PREVALENCE AND INCIDENCE ESTIMATES OF PDU

A knowledge of the prevalence and incidence of problem heroin and cocaine use is highly useful for designing and evaluating health programs. There are, however, many methodological limitations for gathering this information directly from populational surveys. One alternative is to make estimates on the basis of drug problem indicators based generally on the drug users seen by certain services. In this regard, a growing interest exists in Europe concerning estimating the trends in problem heroin and cocaine use (new users), because this will make it possible to ascertain the dynamics of the heroin and cocaine epidemics and to evaluate the suitability of the interventions carried out, although it be within a historic context. This is why the decision was made to undertake this task in Spain.

The study presented in following arose following that which was recently published in the journal *Addiction*[4] and was conducted employing a similar methodology. The objective of this study was to estimate the evolution of the incidence of problem heroin use in Spain within the 1971-2006 period, and the incidence of problem cocaine use within the 1978-2006 period, based on the indicator admissions to treatment for drug abuse or addiction, which, as of 1991, distinguishes between those admitted to treatment for the first time in their lives (first treatments) and those who have previously been treated. A total of 169,682 individuals within the 15-54 age range who started their first treatment for heroin abuse or addiction within the 1991-2006 period and 89,760 individuals within the 15-59 age range who did so for cocaine were selected (Table 4.1).

Table 4.1 Restrictions determined for the analysis of those admitted to treatment for heroin or cocaine for the purpose of estimating the evolution of the incidence of problem use of these drugs in Spain.

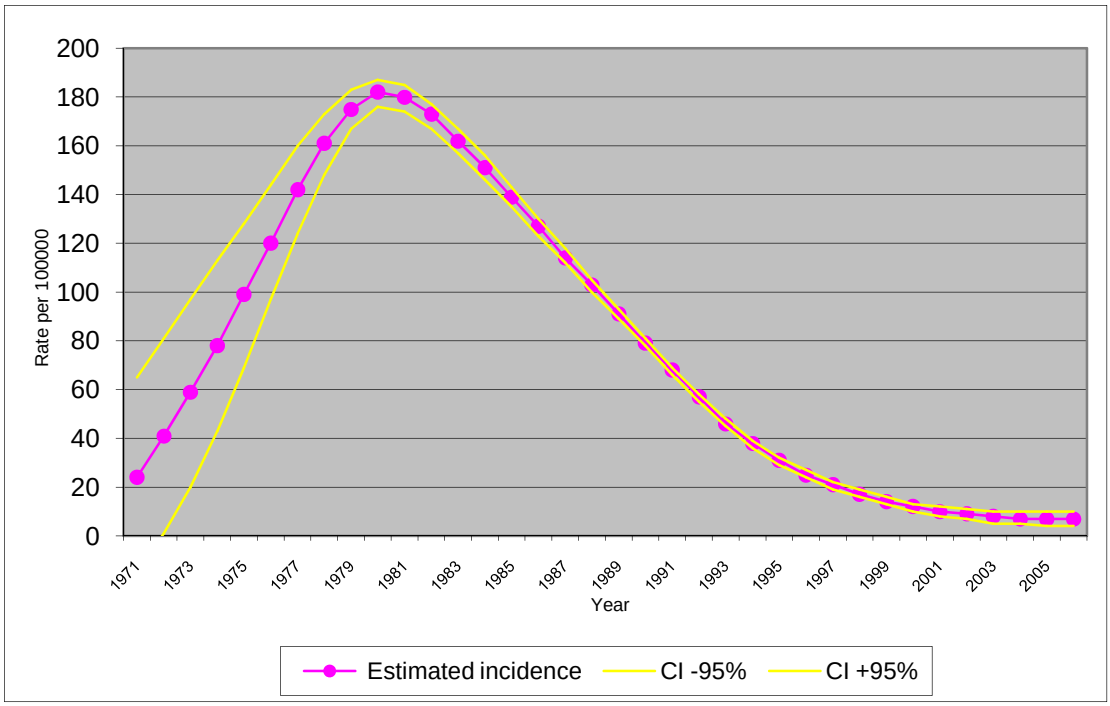
	Heroin	Cocaine
Year of first known use	1971-2006	1978-2006
Age at first use	Age 10-44 age	Age 10-54
Age at first treatment for this drug	Age 15-54	Age 15-59
n	169,682	89,760

Each person was classified on a contingency table according to the year in which the heroin or cocaine use first started and the latency period or length of time the person in question had taken to start their first treatment since the start of use. This table was incomplete due to the truncating caused by the data (to the left due to the individuals who started their first treatment prior to 1991, the first year observed, and to the right due to the individuals who had still not as yet been admitted to treatment in 2006). This is why the table was reconstructed by means of a quasi independent log-lineal model adjusted to the data observed. The row totals (marginal) of the new table comprise the new incidence estimated for each year. Based on the parameters estimated in this

[4] Sánchez-Niubó A, Fortiana J, Barrio G, Suelves JM, Correa JF, Domingo-Salvany A. Problematic heroin use incidence trends in Spain. Addiction 2009; 104(2):248-255.

model, the spread for the latency period was also found. By layering the table by Autonomous Communities, their respective incidences of use and latency periods can be found. The results show that a rapid increase of the incidence occurred during the 1970's, going from a very small number of users per 1000,000 inhabitants up to 182/100,000 in 1980. Afterward, the incidence dropped off sharply up until the mid-nineties, reaching rates of 31/100,000 in 1995, and quite slower as of that time to the point of reaching approximate rates of 7/100,000 in 2006 (Figure 4.1).

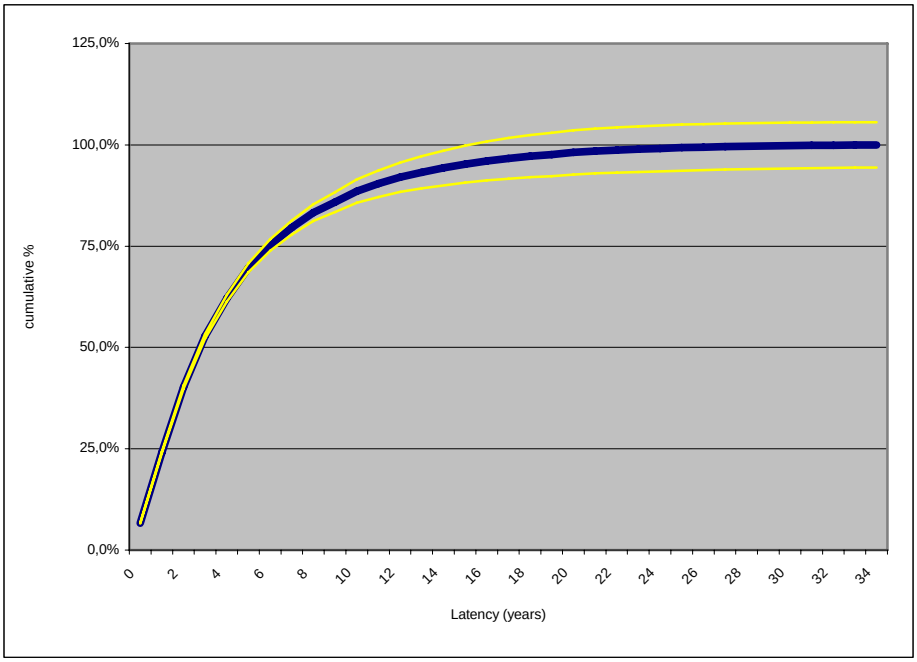
Figure 4.1. Estimate of the incidence of problem heroin use according to the year in which use was started. Smoothed rates of new users per 100,000 inhabitants within the 15-44 age range and 95% confidence intervals. Spain, 1971-2006.



On the other hand, the incidence was, on the average, 5.7 times higher among males than among females. The analysis according to the route of administration entails greater limitations, because it is assumed that the starting route was the main route of use at the point in time of admission to treatment (and that is not necessarily the case, given that changes in route often occur). In any case, the results show that the maximum incidence of problem injected heroin use could have occurred around 1980, followed by a fast drop, whilst the incidence in use via the lung route (smoked) did not reach figures as high as the injected heroin, which remain at its maximum level (plateau) through the eighties, to then begin to drop off at the beginning of the nineties.

The distribution of the overall latency period for the estimated problem heroin users revealed that 50% of these individuals took somewhat less than 3 years to start their first treatment for this drug (Figure 4.2).

Figure 4.2. Cumulative spread for the latency period (years) of the new problem heroin users within the 15-44 age range. Spain 1971-2006 (n=169,682)



As regards the spread of the latency period by Autonomous Communities, differences were found as a whole, Asturias being where, for the period as a whole, it took less time for a first treatment to be started (50% took approximately 1.5 years), whilst Madrid was where it took longer (50% having taken approximately 6 years).

This study confirms the downward trend in problem heroin use suggested by the indirect indicators (emergency services, treatment, mortality) as of the beginning of the nineties. It also indicates that this downward trend began ten years prior to what said indicators reveal, and that the incidence of new problem heroin users in Spain is probably currently stabilized at a lower figure than at the beginning of the seventies, and approximately 25 times lower than during the 1979-1982 period, the point in time at which it was at its highpoint. The causes of the sharp drop off in starting heroin use are surely complex and cannot revolve solely around the perception of the risk and harm caused by HIV infection, because it seems clear that both the drop in the incidence of problem heroin use as well as the drop in injected heroin use started prior to there having been an awareness of said risks among the professionals and the users. What is more, the drop in the incidence of use first began prior to there having been an awareness of the seriousness of the heroin use epidemic and therefore prior to any health measure or policy having been put into place in this regard.

Although the models must be finer-honed, the same methodology applied to those admitted to treatment for the first time in their lives for cocaine shows that the incidence of problem cocaine use was still at very low levels in 1978 (when the incidence of problem heroin use was in the highpoint of its boom), having risen slowly up to 1993, to then have subsequently shot up to the point of totalling over 100,000 new problem users annuals at around 2002-2004, to then show signs of dropping off as of those years. On the other hand, the latency period for cocaine has been much longer than for heroin. In fact, 50% of the problem users would take approximately 20 years to start the first treatment for cocaine abuse or addiction.

When interpreting the results, one must bear in mind that the estimated incidence refers solely to heroin or cocaine users who finally started treatment or will finally start treatment at a public or publicly-funded outpatient centre. Even so, this marks the evolution of the overall incidence, assuming that the percentage of unobserved users is constant. The magnitude of the estimated incidence may be biased, because the model employed requires that the latency period be stable throughout all years of study, and in the case of heroin, the expansion of the methadone maintenance programs at the beginning of the nineties must have caused changes in the patterns of requesting treatment. Additionally, when the rates are compared among Autonomous Communities, it must be assumed that the information placed on record is consistent amongst them, which, in some cases, may not be the case. It will be necessary to continuing making these estimates in the future for a larger volume of cases so as to gain a better knowledge of the evolution of this phenomenon.

As far as the prevalence of problem heroin and cocaine use is concerned (the new and already existing users added together until they cease to be users) the estimates indicate that the total number of problem heroin users (prevalence) reached its highpoint in Spain in the early nineties, with over 150,000 users, this number having subsequently dropped. The latest estimates of problem use of these drugs published to date are from 2002 and were made employing the treatment-multiplying method and the demographic method, having situated the figure of problem heroin users within the 70,000-120,000 range, and the problem cocaine users within the 120,000-170,000 range. Afterward, further estimates have been tried using different sources of information, but have come up against the same difficulties. Due to the low number of heroin users included in the samples, it is practically impossible to obtain reliable estimates directly from the populational surveys regarding the percentage of users who have started treatment so as to be able to employ the treatment multiplying method. However, on the 2007 Home Survey on Alcohol and Drugs in Spain, an attempt was made to employ the nominative method, a variation on the aforementioned method. To this end, those surveyed were asked if they knew heroin users, and for each one of those they knew, if they knew whether or not they had started treatment for heroin addiction within the last 12 months. Valid responses were obtained on solely 1268 named users, 581 (46%) of whom, according to those surveyed, had started a treatment for addiction. By applying this multiplier to the 18,407 individuals admitted to treatment for heroin in 2008, a figure of 40,015 problem heroin users was calculated. This figure may seem low, but if it is assumed that it refers to heroin users who were not on opiate maintenance (OMT), and that there were 81,390 people in OMT in 2008 according to the annual report of the National Plan on Drugs, it being reasonable to think that 40% (32,556) had user heroin at some time in the last 12 months, the total estimate of the number of problem heroin users in Spain in 2008 is then 72,571 (40,015 + 32,556). This figure is likely to still be underestimated, because those surveyed could have confused "starting treatment" with "being in treatment" and also due to heroin users in treatment being more visible and recognized than the rest. Therefore, the multiplier was also applied to the estimated number of heroin users who underwent some treatment for heroin abuse or addition in 2008 (80,397 drug users admitted at outpatient centres in 2008 x 34.6% of cases attributable to heroin use) which is 27,817 people, as a result of which an estimate of 93,027 [60,471 (=27,817/0.46) + 32,556] problem heroin users was made, compared to the estimate made for 2007 (included in the 2009 REITOX Report), meaning approximately a 4% reduction in the estimated number of problem heroin users.

As far as the estimate of the number of drug injectors is concerned, in the 2007 Home Survey on Alcohol and Drugs in Spain, valid response were obtained on 1407 named injectors, 605 (43%) of whom had started a treatment for drug abuse or addiction according to those surveyed, which, applied to the 4,546 injectors (injection in the last

12 months prior to admission to treatment) admitted to treatment in Spain in 2008 lead to an estimate of (4,546/0.43) 10.572 recent drug injectors in 2008, who would not be in OMT. If the 13,022 injectors who were in OMT in 2008 are added to this number (assuming that, among this population, 40% of those who have consumed heroin within the last 12 months have used the injected route), the estimate would be of (81,390 x 40% who have user heroin within the last 12 months = 32,556, a total of 40% of whom have used the injected route 32,556 x 40% = 13,022) 23,594 (10,572+13,022 recent drug injectors. When instead of using the number of injectors admitted to treatment, the estimated number of injectors who underwent some treatment for drug abuse or addiction in 2008 was used (7638 individuals, calculated based on the number of drug users for whom care was provided at outpatient centres in 2008 = 80,397, multiplied by 9.5%, which is the percentage of those admitted to treatment in 2008 who had injected drugs within the last 12 months), an estimate was made of (7,638/0.43 = 17,763) of 28,335 (10,572+ 17,763) recent injectors. These figures, compared to those estimated for 2007, show a 4.7% reduction, which seems to be in line with the drop observed in the estimate of problem heroin users.

As far as cocaine is concerned, in the 2007 Home Survey of Alcohol and Drugs in Spain obtained valid responses on 810 named users, 25 (3%) of whom had started a treatment for cocaine abuse or addiction within the last 12 months according to those surveyed, which, applied to the 24,680 admitted to treatment for cocaine abuse or addiction in Spain in 2008, leads to a very high problem user figure of 822,666 (24,680/0.03), which surely greatly overestimates the actual figure. The reason probably lies in the fact that in the case of cocaine, there is a long time lapse between the start of use and the start of treatment (averaging 20 years), and so it would therefore not be proper to apply this annual rate of treatment of 3% of the users for 2008. Different estimates can however be made in this case by the direct method based on the 2009 Home Survey on Alcohol and Drugs in Spain (direct extrapolation of the prevalence figures), as a result of which lower figures are obtained, although they may be underestimated due to a certain degree of concealment of the most highly intensive degrees of use, can at least be considered to represent a minimum. These estimates made by the direct method indicate that there were 129,097 cocaine users in Spain in 2009 who had used this drug on more than 30 days within the last 12 months, 128,843 who had used cocaine on 4 or more days within the last 30 days and 41,662 who had used it on 10 or more days within the last 30 days (groups which are not mutually exclusive). These figures mean a drop, compared to 2007 (the last edition of the Home Survey on Alcohol and Drugs in Spain prior to the 2009 Survey) of 38%, 30.9% and 35.6%, respectively.

The decrease found may be due to the reduction, in the 2009 Home Survey on Alcohol and Drugs in Spain, of the overall cocaine use prevalences for the last 12 months (2.7%) and for the last 30 days (1.3%) compared to 2007 (3.1% and 1.7% respectively), although a possible move of cocaine users toward less intense or problem uses might also be a contributing factor.

Considering the limitations of the methods used for making the aforementioned prevalence-related estimates, the numerous assumptions which must be made in view of the lack of updated basic information for employing the different methods, the results of the preceding years must be taken and used with great precaution.

DATA ON PDUs FROM NON TREATMENT SOURCES

If we move away a bit from the problem use concept used up to this point in this report, that is to say, without going by the definition of problem use employed in the European Monitoring Centre for Drugs and Drug Addiction, it may be useful to evaluate the existence of problem use regarding the extent to which is causes harm to the individuals (personal consequences on physical and mental health, family or social consequences). The date of this type of problem use are taken from the information recorded by the indicators, the Spanish Observatory on Drugs. surveys and other specific studies conducted.

Emergency Services Indicator: This indicator provides a knowledge of the episodes of emergencies associated with the use of certain substances (described in Chapter 6).

Specific studies conducted in Autonomous Communities and nationwide: In 2009, the 2009 Spanish National Report reported on some of the socio-demographic characteristics and drug use patterns of two cohorts of heroin and cocaine users recruited on the street in three Spanish cities described in the basic articles for setting up said cohorts (See De la Fuente et al 2005[5], Pulido J et al[6]).

Spanish Observatory on Drugs.populational surveys: The 2009 edition of the Home Survey on Alcohol and Drugs in Spain included several questions providing information on those individuals from among those surveyed who have undergone treatment (ever in their lifetimes and/or within the last 12 months) for use/abuse of any of the aforementioned legal or illegal drugs (Figure 4.3).

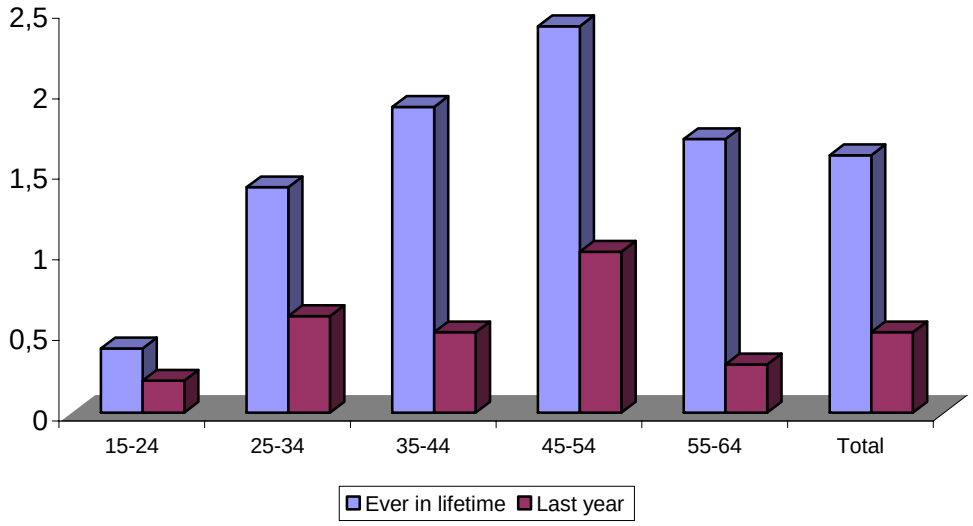
A total of 1.6% of Spain's population within the 15-64 age range (2.2% of the males and 1.0% of the females) admit having started outpatient treatment as some time in their lives for problems linked to legal or illegal drugs. The 45-54 age group is that which has underdone some treatment of this type, to the greatest extent, at some time during their lifetimes.

If we refer to the start of a treatment within the 12 months immediately prior to being surveyed, 0.5% stated having started a drug use-related treatment, the 35-64 age group being that having shown the highest prevalence.

[5] de la Fuente de Hoz, Brugal Puig MT, Ballesta R, Bravo MJ, Barrio G, Domingo A et al. [Cohort study methodology of the ITINERE Project on heroin users in three Spanish cities and main characteristics of the participants]. Rev Esp Salud Publica 2005; 79(4):475-491.

[6] Pulido J, Brugal MT, de la FL, Ballesta R, Barrio G, Bravo MJ et al. [Recruitment methodology and characteristics of a cohort of young regular cocaine users in three Spanish cities (the Itinere-cocaine Project)]. Gac Sanit 2009; 23(3):200-207.

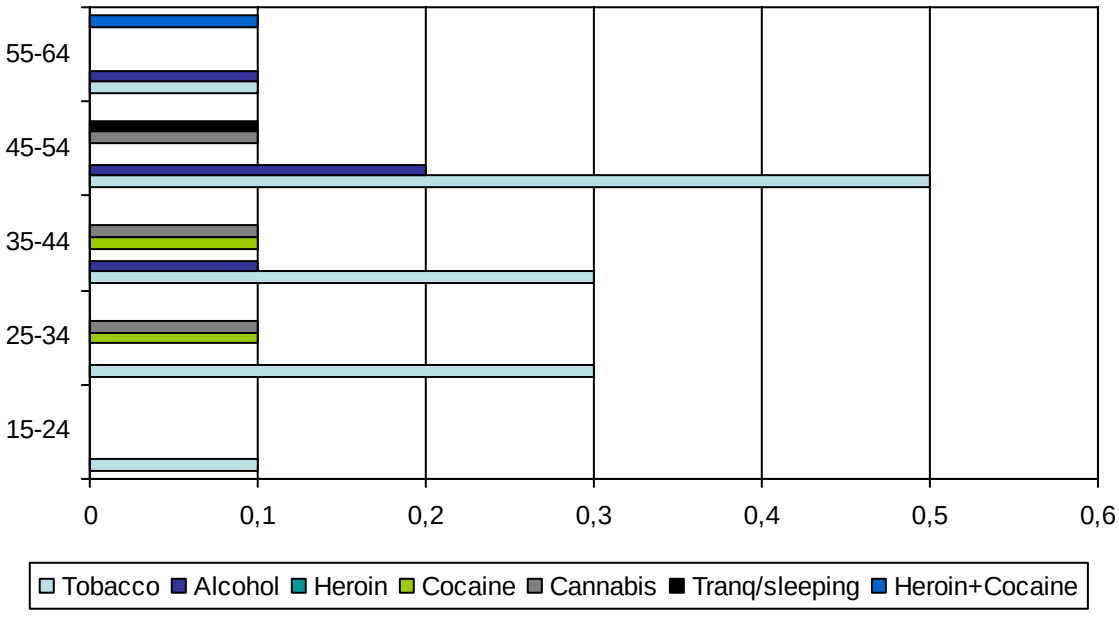
Figure 4.3. Prevalences of start of outpatient treatment for quitting smoking, drinking alcohol or another drug (population within the 15-64 age group). Home Survey on Alcohol and Drugs in Spain, 2009 (%)



Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009.

The substances for which the greatest number of started treatments were stated were tobacco and alcohol. As far as the illegal substances are concerned, among those having stated having started some treatment within the last 12 months, the treatments were main for cannabis, heroin plus cocaine or cocaine alone (Figure 4.4).

Figure 4.4. Primary drug for which treatment was started within the last 12 months (15-64 age range). Home Survey on Alcohol and Drugs in Spain, 2009 (%)

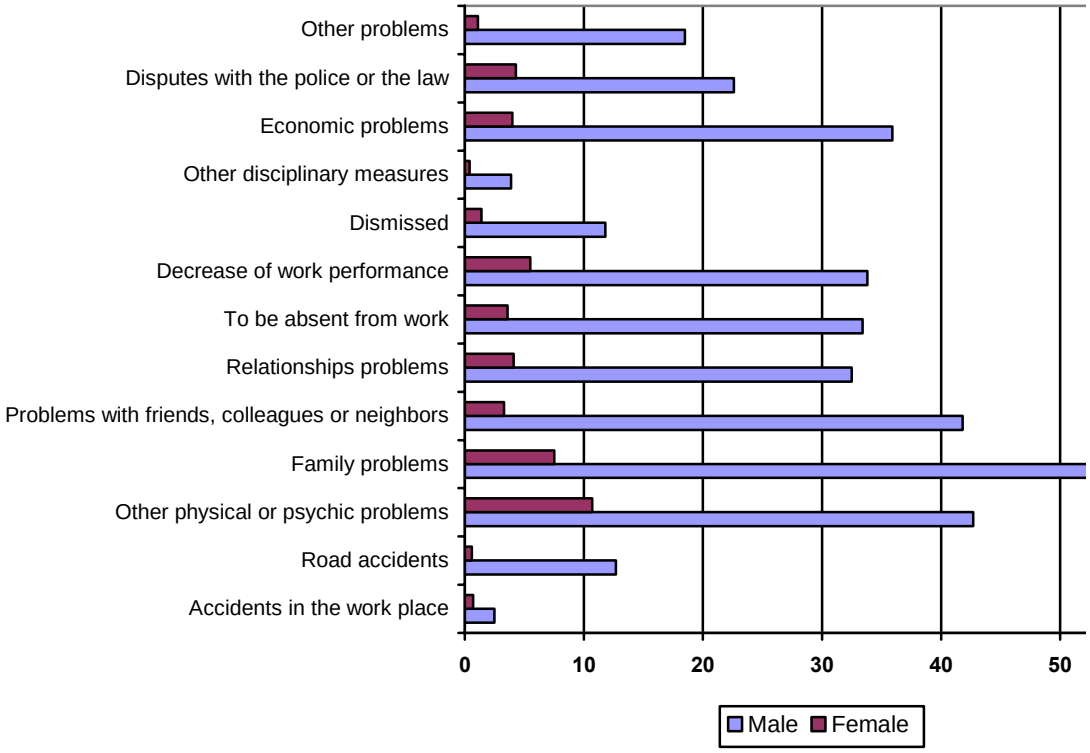


Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009.

The Home Survey on Alcohol and Drugs in Spain also makes a record of whether those surveyed have ever had a number of problems at some time in their lifetimes which may be related to legal or illegal drug use. In 2009, 0.3% of Spain's population within the 15-64 age range admitted having missed some day of work or having reduced their work performance due to drugs, 0.1% having been dismissed at some time for this reason. Similarly, 0.3% stated having had economic problems or conflicts with friends, colleagues or neighbours.

Nevertheless, the most outstanding problems, although with low prevalences, have to do with physical and mental health problems (0.4%) and problems in relations with their families (0.4%). A total of 0.2% admits having had disputes with the police or the law. The prevalence figures are higher among males than among females for all of the types of problems assessed (Figure 4.5).

Figure 4.5. Distribution of the problems stated among the population within the 15-64 age range mentioning having had some problem due to drug use, by genders. Home Survey on Alcohol and Drugs in Spain, 2009.



Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Home Survey on Alcohol and Drugs in Spain, 2009.

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

Another way of assessing problem drug use is by means of adding screening tools into the surveys for the purpose of achieving an overall view of the population with regard to the use of certain substances. In the 2009 Home Survey on Alcohol and Drugs in Spain, the AUDIT scale was added for the purpose of assessing at-risk or harmful drinking among Spain's population. The results are currently in the data mining and analysis stage.

Similarly, in the 2006 Nationwide Survey on Drug Use Among Secondary School Students targeting secondary school students within the 14-18 age range, a sub-sample was selected and three scales were added for the purpose of evaluating problem cannabis use and dependency. The aim was more methodological than for making a valid estimate of the prevalence of problem cannabis use. The findings of this study conduced in collaboration with the EMCDDA, are provided in a joint publication by both institutions[7].

Spain will be taking part, once again, in collaboration with the European Monitoring Centre for Drugs and Drug Addiction, in a study for assessing the suitability and usefulness of different problem cannabis use scales among the adolescent population within the 14-18 age range (2010 Nationwide Survey on Drug Use Among Secondary School Students.

[7] Klempova D, Sánchez A, Vicente J, Barrio G et al. Problem cannabis use among Spanish students within the 14-18 age range: Scale validation. Collaborative study between the Spanish Government Delegation for the National Plan on Drugs and the European Monitoring Center for Drugs and Drug Addiction. Madrid: Ministry of Health & Social Policy, 2009.

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

STRATEGY AND POLICY AND TREATMENT SYSTEMS

In Spain, the implementation, management and evaluation of the resources and programs for providing care for drug users come under the authority of the Autonomous Communities and Autonomous Cities, as does providing help and counselling for the families of these individuals.

These Autonomous Communities avail of a number of strategic tools for planning, regulating and coordinating the drug abuse-related measures carried out within their respective territories, which are known by different names: "Regional Drug Plans", "Strategies for Action", etc. (See Chapter 1 of this report).

In general, the main objective of these plans is to reduce the morbimortality and the health and social problems related most directly to drug abuse.

Thus, in the care provided for drug-dependent individuals, the priorities include heightening the quality of the services provided by the treatment centres, developing effective treatment programs, providing care for those drug-dependent individuals who have special problems and further expanding and diversifying the care offer.

Within the scope of the reducing the resulting harm caused, priority is placed on the strategies aimed at reducing deaths due to adverse reactions to these drugs and those for reducing the prevalence of infectious diseases (HIV, hepatitis, etc.). among opiate and cocaine consumers detected at the care system centres.

These measures target not only drug users, but also third parties and society as a whole.

It is important to highlight the fact that the care system for drug-dependent individuals has conventionally functioned in parallel to all of the other healthcare resources (both Primary Care and Mental Health), although in close collaboration with these resources. Nevertheless, in recent years, these Plans are aimed toward the progressive integration and coordination of the different resources which carry out the different measures within the scope of health promotion and the treatment of the diseases related to mental health and addictions.

The Autonomous Government Administrations set out both the criteria as well as the tools for monitoring and evaluating the effectiveness of the treatments which are carried out in the care-providing programs, which are carried out , in turn, at specific centres for providing care for drug-dependent individuals.

In this regard, some Autonomous Communities are researching and/or (depending on the cases) are using tools validated for monitoring and evaluating the effectiveness of the treatments. The treatments mentioned in the immediately preceding section are governed by way of homologation and monitoring criteria set forth by the Autonomous Communities.

The aforementioned criteria are governed and organized by means of some "rules (conditions required of the care centres carrying out the programs), one of the most outstanding of which is the indispensable qualification and academic degrees which the professionals providing the care must hold, as well as the multidisciplinary make-up of the working teams which are comprised in most cases by healthcare personnel (physicians, nurses, nursing aids), psychologists and professionals from the social services realm (academically-qualified social workers).

CHARACTERISTICS OF TREATED CLIENTS AND TRENDS OF CLIENTS IN TREATMENT

Methodology

A working protocol of the "indicator admissions to treatment for psychoactive substance abuse or dependence", the latest version of which dates from 2003, is summarised in this section. Included in this protocol are operating criteria for including and excluding episodes, criteria for selecting the centres which are to take part in the notification, definitions and criteria for classifying the different variables as well as details on the instruments and the circuit for gathering and conveying the information and on the indicator's coverage.

The admissions to Treatment Demand Indicator is a record including individualized data on admissions for outpatient treatment for psychoactive substance abuse or dependence throughout all Spain and has been in existence since 1987. This registry comprises part of a sub-system of broader-ranging information developed within the framework of the National Plan on Drugs in collaboration with the Autonomous Communities, which also includes the drug-related hospital emergencies indicator and the acute drug reaction Drug-related Deaths Indicator. This information sub-system, which was originally terms the National Drug Addiction Information System and which was later referred to by different names, came into being for the purpose of monitoring the evolution and the characteristics of problem psychoactive drug use, especially of those which, such as opiates or cocaine, are more prone to giving rise to problems more often and are difficult to explore employing other methods.

The admissions to Treatment Demand Indicator is defined, in its current version (2003 Protocol) as the number of individuals admitted for outpatient treatment for abuse or dependence in relation to each one of the psychoactive substances listed in an annex to the protocol in an Autonomous Community within a given year. If the person is admitted to treatment more than once within one same year in the same Autonomous Community, only the first admission for the year in question will be taken into consideration for this indicator, ruling out, within the Autonomous Community scope, the repeated episodes with the aid of a personal identification number (PIN) consisting of the first two letters of the two surnames, the date and province of birth and the gender of the person in question. The value of the indicator at the nationwide level is determined by means of the sum of the admissions to treatment on record in each one of the Autonomous Communities, but given that the PINs are not conveyed at the nationwide level, the repeated episodes of admissions of one same person during the same year in two or more different Autonomous Communities cannot be separated. Although the information available indicates that this situation is infrequent, it may give rise to a minor overestimation of the indicator at the nationwide level.

Any intervention carried out by qualified professionals for the purpose of eliminating the psychoactive substance abuse or dependence or reducing the intensity thereof is considered treatment. Those treatments in which the patient does not stay overnight at the centre of those carried out at prison drug dependence treatment facilities are considered outpatient treatments. It must be taken into account that some notifying centres may carry out - in addition to outpatient treatments - treatments entailing hospitalization or combined modalities. However, for the purposes of this indicator, only the outpatient treatments are notified. The dependence and abuse-related diagnostic criteria are those employed by the professionals processing the admission to treatment, although this must tend to apply those of the two main international classifications in effect (DSM-IV or ICD-10).

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

Any of the following situations are notified as episodes of admission to treatment:

1) Admission to treatment to a centre for the first time, considering this situation to be when care is being provided for the first time for a patient at a certain notifying centre and a clinical (medical, social or psychological) record is started in the presence of a qualified professional (physician, psychologists, registered nurse, social worker, etc.) for the purpose of starting a process for the treatment of psychoactive substance abuse or dependence, even though this treatment not be the first one carried out on the drug user in question within the network of centres notifying the indicator in question. The admissions to treatment are notified regardless of their modality, including the treatments with replacement opiate substances, both if the objective is detoxification as well as if it is maintenance. In the case of the treatments with replacements, the drug which has been used therapeutically in the maintenance program (i.e. methadone) is not considered the primary drug, the primary drug rather being the substance for which the abuse or dependence gave rise to the first treatment (generally heroin). The transition from a maintenance program with replacements to another which is "drug-free" without any space of time in between is considered as being one single treatment.

2) Readmission to treatment at one same centre, considering *readmission* to be an admission to treatment of an individual who has already previously undergone one or more treatments at the same centre and who has completed the same ending in treatment release, expulsion or abandonment. The criteria for treatment release, expulsion or abandonment are described in the protocol for the indicator. The patient will be considered to have *abandoned* the treatment when the patient does not physically to contact the centre within a six-month period without any express indication from the professionals.

3) The continuation of a treatment already begun, either for reasons of emergency or for other reasons, in services which are not notifying the indicator, such as hospitals, medical centres or social services centres and who subsequently go to a notifying centre to continue the treatment.

4) The admission to treatment of individuals involved in a judicial or administrative situation (conditional remission of sentence, release from prison as a result of serving out their time at a treatment centre, treatment in lieu of administrative penalty, or treatment of an individual in the lowest category in prison system allowing day release privileges).

The following are not notified as admissions to treatment:

1) Mere personal or telephone contacts to request information or treatment, nor the requests which are placed on the waiting list.

2) The contacts for the sole purpose of requesting welfare benefits or aid.

3) The treatments for the sole purpose of treating organic complications related to drug use (i.e. the treatment of an overdose, a case of abstinence syndrome or an infection.

4) The interventions consisting exclusively of sharing needles or other injection material, dispensing condoms or providing counselling concerning safe drug use and sexual techniques.

5) The treatments entailing overnight stays in hospitals, psychiatric hospitals, therapeutic communities, living facilities, etc.

Although it would be desirable for all the mechanisms which may potentially carry out treatments in Spain for psychoactive substance abuse or dependence to provide notification, it is quite difficult and costly for all of them (primary health care centres, hospital, private clinics, etc.) to be included. That is why, in practice, the public or subsidized or officially funded programs, services or centres which provide outpatient treatments for psychoactive substance abuse or dependence are included. These may be specific drug dependence centres, mental health centres or services which provide outpatient treatments for drug dependence (whether they be independent centres or are integrated into general health centres, hospitals or other types of centres), prison drug dependence programs, centres providing complex treatments which include an ambulatory phase, or mobile units carrying out treatments with opiate replacements which are staffed by medical and nursing personnel. In general, those centres which provide solely hospitalized treatment (hospital detoxification units, therapeutic communities, some psychiatric hospitals or services) are not included as notifying centres, because it is thought that most of the drug-dependent individuals treated at these centres have been referred from notifying outpatient centres.

The coverage of the Treatment Demand Indicator with regard to the public or subsidized private centres which carry out ambulatory treatments for drug abuse or dependence has been practically total coverage since this indicator was first put into practice and, taking into account the characteristics of the health system in Spain, it would be difficult for a major part of psychoactive drug treatments to be carried out at exclusively private centres, although the percentage might be greater in the case of cocaine and cannabis than in the case of opiates.

As regards the information collection and transfer circuit, the treatment centres select the episodes of admission to treatment and notify them as an individualized record to the Autonomous Community units in either hard copy or electronic format. At the Autonomous Community units, the data is validated and purged, the cases which are to be sent to the national unit being extracted by filtering out the repeated episodes within the year in question. This data is submitted as an aggregate electronic file. At the central unit, the information is received, is adapted to the file formats, which is not always the same, the data then being validated and purged again and the information tabulated and analyzed.

A computer program is available for this indicator which most of the Autonomous Communities use, enabling them to save the data with a number of logic and range controls, to filter out the repeated episodes and to export the data in a format suitable for its transfer to the national unit.

To appropriately interpret the data for this indicator, it must be taken into account that, although this data has remained stable as regards its basic elements over the course of time in the process of its having been transferred from one point to another, it therefore being possible for statistics comparable over the course of time to be prepared, this indicator has undergone three modifications since 1987. Up until 1990, solely information on opiates or cocaine was being collected. Additionally, it was not possible to know whether the person admitted to treatment had been treated previously for the same primary drug (the drug having given rise to the treatment in question) or it was the person's first treatment even in his/her lifetime, nor what the main route of administration of the drug in question was. Therefore, in 1991, some changes were made having made it possible to provide a solution to the two last-mentioned

limitations, others also having entered into effect in 1996 consisting mainly of gathering information on the admissions for reasons of any psychoactive substance (except tobacco) and not solely for opiates or cocaine, and to include variables for the first time for the purpose of knowing the highest educational level completed, the main labour situation within the 30 days immediately prior to the treatment, the length of time having lapsed since the last injection of a psychoactive substance, and the serological condition with respect to HIV. Finally, in 2003, a new methodological protocol entered into effect for the admissions to Treatment Demand Indicator prepared for the purpose of its adaptation to the European TDI standard (Treatment Demand Indicator) promoted by the European Monitoring Centre for Drugs and Drug Addiction and to correct some glitches detected.

The main changes made were as follows:

1) Five variables were included from the TDI were had not previously existed in Spain's indicator (nationality, and in regard to the 30 days immediately prior to the admission to treatment, frequency of use of the primary drug, person or service having referred the patient for treatment, living status (with whom) and living status (where).

2) Specific codes were assigned to the use of the heroin+cocaine chlorhydrate, of base heroin or crack and of heroin+ cocaine in the primary drug and secondary drugs variables, and the decision was made to classify these categories as heroin at the point in time of the analysis.

3) The categories of the administration route variable were modified, having grouped into one single category the former two pulmonary route-related categories: "smoked in cigarettes or pipe" and "sniffed" (including "tube or aluminium foil, known as "chasing the dragon"), the new category being labelled as "pulmonary or smoked (inhaling gases or vapours, chasing the dragon)". This change was considered for the purpose of eliminating the term "inhale", which is ambiguous with regard to the route of absorption and was construed differently by the different notifiers, either as "sniffing powder, nasal route" and for others as "inhaling gases or vapours, pulmonary route".

4) The categories of the "highest level of studies completed" variable were changed, being reduced from the 9 categories of the immediately previous version to 8 in the new version, which is a combination of the 2000 National Education Classification and the 2001 Population and Housing Census.

5) The categories of the "country where born" variable were changed, a code being assigned to each country according to the system used by Spain's National Institute of Statistics. In the immediately preceding version, only groups of countries were individualized.

   In addition to these changes, the prior decision was upheld of not recording the methadone or other opiate replacements prescribed within the framework of treatment programs, neither as a primary nor as a secondary drug. At this point, Spain's indicator differs from the TDI criterion, which stipulates that the opiate replacements are to be recorded as a primary drug if they are the drugs most used by the subject, whether in an uncontrolled or controlled manner, this last-mentioned circumstance then being differentiated at a later point by means of a new variable indicating whether or not the patient is undergoing treatment with replacements at the point in time of the notification. Had the TDI criterion been

adopted in Spain, it would have then been necessary for profound changes to have been made in the way in which this indicator has conventionally worked, given that, at the point in time at which notification must theoretically be given (when a clinical record is first started or the patient is readmitted to treatment), the treatment modality to which the patient in question is going to be assigned is often not known. The TDI requires a waiting period prior to notification, which may entail a major risk of notification being either delayed or overlooked and would most certainly somehow force the communities who do not have an individual monitoring system implemented to carry out this follow-up for at least a few months.

Results

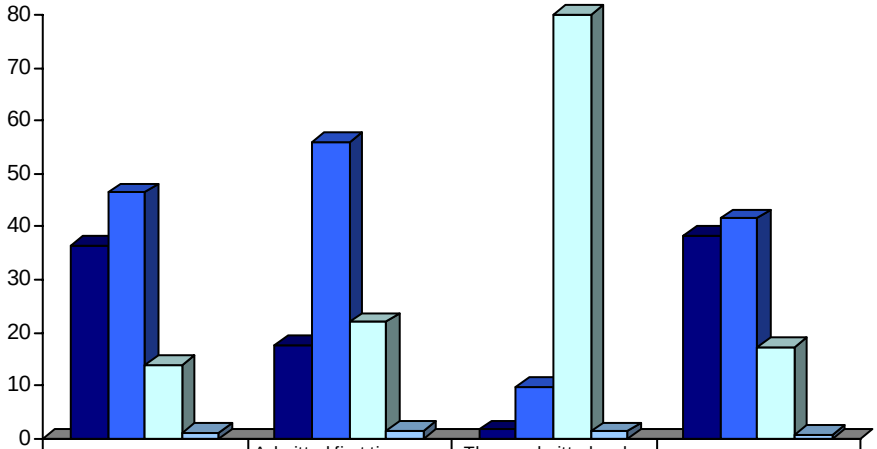
In 2008, a total of 53,155 admissions to treatment for psychoactive substance abuse or dependence (not including alcohol and tobacco) were recorded. Within the 1998-2002 period, the number of admissions to treatment decreased, dropping from 54,338 in 1998 (the year in which the largest number of admissions was recorded) to 46,744 in 2002. However, within the 2002-2004 period, there was a rise up to 52,128 admissions in 2004, having then fallen once again in 2005 (50,630) and 2006 (49,283). As of 2006, there has been a further rise, leading to the admissions to treatment totalling numbers nearing those of 1998.

The drop within the 1998-2002 period could have been due to the effect of the methadone-based methadone programs which meant that many heroin users were no longer rotating through the treatment services. The rise within the 2002-2004 period and from 2006 to 2008 might be explained by the increased number of admissions to treatment for cocaine and cannabis.

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

With regard to the relative importance of each drug in 2008 within the total number of admissions to treatment for psychoactive substance abuse or dependence, Figure 5.1 shows cocaine as being the illegal drug having given rise the greatest number of admissions to treatment (46.4% of the total number), followed by the opiates (36.4%) and cannabis (14%). If solely the data related to the admissions for the first time even in their lives (first time ever admissions), the differences in favour of cocaine are even greater. In this case, cocaine is the drug having been the cause of more first time ever admissions (56%), followed by cannabis (22%) and the opiates (17.7%).

Figure 5.1. Percentage of individuals treated for psychoactive substance abuse or dependence in Spain, 2008.



	All admissions	Admitted first time ever in their lives	Those admitted under 18 years of age	Born outside of Spain
Opiods	36,4	17,7	1,7	38,2
Cocaine	46,4	56	9,8	41,5
Cannabis	14	22	83,8	17,3
Other estimulants (anphetamines, ecstasy..)	1,2	1,6	1,3	0,7

All admissions	53.155	22.944	1.817	3.900

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator

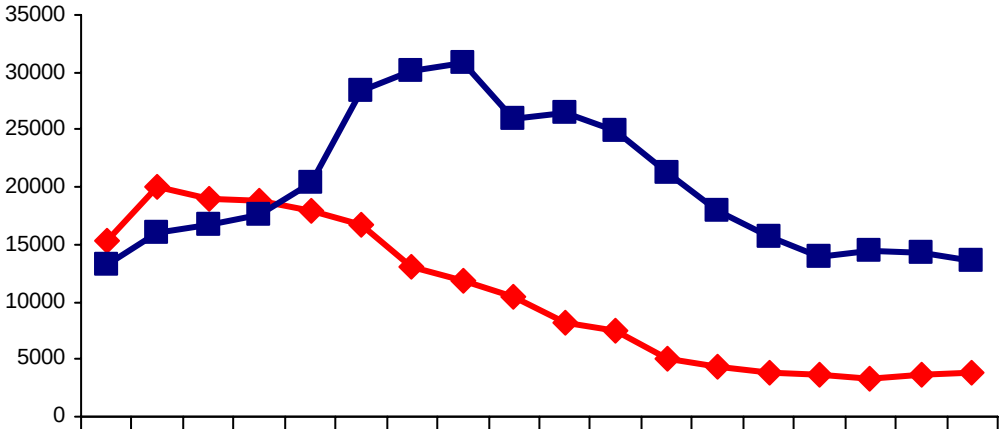
Similarly, cannabis use has been found to be responsible for a vast majority (83.8%) of the admissions to treatment for substance abuse among minors, it also having been fount that among those born outside of Spain, cocaine (41.5%) and opiate (38.2%) use are those which have given rise to three fourths of the admissions to treatment for illegal drugs in Spain.

Heroin

The number of admissions to treatment for heroin use was 18,407 in 2008, thus totalling 34.6% of all admissions recorded for that year.

The number of first admissions to treatment for heroin decreased from 1992 (the year in which the largest number of first admissions for use of this substance was recorded) up to 2006, having dropped from 20,017 in 1992 to 3,318 in 2006. As of hat time, a slight rise was registered in 2007 (3,672) and 2008 (3,840). The number of individuals admitted to treatment for heroin who had undergone treatment previously of this same drug also showed a downward trend as of 1998 (when the largest number of admissions with previous treatment for heroin were recorded), dropping from 30,756 to 13,616 in 2008 (Figure 5.2). Nevertheless, a stabilization has been noted as of 2005 in the number of admissions among those who have already undergone treatment with a slight downward trend which will have to be confirmed over the years to come.

Figure 5.2 Evolution of the number of individuals treated for heroin abuse or dependence in Spain, 1991-2008.



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

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator.

Cannabis

The admissions to treatment for cannabis use totalled 7,419 in 2008, thus amounting to 14% of all admissions recorded for that year.

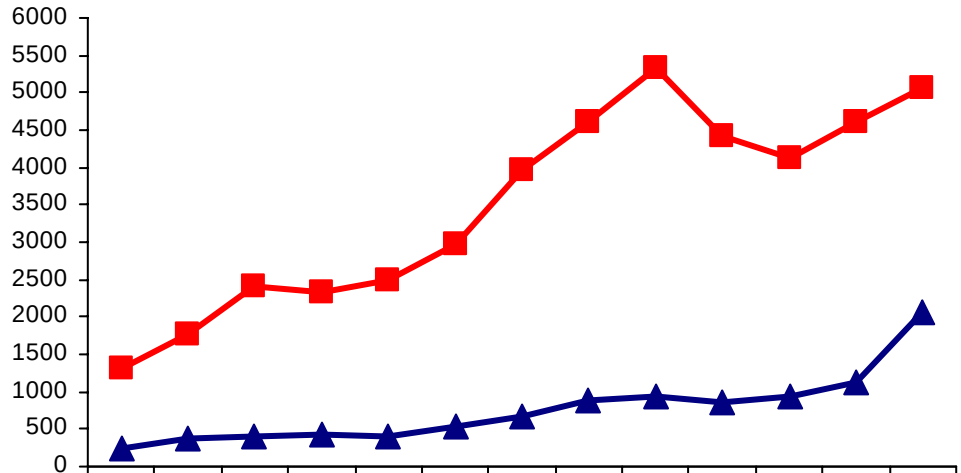
The number of admissions to treatment for cannabis abuse or dependence increased within the 1996-2004 period (2004 being the year in which the larges number of first admission for cannabis use were recorded); and despite the fact that, in 2005 and 2006, these figures were found to have dropped off slightly, an upward trend has once again been recorded as of 2007 (increase of 8.6% over 2007).

On the other hand, the number of admissions to treatment among those who had already undergone prior treatment of cannabis use currently continues on the rise, having risen from 230 in 1996 to 2,055 in 2008 (Figure 5.3)., nearly twice the number of admissions having been recorded in 2008 as those recorded in 2007 (45.8% rise) and 2006.

In this regard, although the most striking increase in Spain in both absolute figures as well as percentages with regard to the overall admissions to treatment for psychoactive substance abuse or dependence has been for cocaine, the rise in the demands for treatment for cannabis use is in keeping with a similar trend in other countries in our close environment.

In our case, as has occurred for the case of other substances, this upward trend is readily falls within a context of prevalences of use among the general population which are remaining at relatively high levels and which have continued to show an increase for all indicators considered on the latest Home Survey on Alcohol and Drugs in Spain 2009 (See Chapter 2 of this report). Nevertheless, it cannot be completely ruled out that the reasons for the rise in the demand for treatment for cannabis use may be of another type.

Figure 5.3. Evolution of the number of individuals treated for cannabis abuse or dependence (absolute figures). Spain, 1996-2008.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
First treatments	1300	1768	2412	2335	2487	2966	3972	4613	5319	4426	4125	4619	5058
With previous treatment	230	387	407	418	408	540	665	871	928	844	941	1114	2055

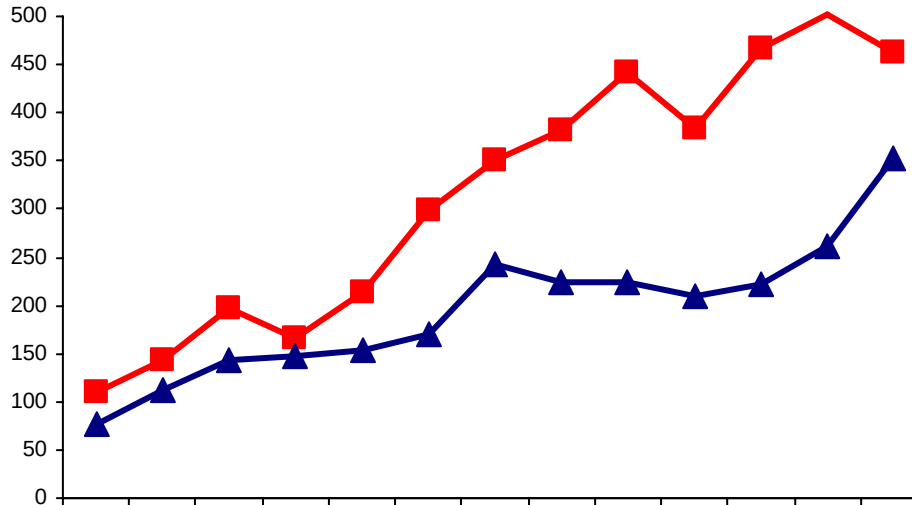
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator

Hypnosedatives

There were a total of 845 admissions to treatment for hypnosedative use in 2008, thus amounting to 1.6% of all admissions recorded for that year.

The admissions to treatment for hypnosedatives (tranquilizers, sedatives or sleeping pills) show a rising trend as of 1996, despite some occasional drops having been detected for some years (1999 and 2005), signs of stabilisation subsequently having been noted as of 2006. The number of first admissions rose from 109 in 1996 to 441 in 2004, 383 in 2005, 466 in 2006 and 463 in 2008 (Figure 5.4).

Figure 5.4. Evolution of the number of individuals treated for hypnosedative abuse or dependence (absolute figures). Spain, 1996-2008.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
First treatments	109	144	197	165	214	299	350	382	441	383	466	503	463
With previous treatments	77	111	143	147	154	170	242	225	224	209	223	261	352

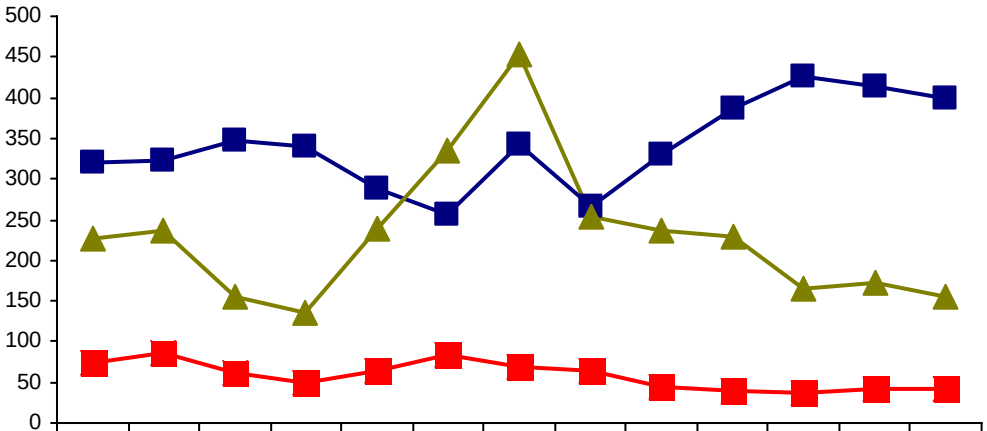
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator

Other drugs

All of the other drugs are dealt with quite infrequently in the treatment services. In fact, the stimulants other than cocaine (amphetamines, ecstasy and others) totalling solely 1.6% of the first admissions and 1.2% of all admissions in general in 2008. If these figures are compared to these for cocaine, heroin and cannabis, the impact of these drugs on the specific drug addiction treatment services in Spain is seen to be minimal.

As regards the evolution over the course of time, a slight upward trend in treatments for amphetamines and ecstasy is noted, whilst the number of individuals admitted to treatment for hallucinogen abuse remains stable (Figure 5.5).

Figure 5.5. Evolution of the number of individuals treated for amphetamine, ecstasy and hallucinogen abuse or dependence. Spain, 1996-2008



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Anphetamines	319	323	347	339	288	255	342	266	330	386	426	415	400
Ecstasy	226	237	154	135	240	335	452	254	236	229	165	172	155
Hallucinogens	74	85	62	50	64	83	68	63	44	39	37	43	43

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator

Predominant administration route of the primary drug used among those admitted to treatment

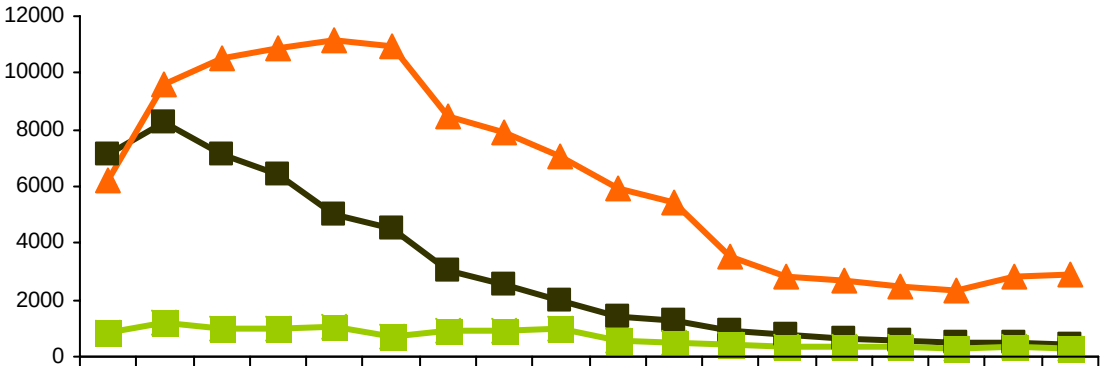
In 2008, the predominant administration route of the primary drug among the total number of individuals admitted to treatment for heroin use (within the 30 days immediately prior to starting treatment) was pulmonary or smoked ("chasing the dragon"), amounting to 70.8%, following by the injected route (17.9%) and the intranasal or sniffed route (6.2%).

With regard to the 1980's, when, independently of the use of other routes, use of the injected route as the predominant route for administering heroin was practically universal among those consuming this substance, a radical change has taken place in the predominant administration route, which is currently the pulmonary or smoked route being predominant.

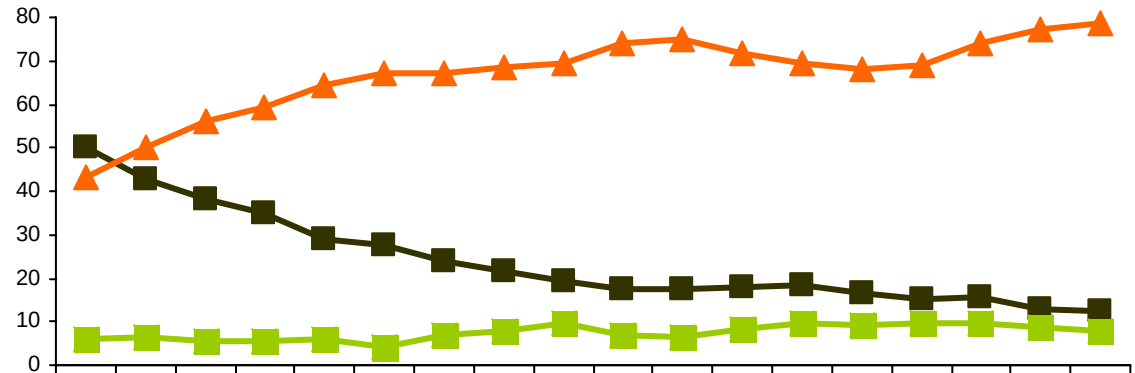
Thus, the number of individuals admitted to treatment for the first time ever in their lives for heroin abuse or dependence using injection as the most frequent (or primary or

preferred) route of administration dropped from 8232 in 1992 (the year in which the highest figure was recorded) to 455 in 2008, and although this might seem to be solely a matter of the effect of the drop in the absolute number of individuals admitted for the first time ever for heroin abuse, this change is confirmed on seeing how the percentage these individuals totalled of all of the individuals as a whole who were admitted for heroin dropped from 42.9% in 1992 to 15.1% in 2005 and to 12.4% in 2008 (Figure 5.6).

Figure 5.6. Spread of the treatments for the first time ever for heroin abuse or dependence, by main route of heroin administration. (Absolute numbers and percentages). Spain 1991-2008



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Injected	7164	8232	7129	6435	5033	4488	3011	2518	1969	1414	1276	894	748	648	544	486	470	455
Pulmonary	6188	9585	1049	1087	1116	1093	8487	7884	7033	5917	5461	3540	2805	2690	2487	2320	2842	2891
Sniffed	822	1.219	995	978	1.028	696	887	910	968	532	471	399	386	358	350	303	327	285



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Injected	50,3	42,9	38,1	35	29,1	27,5	23,8	21,8	19,4	17,7	17,5	18,1	18,5	16,4	15,1	15,5	12,8	12,4
Pulmonary	43,4	50	56,1	59,2	64,5	67	67,2	68,3	69,3	74,1	74,9	71,8	69,3	68	69	73,8	77,4	78,5
Sniffed	5,8	6,4	5,3	5,3	5,9	4,3	7	7,9	9,5	6,7	6,5	8,1	9,5	9	9,7	9,6	8,9	7,7

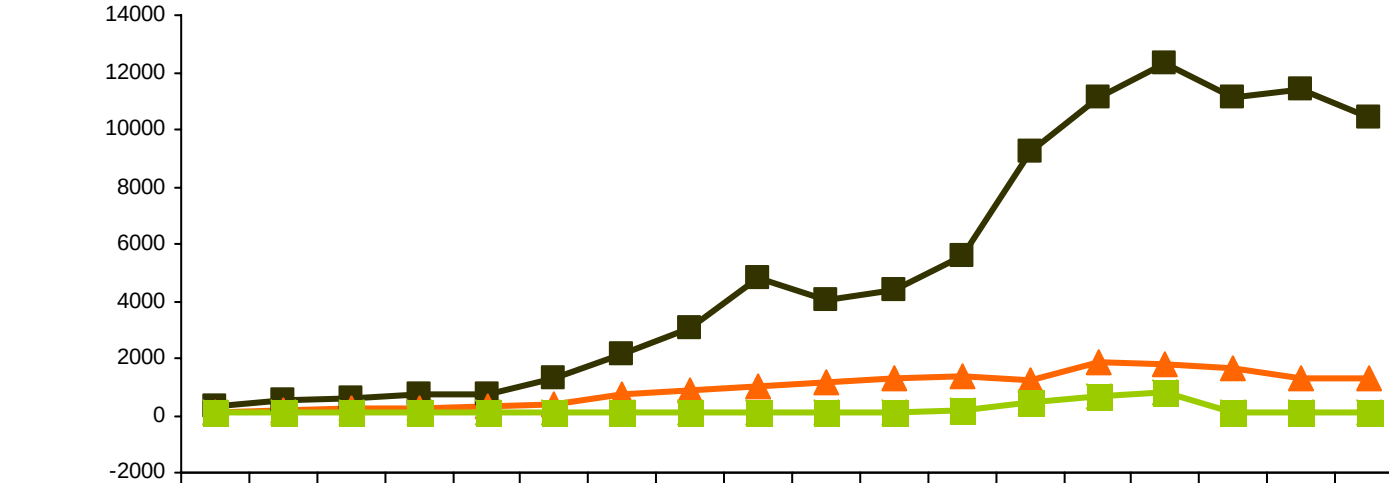
Note: The estimates of the number of individuals treated for heroin for all Spain as a whole, by the primary route of administration, has been calculated by multiplying the number of individuals treated for heroin nationwide in Spain by the percentage of individuals admitted using each route of administration. (a percentage which was not available for all of the Autonomous Communities for some of the years within the period in question).
SOURCE: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator.

Despite the decrease in injected heroin abuse in an overall trend among all the Autonomous Communities, some major differences exist among Communities in the percentage of individuals treated for heroin who use this drug preferably by injection, due, for the most part, to the type of heroin which is available in the Autonomous Communities favouring, to a greater or lesser degree, the use of one type or another and therefore the use of one route of administration or another.

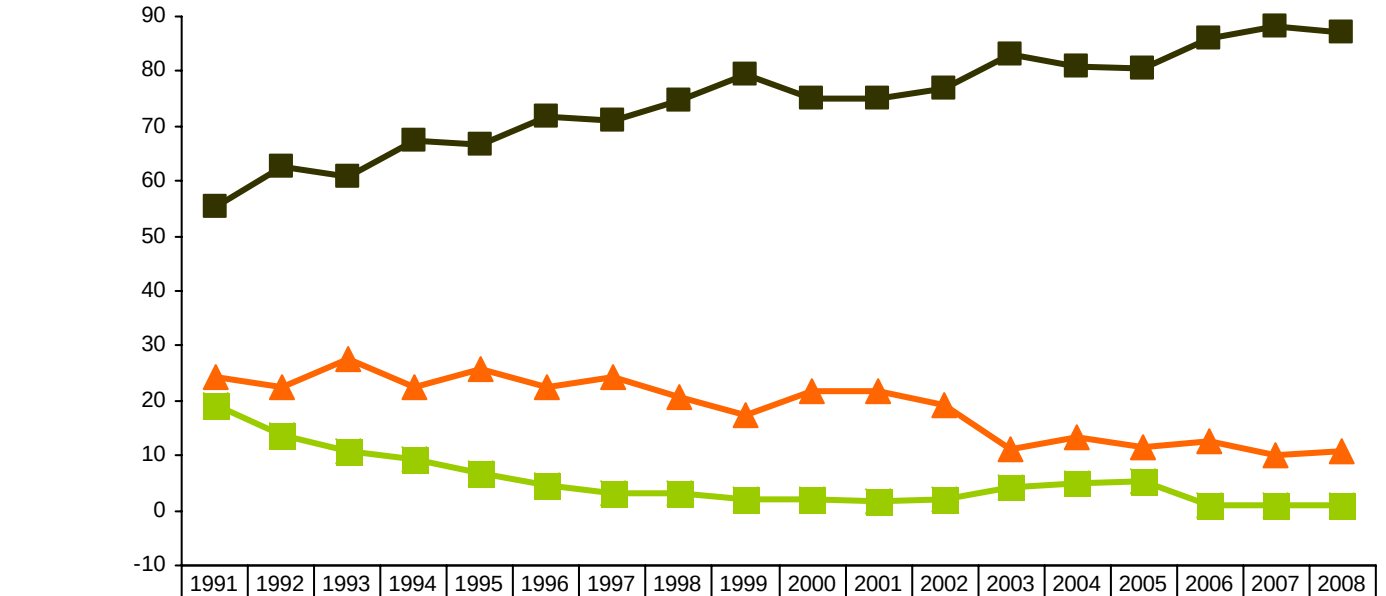
In 2008, among all of the individuals admitted to treatment for cocaine as a whole, the predominant route of administration is the intranasal or sniffed route (86.9%), followed by the pulmonary or smoked route (10.7%) and the injected route (1%). The percentage of individuals admitted for the first time ever for cocaine abuse using injection as the primary route of cocaine administration dropped within the 1991-2001 period from 19.2% in 1991 to 1.6% in 2001. As of that point in time, this percentage has rise to 5.2% in 2005, having dropped back down to 1% in 2008.

On the other hand, the absolute number of individuals admitted to treatment for the first time ever for cocaine abuse using preferably the intravenous route as the primary route of administration remained more or less table from 1991 (109 individuals) to 2001 (91 individuals), having risen considerably up to 793 individuals in 2005 to then have dropped back down to levels similar to those of the period prior to 1991 (117 individuals in 2008) (Figure 5.7).

Figure 5.7. Individuals admitted to treatment for the first time ever in their lives for cocaine abuse or dependence, by primary route of cocaine administration. (Absolute numbers and percentages). Spain, 1991-2008



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Sniffed	315	547	611	714	739	1307	2172	3073	4777	4067	4413	5613	9228	11140	12298	11155	11393	10391
Pulmonary	139	196	278	238	287	413	741	856	1048	1172	1284	1403	1242	1837	1755	1617	1295	1276
Injected	109	121	108	97	74	82	100	128	128	105	91	156	485	693	793	103	130	117



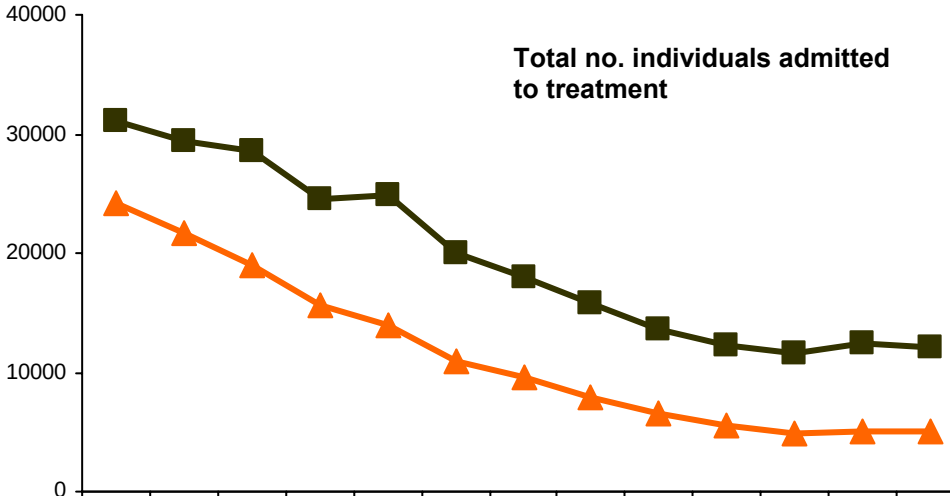
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Sniffed	55,4	62,7	60,8	67,4	66,5	71,7	71	74,8	79,5	75,2	75,2	77	83	80,9	80,6	86	88	86,9
Pulmonary	24,4	22,5	27,7	22,5	25,8	22,6	24,2	20,8	17,4	21,7	21,9	19,2	11,2	13,3	11,5	12,5	10	10,7
Injected	19,2	13,9	10,7	9,2	6,7	4,5	3,3	3,3	2,1	1,9	1,6	2,1	4,4	4,8	5,2	0,8	1	1

Note: The estimates of the number of individuals treated for cocaine for all Spain as a whole, by primary route of administration, have been calculated by multiplying the number of individuals treated for cocaine nationwide in Spain by the percentage of individuals admitted using each type of route of administration (a percentage which was not available for all of the Autonomous Communities for some of the years within the period in question).

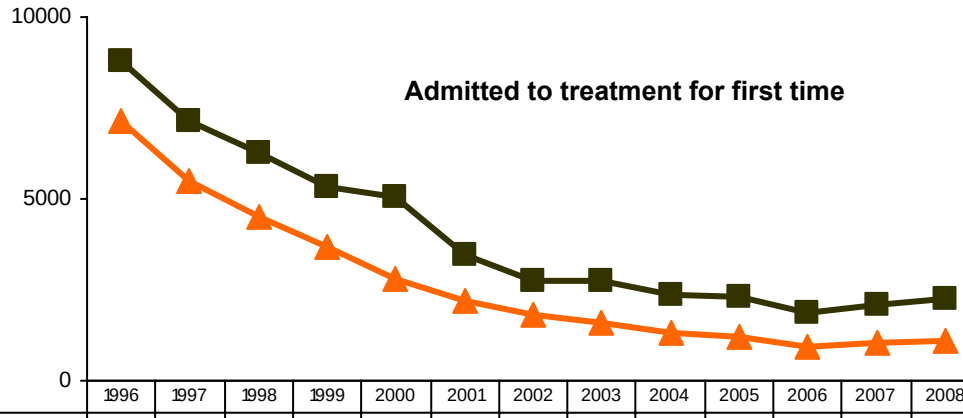
SOURCE: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator

As a whole, the use of the injected route among those admitted to treatment became used to a progressively lesser degree over the nineties, currently marking a prevalence of nearly 1%, which has remained constant over the past few years. The number of individuals admitted for any psychoactive drug for the first time ever in their lives who had ever injected the same in the lives dropped from 8801 in 199g to 2271 in 2008. On the other hand, the number of those who had used the injection route of administration within the last 12 months dropped from the 7132 in 1996 to 1124 in 2008 (Figure 5.8) In general, a downward trend is noted, seeming to have stabilized over the past few years.

Figure 5.8. Evolution of the number of injectors admitted to treatment for drug abuse or dependence in Spain, 1996-2008.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ever in lifetime inyection	31046	29419	28527	24520	24941	19988	17950	15806	13605	12252	11601	12487	12066
Injections during last year previous to admission	24224	21605	18910	15562	13955	10898	9583	7966	6516	5620	4892	5055	5050



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Ever in lifetime inyection	8801	7154	6247	5315	5055	3483	2765	2722	2356	2283	1879	2073	2271
Injections during last year previous to admission	7132	5488	4526	3655	2793	2181	1801	1583	1303	1228	928	1060	1124

Note: The estimates of the number of injectors admitted to treatment nationwide in Spain has been calculated by multiplying the number of individuals admitted to treatment nationwide in Spain by the percentage of individuals admitted who had ever injected drugs in their lives or within the 12 months immediately prior to the admission (a percentage which was not available for all of the Autonomous Communities for some years within the period in question).

SOURCE: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator

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

In 2008, the vast majority of the patients admitted to treatment for illegal drug abuse or dependence (85.3% of all individuals admitted and 84.3% of those admitted for the first time ever) were males. The females total a higher percentage among the admissions for hypnosedatives, where they amount to 40% of the admissions. The average age of those admitted to treatment was 33.1 years of age for all admissions as a whole and 30.3 for the first admissions. A total of 7.4% of all individuals admitted were born outside of Spain (Table 5.1).

The average age of the individuals admitted varies depending on the primary drug. hence, the average age of the individuals admitted for heroin was 37.5 years of age, for hypnosedatives, 37.2 years of age; for cocaine, 32.1 years of age and for cannabis, 24.8 years of age.

The highest educational level completed of the patients admitted to treatment has improved slightly over the course of time, but continues showing significant variations depending on the primary drug for which they are admitted to treatment. In 2008, the majority (56.0%) of the patients admitted to treatment for heroin had an elementary school or lower education, whilst solely 40.9% of those admitted for cocaine abuse and 46.1% of those admitted for cannabis abuse had only elementary school educations. With regard to the labour situation, the percentage of gainfully employed individuals among those treated for cocaine (54%) was much higher than the percentage of gainfully employed individuals treated for heroin (29.3%), and even though for quite a much younger population, the percentage of gainfully employed individuals among those treated for cannabis (33.3%) was higher than the percentage of gainfully employed individually among those treated for heroin.

In 2003, variables were added related to the living status with regard to type of accommodations and also with whom the patients were living and the source or service which had referred these patients for treatment. In Spain, the large majority of the patients admitted to treatment for illegal drugs live in family households (single-family homes, apartments, etc.) In 2008, the percentage of individuals admitted to treatment who were living in institutions was 8.3%, those having precarious or unstable accommodations (homeless) totalling 2.9%. The living status model most often found as far as with whom the patient is living is their original family (with their parents) or their own family (with spouse and/or children). Some major differences are also found in the living status models regarding with whom and where the patient is living by the primary drug for which the patient is admitted to treatment. In 2008, living in an institution or having precarious or unstable accommodations was much more frequent among those admitted to treatment for heroin (18.6%) than among those admitted for cannabis (7.8%) or cocaine (8.7%), the opposite having been true for the percentage of patients who were living at home with their parents or on their own with their own families.

As regards the service or the source which referred the patients for treatment, approximately half (50,2%) of the patients started treatment on their own initiative or were encouraged to do so by their family members or friends, although the public health system referred one third (33.2%) of those admitted to treatment.

The pattern of polydrug use is firmly established among those admitted to treatment. The most part (66.1%) of those admitted in 2008 had used other drugs different from that for which they were admitted to treatment (secondary drugs) within the last 30 days immediately prior to admission. Solely 33% had used the drug for which they were being admitted to treatment. A total of 35.8% reported using one single drug; 21.4% having used two drugs; 6.9% admitting using 3 drugs and 2% more than three

drugs. Among those admitted for heroin, the secondary drugs reported most often were cocaine and cannabis; and among those admitted for cocaine, alcohol and cannabis.

Somewhat less than half (45.2%) of those admitted to treatment for psychoactive drugs in Spain in 2008 was the first time they were undergoing treatment for the same primary drug, this being a percentage which was much lower among those admitted for heroin (22%) than among those admitted for cocaine (54.4%), cannabis (71.1%), amphetamines (59.3%) or ecstasy (71%).

Table 5.1. Socio-demographic characteristics of the individuals admitted to treatment for psychoactive drug abuse or dependence, according to whether or not they had undergone prior treatment and by gender. Spain, 2008

	Total	Prior treatment[1]		Gender[1]	
		Yes	No	Males	Females
No. cases	53,155	27,769	22,944	44,885	8,037
Treated for first time for the primary drug (%)	45.2			45.0	47.0
Average age (years)	33.1	35.3	30.3	33.1	32.9
Females (%)	15.2	14.7	15.7		
Highest level of education completed (%):					
No schooling	1.3	1.3	1.2	1.2	1.6
Elementary education	45.8	47.0	44.0	46.9	39.7
Secondary education	48.7	47.8	50.2	48.1	52.0
University Studies	3.8	3.5	4.2	3.4	6.3
Others	0.4	0.4	0.5	0.4	0.5
Primary labour status (%):					
Currently gainfully employed	41.6	38.1	46.1	43.4	32.1
Unemployed, not having been employed	4.7	4.7	4.7	4.3	7.2
Unemployed, having been employed	35.4	39.8	30.2	35.2	36.2
Others	18.3	17.5	19.0	17.1	24.5
Individuals born outside of Spain (%)	7.4	6.7	7.9	7.2	8.6
Main source having referred them for treatment (%):					
Other drug dependence treatment services	12.9	16.8	8.4	12.5	15.6
General practitioners, primary care physicians	12.4	9.5	15.9	12.3	13.4
Hospitals or other health services	5.6	6.4	4.6	5.2	7.9
Social services	2.3	2.1	2.5	1.9	4.7
Prisons, closed juvenile detention centres	7.3	7.8	6.5	7.6	5.1
Legal or police services	5.9	4.4	7.9	6.2	4.1
Companies or employers	1.3	1.2	1.4	1.4	1.1
Family members or friends	15.4	11.2	20.5	15.6	14.4
Own initiative	34.8	39.0	29.7	35.3	31.8
Others	2.1	1.6	2.7	2.1	2.0
Longest living status (with whom) within the last 30 days immediately prior to the admission to treatment (%)					
Alone	13.8	15.0	12.5	14.2	12.0
Only with spouse	13.0	13.3	12.4	11.9	19.5
Only with children	4.6	4.1	5.3	3.8	9.2
With spouse and children	14.4	14.9	14.3	14.4	14.4
With parents or original family	41.1	38.2	44.8	42.6	32.6
With friends	3.0	3.2	2.8	2.9	4.1
Others	9.9	11.3	7.9	10.2	8.2
Main living status (where) within the last 30 days immediately prior to admission to treatment (%):					
Single-family homes, apartments	85.4	83.0	88.8	85.0	87.5
Prisons, closed juvenile detention centres	5.8	6.6	4.4	6.4	2.6
Other institutions	2.5	2.8	2.2	2.5	2.7
Boarding houses, hotels, hostals	1.0	1.1	0.8	1.0	1.1
Unstable/precarious accommodations	2.9	3.6	1.9	2.8	3.5
Other places	2.4	2.9	1.9	2.4	2.6

1. The number of cases with or without prior treatment or the number of males plus the number of females may not add up to the total due to there being cases with unknown values for these variables.

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Treatment Demand Indicator.

DRUG-RELATED INFECTIOUS DISEASES

HIV/AIDS

Over the past 20 years, AIDS and HIV infection have been one of the main health problems associated with drug use in Spain. Data is available from different sources of information which, as a whole, aids toward understanding the evolution of this phenomenon as well as the current situation.

In following the main results are presented from:

1. Permanent information records and sources: National AIDS Cases Register, Information Systems on New HIV cases diagnosed, Treatment Demand Indictator for Drug Abuse or Dependence

2. Specific periodic studies: In-Hospital Survey of HIV/AIDS Patients, Itínere Project, EPI-HIV Project and at-risk behaviour studies.

Permanent information records and sources

a) National AIDS Cases Register

In Spain, there is a National AIDS Cases Register which gathers information on the new AIDS cases at the nationwide level. Data as of 1981 to present is available. This register provides useful information in regard to the transmission mechanism.

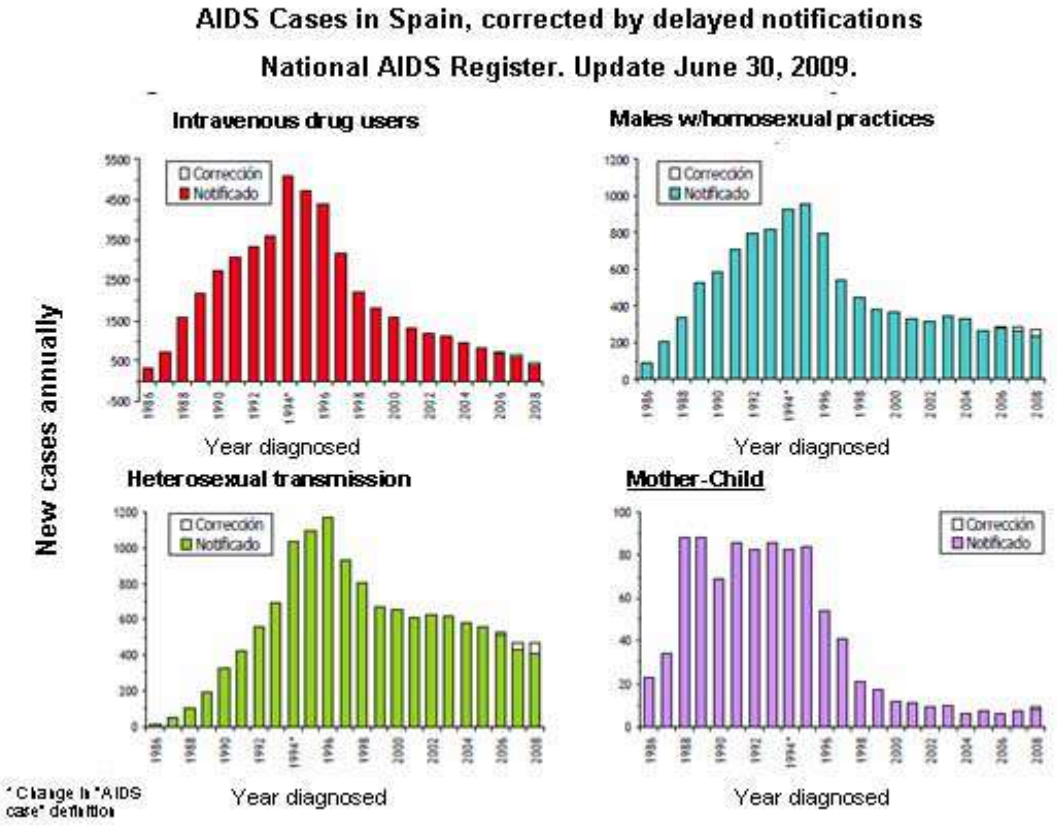
According to the National Epidemiology Centre, as of 1981, the year of the outbreak of this epidemic, up to June 30, 2009, a total of 77,953 AIDS cases had been notified in Spain. Viewed overall, the most frequent transmission mechanism is "transmission by drug injection" (61.4%), followed by the "sexual route" (14.1%).

Evolution over time: The percentage of AIDS cases which can be attributed to intravenous drug users has fallen over the last few years following the peak recorded in 1990 (69.7%), whilst the percentage of cases in the sexual transmission category has risen. The absolute number of new cases of AIDS diagnosed as having been acquired in a manner attributable to intravenous drug users has also decreased. This decrease may be the result of several factors which have had a bearing on the course of this epidemic over the past few years, one of the most worthy of note of which is the high degree to which methadone maintenance treatments are available, and the sharp drop in the use of the injected route for heroin use.

Current situation: In 2008, a total of 1170 new cases were reported. The most frequent transmission route (55.2%) being the sexual route (heterosexual relations (34.9%) and homosexual relations among males (20.3%)). The second most frequent transmission mechanism (34.4%) is due to the fact of sharing injection material for injected drug administration (37.6% males and 23.4% females). In 2008, the downward trend in this behaviour, which had begun years ago, was confirmed among the group of current and ex-intravenous drug users (having dropped by 28% within the 2007-2008 period)

Figure 6.1 shows the evolution over the course of time, from 1986 to 2008, of the new cases of AIDS in relation to the risk factor associated to HIV transmission. The first graph shows the drop in the number of AIDS cases starting as of 1995.

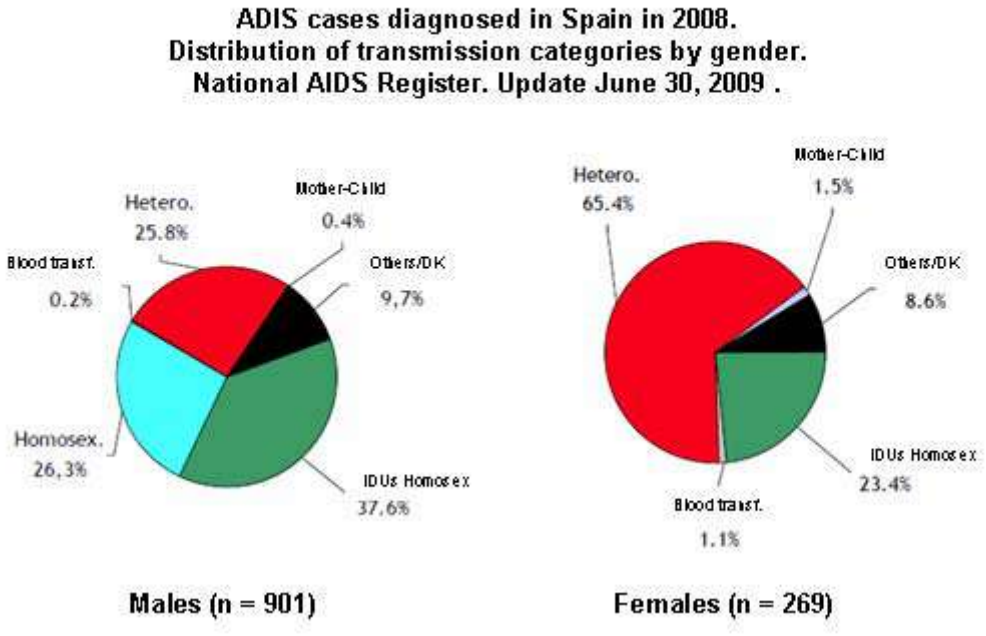
Figure. 6.1: New AIDS cases, by associated risk factor. Spain. 1986-2008.



Source: National AIDS Register. National Epidemiology Centre

Figure 6.2 shows the new AIDS cases in 2008 in relation to the risk factor (Spain 2008) associated with HIV transmission, in which the predominance of the sexual route as whole is noted, especially of the heterosexual relations in females.

Figure. 6.2: New cases of AIDS by the associated risk factor. Spain. 2009.



Source: National AIDS Register. National Epidemiology Centre

b) Information system on new HIV cases diagnosed

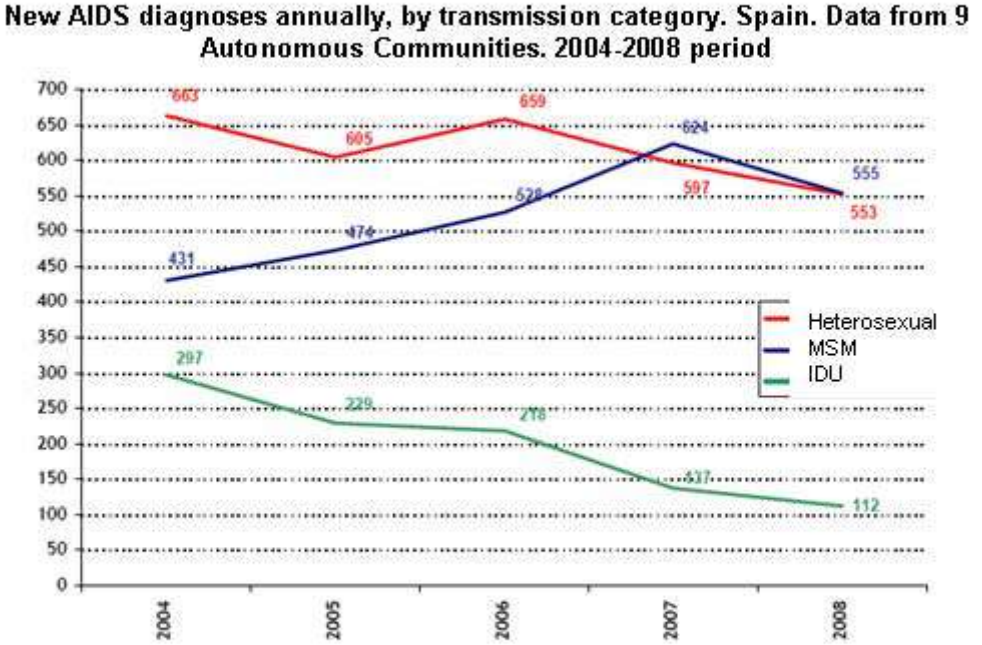
In Spain, there is also an information system which has been in use since 2003 making it possible to know the new HIV cases diagnosed. The number of Autonomous Communities this information includes has varied since its creation, 12 of the 19 Autonomous Communities currently declaring, thus representing approximately 19 of Spain's 49 million inhabitants.

According to the National Epidemiology Centre, the current rate of new HIV cases diagnosed totals a figure similar to that of other countries in the European Union environment. However, despite the improvement over past decades, a trend toward the stabilisation of the number of new diagnoses is apparently found to exist within the period analyzed (2003-2008).

Evolution over time: The epidemiological virus transmission patterns have radically changed. Whilst during the first years of the epidemic, most of the new infections were caused by sharing drug injection material, HIV is currently being transmitted mostly by the sexual route. By analyzing the trend in the group of intravenous drug users, a progressive drop during this period is found both for the number of cases diagnosed as well as the percentage this category of transmissions totals within the overall total: of 19.9% (n=297) in 2004 to 8.2% (n=112) in 2008. Figure 6.3).

Current situation: Up to June 30, 2009, a total of 1583 new HIV cases diagnosed have been notified in 2008. The heterosexual transmission category was the most frequent (41.8%), followed by that of the males who have sexual relations with males (38.8%), and that of intravenous drug users (9.2%). (Figure 6.4). When the categories are broken down by gender, the intravenous drug users total 9.9% of the males and 6.8% of the females. (Figure 6.5).

Figure 6.3. New HIV cases diagnosed by transmission category. Spain* 2004-2008



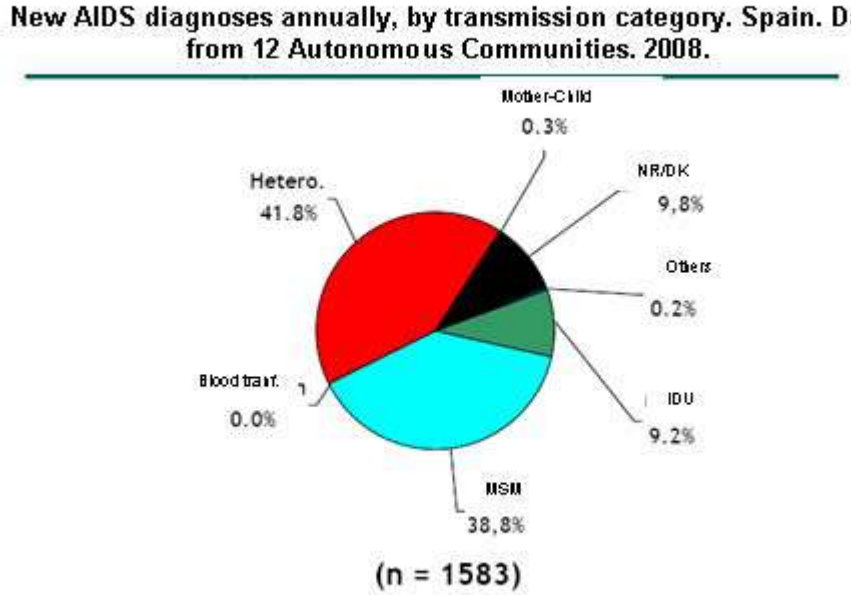
Balearic Islands, Basque Country, Canary Islands, Catalonia, Ceuta, Extremadura, Galicia, Navarre, Rioja.

MSM: Males who practice sex with males.

IDU: Intravenous drug users.

Source: Information System on New HIV cases diagnosed in Autonomous Communities. National Epidemiology Centre.

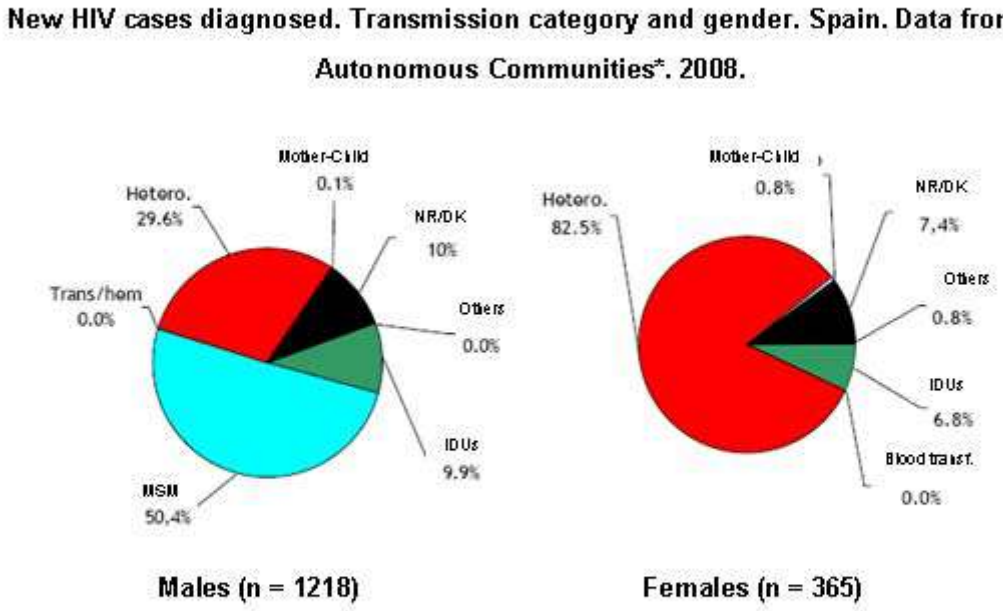
Figure 6.4. New HIV cases diagnosed, by transmission category. Spain* 2008



•Aragon, Asturias Balearic Islands, Basque Country, Canary Islands, Catalonia, Ceuta, Extremadura, Galicia, Melilla, Navarre and Rioja.
MSM: Males who practice sex with males.
IDU: Intravenous drug users.

Source: Information System on New HIV cases diagnosed in Autonomous Communities. National Epidemiology Centre.

Figure 6.5. New HIV cases diagnosed, by transmission category and gender. Spain* 2008



*Aragon, Asturias, Balearic Islands, Basque Country, Canary Islands, Catalonia, Ceuta, Extremadura, Galicia, Melilla, Navarra and Rioja.

MSM: Males who practice sex with males.

IDU: Intravenous drug users.

Source: Information System on New HIV cases diagnosed in Autonomous Communities. National Epidemiology Centre.

c) Indicator of admissions to treatments for drug abuse or dependence

Methodology

Description:

This indicator is for the purpose of determining the number of individuals admitted to outpatient treatment for abuse or dependence related to each one of the psychoactive substances in an Autonomous Community within a given year. Treatment is considered as being any intervention carried out by qualified professionals for eliminating the psychoactive substance abuse or dependence or reducing its intensity. Outpatient treatments are considered as being those treatments in which the patient does not stay overnight at the treatment centre.

The information collected by means of this indicator is useful for obtaining information on the infections in users.

Coverage:

The coverage of this indicator is nationwide. In 2008, a total of 53,155 admissions to treatment were notified from Spain's 19 Autonomous Communities. This indicator first started functioning throughout the entire system as of 1987.

Treatment Demand Indicator information-collecting mechanism:

The treatment centres collect the information on a file cared which they send to the Autonomous Communities, who forward this aggregate information to the national level. For the notification of cases, the public or private subsidized centres which provide outpatient treatment for psychoactive substance abuse or dependence are included. These may be specific drug dependence centres, mental health centres or services which provide outpatient drug dependence treatments (whether they be independent centres or centres integrated into general health care centres, hospitals or another type of centres), prison drug dependence treatment programs, centres which provide complex treatments that include an outpatient phase, or mobile units providing substitution opiate treatments which are staffed by physicians and nurses.

Variables:

The data collection card is comprised of 23 variables, some of which have several different sections. The information collected includes:

- Enrolment information (Medical record number, date admitted to treatment, centre identification number).
- Socio-demographic information (gender, date of birth, country, province, and city/town of birth, nationality, labour status, highest educational level completed, living status (with whom) within the last 30 days, where lived.
- Information on health and drug use (source of treatment referral, primary drug for which admitted to treatment, how often primary drug is used, year started use of primary drug, prior treatment for this same drug, route of administration used most often, other drugs, etc. Information is additionally collection of the serological condition with respect to HIV, it being planned to start collecting hepatitis B and C.

Treatment Demand Indicator inclusion /exclusion criteria:

The cases fulfilling any of the following requirements are included:

(a) Admission to treatment at a centre for the first time
(b) Re-admission to treatment at the same centre
(c) Continuation of a treatment already started, for reasons of emergency or for other reasons, at services which do not notify the indicator, such as hospitals, medical centres or social services centres, who subsequently come to a notifying centre to continue treatment.
(d) The admission to a treatment on which a judicial or administrative situation has a bearing.

The cases which are of any of these characteristics are not notified as admissions to treatment:

(a) Neither the mere personal or telephone contacts to request information or treatment nor the demands which are placed on the waiting list.
(b) The contacts for the sole purpose of requesting welfare aid or benefits.
(c) The treatments for the sole purpose of treating the organic complications related to drug use.
(d) The interventions consisting exclusively of exchanging needles or other injection material, distributing condoms or counselling regarding safe sexual and drug use methods.

(e) The treatments involving an overnight stay in hospital units, psychiatric hospitals, therapeutic communities, living facilities, etc.

d) Results

Some of the results prepared by the Spanish Observatory on Drugs based on the information taken from this indicator are provided in following.

Injectors admitted to treatment: knowledge of serological condition and HIV prevalence. Spain 2008

Table 6.1 shows some of the data on the knowledge of the HIV-related serological condition and HIV prevalence among the injectors admitted to treatment for psychoactive drug abuse or dependence in Spain in 2008, taking into account their age and gender and whether they had ever injected in their lives or within the last 12 months immediately prior to this admission.

In short, a total of 10,895 individuals were admitted to treatment in 2008 who had injected at some time in their lives, a total of 4,546 having done so within the last 12 months immediately prior to the admission in question. A total of 75.0% of the former were aware of their serological condition, 70.5% of the latter being aware thereof.

Focusing on those individuals who had injected within the last 12 months, no differences exist between males (70.6%) and females (70%) with regard to their awareness of their serological condition. A difference does however exist in terms of the age, given that, the older the individual, the greater the more well-informed they are in this regard. Hence, solely 46.3% of those under 25 years of age are aware of their serological condition, compared to 76% of those over 34 years of age. The difference is also striking between those who had previously undergone treatment (74.8% were aware of their serological condition) and those coming in for the first time for treatment (solely 23.4% being aware of whether or not they were HIV-positive), this fact being justifiable by it being standard practice to run HIV serology tests on all individuals admitted to treatment.

In relation to HIV prevalence, a total of 27.6% of those who had injected within the last 12 months were HIV-positive, a somewhat higher percentage being found among females (33.3%) than among males (26.7%). Clear differences were age-based differences were also found (3.2% among those under age 25 and 35.6% among those over 34 years of age).

Table 6.1. Injectors admitted to treatment: awareness of serological condition and HIV prevalence. Spain, 2008

	Injection within the last 12 months immediately prior to the admission			Injection ever in their lifetime		
	Total	Prior treatment		Total	Prior treatment	
		Yes	No		Yes	No
Total injectors (No.)	4,546	3,399	1,062	10,895	8,539	2,146
No. injectors aware of their HIV-related serological condition	3,203	2,549	610	8,126	6,594	1,393
Prevalence [(1)] HIV infection (%)	27.6	29.9	18	32.5	33.7	26.2
Male injectors (No.)	3,904	2,951	886	9,304	7,340	1,792
Aware of their HIV-related serological condition (No.)	2,756	2,211	509	6,901	5,628	1,159
Prevalence HIV infection (%)	26.7	28.7	17.9	31.1	32.1	26
Female injectors (No.)	626	436	177	1,544	1,164	345
Aware of their HIV-related serological condition (No.)	438	331	99	1,192	940	229
Prevalence HIV infection (%)	33.3	37.8	18.2	40.3	43.1	27.1
Injectors < age 25 (No.)	406	204	188	509	253	235
Aware of their HIV-related serological condition (No.)	188	110	75	242	142	95
Prevalence HIV infection (%)	3.2	3.6	2.7	4.5	4.9	4.2
Injectors ages 25-34 (No.)	1,541	1,081	429	2,764	2,034	678
Aware of their HIV-related serological condition (No.)	1,043	804	224	1,960	1,546	383
Prevalence HIV infection (%)	16.9	19.4	8.9	17.9	18.9	14.4
Injectors > age 34 (No.)	2,595	2,111	449	7,608	6,241	1,231
Aware of their HIV-related serological condition (No.)	1,971	1,635	310	5,915	4,900	913
Prevalence HIV infection (%)	35.6	36.8	28.4	38.5	39.2	33.5
Injectors users opiates[2]	3,719	2,957	695	9,157	7,547	1,441
Aware of their HIV-related serological condition (No.)	2,784	2,287	457	7,069	5,917	1,035
Prevalence HIV infection (%)	29.1	31.1	19.5	34	35	27.9
Injectors non-users opiates	827	442	372	1,738	992	705
Aware of their HIV-related serological condition (No.)	419	262	153	1,057	677	358
Prevalence HIV infection (%)	17.4	19.5	13.7	22.4	22.9	21.2

[1] The prevalence is calculated on the number of cases with information on the HIV-related serological condition and on the other variables that are crossed.[2].. Both those individuals admitted to treatment for opiate dependence and those admitted for other psychoactive drugs who have used opiates within the last 30 days immediately prior to the admission in question are included.

Source: Treatment Demand Indicator. Spanish Observatory on Drugs..

Individuals admitted to treatment: Serological condition and primary drug administration route. Spain 2008

Table 6.2 provides information on those individuals admitted to treatment in 2008, classified in terms of the primary drug for which they were admitted, detailing whether or not they injected, as well as the route of administration used most often and the HIV-related serological condition.

A total of 7.8% of all those individuals admitted to treatment showed positive HIV-related serology, many differences being found in terms of the primary drug for which they were admitted to treatment. The highest percentage of HIV-positive individuals was found among the group admitted to treatment for opiate abuse (17.4%). Within this group, differences exist according to the specific substance used. Hence, 26.7% of those on methadone, 17.2% of the heroin users and 14.8% of those who use other opiates are HIV-positive.

Table 6.2. Individuals admitted to treatment: Serological condition and primary drug administration route. Spain 2008

	No. cases	Has injected drugs		HIV-related serological condition(%)				Primary drug administration route used most often in last 30 days (%)				
		Ever in life	In last 12 months	Positive	Negative (analysis last 6 months	Negative (no analysis date)	No known analysis or results	Oral	Pulmonary	Intranasal	Injected	Others
Opiates	**19,356**	**51.2**	**20.5**	**17.4**	**27.0**	**29.7**	**26.0**	**4.4**	**70.8**	**6.2**	**17.9**	**0.7**
Heroin	18,407	51.4	20.9	17.2	27.0	29.9	25.9	0.8	73.8	6.4	18.4	0.7
Methadone	582	47.9	10.8	26.7	23.5	26.9	22.9	93.5	4.7	0.4	1.3	0.2
Other opiates	365	43.1	17.0	14.8	29.3	23.8	32.1	40.1	30.3	7.9	20.8	0.9
Cocaine	**24,680**	**8.3**	**4.2**	**2.4**	**28.1**	**22.9**	**46.7**	**0.8**	**15.1**	**81.6**	**1.8**	**0.7**
Cocaine CLH	23,649	8.1	4.2	2.3	28.6	22.7	46.3	0.9	12.5	84.1	1.9	0.7
Crack	1,026	14.5	3.6	3.5	16.8	25.8	53.9	0.1	77.3	21.6	0.6	0.3
Other stimulants	**632**	**4.0**	**2.9**	**1.3**	**21.5**	**20.4**	**56.7**	**41.9**	**4.4**	**52.5**	**0.7**	**0.5**
Amphetamines	424	4.6	3.3	0.9	20.6	22.1	56.4	27.0	3.2	68.3	0.7	0.7
MDMA and derivatives	164	3.5	2.8	3.0	20.9	16.4	59.7	84.8	6.2	8.3	0.7	0.0
Hypnosedatives	**845**	**12.7**	**3.5**	**5.5**	**14.5**	**24.2**	**55.7**	**97.0**	**1.3**	**1.0**	**0.4**	**0.4**
Benzodiazepines	774	12.9	3.6	5.8	13.8	25.1	55.2	96.7	1.4	1.1	0.4	0.4
Hallucinogens	**44**	**0.0**	**0.0**	**2.5**	**32.5**	**17.5**	**47.5**	**57.1**	**2.4**	**40.5**	**0.0**	**0.0**
Volatile inhalants	**67**	**7.4**	**1.9**	**0.0**	**32.1**	**7.5**	**60.4**	**7.7**	**61.5**	**26.2**	**0.0**	**4.6**
Cannabis	**7,419**	**4.1**	**1.4**	**1.1**	**16.2**	**17.3**	**65.4**	**2.6**	**96.6**	**0.7**	**0.0**	**0.1**

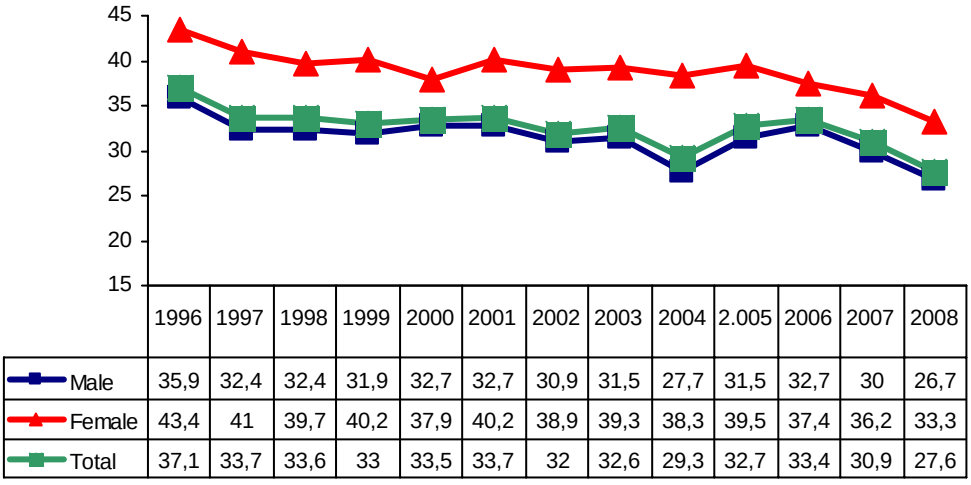
Source: Treatment Demand Indicator. Spanish Observatory on Drugs.

Individuals admitted to treatment: HIV prevalence, by age and gender. Spain 1996-2008

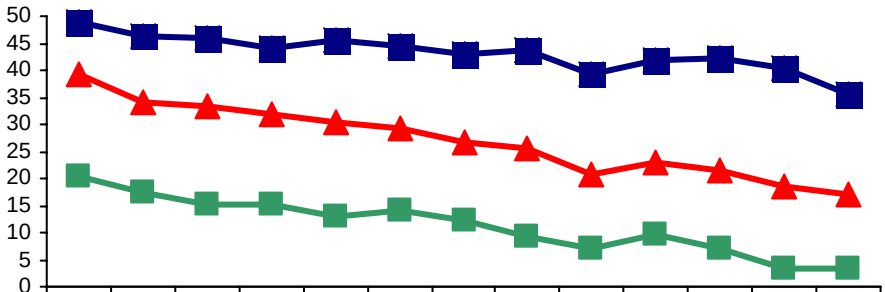
Figure 6.6 provides the HIV prevalence data, by age and gender, among those individuals admitted to treatment who had injected drugs within the last 12 month immediately prior to admission and who were aware of their serological condition. It is advisable to bear in mind that the percentage of injectors admitted to treatment who were not aware of their HIV-related serological condition was 33.5% in 1997; 29.4% in 1999; 25.5% in 2001; 26.1% in 2003; 27.5% in 2004; 26.7% in 2005; 21.8% in 2006; 23.2% in 2007 and 29.5% in 2008.

In general, a slight downward trend may be noted. As has previously been mentioned, the prevalence is higher among females than among males and among those individuals over 34 years of age.

Figure 6.6. HIV prevalence among those individuals admitted to treatment who had injected within the last 12 months(1) by age and gender. Spain 1996-2008



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2.005	2006	2007	2008
Male	35,9	32,4	32,4	31,9	32,7	32,7	30,9	31,5	27,7	31,5	32,7	30	26,7
Female	43,4	41	39,7	40,2	37,9	40,2	38,9	39,3	38,3	39,5	37,4	36,2	33,3
Total	37,1	33,7	33,6	33	33,5	33,7	32	32,6	29,3	32,7	33,4	30,9	27,6



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2.005	2006	2007	2008
<25	20,3	17,5	15,1	15,2	13,1	14	12,1	9,2	7,1	9,7	7,2	3,2	3,2
25-34	39,3	34	33,4	32	30,5	29,1	26,7	25,5	20,9	23,1	21,4	18,7	16,9
>34	48,9	46,4	45,8	44	45,5	44,4	42,8	43,8	39,4	41,9	42,2	40,3	35,6

(1) Those individuals admitted to treatment who were aware of their serological condition and who had injected some substance within the last 12 months immediately prior to the admission in question.

Source: Treatment Demand Indicator. Spanish Observatory on Drugs.

Special specific studies

a) In-hospital HIV-AIDS patient survey

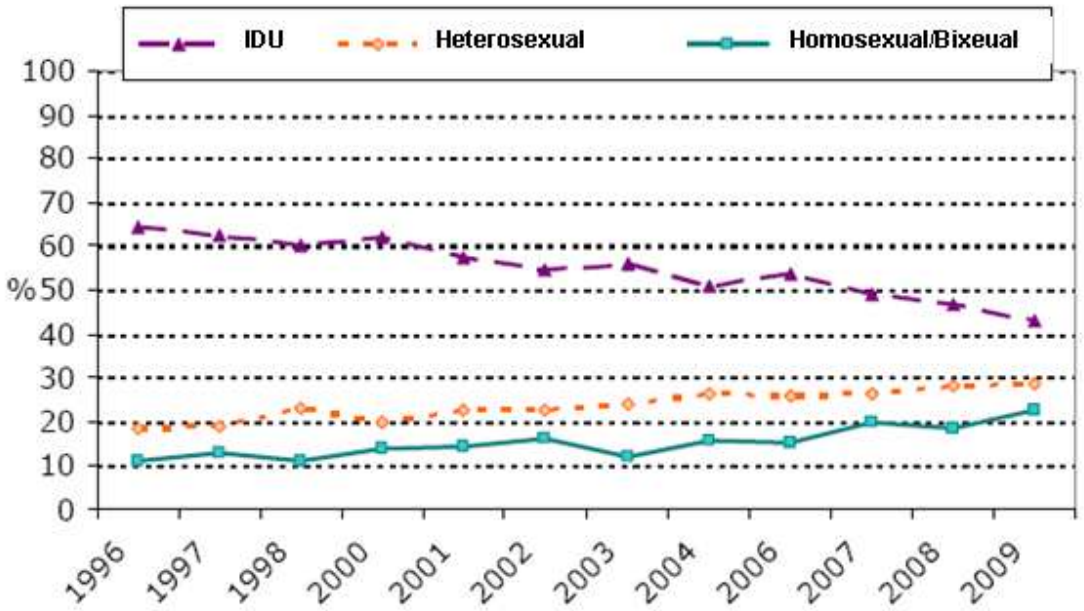
Methodology: An observational study was conducted in Spain in 2009 by means of an in-hospital HIV/AIDS patient survey. The study population are those patients diagnosed with HIV in contact with Spain's National Health System. The scope is that of the network of National Health System hospitals in the Autonomous Communities taking part in the study in the 1996-2009 period. The hospitalized, outpatient and day hospital HIV patients who were there on the day the survey was conducted were included. The data was gathered by way of a questionnaire completed by the physicians.

The information published by the National Epidemiology Centre shows a profile for the 1996-2009 period mostly of males, progressively older in age, gainfully employed and having completed a low level of education.

Evolution over time: With regard to the transmission mechanism, intravenous drug use (57%) and heterosexual transmission (23%) show the highest percentages. Some significant changes have however occurred over the course of time, one of the most outstanding of which is the progressive drop in the number of patients who contracted this infection as a result of being intravenous drug users, from 64% in 1996 to 43% in 2009; and the rise in the percentage of those who contracted it by the heterosexual route, from 18% in 1996 to 29% in 2009. The percentage of cases attributed to sexual relations among males has also risen from 11% in 1996 to 22% in 2009. (Figure 6.7).

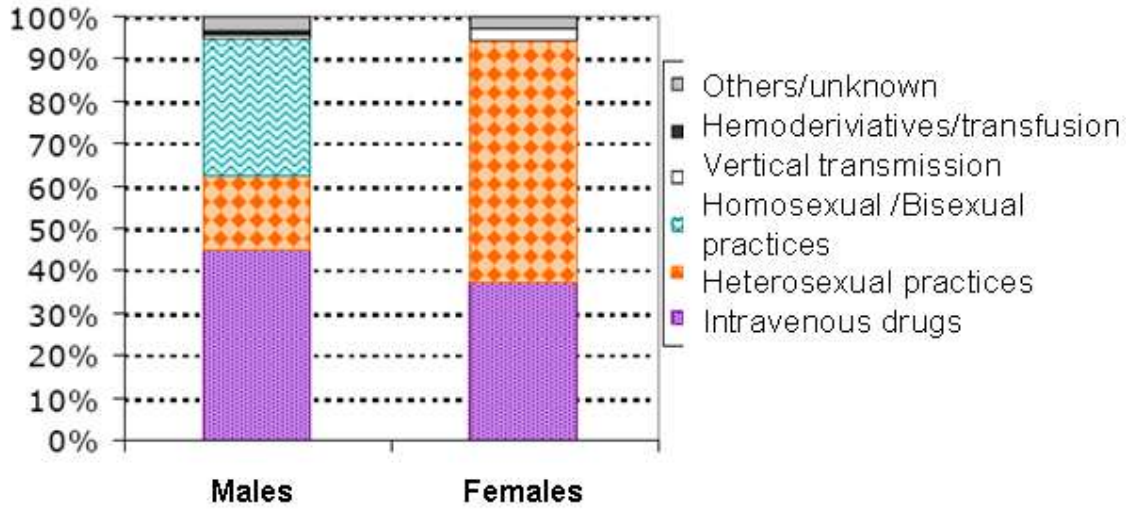
Current situation: Among those diagnosed for the first time in 2009, the males who have sex with other males are predominant (40%). Second-ranked is the transmission by way of heterosexual practices (37%), then intravenous drug use (6%). The analysis by gender reveals that 57% of the females had contracted this infection by heterosexual transmission, and 37% as a result of sharing injection material, whilst among the males, the most frequent transmission mechanism was intravenous drug use (45%), following by homosexual / bisexual relations (32%). (Figure 6.8).

Figure 6.7: Distribution of cases by transmission mechanism. Spain 1996-2009.



Source: In-hospital HIV/AIDS patient survey. Results 2009.
National Epidemiology Centre.

Figure 6.8. Distribution of cases by transmission mechanism and gender. Spain 2009



Source: In-hospital HIV/AIDS patient survey. 2009 Results National Epidemiology Centre.

b) Itínere Project

In Spain, a cohort study was conducted in Madrid, Seville and Barcelona on heroin users 30 years of age or younger. For the 2001-2003 period, this study showed a high incidence rate of HIV infection (4.5/100 individuals/year, 95% confidence interval) in young injectors, which suggests that the drop in the number of infections linked to intravenous drug use has been due more to the drop in the total number of injectors that to the drop in the prevalence of HIV transmission-related risk behaviours, which, in fact, continues to be high.

On the other hand, HIV infection in non-intravenous heroin users had been thought to be rare until now, but this same source shows a high incidence rate among young users from some certain geographic areas in particular. This places major importance on sexual transmission and on the need of focusing greater attention on couples who are serum-positive injectors.

Among the heroin injectors detected in 2001-2003 by this project, the HIV infection prevalences were 20.8% in Barcelona, 22.2% in Seville and 34.9% in Madrid, with major drops between 1995 and 2001-2003 in Barcelona and Seville, but not in Madrid. This different situation and evolution of these three cities could be related to the methadone maintenance treatments having been started later in Madrid. The prevalence among the non-intravenous heroin users was 4.0%, without any differences among these 3 cities, being a female having been strongly associated with infection in this group.

c) EPI-HIV Project

The EPI-HIV project provides data on HIV infection in individuals who come in for testing to sexually-transmitted disease and/or HIV diagnosis centres for the first time. This project shows that the number of first visits by injectors has dropped from 1,547 in 1991 to 595 in 2000 and 180 in 2006; the number of cases of HIV infection in this group having dropped from 690 in 1991 to 134 in 2000 and 54 in 2006; HIV prevalence having gone from 46.6% in 2000 to 22.5% in 2000 and then to 30.0% in 2006. One must bear in mind that the infection prevalence figures in individuals who come in for testing voluntarily underestimate the actual prevalence, because they do not customarily include those individuals who know they are infected. However, they may be sensitive for detecting time-related changes in HIV transmission.

d) At-risk behaviour studies

The studies of at-risk behaviours for the transmission of HIV infections or hepatitis virus in drug injectors in conjunction with those making it possible to determine the incidence of these infections are of far-reaching importance for knowing their natural history, the associated factors and forecasting the future behaviour of the hepatic morbidity or AIDS epidemic. There are hardly any studies, however, in Spain which delve into the at-risk behaviours for blood or sexual transmission of infections among these populations. In one Autonomous Community sample comprised of 300 drug users detected in Barcelona and the metropolitan area during 2004, a total of 17.7% had received used needles within the last 6 months, 74.8% gave or received drug dissolved in a used needle, and 77.9% shared other material, which suggests that populations still currently exist of drug users with at-risk injection patterns.

VIRAL HEPATITIS

The major consequence HIV infection has on a person's health and the impact of this epidemic among drug injectors has taken a back seat for years to the problems associated with hepatitis B or C infections among those who inject drugs. The HIV test has been essential with regard to an awareness having been created over the past few years as to the importance of the viral hepatitis epidemic on the morbimortality of these populations, as well as the impact it will be having in the future.

The prevalence of hepatitis B virus (HBV) infection is generally higher among drug injectors or among intensive users of drugs by other routes than among the general population. According to the Itínere project, the infection prevalences in 2001-2003 among young injectors of the cities of Madrid, Barcelona and Seville ranged from 20% to 35%, and from 4.4% to 8.9% among non-injection heroin users. Additionally, despite taking vaccine being recommending for those individuals who have at-risk practices and the specific HBV vaccine programs among adolescents, the protection of young heroin users against HBV has been revealed in some recent studies to continue to be low in these 3 cities.

The prevalence of hepatitis C virus (HCV) infection is very high among drug injectors in Spain, just as throughout the rest of the European Union. In Spain, 65%-90% of all injectors are infected, depending on the geographic area and the source of the sample studied. The Itínere study data show HCV incidence among young injectors to be 34.8/100 individuals/year (95% CI). This high incidence rate is consistent with the stabilisation of the HCV infection epidemic at the aforementioned prevalence levels.

The problem of HCV infection is a source of concern, given that, in addition to being widespread among drug injectors, there is currently no vaccine, nor does it seem likely that there will be one in the near future, given the structure and biology of this virus, so every possible emphasis must therefore be placed on prevention. This is an infection which foes not usually show any symptoms in the acute stage, 66%-80% therefore going undiagnosed. Additionally, it very often (55%-85%) evolves into chronic hepatitis, which also often develops with very few signs and symptoms. The main problem is that at least 5%-10% of all cases of chronic hepatitis evolve into serious liver disease, such as cirrhosis or liver cancer or lead to premature death.

HCV transmission by means of using shared injection material occurs in a way similar to other pathogens transmitted by the blood, it however being calculated that it is ten times more infectious that HIV. This explains why the infection rates worldwide among the young people who are injectors are four or fie times higher than the HIV rates and that HCV infection is the first infection that is acquired.

Additionally, another aspect to be taken into account is the high degree of co-infection by HIV and HCV, which has consequences on the clinical evolution of both disorders and on their response to treatment.

In Spain, the prevalence of HCV antibodies among the general population ranges from 1% to 2.6% (2.5%-2.6% in Madrid and Catalonia). The high prevalence of infection among the drug injectors foreseeably contributes greatly to this prevalence. Over the past few years, probably due o the drop in injected drug use, among other factors, has lowered the populational incidence of infection. However, the number of patients with advanced liver disease is anticipated to increase over the next few years.

OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES

Non-fatal overdoses and drug-related emergencies

Methodology

A summary is provided in this sector of the working protocol for the "indicator of hospital emergencies among users of psychoactive substances", the latest version of which dates from 2003. In the protocol in question, operating criteria are included for including and excluding episodes, criteria for selecting the areas and hospitals monitored definitions and criteria for classifying the different variables, as well as details on the information collection and transmission instruments and circuit.

This indicator is aimed at monitoring the hospital emergencies related to the non-medical or non-therapeutic use of psychoactive drugs in Spain. It as first put into practice in 1987, comprising part of a broader-ranging information sub-system developed within the framework of the National Plan on Drugs in collaboration with the Autonomous Communities for monitoring the evolution and the characteristics of problem psychoactive drug use, especially of those which, such as the opiates or cocaine, usually cause problems more often and are difficult to explore by other means.

Unlike the "Treatment Admissions Indicator", this indicator has never made its way into being implemented in all of the Autonomous Communities and, save some exceptions, the areas covered have varied from year to year, as well as the number of hospitals monitored in each one of the areas (degree of collecting thoroughness). Besides, the areas of influence of the hospitals monitored may also have changed. Apart from the above, this indicator underwent some major changes in its definition in both 1996 and 2003. With this past history, from the national scope, the time and space comparisons must be made taking many a precaution and must be based solely on percentage spreads of the characteristics of the emergencies and not on absolute numbers or populational rates.

The current version (Protocol 2003) of the emergencies indicator records all the episodes of hospital emergencies in which mention is made of non-medical or non-therapeutic use of psychoactive drugs (except those in which mention is made exclusively of alcohol, tobacco or xanthenes), independently of more than one being involved in one same individual.

At the point in time of the analysis, however, for the purpose of facilitating drawing a comparison with the Drug-related Deaths Indicator and solve possible differences in information collection criteria among Autonomous Communities, the episodes in which mention is made exclusively of hypnosedatives, antipsychotics or antidepressants or any combination of these drugs with one another or with alcohol or tobacco have also been excluded.

Similarly, the episodes of emergencies caused by pregnancy or the complications of pregnancy has also been excluded, although mention be made of the use of psychoactive substances, the emergencies due to adverse reactions to medications (except in the case in which mention is made exclusively of opiates prescribed in maintenance programs for which the diagnosis is unequivocally related to opiates).

As the criterion for including episodes is the mentioning of the use of psychoactive substances and not the relationship of this use to the patient's clinical symptoms, the episodes are also recorded in the clinical record of which there is no evidence directly

related to drug use, such as infectious complications, injuries or traumatisms due to external causes (accidents, attacks, self-inflicted injuries). Additionally, as an exception, the episodes are also collected in persons who use opiates within the framework of maintenance programs without any other psychoactive drug use being involved, provided that the diagnosis is unequivocally related to the use of these opiates, as is the case with overdoses or withdrawal syndrome.

The criterion of requiring solely the mention of psychoactive substance use facilitates the decision as to which episodes must be included. However, as it is difficult to know with what degree of thoroughness the emergencies are included without evidence of any direct relationship with the drug use in the different areas monitored, the analysis provided in following has been focused mainly on the emergencies related directly to drug use (those in which the physician includes on the clinical record some evidence as to the relationship with drug use), selected with the aid of a dichotomic variable added for this purpose on the data collection sheet. Thus, is it also possible to compare the data for 2003 onward with those of the prior years, in which solely the emergencies related to drug use were included.

As of 2003, the emergencies of individuals within the 15-54 age range have been being collected, whilst only those of individuals within the 15-49 age range had been recorded until that time. Similarly, literally all of the emergency diagnoses mentioned on the clinical record are included, instead of the 5 major diagnosis groups which had been being collected up until 2003. However, the information of the diagnoses have not been analyzed, because although a standard manual has been developed for encoding the diagnoses as per IDC-10, this standardisation has not be implemented in all of the Autonomous Communities

Information is included on the following variable on the date sheet: date of the emergency, gender, age, nationality, the patient's legal status (under arrest/not under arrest), diagnoses of the emergency (literal), psychoactive substances mentioned on the clinical record (up to 6), route used for administering the psychoactive substances mentioned, evidence of the emergency being directly related to the drug use stated by the physician on the clinical record (encodes, the same as the substances mentioned, with the aid of a coding system developed for this purpose), most recent route used for administering the drugs which the physician related to the emergency on the clinical record, and solution provided for the emergency.

According to the protocol, when the decision is made to monitor a given geographical area, all of the major hospitals located within the area in question must be monitored, except for the maternity hospitals, children's hospitals and monographic hospitals, but this is not always done as should be. Each Autonomous Community may decide whether it is going to gather the information continuously or solely throughout one week per month, selected at random at the Central Unit. In the protocol, it is also recommended to actively collect the information by selecting the recordable episodes following a thorough review of all the emergency clinical records, but this procedure has not been followed everywhere, which is one more reason for avoiding the time/space comparisons based on the absolute number of emergencies.

Results

In 2008, a total of 13,274 emergency episodes were recorded in individuals who had used some non-therapeutic or non-medical psychoactive drugs (illegally-sold drugs, opiates other than heroin or volatile inhalants), the use of these substances possibly being or not being the reason for the consultation on coming in to the emergency services or not, the actual cause of the emergency or not or, exclusively, other

accompanying background details going along with the past history of the user of these services.

In this calculation, the episodes in which mention was made solely of alcohol, tobacco, hypnosedatives, antidepressants, anti-psychotics or any combination of these substances are excluded.

The emergencies came from 15 Autonomous Communities. In most of the areas monitored, the information collection was confined to one week per month, selected at random, but in others, such as in the city of Barcelona and on the Island of Ibiza, among others, the information was gathered continuously. Of the 13,274 episodes of emergencies collected, 6,431 were directly related to the non-therapeutic use of psychoactive drugs, that is to say, evidence (stated by the physician) was found on the clinical record making it possible to relate to emergency in question to the non-therapeutic use of any one of these drugs.

Focusing exclusively as of this point on the emergencies directly related to drugs, in 2008, the substances mentioned most often on the clinical record as having been used were cocaine (63.7%), alcohol (44.6%) - despite the fact that it was included solely when it was mentioned in conjunction with some other drug -, cannabis (33.6%), hypnosedatives (21.3%), heroin (21.5%) and other unspecified opiates (14.7%) (Table 6.3).

In the comparison of the substance mentioned in males and females, it was found that the males mention a higher percentage of heroin, cocaine, cannabis and alcohol, whilst the females mention hypnosedatives, amphetamines, MDMA and derivatives to a greater extent (Table 6.3).

Table 6.3. General characteristics of the hospital emergency episodes among psychoactive substance users, by type of emergency and gender. Spain, 2008.

EMERGENCIES RELATED DIRECTLY TO DRUGS			
	MALES	FEMALES	TOTAL
NO. EPISODES	4,955	1,454	6,431
AVG. AGE (years)	32.6	31.5	32.4
FEMALES (%)	-	22.7	22.7
PSYCHOACTIVE SUBSTANCES MENTIONED (%)[1]			
Heroin	22.5	18.2	21.5
Other Opiates	14.4	15.7	14.7
Cocaine	64.4	61.7	63.7
Amphetamines	4.9	6.3	5.2
MDMA and Derv.	4.8	6.1	5.0
Hypnosedatives	19.9	26.3	21.3
Cannabis	34.7	30.0	33.6
Hallucinogens	2.0	2.3	2.0
Volatile Substances	0.6	0.2	0.5
Alcohol	45.6	41.1	44.6
Other substances	3.1	3.8	3.3
RELATED PSYCHOACTIVE SUBSTANCES (%)[2]			
Heroin	17.9	14.4	17.2
Other Opiates	7.3	8.1	7.5
Cocaine	55.7	52.8	55.1
Amphetamines	4.1	5.3	4.4
MDMA and Derv.	4.0	5.2	4.2
Hypnosedatives	14.1	20.7	15.6
Cannabis	25.6	21.8	24.7
Hallucinogens	1.5	1.7	1.6
Volatile Substances	0.6	0.2	0.5
Alcohol	37.9	35.4	37.3
Other substances	1.8	2.1	1.8
ARRESTED (%)	5.1	2.0	4.4
EMERGENCY OUTCOME IN (%)			
Medical release	79.5	81.7	80.0
Voluntary release	8.7	7.7	8.5
Hospital admission	8.0	6.8	7.8
Exitus in emergency services	0.1	0.1	0.1
Transferred to another centre	3.7	3.7	3.7

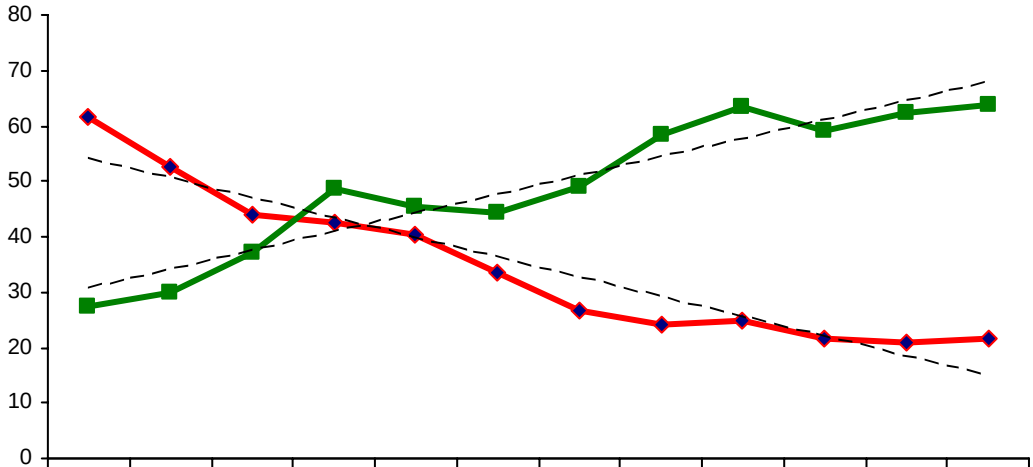
1. Includes the substances regularly or sporadically used and the substances related to the emergency in question

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Emergency Indicator. 2008.

In relation to the previous years, a major drop was found in the percentage of mentions of heroin (61.4% in 1996; 40.5% in 2000; 26.8% in 2002; 24.2% in 2004; 21.8% in 2006; 21% in 2007 and 21.5% in 2008) which seems to have stabilised over the last 3 years (Table 6.4. Figure 6.9). As far as the percentage of mentions of cocaine is concerned, the opposite trend is found to exist, the number of mentions having risen as of 1996 (27.4% in 1996; 48.7% in 1997; 63.4% in 2005 and 63.7 in 2008) stabilising at around 60-63% as of 2005.

Heroin has progressively been seen less in the emergency services as of 1999, the year in which cocaine took over as the drug most often mentioned in emergencies (Table 6.4 Figure 6.9). As of 2002, even the number of emergencies entailing a mention of alcohol surpass the number of emergencies entailing a mention of heroin, despite alcohol only being recorded when concomitant use in conjunction with other drugs exists.

Figure 6.9. Evolution of the percentage of emergencies due to acute reaction following psychoactive substance use entailing a mention of heroin or cocaine (%). Spain, 1996-2008

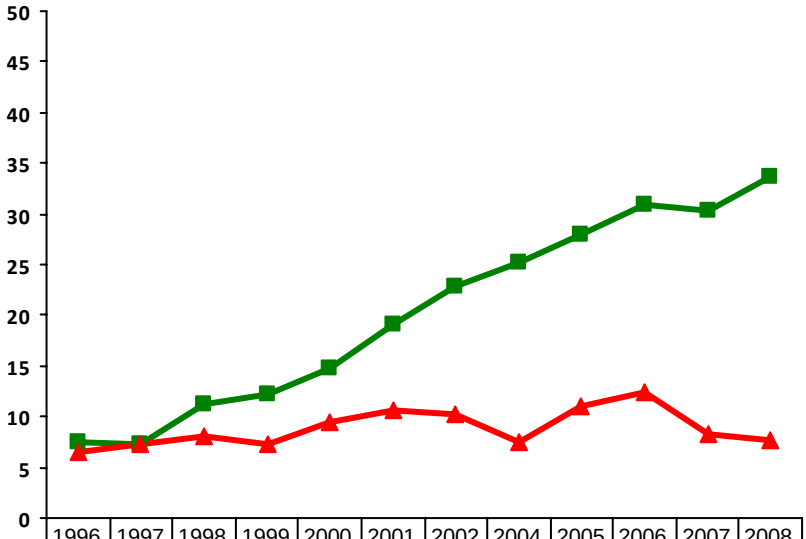


	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008
Heroin	61,5	52,6	43,9	42,5	40,5	33,5	26,8	24,2	24,8	21,8	21	21,5
Cocaine	27,4	30	37,2	48,7	45,3	44,4	49	58,5	63,4	59,2	62,4	63,7

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Emergency Indicator. 1996-2008.

All of the other substances mentioned have shown changes over the past few years. For example, the mention of cannabis has increased considerably, having risen from 7.4% in 1996 to 33.6% in 2008 (Figure 6.10 Table 6.4) and the same as for school having risen from 13.3% in 1996 to 44.6% in 2008. On the other hand, the mention of ecstasy increased from 1996 to 2006, having risen from 1.6% to 7.2%, the year in which it reached its highpoint, to then have dropped down to 5% in 2008. The mention of amphetamines reveals an up-and-down trend, the percentage of mentions having remained stable at around 5% over the last four years. The trends over the course of time in the mention of hypnosedatives are not assessable, especially as of 2002, due to the difference in the information-collecting criteria among Autonomous Communities and in the analysis of the data.

Figure 6.10. Evolution of the mentions of different substances in hospital emergencies for acute reaction to psychoactive drugs (%). Spain, 1996-2008.



	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008
Cannabis	7,4	7,3	11,3	12,2	14,8	19,1	22,8	25,1	27,9	30,9	30,3	33,6
Ecstasy, anphetamines or hallucinogens	6,5	7,3	8,1	7,2	9,5	10,7	10,3	7,5	11	12,4	8,2	7,6

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Emergency Indicator1996-2008.

Hallucinogens are rarely mentioned, the number of mentions however having risen in 2005 after several years of a continuous downward trend, having remained stable at around 2% since that year. If amphetamines, ecstasy and hallucinogens are all taken together, the highpoint for their being mentioned in emergency cases reached its highpoint in 2006, although, as shown on the graph, this mention shows an unstable trend, apparently indicating a major drop in the last two years (Figure 6.10 Table 6.4).

Table 6.4. General characteristics of the episodes of emergencies related directly to psychoactive substance use (absolute numbers, average and percentages). Spain, 1996,2008.

	1996	1997	1998	1999	2000	2001	2002	2004	2005	2006	2007	2008
NUMBER EPISODES	2,585	1,932	2,099	2,141	2,328	2,145	2,673	5,828	7,089	7,042	7,822	6,431
AVG AGE (years	27.8	28.1	29.1	29.4	30.3	29.8	29.8	31.0	30.7	31.6	32.0	32.4
GENDER (%)Females	21.4	20.8	23.1	23.5	27.4	27.1	27.4	28.0	25.0	26.1	23.4	22.7
PSYCHOACTVIE SUBSTANCES MENTIONED (%)*												
Heroin	61.4	52.6	43.8	41.9	40.5	33.5	26.8	24.2	24.8	21.8	21.0	21.5
Other Opiates	17.3	26.2	23.3	23.4	20.9	21.9	17.7	14.0	13.6	13.7	15.0	14.7
Cocaine	27.3	29.9	37.2	48.1	45.3	44.4	49.0	58.5	63.4	59.2	62.4	63.7
Amphetamines	3.1	3.3	3.4	2.7	2.6	4.6	3.8	3.0	4.8	5.4	4.8	5.2
MDMA and derivatives	1.6	2.7	2.9	3.1	4.8	5.2	6.3	4.2	5.7	7.2	5.8	5.0
Hypnosedatives	25.7	21.6	26.1	25.1	30.6	32.0	34.1	27.7	24.6	28.3	23.5	21.3
Cannabis	7.4	7.3	11.3	12.2	14.8	19.1	22.8	25.1	27.9	30.9	30.3	33.6
Hallucinogens	2.7	2.2	2.9	2.1	2.9	2.4	1.4	1.2	2.0	2.4	2.3	2.0
Volatile Substances	0.3	0.1	0.5	0.1	0.3	0.9	0.3	0.7	0.5	0.4	0.5	0.5
Alcohol	13.3	15.8	22.9	22.0	29.5	33.8	39.0	36.3	39.0	42.9	41.9	44.6
Other Substances	5.1	3.6	6.0	2.0	0.8	2.8	4.5	12.5	4.7	9.3	10.5	3.3
RELATED PSYCHOACTIVE SUBSTANCES (%)												
Heroin	56.1	50.9	38.7	33.0	35.3	29.2	21.4	17.5	19.0	16.9	16.9	17.2
Other opiates	13.5	17.4	16.8	18.9	18.0	17.4	13.1	9.1	8.3	8.5	8.1	7.5
Cocaine	19.9	25.0	31.6	39.4	40.9	40.5	44.7	50.0	55.5	51.1	53.8	55.1
Amphetamines	2.2	2.9	3.0	9.8	2.2	4.2	3.4	2.3	4.2	4.7	4.2	4.4
MDMA and Derivatives	1.3	2.2	2.2	2.4	4.5	4.4	5.3	3.2	4.7	6.4	5.0	4.2
Hypnotics and sedatives	23.6	18.9	24.3	23.8	28.9	29.2	30.1	22.3	17.0	21.0	15.8	15.6
Cannabis	6.2	6.6	8.9	9.3	12.8	16.9	19.9	19.3	21.7	23.9	22.9	24.7
Hallucinogens	2.1	1.8	2.4	1.7	2.7	1.9	1.3	0.8	1.7	1.7	2.0	1.6
Volatile Substances	0.2	0.1	0.3	0.1	0.3	0.9	0.2	0.6	0.5	0.4	0.5	0.5
Alcohol	12.4	15.2	22.2	20.0	26.8	29.0	35.4	30.7	32.3	36.0	35.7	37.3
Other Substances	4.1	3.2	4.9	1.3	0.8	1.6	1.8	8.7	3.3	4.9	6.0	1.8
LEGAL STATUS (%)												
Under Arrest	14.4	22.4	11.7	9.4	6.4	5.7	5.2	4.1	4.9	3.7	3.8	4.4
EMERGENCY OUTCOME(%)												
Medical release	80.5	82.0	81.2	80.9	78.7	79.1	82.1	81.4	79.1	76.2	79.1	80.0
Voluntary release	7.0	6.7	8.8	8.6	8.5	7.5	7.4	5.3	6.7	8.6	7.8	8.5
Hospital admission	7.6	7.2	6.0	6.5	8.3	7.8	6.3	8.0	8.4	8.8	9.0	7.8
Exitus in emergency services	0.1	0.1	0.0	0.2	0.7	0.2	0.1	0.0	0.1	0.1	0.0	0.1
Transfer to another centre	4.8	4.1	3.9	3.9	3.7	5.4	4.0	5.3	5.7	6.3	4.1	3.7

1. Includes the substances regularly or sporadically used and the substances related to the emergency in question
2. Includes the substances for which the physician states a direct relationship with the emergency in question on the clinical record
Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Emergency Indicator. 1996-2008.

Until now, substances mentioned in the cases in which there is considered to have been a relationship between the emergency and the substances use have been reported. On interpreting the prior data, one must bear in mind that these are mentions of use of these drugs taken from the clinical record and not of the emergencies having been cause by (or related to) the use of these drugs.

However, when the drugs which the physician relates to the emergency are considered by themselves, the panorama is similar, the substances related most often in 2008 having been: cocaine (55.1% of the emergencies), alcohol (37.3%), cannabis (24.7%), heroin (17.2%) and hypnosedatives (15.6%). As one same emergency may be related to the use of more than one substance, they may add up to over 100%. Considering the evolution throughout the 1996-2008 period, the same trends as in the case of the drugs mentioned on the clinical record are found to exist (Table 6.4).

Continuing solely with the emergencies directly related to drugs, in 2008, the largest part of the patients were still males (77.3%), the highest percentages of females being found in the emergencies with a mention of the use of hypnosedatives (27.9%), amphetamines (27.4%), MDMA and derivatives (27.2%) and hallucinogens (26.0%) (Table 6.5)

Table 6.5. General characteristics of the drug emergencies by type of emergency and substances mentioned or related to the emergency (absolute number, average and percentages). Spain, 2008

TOTAL DRUG USER EMERGENCIES

SUBSTANCES MENTIONED

	Heroin	Other opiates	Cocaine	Amph eta.	MDMA & deriv.	Sleeping pills and sedatives	Cannabis	Hallucinogens	Volatile substances	Alcohol	Others
NUMBER OF EPISODES WITH EACH DRUG	2,556	2,525	7,452	452	480	1947	5,104	218	46	4,798	558
AVG. AGE (years)	36.4	38.6	33.3	28.5	26.7	34.5	30.1	26.9	24.0	33.2	37.6
FEMALES (%)	19.3	24.0	22.5	28.3	25.3	27.6	20.7	22.0	8.7	20.0	19.4
ARRESTED (%)	9.0	8.1	5.0	2.7	2.1	6.7	3.5	2.3	4.3	3.3	4.5
EMERGENCY OUTCOME (%)											
Medical release	75.4	74.3	80.3	81.6	86.6	76.1	81.9	78.3	72.2	80.3	57.7
Voluntary release	9.5	9.2	7.5	7.5	8.8	8.6	5.4	8.7	0.0	7.6	5.3
Hospital admission	11.9	13.4	9.2	6.6	3.3	9.4	9.7	11.3	22.2	9.0	33.0
Exitus in emergency services	0.3	0.2	0.1	0.0	0.0	0.1	0.1	0.0	0.0	0.1	0.2
Transfer to another centre	3.0	3.0	2.9	4.4	1.3	5.8	2.9	1.7	5.6	3.0	3.8

EMERGENCIES RELATED DIRECTLY TO DRUG USE

SUSTANCES MENTIONED[1]

	Heroin	Other opiates	Cocaine	Amph eta.	MDMA & deriv.	Sleeping pills and sedatives	Cannabis	Hallucinogens	Volatile Substances	Alcohol	Others
NUMBER OF EPISODES FOR EACH DRUG	1,385	943	4,098	336	324	1,371	2,161	131	32	2,866	211
AVG. AGE (years)	36.0	37.8	32.7	27.8	26.2	34.2	29.5	26.2	24.7	32.6	34.9
FEMALES (%)	19.1	24.3	21.9	27.4	27.2	27.9	20.2	26.0	9.4	20.9	26.1
ARRESTED (%)	6.5	7.5	4.2	2.4	1.9	4.9	3.5	3.1	6.3	3.2	5.7
EMERGENCY OUTSOME(%)											
Medical release	77.1	74.0	80.6	82.1	86.9	75.7	81.8	76.3	66.7	80.7	55.8
Voluntary release	10.7	13.0	8.5	7.4	9.3	9.6	6.3	10.0	0.0	9.4	7.8
Hospital admission	8.2	9.6	7.1	5.4	2.1	7.8	7.7	11.3	26.7	6.7	28.2
Exitus in emergency services	0.3	0.2	0.1	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Transfer to	3.6	3.2	3.6	5.1	1.7	6.8	4.3	2.5	6.7	3.3	8.3

EMERGENCIES RELATED DIRECTLY TO DRUG USE

RELATED SUBSTANCES[2]

	Heroin	Other opiates	Cocaine	Amphetamines	MDMA & deriv.	Sleeping pills and sedatives	Cannabis	Hallucinogens	Volatile substances	Alcohol	Others
NUMBER OF EPISODES FOR EACH DRUGV	1,081	470	3,464	274	265	981	1,553	99	30	2,346	116
AVG. AGE (years)	35.6	37.1	32.6	27.3	25.9	34.0	28.6	25.3	24.8	32.5	33.2
FEMALES (%)	18.9	24.3	21.6	27.4	27.5	29.8	19.8	24.2	10.0	21.3	25.0
ARRESTED (%)	7.1	9.3	4.3	1.5	1.5	5.3	3.2	1.0	6.7	3.0	8.7
EMERGENCY OUTCOME (%)											
Medical release	76.6	80.2	81.4	84.4	87.4	75.8	83.1	81.0	71.4	81.1	51.3
Voluntary release	10.7	9.7	8.6	7.3	10.1	9.6	5.3	10.3	0.0	9.2	7.1
Hospital admission	8.7	6.3	6.6	2.9	1.0	7.6	7.7	8.6	21.4	6.5	31.9
Exitus in emergency services	0.5	0.0	0.1	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Transfer to another centre	3.5	3.7	3.3	5.4	1.5	6.9	3.9	0.0	7.1	3.1	9.7

1. Includes the substances regularly or sporadically used and the substances related to the emergency in question
2. Includes the substances for which the physician states a direct relation to the emergency in question on the clinical record

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Emergency Indicator.

The percentage of females for whom care was provided in emergency services has been varying, having ranged from 20.8% (in 1997) to 28% (2004), a decline having occurred in 2007 and 2008, having dropped to 22.7% that year (Table 6.4). In 2008, the average age of the individuals for whom care was provided was 32.4 years of age (somewhat older in males than in females), the youngest-aged individuals being those having emergencies with a mention of volatile inhalants (24.7 years of age), ecstasy (26.2 years of age) and hallucinogens (26.2 years of age; the oldest individuals being those having emergencies with a mention of heroin (36.0 years of age) or other opiates (37.8 year of age) Table 6.5). In general, a trend was noted for all years studied toward a rise in the average age of the individuals for whom care was provided in emergency services (27.8 years of age in 1996; 30.3 years of age in 2000; 31.0 years of age in 2004 and 32.4 years of age in 2008) (Table 6.4).

As far as patient legal status is concerned, in 2008, 4.4% of the emergencies directly related to drugs involved individuals under arrest, the highest percentage of arrested

individuals having been in the emergencies related to heroin (7.1%) or other opiates (9.3%) (Table 6.2.1.3.). The legal status of the patients has progressively evolved toward a higher percentage of individuals under arrest in 1997, the year as of which the decline began, having reached its lowest point in 2006 (3.7%) (Table 6.4).

In 2008, the outcome of most of the emergencies directly related to drugs was a discharge release (80.0%) Table 6.4). The distribution of the emergencies by outcomes has not varied much over the years, nor have great differences been found as regards the drugs mentioned or regarding gender (Tables 6.4 and 6.5).

As regards the most frequent administration route of the drugs mentioned in the emergencies directly related to drugs, one must bear in mind that there is a major percentage of unknown values, it therefore being necessary for the results to be taken with precaution. In 2008, in the emergencies entailing a mention of heroin, the predominant administration route was intravenous (60,0%), followed by the pulmonary route (32.7%, and the intranasal or sniffed (6.8%); and in the emergencies entailing a mention of cocaine, the intranasal or sniffed (54.7%), followed by the injected (23.1%) and the pulmonary or smoked (20.6%) (Table 6.6).

An improvement has been made in the administration route classification of the emergency episodes in which mention was made of "inhaled use". Up until 2003, they had been being attributed to the pulmonary or smoked route, but now with the 2003 protocol, the majority of these episodes have been found to actually pertain to the intranasal or sniffed route. This enhancement of the classification in the case of cocaine entails a major change, because the most frequent administration route in emergencies is now no longer the pulmonary, but has become, by far, the intranasal route, just as is the case of the Treatment Demand Indicator. In the case of heroin, it is confirmed that, in emergencies, the injected route is much higher in percentage among the individuals admitted to treatment for heroin abuse or dependence by the intranasal or sniffed route, which is revealing of the greater risk of some acute problems, such as overdosing, among injectors.

The data on the administration route related to other drugs agrees with that known based on other sources. In the case of ecstasy and hypnosedatives, the route is almost exclusively oral, and in the case of the amphetamines and hallucinogens the oral route is mainly predominant. The use of opiates other than heron is mostly by the oral route, although there are around 3% of the cases in which the intravenous route is used. In the case of cannabis, the predominant administration route was the pulmonary route (96.3%), with a small percentage of users using the oral route (3%) (Table 6.6).

The comparison of the data related to the administration route to those of previous years must be avoided in principle due to the improvement made in the classification of the variable and other changes, such as the incorporation of all of the emergency episodes recorded in the city of Barcelona as of 2004, which are of major relative importance among the whole and which, due to the characteristics of its population (preferably urban), adds a large number of cases of use by the injected route to the total.

Table 6.6. Administration route of the drugs mentions and related to the emergency in the emergencies directly related to psychoactive substance use. Spain 2008.

EMERGENCIES RELATED DIRECTLY TO DRUG USE				
	DRUGS MENTIONED		DRUGS RELATED	
	No.	%	No.	%
HEROIN				
Oral	2	0.3	5	0.9
Pulmonary or smoked	212	32.7	166	29.7
Intranasal or sniffed	44	6.8	39	7.0
Injected	389	60.0	349	62.4
Other route	1	0.2	0	0.0
OTHER OPIATES				
Oral	853	95.6	412	93.0
Pulmonary or smoked	10	1.1	9	2.0
Intranasal or sniffed	2	0.2	5	1.1
Injected	24	2.7	16	3.6
Other route	3	0.3	1	0.2
COCAINE				
Oral	18	1.4	22	2.0
Pulmonary or smoked	273	20.6	232	20.7
Intranasal or sniffed	725	54.7	604	53.9
Injected	306	23.1	259	23.1
Other route	4	0.3	3	0.3
AMPHETAMINES				
Oral	177	85.5	148	85.1
Pulmonary or smoked	13	6.3	12	6.9
Intranasal or sniffed	17	8.2	14	8.0
Injected	0	0.0	0	0.0
Other route	0	0.0	0	0.0
MDMA				
Oral	256	100.0	202	100.0
Pulmonary or smoked	0	0.0	0	0.0
Intranasal or sniffed	0	0.0	0	0.0
Injected	0	0.0	0	0.0
Other route	0	0.0	0	0.0
HYPNOSEDATIVES				
Oral	1,567	99.1	978	99.8
Pulmonary or smoked	5	0.3	1	0.1
Intranasal or sniffed	1	0.1	1	0.1
Injected	7	0.4	0	0.0
Other route	1	0.1	0	0.0
CANNABIS				
Oral	42	3.0	45	4.7
Pulmonary or smoked	1,336	96.3	911	95.0
Intranasal or sniffed	6	0.4	2	0.2
Injected	0	0.0	0	0.0
Other route	3	0.2	1	0.1
HALLUCINOGENS				
Oral	58	92.1	48	92.3
Pulmonary or smoked	0	0.0	0	0.0
Intranasal or sniffed	5	7.9	4	7.7
Injected	0	0.0	0	0.0
Other route	0	0.0	0	0.0

Source: Spanish Government Delegation for the National Plan on Drugs. Spanish Observatory on Drugs. Emergency indicator 2008.

In summary of the foregoing, emergencies occur mainly among males, the average age of the individuals for whom care is provided showing an upward trend, but some major changes having been fund in terms of the substance responsible for these emergencies. A total of 48.4% (6,431 of the 13,274 total) of the episodes of emergencies in drug users are caused by the use of some substance. The main substances both mentioned by the patients for whom care was provided, as well as those related to the episodes of emergencies are cocaine, alcohol and cannabis. Heroin is related to less than 20% of the emergencies and has remained stable over the past few years.

DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

Drug – related deaths

Special Register (SR)

Methodology

Description:

This is a special mortality register the purpose of which is to gather information on deaths with judicial intervention in which the main, direct cause of death is an acute adverse reaction following intentional, non-medical use of psychoactive substances (except alcohol and tobacco).

Coverage:

The population coverage at the geographic level has been progressively increasing. In 2008, 11 of Spain's current 19 Autonomous Communities notified data, which would mean approximately half of Spain's total population. The characteristics of the populations of these Autonomous Communities can be considered representative of all of Spain as a whole. From the time-related standpoint, this indicator began functioning throughout the entire system as of 1990, although partial information is available starting as of 1983.

Drug-related Deaths Indicator information collection mechanism:

The primary source of information comes from the Forensic Medicine Institutes, Forensics, National Institute of Toxicology and University Forensic Medicine Departments notified the data to their Autonomous Communities, which forward the data to the database of the Spanish Government Delegation for the National Plan on Drugs. This is currently done in a file format, but will soon be done by way of a website designed for this purpose.
There is a detailed protocol providing a description of the variables to be included and the way in which this is to be done, in addition to the criteria for inclusion and exclusion. A summary is provided in following of the most important aspects of this protocol.

Variables:

The data collection file is comprised of 26 variables, some of which have several sections. The information collected includes:

- Enrolment information (forensic report or autopsy number, toxicological report number, preliminary formalities number, institution collecting the information, number of the court prosecuting the case, court province and municipality).
- Socio-demographic information (gender, date of birth, province and municipality of birth, nationality, province and municipality where residing, marital status, data of death, province and municipality of death).
- Information on the corpse and the drugs (provenance of the corpse, clinical criteria and signs from the autopsy compatible with an acute reaction due to drug use, forensic's diagnosis of death, evidence of suicide, signs of vein puncture and anti-HIV antibodies).

Inclusion criteria:

A case is selected and is included in the register if it meets any of the following four criteria for inclusion:

1. Evidence of recent use of psychoactive drugs. This evidence may be of different types:
    - Clinical evidence of acute intoxication by psychoactive substances immediately prior to death recorded on any document (hospital report, clinical record, etc.).
    - External physical signs of recent administration of psychoactive substances (recent vein punctures, presence of remaining portions of psychoactive substance in the mouth, nasal passages, stomach, etc., smell of solvent in hair, on breath or clothing, etc.)
    - Presence of psychoactive substances or utensils for their use in the place of death (needle or other injection materials, aluminium foil, pipe, pill bottle, empty cans of glue or spray cans, lighter refills, plastic bags for inhaling, etc.).
    - Recent use (7 days prior to death) reported by family members or detected by the forensic in a recent forensic assistance or expert testimony concerning the individual now deceased.
2. Presence of positive toxicological analyses for any substance subject to registry.
3. Anatomical pathology findings of autopsy compatible with death due to recent use of any psychoactive substance.
4. Existence of a forensic's diagnosis of death due to acute reaction to any psychoactive substance.

Exclusion criteria:

According to the definition initially set forth, the following types of deaths are excluded:

1. Deaths in which there is no judicial intervention or forensic report as to the causes with written record of the findings. However, toxicological analyses not being made is not reason for exclusion, although the availability of the findings of these analyses is highly advisable. Deaths not related to the use of psychoactive substances. However, the deaths caused by disorders which may have worsened or been complicated by the recent use of psychoactive substances are not excluded, provided that they meet the inclusion criteria.
2. Deaths *indirectly* related to the use of psychoactive substances subject to registry, in other words, those in which the use of a psychoactive drug has been a contributing factor but not the main or fundamental cause of death.

The deaths due to the following causes are therefore not included:

- Infectious diseases presumably acquired as a result of drug use (AIDS, endocarditis, hepatitis, septicaemia, tetanus, etc.).
- Homicides of any type, even though the deceased were to have been under the influence of psychoactive substances, which were to have occurred in the course of activities related to the drug trafficking or use, or the perpetrator of the homicide were to have employed psychoactive substances to cause the death.
- Accidents of any type (occupational, household, traffic, etc.) in persons under the effects of psychoactive substances, with the exception of the deaths caused directly by acute intoxication or poisoning with these substances.
- Suicides (hanging, jumping into open space, immersion, by firearm, etc.) in persons under the effects of psychoactive substances. On the other hand, the deaths caused directly by acute self-inflicted poisoning or intoxication with psychoactive substances are included. Deaths due to involuntary or unintentional exposure to or ingestion of psychoactive substances.
- Deaths due to adverse reactions to psychoactive pharmaceutical products or medications correctly prescribed and administered. Included are the deaths due to acute reaction to psychoactive substances in individuals in methadone maintenance programs, unless it can be demonstrated that all of the psychoactive drugs taken by the deceased have been correctly prescribed and administered.
- Deaths due to a chronic disease related to drinking alcoholic beverages and deaths due to exclusively acute alcohol poisoning (drunkenness).

Results

The main results from having kept this special mortality register in Spain throughout the 1983-2008 period are provided in following:

1- General characteristics of those having died from an acute reaction following the use of psychoactive substances

A description is provided of the general characteristics of those individuals having died as a result of an acute reaction following the use of psychoactive substances in Spain in 2008 and the evolution thereof as of 2003. The data detailed is provided in Table 6.7

A total of 85.6% of those who died were males, as compared to the 14.4% who were females. This male predominance has been a constant trait since the beginning of the series. The average age in 2008 was 38.1 years of age, an upward trend having been found to exist since 2003. A total of 22.2% were within the 35-39 age range, 23.1% being over 45 years of age. A total of 61.4% of the individuals on whom information was available were single. In 89% of the cases, there was evidence of recent use of some substance, there having been no signs of vein puncture in 64.6% of the cases. In the largest part of the cases (91.0%, no evidence of suicide were found. In regard to other disorders, 26.6% of the deaths were due to a previously-existing disorder worsened by substance abuse, and 40.7% were HIV-positive.

Bearing in mind the limitations of approximation, it might be said that the most frequent profile of death due to acute reaction to psychoactive substances is that of a male over

35 years of age, single, with no prior disorder, who has recently used some substance and in whom no signs of suicide are found.

Table 6.7. General characteristics of the individuals having died due to an acute reaction following psychoactive substance use. Spain, 2003-2008

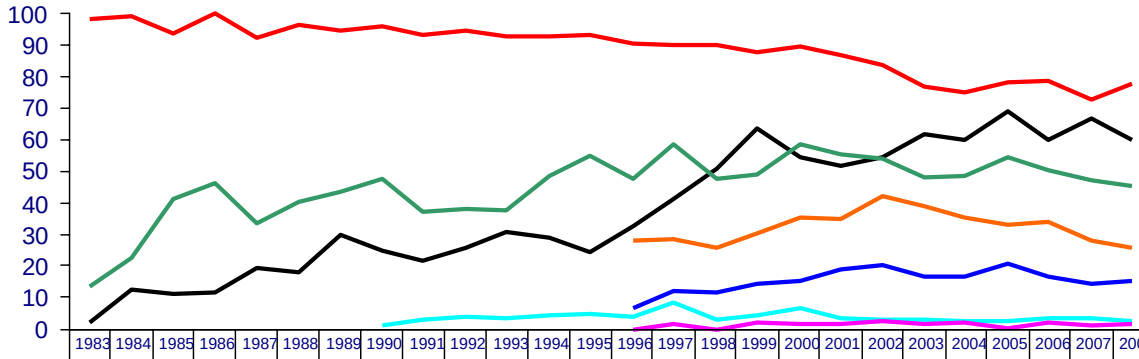
	2003	2004	2005	2006	2007	2008
Number deceased	493	468	455	428	475	424
Gender (%)						
Males	85.3	83.9	86.3	84.3	87.4	85.6
Females	14.7	16.1	13.7	15.7	12.6	14.4
Avg. age (years)	35.3	37.0	36.1	37.2	38.2	38.1
Age group (ears)						
15-19	0.8	1.3	1.4	0.9	0.6	1.9
20-24	6.7	4.1	6.2	4.2	4.3	6.1
25-29	14.6	11.9	11.2	12.9	9.7	10.6
30-34	22.6	20.5	20.0	18.0	17.6	16.3
35-39	28.2	27.9	28.9	23.8	24.1	22.2
40-44	16.9	19.2	20.7	21.3	22.2	19.8
>= 45	10.2	15.1	11.6	18.9	21.5	23.1
Marital status(%)						
Single	69.4	68.9	68.7	72.0	62.8	61.4
Married	19.0	15.6	16.4	12.2	19.1	16.8
Separated/Divorced	10.5	14.4	13.7	13.6	17.4	18.9
Widowed	1.0	1.1	1.1	2.2	0.7	2.9
Provenance of corpse (%)						
Home	54.5	55.2	58.1	52.3	60.6	60.0
Hotel-Boarding House	5.3	5.1	6.2	5.8	4.6	3.9
Street	18.5	17.4	13.5	20.1	13.1	15.8
Public establishment	1.8	1.3	2.5	4.8	2.4	1.7
Hospital	10.6	9.5	6.4	7.7	5.7	6.8
Prison	1.1	3.5	4.8	3.9	3.7	4.9
Other	8.2	8.1	8.5	5.3	9.8	7.0
Evidence of recent drug use (%)						
Yes	85.6	92.6	94.4	92.4	85.3	89.0
No	14.4	7.4	5.6	7.6	14.7	11.0
Evidence of suicide (%)						
Yes	12.1	8.8	5.7	10.8	8.8	9.0
No	87.9	91.2	94.3	89.2	91.2	91.0
Signs recent vein puncture (%)						
Yes	53.3	43.0	51.7	40.6	35.2	35.4
No	46.7	57.0	48.3	59.4	64.8	64.6
Death caused by previously-existing disorder worsened by psychoactive substance use (%)						
Yes	35.4	32.6	35.5	28.6	20.4	26.6
No	64.6	67.4	64.5	71.4	79.6	73.4
Anti-HIV antibodies (%)						
Positive	42.7	40.6	42.8	36.9	37.4	40.7
Negative	57.3	59.4	57.2	63.1	62.6	59.3

Source: Drug-related Deaths Indicator. Declaring Autonomous Communities. Spanish

Evolution of the deaths due to acute reaction following psychoactive substance use, by type of substance. Spain 1983-2008

Figure 6.11 shows the evolution of the deaths due to acute reaction following the use of psychoactive substances in Spain within the 1983-2008 period. The data presented show the percentage of deaths in which each one of the substance or metabolites to which reference is made were identified in the toxicological analyses. When added together, all of the percentages for each one of the years studied total over 100 due to the identification of more than one substance and their metabolites at one same time in one same toxicological analysis. Polydrug use is, hence, the pattern most frequently found among those who died due to an acute reaction to psychoactive substances. In 2008, opiates continue to be the substance identified in the largest number of deceased individuals (77.7% of the samples), although it is progressively nearing cocaine (60.2%), which is currently ranked second. This approximation of the figures found for these two substances is due to a lesser presence of opiates and an increased presence of cocaine throughout the period in question. Although the data collected in 2008 does not mark any changes in the overall downward trend for opiates, a 5% increase over 2007 has, indeed, been noted for this substance, and a 7% decrease in the case of cocaine, it therefore being necessary to continue monitoring this trend over the next few years. Ranked third are the hypnosedatives (45.1%), the most outstanding of which are the benzodiazepines (44.6%), followed by alcohol, cannabis and amphetamines, the trends for which have remained more or less stable over the past few years.

Figure 6.11. Evolution of the percentage of deaths due to an acute reaction following the use of psychoactive substances, by the type of substance detected in the toxicological analysis. Spain, 1983-2008 (%)



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Opiates	98	98,8	93,9	100	92,4	96,6	94,8	96	93,1	94,9	92,8	92,9	93,4	90,4	89,8	90,1	88	89,4	86,8	83,8	76,7	74,9	78,20	78,7	72,8	77,7
Cocaine	2	12,5	11	11,5	19,3	18,4	29,6	24,8	21,6	26	30,9	28,8	24,7	32,7	41,4	51,2	63,3	54,4	51,7	54,2	62,2	60,1	69,20	60	67	60,2
Hypnosedatives	13,7	22,5	41,5	46	33,8	40,2	43,8	47,4	37,2	37,9	37,4	48,4	54,8	47,7	58,6	47,4	48,8	58,5	55,2	54	48	48,7	54,10	50,7	46,9	45,1
Amphetamines								1	2,9	3,8	3,2	4,3	4,9	4	8,6	2,8	4,5	6,9	3,4	2,9	3,1	2,6	2,60	3,6	3,6	2,2
Cannabis														6,5	12,2	11,3	14,3	15,2	18,7	20	16,7	16,7	20,90	16,8	14,6	15,6
MDMA														0,1	1,5	0	1,8	1,6	1,5	2,5	1,6	1,9	0,40	1,7	1,1	1,4
Alcohol														27,7	28,6	26,2	30,5	35,5	35,3	42,5	39	35,8	33,00	34,3	27,8	25,9

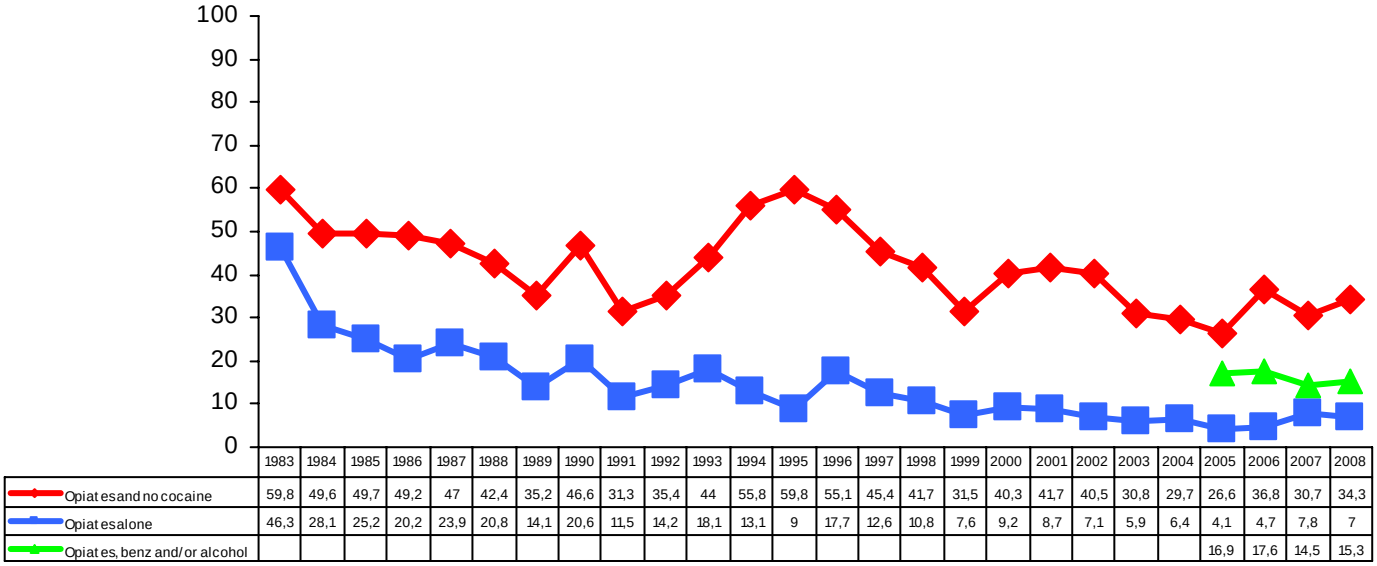
Source: Drug-related Deaths Indicator Spanish Observatory on Drugs. Spanish Government Delegation for the National Plan on Drugs.

In figures 6.12 and 6.13, a more detailed analysis is made of the evolution over the course of time of the data for opiates and cocaine, taking into account, in the case of opiates, the opiates and not cocaine, opiates alone and opiates plus benzodiazepines.

In the case of cocaine, an assessment is made of the presence of: cocaine and no opiates, cocaine alone and cocaine with alcohol.

The evolution over the course of time shows a downward trend of deaths in which solely opiates are detected, although a minor return to an upward trend might be starting in 2007 and 2008, which must be assessed with precaution and which it will be necessary to monitor in any case. There is similarly a minor rise in the pair "cocaine alone and alcohol", which is undergoing a change to an upward trend following two years of a downward trend. "Cocaine alone" has been showing a stabilisation over the past few years.

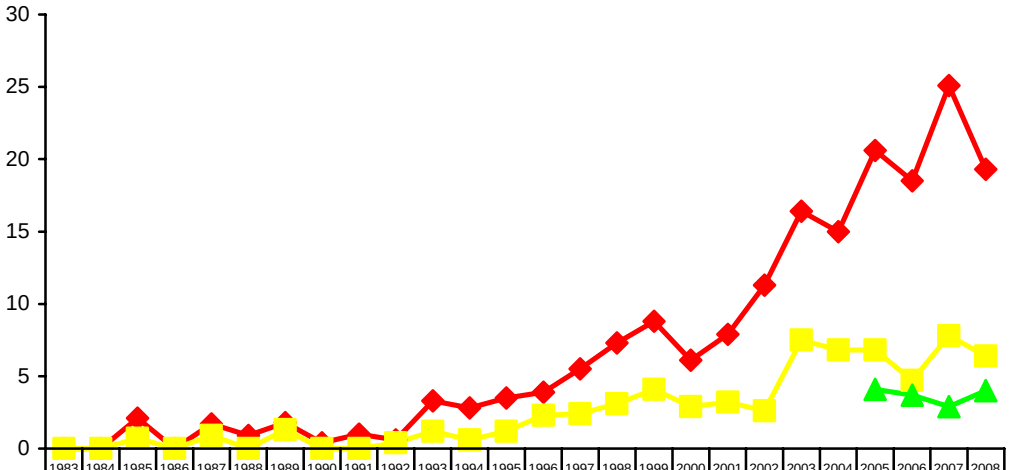
Figure 6.12. Evolution of the percentage (%) of deaths due to an acute reaction to psychoactive substances in the toxicological analyses of which, the following are detected: opiates and no cocaine, only opiates and opiates plus benzodiazepines. Spain 1983-2008.



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Opiates and no cocaine	59,8	49,6	49,7	49,2	47	42,4	35,2	46,6	31,3	35,4	44	55,8	59,8	55,1	45,4	41,7	31,5	40,3	41,7	40,5	30,8	29,7	26,6	36,8	30,7	34,3
Opiates alone	46,3	28,1	25,2	20,2	23,9	20,8	14,1	20,6	11,5	14,2	18,1	13,1	9	17,7	12,6	10,8	7,6	9,2	8,7	7,1	5,9	6,4	4,1	4,7	7,8	7
Opiates, benz and/or alcohol																							16,9	17,6	14,5	15,3

Source: Drug-related Deaths Indicator. Spanish Observatory on Drugs. Spanish Government Delegation for the National Plan on Drugs.

Figure 6.13. Evolution of the percentage (%) of deaths due to an acute reaction to psychoactive substances in the toxicological analyses of which the following are detected: cocaine and no opiates, cocaine alone and cocaine w/alcohol. Spain, 1983-2008



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Cocaine and no opiates	0	0	2,1	0	1,7	0,9	1,8	0,4	1	0,6	3,3	2,8	3,5	3,9	5,5	7,3	8,8	6,1	7,9	11,3	16,4	15	20,6	18,5	25,1	19,3
Cocaine alone	0	0	0,7	0	0,9	0	1,3	0	0	0,4	1,2	0,6	1,2	2,3	2,4	3,1	4,1	2,9	3,2	2,6	7,5	6,8	6,8	4,7	7,8	6,4
Cocaine alone w/alcohol																							4,1	3,7	2,9	4

Source: Drug-related Deaths Indicator. Spanish Observatory on Drugs. Spanish Government Delegation for the National Plan on Drugs.

Evolution of the deaths due to an acute reaction following the use of psychoactive substances. Spain 1983-2008

The evolution over the course of time of the deaths due to an acute reaction following the use of psychoactive substances in Spain is provided in following.

All of the results presented up to this point include the mortality data taken from the declaration made by the Autonomous Communities who notify the Spanish Observatory on Drugs. specific mortality register, but one must bear in mind that not all of the Autonomous Communities make declarations to this specific register ad that, additionally, the Autonomous Communities which do make declarations, vary depending on the year in question. In order to provide a solution to these limitations, a number of estimates are made.

Firstly, to attempt to provide a solution to the fact that not all of the Autonomous Communities make declarations to the specific register, the number of deaths at the nationwide level is estimated based on the National Institute of Statistics general mortality register, to which all of the Autonomous Communities make declarations.

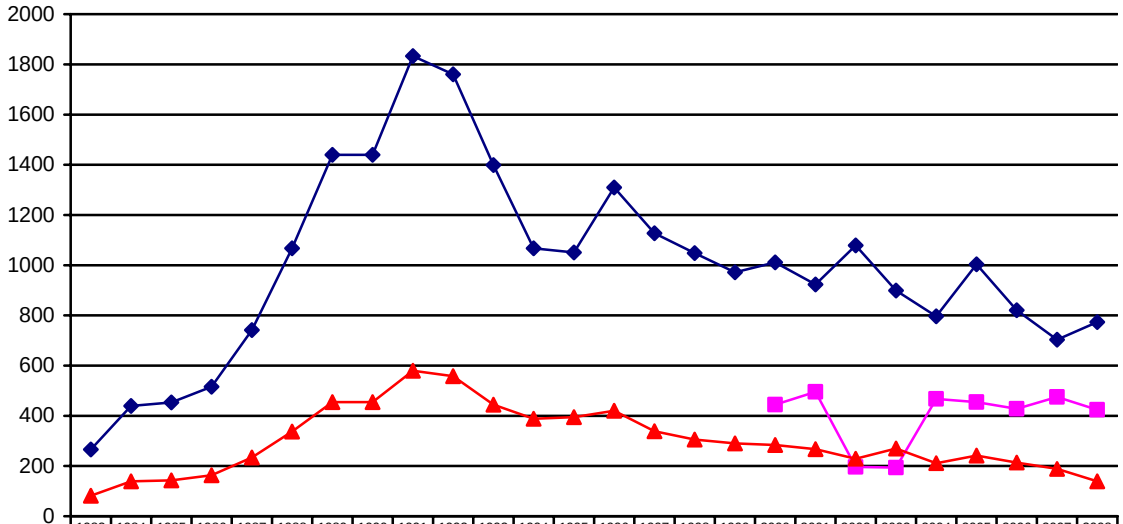
Secondly, so as to assure the comparability of the data among the different years, there is a time series available with 6 Spanish cities (always the same cities) from 1983 to 2008. The data is taken from the information on the deaths stated in the judicial reports of Barcelona, Bilbao, Madrid, Seville, Valencia and Zaragoza. In the case of

Seville, the data for the 1997-2000 period and the 2005-2006 period is estimated, as is that for the 2003-2004 period for Zaragoza. Special note must be made of the fact that, up until 1995, solely the deaths due to an acute reaction to opiates or cocaine had been being collected.

Figure 6.14 shows three lines: the estimated deaths for all Spain as a whole, the deaths notified by the Autonomous Communities which make declarations to the special mortality register and the deaths for 6 of Spain's cities.

In general, following the upward spurt found during the eighties, associated with intravenous heroin abuse, a downward trend is noted in mortality which remains unchanged in 2008.

Figure 6.14 Evolution of the deaths due to an acute reaction following the use of psychoactive substances. Spain 1983-2008



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Estimate for all Spain (1)	266	440	453	516	741	1067	1440	1440	1833	1760	1399	1067	1051	1310	1127	1049	972	1012	923	1079	900	796	1004	820	703	773
Aut. Com.providing data(2)																		444	496	196	193	468	455	428	475	424
Six Spanish cities (3)	82	139	143	163	234	337	455	455	579	558	444	388	395	421	339	306	291	284	268	229	270	212	242	214	188	139

(1) Estimate of the total number of deaths in Spain: (No. deaths in Autonomous Communities who make declarations to the special register) + (estimate of no. deaths in those Autonomous Communities not declaring to the special register based on the general mortality register data). Source: Spanish Observatory on Drugs. Special Mortality Registers and National Institute of Statistics' General Mortality Register.
(2) Number of deaths from the Autonomous Communities who make declarations to the special mortality register (approximately 50% of Spain's population). Source: Spanish Observatory on Drugs. Special Mortality Register.
(3). Number of deaths in 6 of Spain's cities taken from the judicial reports of Barcelona, Bilbao, Madrid, Seville, Valencia and Zaragoza. Source. Spanish Observatory on Drugs. Special Mortality Register

General Mortality Register (GMR)

Methodology

In Spain, the National Institute of Statistics (http://www.ine.es/) has a general mortality register for the causes of death classified according to IDC-10. The mortality databases are prepared in collaboration with the Autonomous Communities. The primary source of information are the Civil Registries which submit death reports to the local National

Institute of Statistics offices on a monthly basis. The latest mortality database available at the national level is the 2008 database.

An analysis is presented in following of the mortality rate by selecting the IDC-10 recommended by the European Monitoring Centre for Drugs and Drug Addiction (The DRD-Standard, version 3.0 EMCDDA Scientific Report. EMCDDA/P1/2002, www.emcdda.eu.int), including IDC-10:F11-F12, F14-F16, F19, X42, X62 and Y12. To adapt to the Spanish context, X44 has been added to the foregoing. This last code includes accidental poisoning due to exposure to drugs and is used a great deal in Spain to encode death by "overdose".

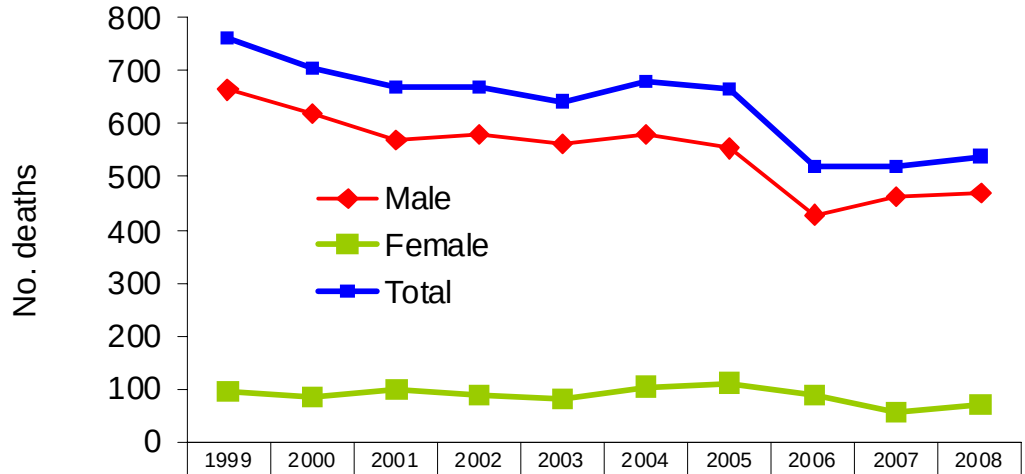
This source of information entails some limitations, given that, although the quality of the mortality register is good in Spain, it is known that illegal drug use increases the probability of dying due to different causes, and it has been found that the repercussion on the overall mortality rate of the population as a whole is not adequately reflected in the routine mortality statistics. It is estimated that, in Spain, the deaths due to drugs taken from the General Mortality Register are underestimated by 40%. Further studies analyzing the attributable mortality would provide interesting information for determining the repercussion of drugs on the mortality rate of the population as a whole.

Results

In 2008, 540 deaths were encoded under the IDC-10 codes specified hereinabove. This figure has remained relatively stable over the past few years. Throughout the 1999-2008 period, a male predominance was also noted, a total of 87% of the deaths being among males in 2008. (Figure 6.15).

Figure 6.16 shows the evolution of the deaths taking into account whether these deaths were of individuals under or over 35 years of age. A mirror image is noted, where, as of 2003, those individuals 35 years of age are overtaken by those over 35 years of age.

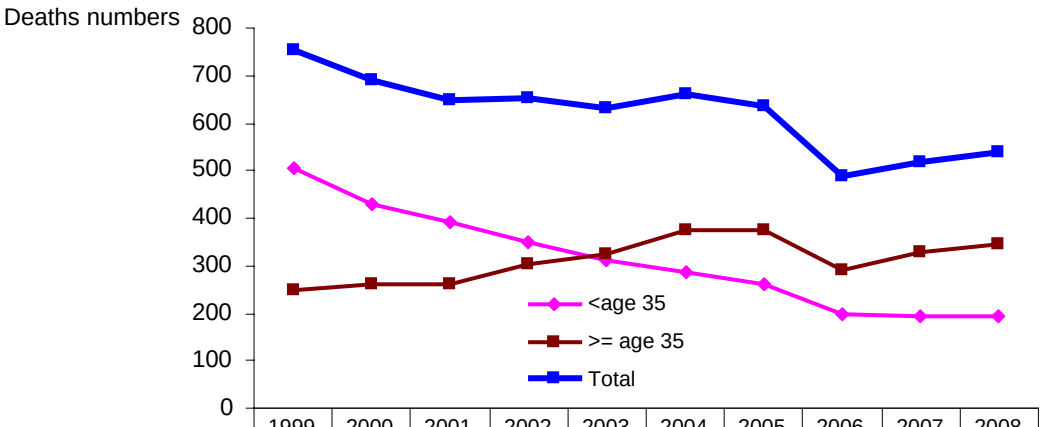
Figure 6.15. Evolution of the mortality due to the use of psychoactive substances*, by gender. Spain 1983-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Male	664	619	567	577	562	577	553	429	462	470
Female	97	86	99	90	81	102	112	89	57	70
Total	761	705	666	667	643	679	665	518	519	540

* IDC-10 Codes: IDC-10:F11-F12, F14-F16, F19, X42, X44, X62, Y12.
Source: General Mortality Register. National Institute of Statistics.

Figure 6.16. Evolution of the mortality due to the use of psychoactive substances*, by age. Spain 1983-2008



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
<35 years	505	429	391	349	310	285	262	200	192	193
>= 35 years	247	262	259	303	323	374	374	289	327	347
Total	752	691	650	652	633	659	636	489	519	540

* IDC-10 Codes: IDC-10:F11-F12, F14-F16, F19, X42, X44, X62, Y12.
Source: General Mortality Register. National Institute of Statistics.

INTRODUCTION

Drug users are provided with care in Spain at public and publicly-funded centres managed directly by the Autonomous Government Communities or by NGO's.

In either of these cases, full compliance is required at these centres with the homologation criteria mentioned in Chapter 5 of this report, which are based, in turn on the evidence-based guidelines set forth under the Regional Drug Plans, integrating the finest research data with clinical experience and patient values.

The information which is given in following on the number of programs and resources, as well as on the individuals who benefit from them are from centres, services and programs of a public nature or, even though managed by some entity of a private nature (mostly NGO's working in the field of drug dependence) which is publicly funded.

This information is furnished by the seventeen Autonomous Communities, as well as by the Autonomous Cities of Ceuta and Melilla which comprise part of the State of Spain.

The data related to the traffic accidents in the regard in which it is related to the tests conducted on vehicle drives, as well as the toxicological analyses on the drivers who died in these accidents are is furnished by the Spanish Civil Guard Traffic Division, which is an institution of a nationwide scope operating under the Central Government.

PREVENTION OF DRUG-RELATED EMERGENCIES AND REDUCTION OF DRUG-RELATED DEATHS

The prevention of drug-related emergencies and reduction of drug-related deaths are being carried out through the harm reduction programs and resources described in following.

Harm reduction programs

The harm reduction programs are carried out mainly at social emergency centres, mobile units, pharmacies and in controlled use rooms (safe injection).

- Social emergency centres: Their main purpose is to provide shelter for the drug-dependent population having the greatest social exclusion-related problems, to see to meeting their basic needs and to put them in touch with other more highly-demanded resources within the care system. In 2008, a total of 37 centres of this type have been operating, having provided care for 18,105 individuals.

- Mobile units. The mobile units are generally walk-up accessible, multi-purpose vehicles which are used for the following main functions: to carry out opiate replacement (methadone) treatments, sample taking and conduct diagnostic testing and first-aid treatments. In 2008, 30 mobile units have been functioning, having provided care for 13,140 individuals.

- Pharmacies. Given the vast network of pharmacies existing in Spain, they are a highly useful resource when those affected by drug use can take

recourse to them. At these pharmacies, needle exchange programs are being carried out in numerous cases; and, in others, methadone is also being dispensed under a medical prescription in coordination with the drug dependence care centres and programs. In 2008, a total of 1,226 pharmacies have collaborated in these activities, having reported providing care for 2,257 individuals, although a strict account of all those for whom care is provided at these pharmacies is not kept in all cases.

- Safe injection rooms. In 2008, a total of 7 safe injection roomshave been operating, having provided care for 8,032 intravenous drug users. In these safe injection rooms, care and health counselling, sterile injection material and spaces for self-injection and personal hygiene are provided. In no case is any type of illegal drug provided or administered on the part of the healthcare personnel assigned to these rooms.

A summary is provided of the aforementioned data in Table 7.1:

Table 7.1. Number of facilities and users for whom care has been provided

Type	No. facilities	No. users for whom care was provided
Social emergency centres	37	18,105
Mobile units	30	13,140
Pharmacies	1,226	2,257
Safe injection rooms	7	8,032

These Harm Reduction Programs make provision for the use of different **"overdose prevention techniques"** which are those aimed at training drug users in the safest modalities of use which will be least harmful to their health. Also in the skills for the preventing overdoses, by explaining to them the factors which are determining in the onset of a possible complication of this type (pharmacological tolerance, contaminating agents, allergic reactions), the signs and symptoms of which to be aware and the basic protocol to follow in the case an overdose should occur (basic cardiopulmonary resuscitation techniques, how to request help, etc.

PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES

There are numerous programs for exchanging and dispensing needles, as well as sanitary kits (in addition to a needle, these kits also usually include liquid disinfectant, condoms, etc.) which are handed out both in outreach programs and at more institutionalized centres and resources.

These programs are offered from the intravenous drug user population for the purpose of reducing, as far as possible, the risk of transmissible infections which are associated with shared or simply less than hygienic use of injection material.

A total of approximately 3,422,000 needles and/or sanitary kits have been handed out nationwide in Spain in 2008.

Similarly, bearing in mind the importance which the new HIV infections by way of sexual (heterosexual and homosexual) relations have taken on, special attention has been focused on this aspect both in the seropositive subjects and intravenous drug users as well as among their partners. Numerous Autonomous Communities are offering workshops on safe, less risky sex among the specific population groups and also among the groups of sex workers, as well as at penitentiaries.

Also in the Autonomous Communities, it is standard practice for serological testing to be done for HIV, HCV, HBV, Mantoux and lues serology.

RESPONSES TO OTHER HEALTH CORRELATES AMONG DRUG USERS

Psychiatric co-morbidity

Care is provided for psychiatric co-morbidity at both the drug dependence care centres and at the mental health centres. In 2008, the Autonomous Community Administrations have reported there being 105 dual disorder care program, having provided are for 9,985 drug-dependent patients with psychiatric co-morbidity.

Traffic accidents

In Spain, all of the Autonomous Communities and Autonomous Cities are carrying out activities in collaboration mostly with the Ministry of the Interior for the purpose of preventing or reducing the number of traffic accidents and their consequences, particularly as far as their relationship with drinking and other drugs is concerned. One of these activities worthy of special mention are the awareness heightening campaigns targeting young people and adolescents, measures in the media, preparing and handing out educational materials, etc.

Driver blood alcohol content checks have been stepped up, carried out by the Civil Guard Traffic Division (Ministry of the Interior), who made as many as 4.5 million of these preventive checks in 2008, 1.84% of which tested positive. As is shown in the following Table, this percentage has undergone a progressively growing drop over the last five-year period.

Table 7.2. 2004-2008 Driver blood alcohol content

	2004	2005	2006	2007	2008
Preventive check tests	2,282,336	2,856,244	3,347,015	3,759,574	4,417,645
Positive	76,560	73,747	82,729	80,155	81,322
% positive	3.35%	2.58%	2.47%	2.13%	1.84%

Special note may be made of the drop in the percentage of drivers who have died in a traffic accident who had a blood alcohol content of over 0.3 g/l. In fact, in 2004 the percentage of drivers who died in traffic accidents who had a higher blood alcohol content compared to the total number of deceased drivers on which a toxicological analysis was performed was 36.1%, whilst in 2008, this percentage had lowered to 30.97%.

As far as illegal drugs are concerned, the results of toxicological analyses performed on these drivers show a return, in 2008 to values similar to those of 2004, after a slight upward trend throughout the years in between. A slight increase is however noted in the percentage of deceased drivers analyzed in whom psychoactive drugs are detected.

Table 7.3. Deceased drives on who an analysis has been performed

	2004	2005	2006	2007	2008
Deceased drivers on which an analysis has been performed	1,349	1,401	1,360	1,259	975
Percentage of positives	42.10	41.39	37.20	39.31	39.79
% Tested positive for blood alcohol content (≥0.3g/L)	36.10	34.12	30..44	30.82	30.97
% Tested positive for illegal drugs	10.75	12.20	11.40	13.02	10.67
% Tested positive for psychoactive drugs	3.85	4.28	5.51	5.95	6.97

. Note: The three rows of positive analysis percentages add up to a higher figure than the "Percentage of positives" row because polydrug use was detected in 79 of the deceased drivers analyzed.

INTRODUCTION

The data provided in this Chapter has been provided by the seventeen Autonomous Communities, as well as by the Autonomous Cities of Ceuta and Melilla which comprise part of the State of Spain.

Very few of the programs and resources mentioned in the able under the titles of "Education /Training Programmes" and "Employment Programmes" quantify the number of users accessing these programs in their capacity as drug-dependent individuals, given that they are social reintegration resources for socially-excluded individuals or those at serious risk of being socially excluded, regardless of whether or not they have problems due to drug use.

1. Social incorporation facilities. These are physical spaces in which activities classified as social reintegration activities are carried out. They may be residential or non-residential.

Non-residential: Facilities where reintegration programs or activities are carried out on an outpatient basis:

- Treatment centres with reintegration activities and/or programs. Including therapeutic treatment.
- Centres offering reintegration activities and/or programs, where no therapeutic treatment is provided.

Residential: Residential facilities are those which provide housing for drug-dependent individuals who are undergoing care treatment or which have completed treatment but are in need of this resource prior to starting a completely self-dependent life. The modalities employed most are:

- Treatment Communities: residential centres with therapeutic treatment and reintegration programs or activities.
- Apartments: may be supervised or unsupervised. These apartments house a small number of drug-dependent individuals, and the educator's work is usually quite intense, especially in the supervised apartments.
- Residence facilities: These facilities differ from the apartments mainly in size. They are a type of resource which, according to our data, was being used only by the "Proyecto Hombre" Association.

2. Training programs. Programs or activities provided for the purpose of furnishing training, regardless of the type: academic, vocational, professional, social skills, etc.

Officially-approved courses:. Courses homologated by the Public Education System: School-Leaving Certificate; Secondary School Diploma; College Entrance, College Degree, etc.

Unofficial courses: Courses which do not lead to accessing an academic diploma but which serving integrating purposes, both due to the knowledge which is taught as well as the acquisition of social skills provided: Computer skills, driver's license, etc.

Employment information, guidance and searches**:** These have been divided from the foregoing skills so as to set apart, in this section, those programs which are structured specifically for the purpose of finding employment. These programs have

been carried out to a great extent over the past few years by the Autonomous Communities with the creation of Services to train drug-dependent individuals to search for and find a job and, at the same time, carry out an important mediating and follow-up activity for possible employers.

Vocational training courses: In no case do these courses involve an employment contract of any type. Worthy of special mention among these courses are those organized as part of the Vocational Training and Reintegration Plans governed by the respective Autonomous Community Employment Agencies and those organized by the NGO's from the drug dependence sector or, in general, groups in a situation of social exclusion.

3. Employment programs. Grouped under this heading are the programs involving gainful employment by means of an employment contract of any type (apprenticeship, temporary, etc.) or are a means of individual or cooperative self-employment.

Five groups may be considered:

- "Apprenticeship workshops", mainly handicrafts.
- "Special employment programs", promoted by the Autonomous Communities and by the Local Administrations (City/ Town Governments.
- "Subsidized in-company contracts"
- “Incentives for organizing "reintegration enterprises.” (See 2009 report)
- "Self-employment promotion" (individual or cooperative)

Apprenticeship Workshops. Form of achieving gainful employment by means of a contract, normally an apprenticeship contract (although it may be of another kind). The employer may be a self-employed worker, a small company or an NGO, foundation, etc. They generally have to do with manual work. This modality will include the Workshop Schools, Trade schools a Employment Workshops, the contents and functioning of which are governed by the Public Employment Agencies

Local Government Employment Programs. These programs are usually the employment exchange most used when providing openings for drug-dependent individuals who are going through the rehabilitation process and have been referred from the Autonomous Community drug dependence care network.

Subsidized contracts. Activity for the purpose of managing openings for employing drug-dependent individuals in companies or entities, normally entailing the inventive of an economic subsidy. Although the name suggests a subsidy, it may also be an regular, constant mediating and employer-contacting activity carried out by the services mentioned in the Training section: "Employment information, guidance and search activities".

Incentives for the creation of "reintegration enterprises".. This type of enterprises are based on an employment fee for those in a situation of social exclusion. They are usually started up by NGO's and receive economic support from the Administrations.

Promotion of self-employment (individual or cooperative) **.** Programs of aid for setting up business as a self-employed worker or for forming cooperatives.

SOCIAL REINTEGRATION

Table 8.1 provides the data furnished by the Autonomous Communities Administrations regarding the number of social reintegration programs and resources as well as the number of those using the same. The number of uses of the centres where the reintegration activities are carried out are not counted so as to avoid counting the program users twice. Those programs and/or resources for which there is data as to drug-dependent individuals for whom care has been provided who have come or been referred from the Autonomous Community drug-dependence network are counted. These drug-dependent individuals will be the number of users shown on the Table, given that it is not possible to determine the number of users not registered by the network.

The types of resources and programs available within this scope are the same as those described in prior National Plan on Drugs Reports (See Introduction within this same chapter).

The number of residential centres (therapeutic communities) seems to have increased minimally within the network of centres, the number of therapeutic centres with social reintegration activities and the centres that do not have therapeutic treatment but rather solely vocational and reintegration activities having decreased. In years to come, it will be seen whether this trend is confirmed.

The increase in the number of users registered in training and employment reintegration programs and resources is confirmed, probably because social reintegration is being construed progressively more as bade on preparing for employment and obtaining employment. In the latter regard, special mention may be made of the consolidation of the employment information, counselling and guidance programs, with 4,423 users (of the total 9,492), that 101 people are on record as having been hired by reintegration enterprises and, the fact that, for example, the NGOS in one single Autonomous Community have promoted and managed 727 drug-dependent individuals' hiring processes.

Table 8.1. Social Reintegration programmes. Type, number of programmes and centres and number of users. Spain, 2008

	Number of programmes and/or centres	Number of users
Treatment centres w/social reintegration activities and/or programmes	306	
Centres of social reintegration activities and/or programmes (w/o treatment)	126	
Residential treatment centres w/social reintegration programmes (therapeutic communities)	126	
Housing facilities	121	2,195
Education and training programmes	391	12,133
Employment programmes	349	9,492

Source: Spanish Government Delegation for the National Plan on Drugs. Data from the Drug Plans of Autonomous Communities and Autonomous Cities.

Employment

The 2009-2016 National Drug Strategy includes as one of its general objectives that of facilitating the reintegration into society of the individuals in the process of rehabilitation by means of integral training and employment preparation and insertion programmes.

This reintegration is a complex task, given that for many people, as the Strategy acknowledges, the problem is not only and exclusively quitting using a certain substance, but also facing other difficult situations, such as polydrug use, mental disease, economic precariousness, social exclusion, exclusion from employment and/or family and, in general, the breaking or non-existence of integrating social connections.

The Spanish Government Delegation for the National Plan on Drugs, being aware of these problems, is supporting different activities aimed at encouraging this goal being accomplished, by way of the calls for applications it is making for granting aid to the non-profit organizations.

The reintegration-related priorities in the calls for applications for the subsidies are:

- Individuals with problems of addiction who have achieved abstinence and can now begin the social and employment reintegration process.

Specifically, the measures which have been supported in 2009 through both the call for application of the Fund of confiscated assets and that of the National Budgets are:

- Training for improving the professional skills of the sociosanitary realm. This training has been carried out by way of different subsidized activities:
    - Congresses where everything related to the social and employment reintegration of the persons with drug use problems is a subject of prime importance, given that it is the treatment process outcome sought.
- Magazines: the different magazine subsidized through the grants in aid deal with this subject.
- Courses: through the Fund:
    - "New skills in sociosanitary workers at the day centres" (Assoc. of entitles with dependence day centres).
    - Training in prevention, early detection and taking action in at-rink population, adolescents and young people, offered for healthcare personnel and pharmacists. (Official Association of Professional Psychologists).
- Studies:
    - Good practices guide (Spanish National Federation of Rehabilitated Alcoholics)
    - Good practices in the employability of ex-drug dependent females (Fund. Atenea. Grupo gic).
    - From recreational use to problem use. The role of the family, work, the contexts and the peer group. (Igenus Foundation).
    - Evaluative study of the accessibility to the drug dependence care resources for females in a situation of exclusion. (Igia Group).
- Supporting conferences and studies on new fields of action the development of which would mean major advancements for the reintegration of underprivileged groups. This is the case of the conference and study subsidized for the Spider Network ("Red Araña" on "corporate social responsibility". This heading encompasses a set of practices, strategies and a entrepreneurial management system aimed at achieving a balance between the economical, social and environmental dimensions, in other words, seeking reconciling entrepreneurial effectiveness with social principles of democracy, self-help, community support and distributive justice. This type of companies insert social clauses favouring the hiring of ex-drug dependent individuals.

The professionals working in social and employment reintegration are of the understanding that gainful employment is not an end it itself, but rather a means which must serve for the personal and social development of people and of their close environments.

Many people have a great many difficulties being able to joint a company to work due to the deterioration of their health caused by drug use. Being fully aware of this problem, the Distance Learning University- UNAD organized a congress on the reintegration enterprises.

These companies come into being for the purpose of guiding people with more difficulties through their social rehabilitation process by offering them not only on-the-job vocational training but additionally specific training in teamwork and personal skills.

These companies first came into being years ago, but it was only quite recently when they have been put under regulation (Law 44/2007 of December 13th for the regulation of the reintegration enterprises (Spanish Official Gazette 14 December 2007).

In 2008, the Federation of Reintegration Enterprise Associations (FAEDEI) came into being. This Federation groups together the Autonomous Community Federations of Reintegration Enterprises. With the exception of 2 Autonomous Communities which are currently setting up contacts to also join, all of the other Autonomous Communities are associated in this Federation.

There are approximately 137 reintegration enterprises located nationwide in Spain. They are mainly doing work entailing gardening, construction, waste recycling, graphic arts, cleaning, laundering, ecological farming, hotel-restaurant-bar trade, wholesale products and textiles.

Some of these enterprises are exclusively for people who have had problems with drug use.

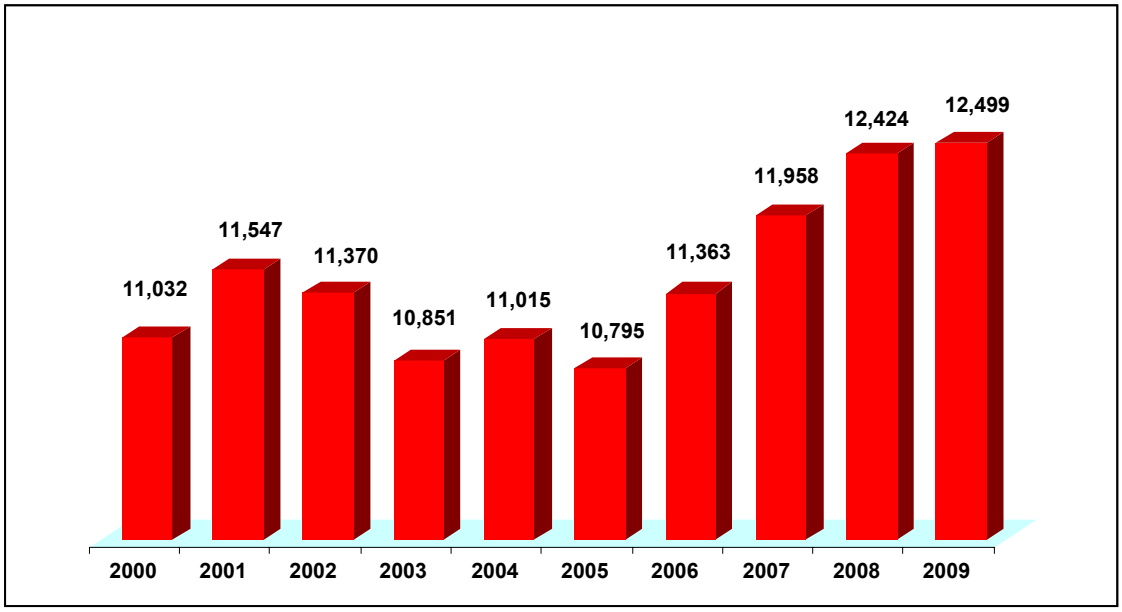
These are initiatives which are currently on the rise by the day, with very high degrees of competitiveness.

DRUG-RELATED CRIME

Evolution of the number of crimes on record for drug trafficking

Figure 9.1 shows how the number of known crimes for drug trafficking has been undergoing an upward trend over the last ten years. In 2009, 13.30% more have been recorded than in 2000, for a 0.56% variation over the immediately preceding year. Nevertheless, the percentage in relation to the total number of crimes in low, having ranged from 1.10% in 2002 to 1.48% in 2009.

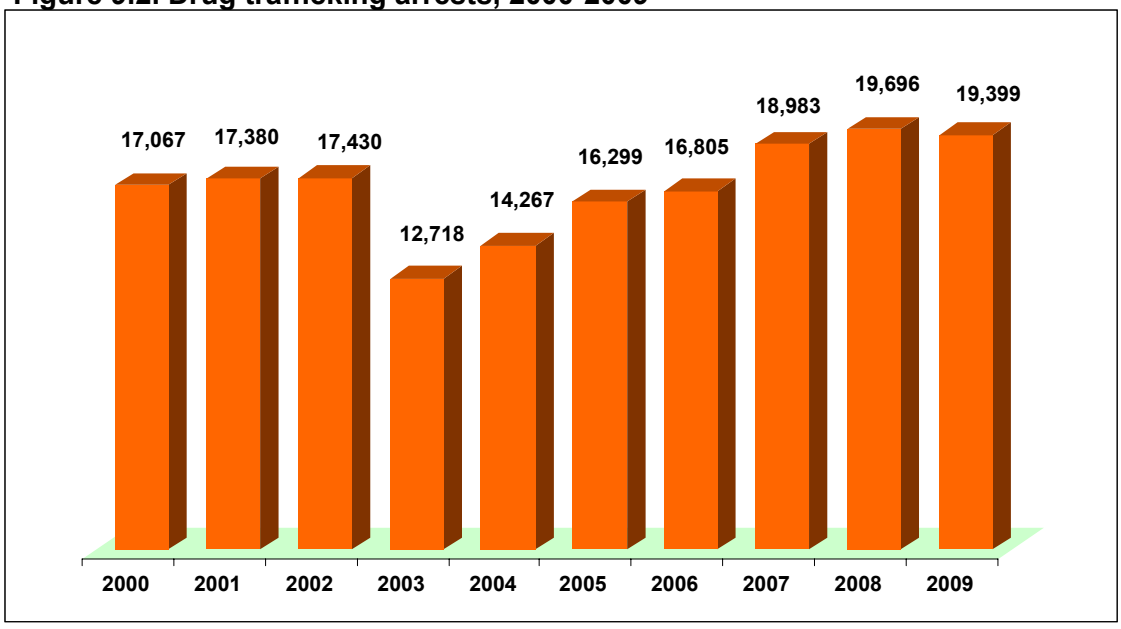
Figure 9.1. Drug trafficking crimes, 2000-2009



Evolution in drug trafficking arrests

The number of arrests for illegal drug trafficking is also continuing an upward trend as shown in Figure 9.2. In 2009, a total of 19,399 arrests were recorded, meaning a 1.51% decline from 2008 and a 52.53% rise compared to 2003, the year for which the lowest percentage was recorded for the time period in question.

Figure 9.2. Drug trafficking arrests, 2000-2009



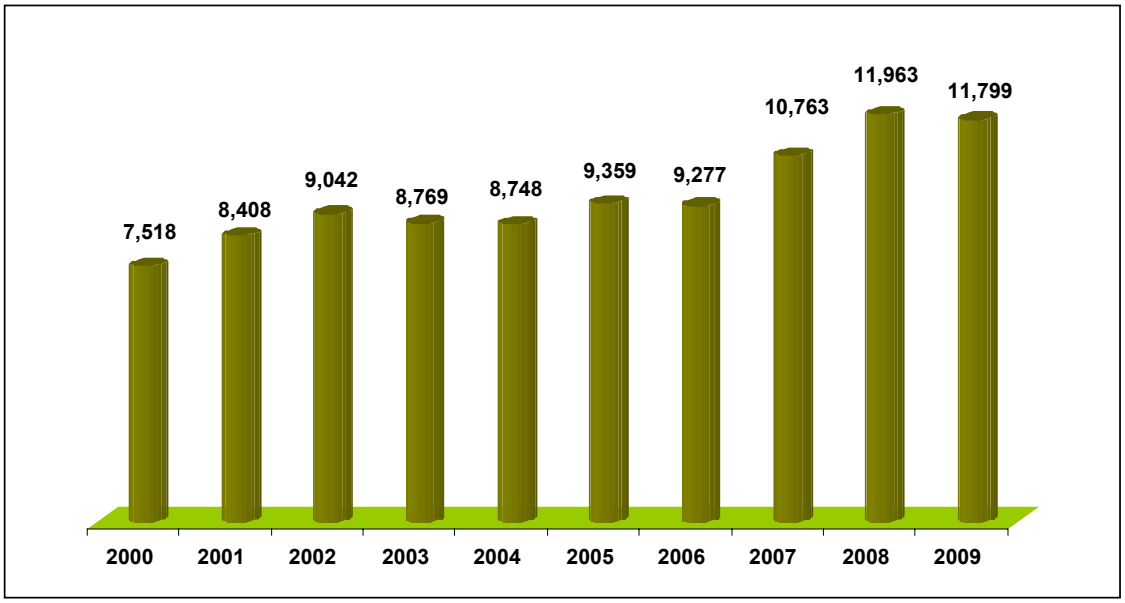
Evolution of the arrests by families of drugs[8]

The following graphs reveal that, over the last ten years, the number of arrests for trafficking of **cannabis, different forms of cocaine and hallucinogens and psychotropic drugs** are showing an upward trend and that, to the contrary, **opiates are undergoing a downward trend**.

In comparison to 2008, the decline in the number of arrests by families of drugs in 2009 is in keeping with the decline in the amounts of drugs seized, being divided as follows:

Figure 9.3. shows at least 1.37% more arrests for cannabis derivatives have been made during 2009 than the year before.

Figure 9.3. Number of individuals arrested for cannabis derivatives, 2000-2009



[8] The number of arrests made do not add up to the same number as the total number of the arrests for each family of drugs detailed, given that any arrest of an individual in which more than one substance is seized is recorded as an arrest for each one of the substances of one same family which have been seized.

Figure 9.4. shows the downward trend over the last two years in the number of arrests for cocaine derivatives, totalling 3.10% less than last year.

Figure 9.4. Number of individuals arrested for cocaine derivatives, 2000-2009

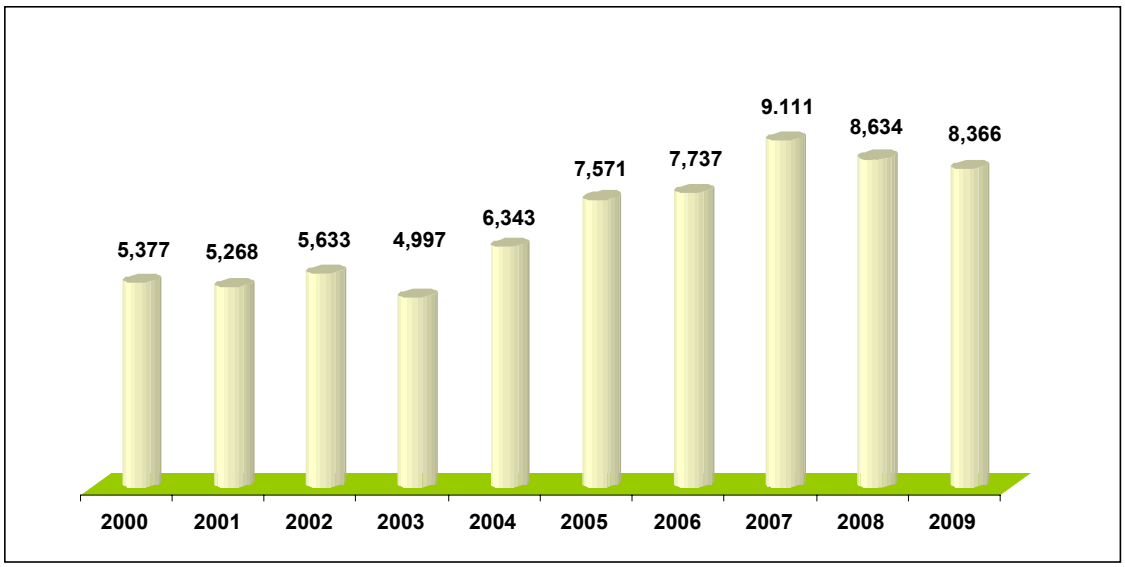
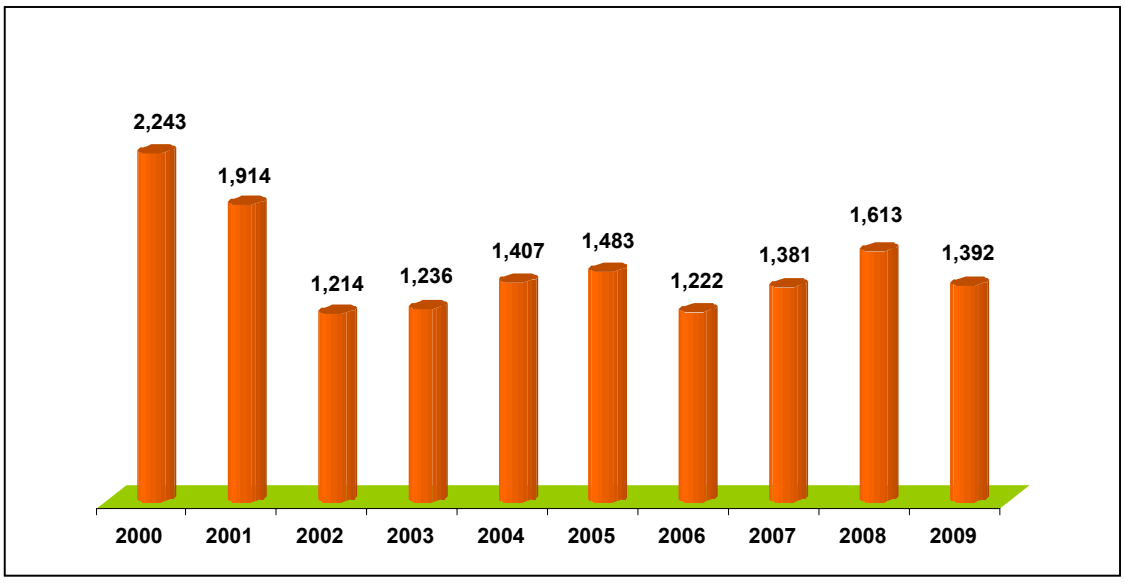


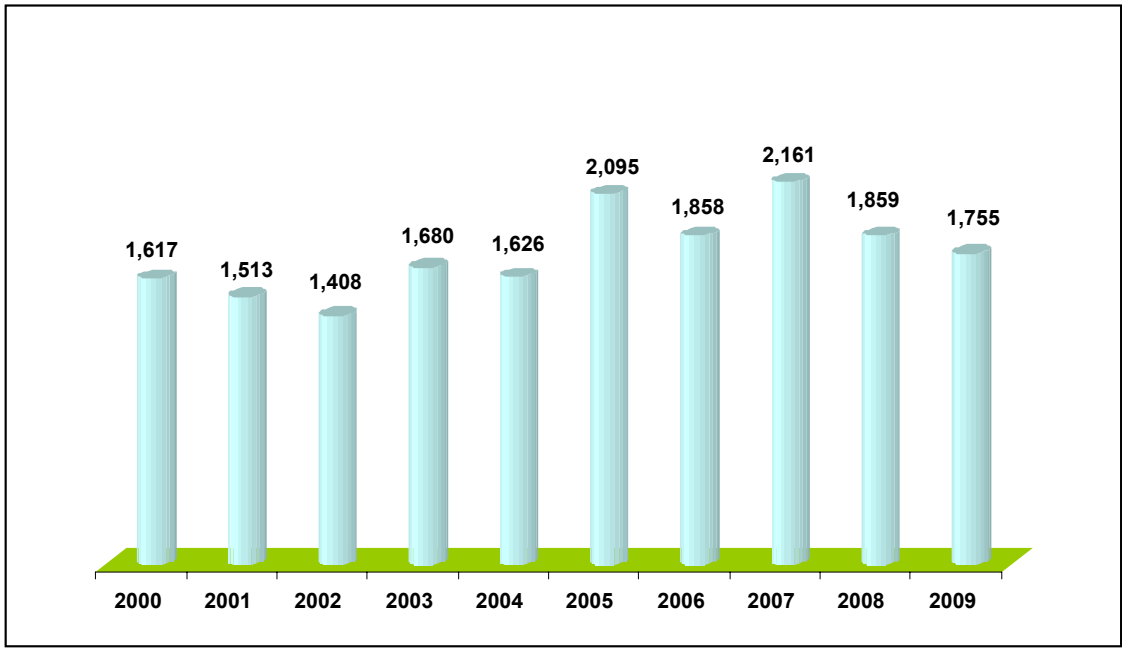
Figure 9.5 clearly reveals that 13.70% fewer individuals were arrested in 2009 in the opiate-related operations.

Figure 9.5. Number of individuals arrested for opiates, 2000-2009



As regards the arrests made for hallucinogens and psychotropic drugs, Figure 9.6 shows the downward trend, totalling 5.59% fewer arrests in 2009.

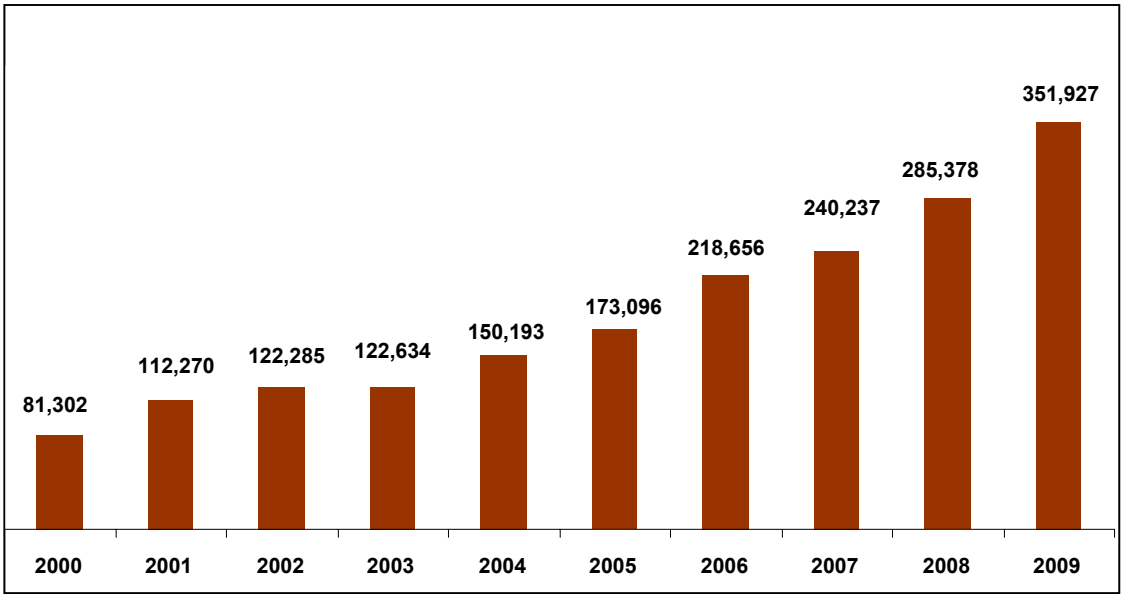
Figure 9.6. Number of individuals arrested for hallucinogens and psychotropic drugs, 2000-2009



Overall evolution of the individuals reported for violation of Organic Law 1/1992 (drug possession or use in public)

In 2009, a new record was achieved in the number of reports (Figure 9.7), a total of 46.49% more individuals than in 2007 and 23.32% more than in 2008 having been reported. The Operative Plans having been put into practice in 2006 on drug dealing and drug use in leisure time establishments and in school environments has meant a major increase in the number of individuals reported.

Figure 9.7. Individuals reported under Organic Law 1/1992 governing drug possession and use in public, 2000-2009

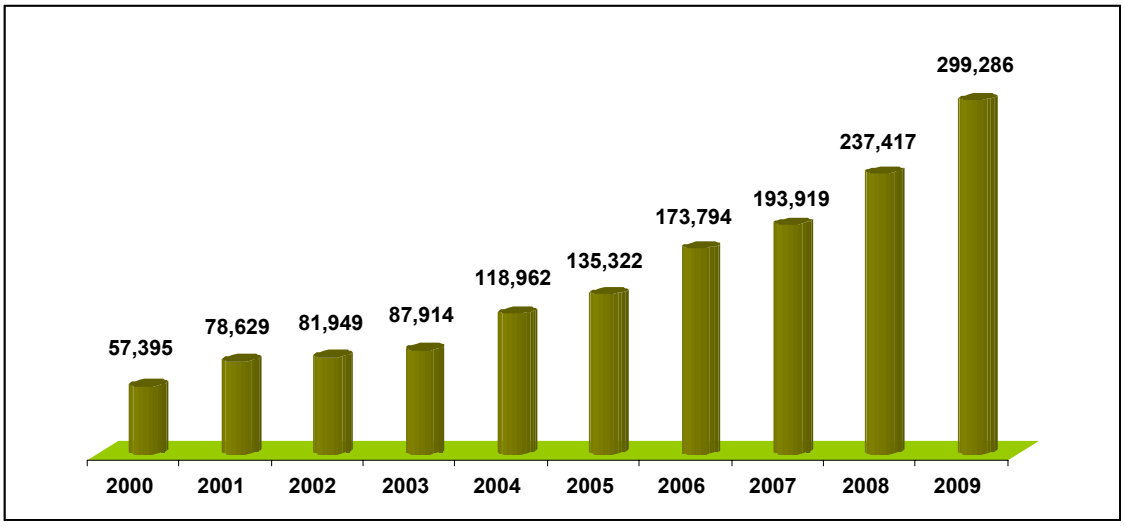


Evolution of the reported cases by families of drugs[9]

The **number of individuals reported** by families of drugs, especially the cannabis and cocaine derivatives, are showing a remarkable **rising trend**, which tallied with the number of drug seizures within the respective families. This effect is due to the fact that most of the drug confiscating is done in enforcement of Organic Law 1/1992.

Figure 9.8. shows the number of individuals reported for cannabis derivative use having continued on the rise, having increased by 26.06% over the previous year

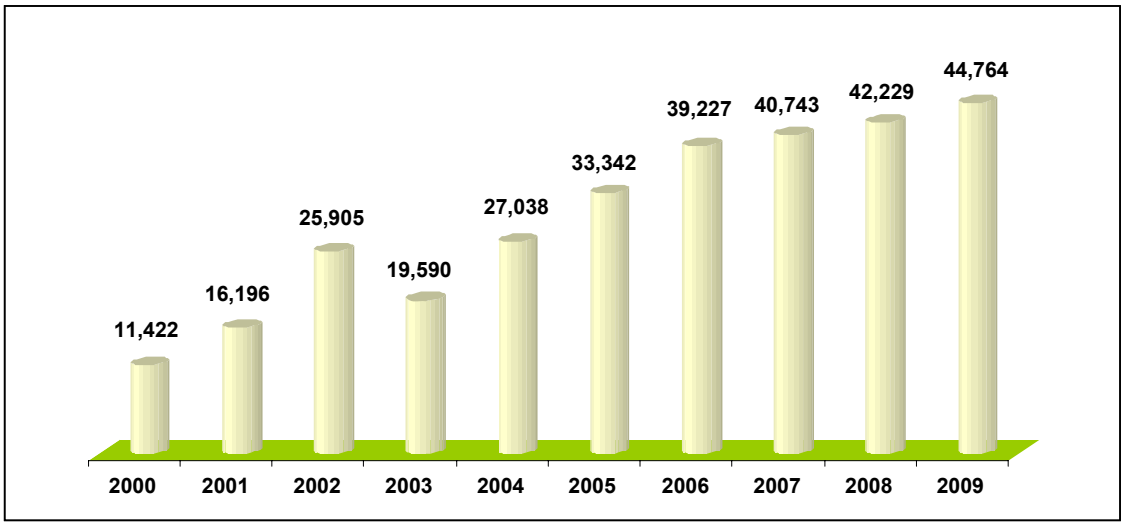
Figure 9.8. Number of individuals reported for cannabis derivatives, 2000-2009



[9] The number of individuals reported do not add up to the same number as the total number of individuals reported for each family of drugs detailed, given that the reporting of an individual entailing the seizure of more than one substance is recorded as an individual reported for each one of the substances of one same family which are seized.

Figure 9.9 shows how the number of individuals reported for cocaine derivative use continued to rise moderately over the past few years, having totalled 6.00% last year.

Figure 9.9. Number of individuals reported for cocaine derivatives, 2000-2009



As shown in Figure 9.10, the number of individuals reported for opiate use continued on the rise, having increased by 28.11% in 2009.

Figure 9.10. Number of individuals reported for opiates, 2000-2009

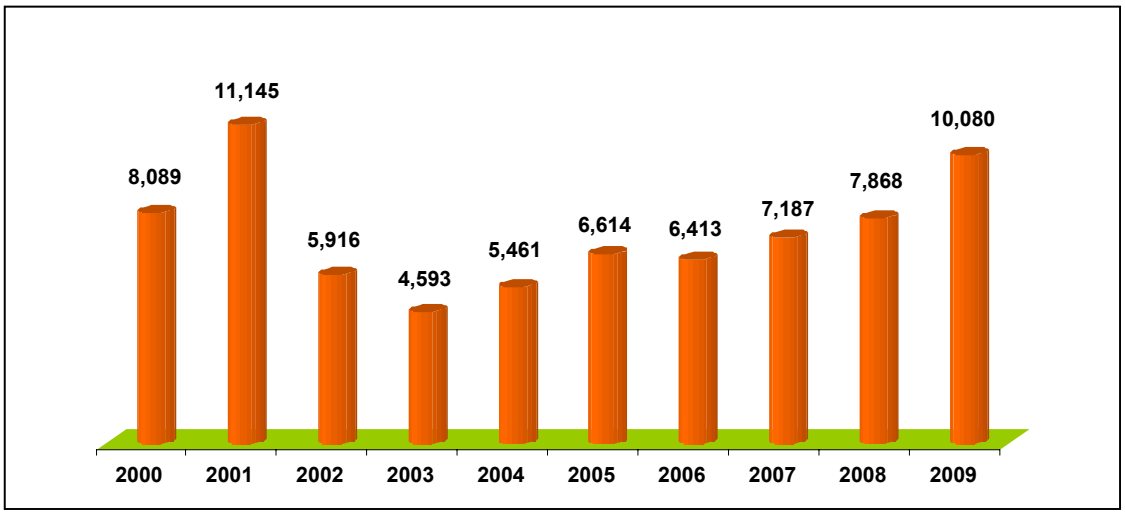
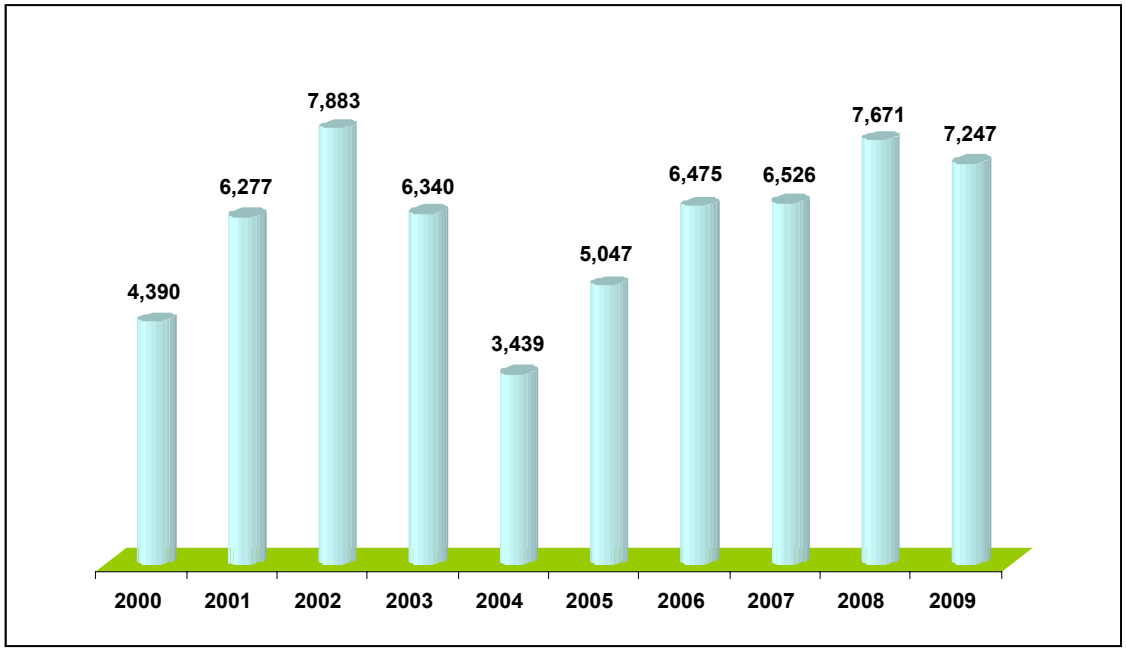


Figure 9.11. reveals the number of individuals having been reported for hallucinogen and psychotropic drug use to have been the only ones having showed a decline in comparison to 2008, having dropped by 5.53%.

Figure 9.11. Number of individuals reported for hallucinogens and psychotropic drugs, 2000-2009



In 2009, the number of individuals reported for cannabis derivatives totalled 85.04% of all those reported, followed by cocaine derivatives (12.72%), opiates (2.86%) and, last of all, hallucinogens-psychotropic drugs (2.06%).

PREVENTION OF DRUG-RELATED CRIME

In 2005, the analysis of the situation concerning the fight against drugs in Spain repeatedly indicated that some phenomena had been occurring over the past few years which, besides being harmful, were diminishing the general population's subjective feeling of safety, such as the lower age at which illegal drugs, particularly hashish, were starting to be used, and the growing number of episodes of use in the near proximity of schools and in the schools proper, whilst a major concentration of drug dealing and use was taking place in leisure-time and recreational entertainment areas, places and establishments at certain times of year, especially on the weekends.

The Operating Plans for police response to drug dealing, possession and use in school environments and leisure-time areas were therefore set out to be **of an essentially preventive nature**, with the following objectives:

- Concerning schools, the main objective is to eradicate drug dealing from the school environments and thus make it possible for the children and young people to be taught and educated in a safe, healthy and peaceful living environment.

- As far as the leisure-time and recreational entertainment areas, places and establishments are concerned, the main objective of this Plan is to take action against drug dealers at specific times in specific geographical areas with the aim of eradicating or diminishing illegal drug pushing in these areas, thus

making it possible for the leisure-time enjoyment activities to be carried out freely in a safe, healthy, peaceful environment and, in this same regard, to target police action on the realm of the control and penalizing of drug possession and use in public areas as well as against the establishments and premises which allow or encourage this use.

The aforementioned Operating Plans have been being carried out since 2006, with 4-5 phases per year during which they are stepped up, the results of which were as following in 2009:

Table 9.1. Plan for the Prevention of Drug Dealing and Use at Schools and in Surrounding Areas, 2009

No. individuals arrested for drug dealing	71
Points of sale of drugs rendered inoperative	73
No. individuals reported for drug possession/use	4,743
Drugs seized	4,862
Drug seizures:	
Heroine (grams)	83
Cocaine (grams)	301
Hashish (grams)	10,541
Hashish oil (cc)	198
Marijuana (grams)	15,112
Amphetamine sulphate (gr) (speed)	103
LSD (doses)	2
MDMA (Ecstasy) (tablets)	43
Psychoactive drugs (tablets)	382

Table 9.2. Plan for the Prevention of Drug Dealing and Use in Leisure-Time and Recreational Entertainment Establishments, 2009

No. individuals arrested for drug dealing	883
Points of sale of drugs rendered inoperative	243
No. individuals reported for drug possession/use	41,594
Drugs seized	44,381
Inspection of public premises:	
Number of individuals arrested for allowing drugs to be sold	109
Number of individuals arrested for allowing minors on premises	40
Number of individuals arrested for selling alcoholic beverages to minors	45
Drug seizures:	
Heroine (grams)	862
Cocaine (grams)	13,854
Hashish (grams)	123,779
Hashish oil (cc)	2,809
Marijuana (gr)	170,962
Amphetamine sulphate (gr) (speed)	1,759
LSD (doses)	7,546
MDMA (Ecstasy) (tablets)	3,624
GHB – Liquid ecstasy (cc)	101
Psychoactive drugs (tablets)	5,181

INTERVENTIONS IN THE CRIMINAL JUSTICE SYSTEM

Alternatives to prison

The number of individuals placed under alternative penal measures as well as the number of subjects imprisoned have increased. The criminally penalized behaviours have surely increased (enforcement of new criminal categories such as domestic violence and blood alcohol content), the number of individuals under penal control thus being on the rise.

An attempt has been made to describe the current situation of these measures in our country in keeping with different sources:

- Central Government Penitentiary Social Services. On December 31, 2008, the Penitentiary Social Services were monitoring 7,248 individuals who were serving time under alternative measures:

  - Suspensions: A total of 6,415 individuals were serving a suspended sentence on that date.
  - Custodial security measure. A total of 186 individuals were serving a custodial measure.
  - Non-custodial security measure. A total of 647 individuals were serving a non-custodial measure.

  The penal measures which are alternatives to incarceration that come under the authority of these services are: parole, probation, community service, electronic security locator measures.

- Autonomous Community of the Basque Country Statistics: Report on the Services for Criminal Law Enforcement Assistance and Social Reintegration (SAER), 2008. During 2008, these Services have provided care for a total of 1,218 individuals, on whom a follow-up has been conducted on a total of 1,845 alternative measures. The 69.07% of all of the measures were granted to individuals with problem drug use, 4.29% having been granted to individuals with alcohol abuse.

  The work done by the SAER Services in 2008 continued to be conditioned by the entry into effect of Royal Decree 515/2005, attributing a large part of the SAER functions to the Penitentiary Social Services.

- Catalonian Juvenile Justice Administration Statistics.. During 2008, the courts reported a total of 11,630 demands for alternative measures to this Administration, which was 114.89% more than in 2007, this having been due to the reform made in the Penal Code with regard to highway safety violations.

  In 2008, the annual average of monitoring measures was 4,828 alternative measures, 36.97% of these measures having entailed dehabituation treatment.

On the other hand, according to the information furnished by the Autonomous Community Drug Plans, in 2008, a total of 4,611 individuals were referred for treatment from courts, 1,889 inmates having been referred to in-community treatment from the prisons. In fact, 1,365 individuals were serving an alternative measure at 95 community treatment facilities funded by the Autonomous Community Drug Plans.

These figures are an underestimate of the actual number of cases for which care was provided, taking into account that not all of the Autonomous Communities have notified data.

Despite the methodological information-collecting shortcomings, the data provides a view of the high percentage of the measures intended for the treatment of drug dependence. Regarding the percentage of failures, we avail solely of partial data, hence according to the data submitted by way of the Report from the Services for Penal Enforcement Assistance and Social Reintegration (2008), 3.737% of all of the measures put into practice in 2008 had been revoked.

Other interventions in the criminal justice system (2008 data)

The Spanish Government Delegation for the National Plan on Drugs has continued boosting the programs offering legal and social support for individuals who have committed offences as a result of their drug addiction, having developed a widespread network of support teams with the objective of the measures aimed at preventing incarceration being put into practice.

Thus, special mention must be made of the fact that a total of 7,797 users were provided with care in 2008 in programs providing care for drug-dependent individuals under arrest. Support was provided for a total of 2,498 of the aforementioned individuals in programs providing care for drug-dependent individuals at police stations, another 5,299 having been provided with support through the programs providing care for drug-dependent individuals in courts.

It must be stressed that these figures are an underestimate of the actual number of cases for which care was provided, given that not all of the Autonomous Communities notified data. Most of these resources are funded in full or in part by the Autonomous Community Plans.

The programs targeting offenders under age were also boosted, taking into account that the latest studies conducted have found that the degree to which these minors are healthy is conditioned by the prior vulnerability of the individuals proper and by the influence the institutions have on them (Serrat Ll, Navarro A and Martín M, 2005).

In 2008, the Autonomous Communities made a considerable effort to develop and consolidate programs targeting this population. Care was provided for a total of 358 minors in treatment programs at juvenile centres (Aragon, Asturias, Canary Islands, Castile and Leon, Ceuta, Extremadura, Madrid, Murcia, Navarre and Rioja).

The following measures must also be highlighted:

- **Asturias**: Community intervention measures were carried out with minors in social and/or criminal conflict. Plus the RECIELLA program, which includes care for minors under judicial measures.

- **Castile and Leon** continues carrying out a selective prevention program for the families of adolescents with problem behaviours (delinquency, violence, etc.). And an intervention program with minors at risk of social exclusion. Special note must therefore be made of the intervention program at the Zambrana reform centre. in 2008, a Cannabis program was started, including care for minors with judicial measures.

- **Catalonia** continues carrying out selective and indicated prevention strategies and those for providing assistance for under-age offenders. In 2008, a pilot project for parents with children having committed offences, called *Limits?* was put into practice.

- **Ceuta**. This Autonomous City is carrying out an intervention program with at-risk minors (minors under protection and reform). A Guide for Juvenile Protection and Reform Centre Educators was designed in 2008

- **Extremadura** is focusing special attention on developing selective and indicated prevention programs in underprivileged districts.

- **Madrid**. The 2006-2009 Autonomous Community of Madrid Plan bolstering the selective and indicated programs targeting at-risk minors by way of the open-environment intervention social education program. Madrid is also promoting indicated prevention programs at shelters and living facilities operated under the Institute for Juveniles and Families. In this regard, special mention must be made of the measures agreed with the "Proyecto Hombre": maintaining a therapeutic community for juvenile offenders, a day centre for young people in social conflict and an open-environment judicial measures program.

- **Navarre**: The selective prevention programs focus on combating school dropouts. In 2008, a *school absenteeism prevention program* was implemented, in which schools, local police and social services took part.

- **Rioja** continues carrying out an intervention program targeting juvenile offenders.

Special mention must similarly be made of the research conducted in this field. In 2008, the Spanish Government Delegation for the National Plan on Drugs funded two research studies: *Drug-Dependent Criminal Offenders in the Process of Employment Reintegration* and *Analysis of the Situation of Families with Juveniles in Protection and Reform Centres.*

AVAILABILITY AND SUPPLY

Production, sources of supply and trafficking patterns

COCAINE

Coca leaf cultivation and cocaine production

All of the cocaine seized in Spain comes from the Andean region in South America.

Cocaine distribution means and routes in Spain and Europe

No significant changes have been found in the use of the air, sea and land means, transported both in cargo holds and by "mules" for moving and distributing cocaine from the points of origin to Spain and the rest of Europe.

The decline in the amounts of cocaine seized in Spain, one of the major countries through which cocaine is routed into Europe, suggests the use of new routes avoiding this drug having to come through Spain.

HASHISH

Cannabis cultivation and hashish production

Practically all of the hashish seized in Spain comes from the Kingdom of Morocco.

The cultivation of hemp plants in Spain has been found to exist for growing marijuana for the grower's own use, rarely for trafficking. Nevertheless, the estimated scope of these crops is totally insignificant in relation to the amounts seized and to those consumed as inferred from the use-related surveys.

Hashish distribution means and routes in Spain and Europe

No significant changes have been found in the use of the air, sea and land means for moving and distributing hashish from Morocco to Spain and the rest of Europe, nor in the routes used. The decline in the amounts of cannabis seized in Spain, the main country through which it is routed into Europe, suggest the possible use of new routes preventing this drug from having to come through Spain.

SYNTHETIC DRUGS - MDMA

MDMA-Ecstasy production

According to the known data, the European Union still continues to be the main producer of ecstasy, although a gradual decrease in the relative importance of this area and production being moved especially to North America is noted.

Ecstasy distribution means and routes in Spain and Europe

No significant changes have been found in the means and routes used for distributing ecstasy in Spain.

HEROIN

Opium poppy cultivation and heroin production

As far as Spain in concerned, most of the heroin seized is of the "brown sugar" variety produced in Afghanistan coming into the country from Turkey by way of the Balkan Route.

Heroin distribution means and routes in Europe

The different variations on the "Balkan Route", "Caucasian Route" and the "Southern Route" continue to be used by the drug trafficking organizations to distribute heroin from Turkey throughout Europe.

The heroin seized in Spain usually comes into the country on overland transport. The use of "runners" flying into the country by plane is relatively frequent at the El Prat airport, given Barcelona's resident Asian community.

The use of recreational craft on the Mediterranean is the option used sometimes, and heroin being shipped in containers is, for the time being, currently practically unusual.

SEIZURES

HASHISH

Number of seizures and amounts seized in Spain

Figure 10.1 shows the number of hashish seizures in 2009, totalling the highest number of drug seizures recorded in Spain 227,539, for a 17.63% rise over the previous year.

Figure 10.1. Hashish seizures, 2000-2009

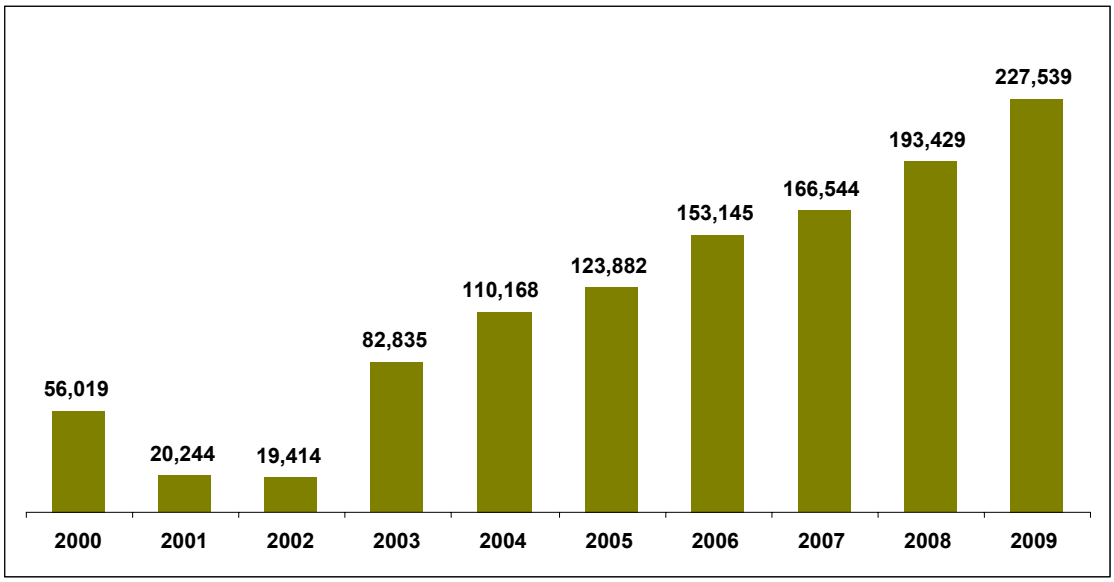
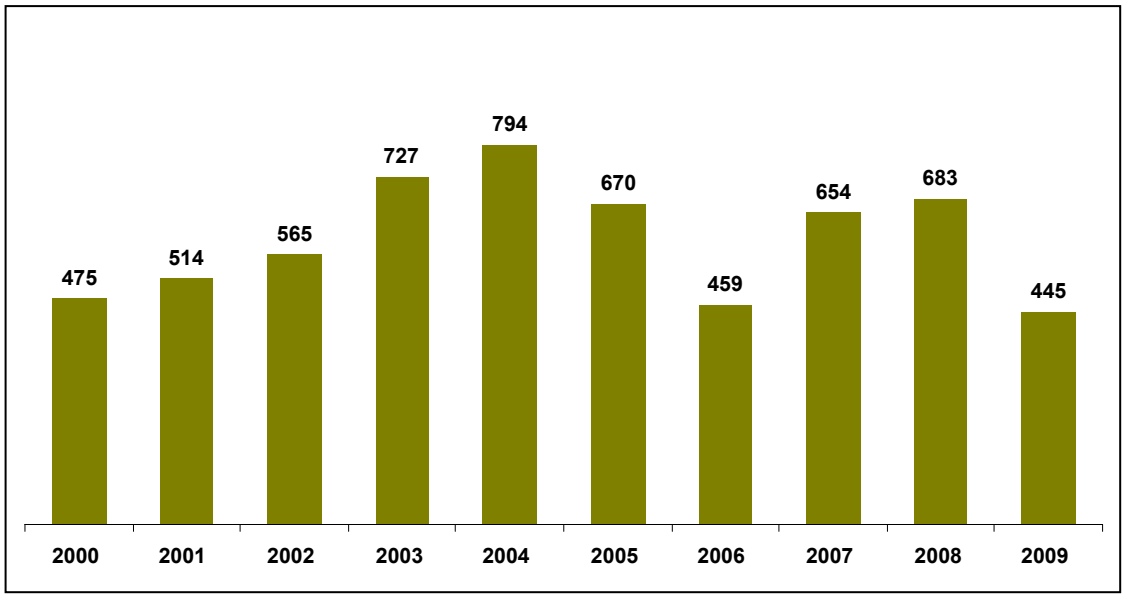


Figure 10.2. Amounts of hashish seized, 2000-2009 (Tons)



The increase in the number of seizures, whilst the amounts seized are also declining (Figure 10.2) suggests trafficking in much smaller seizures than in previous years.

COCAINE

Number of seizures and amounts seized in Spain

Figure 10.3. shows how the number of cocaine seizures has undergone a sustained increased 2002, having totalled 49,156 in 2009, for a 5.96% increase over the previous year.

Figure 10.3. Cocaine seizures, 2000-2009

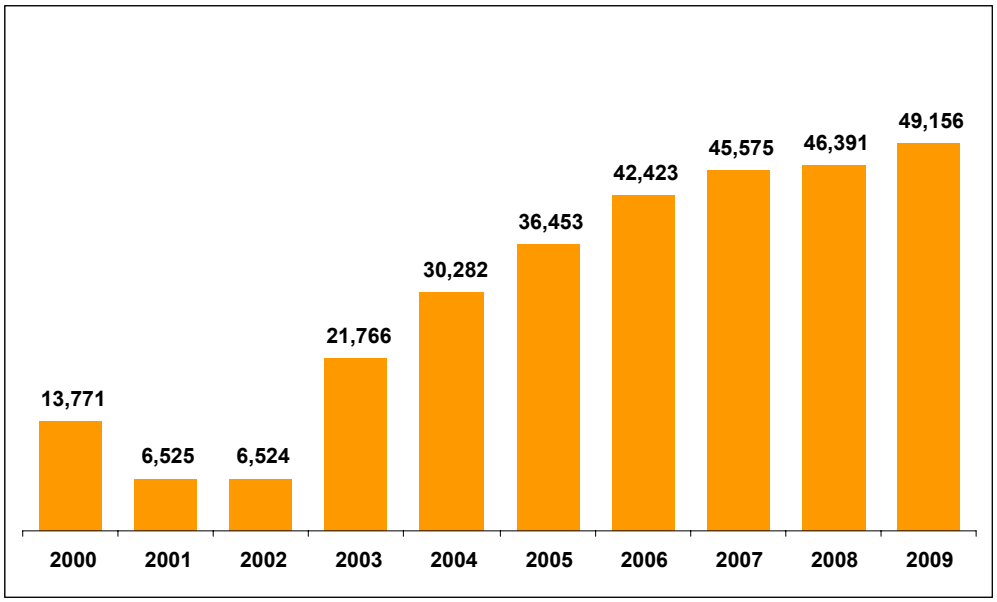
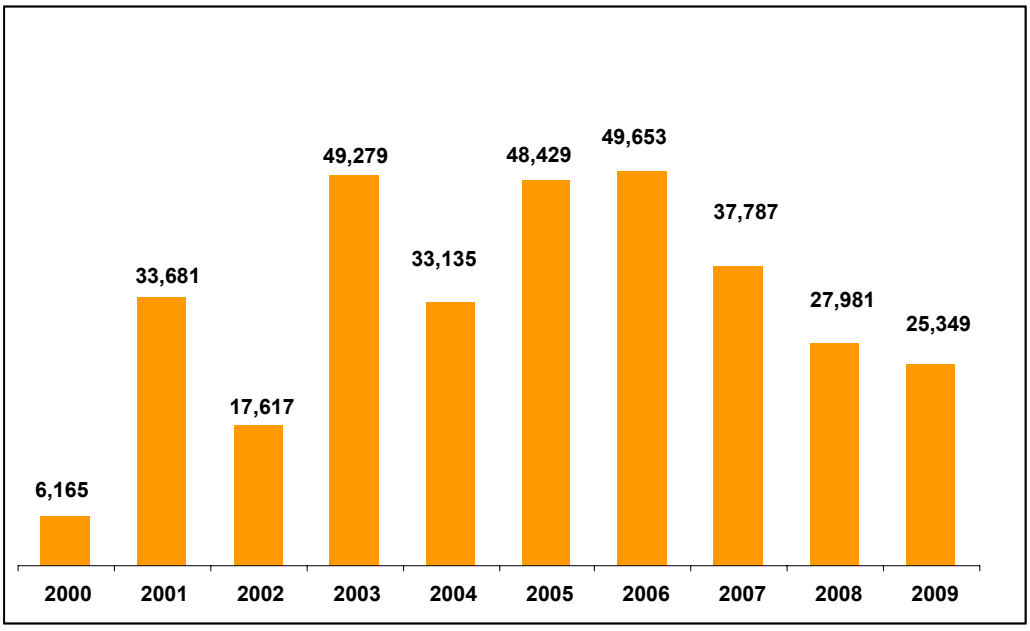


Figure 10.4. shows how the amounts of cocaine seized in Spain are showing a remarkable downward trend over the past few years. In 2009, the amounts seized dropped for the third year running.

Figure 10.4. Amounts of cocaine seized, 2000-2009 (kilograms)



As is the case of hashish, the cocaine seizures have been smaller-sized over the past few years.

MDMA - ECSTASY

Number of seizures and amounts seized in Spain

Figure 10.5 shows the MDMA-ecstasy seizures to have been 1,524 in 2009, an amount meaning a 43.87% drop compared to 2008 and a 55.58% drop compared to 2007.

Figure 10.5. MDMA (Ecstasy) seizures in Spain, 2000-2009

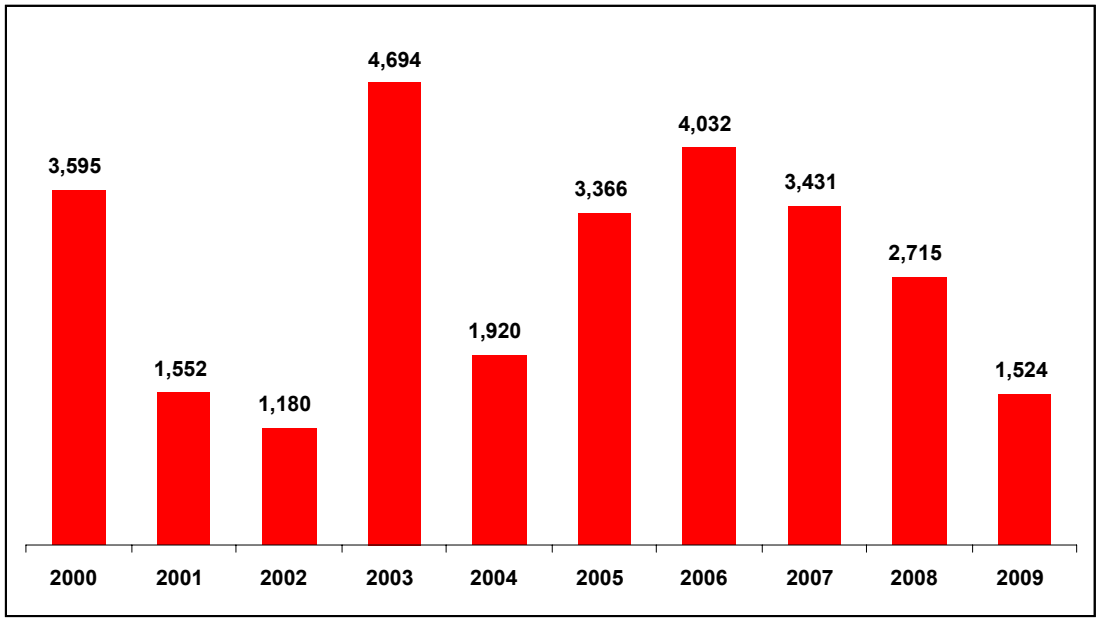
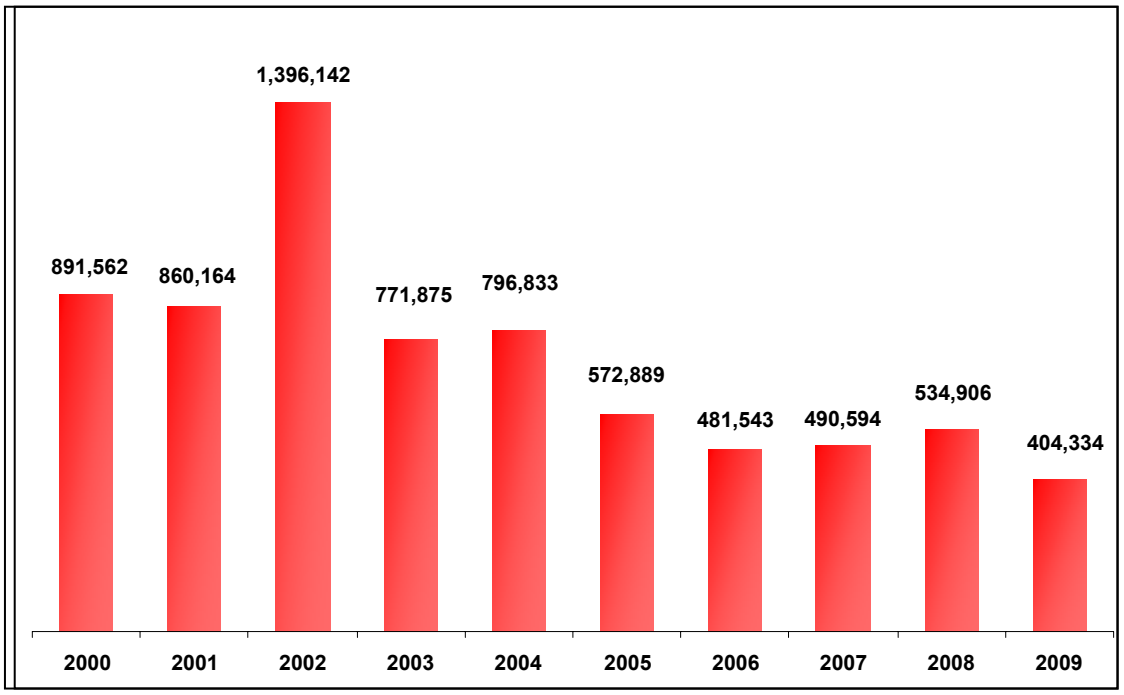


Figure 10.6 shows the total amount seized in 2009, totalling a 24.41% drop compared to the previous year, this percentage confirming the downward trend in these seizures.

Figure 10.6. Ecstasy tablets seized, 2000-2009

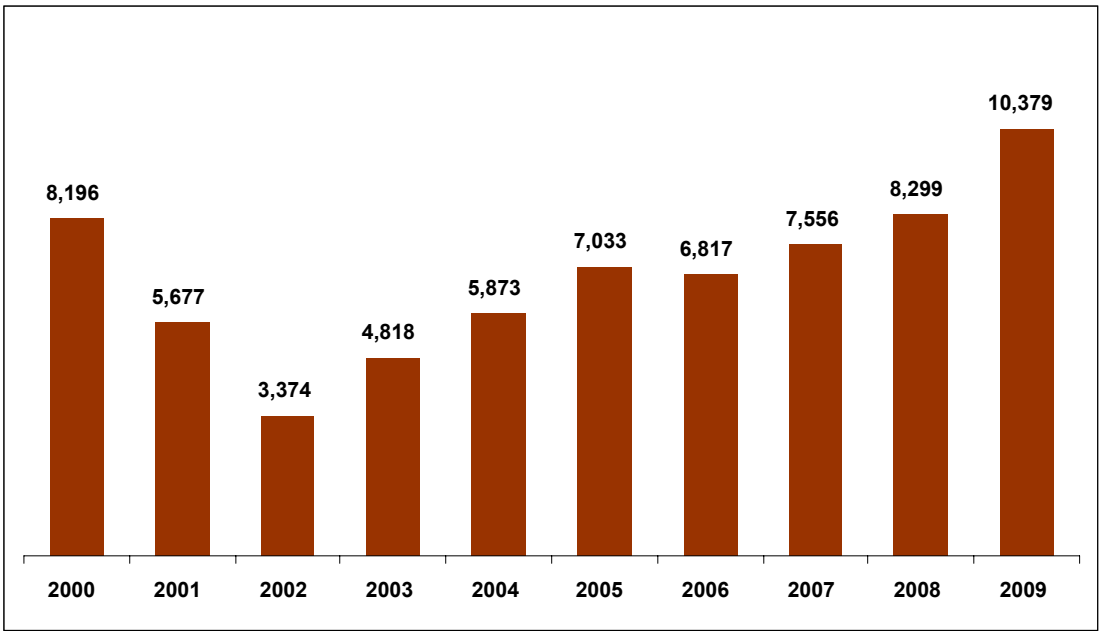


HEROIN

Number of seizures and amounts seized in Spain

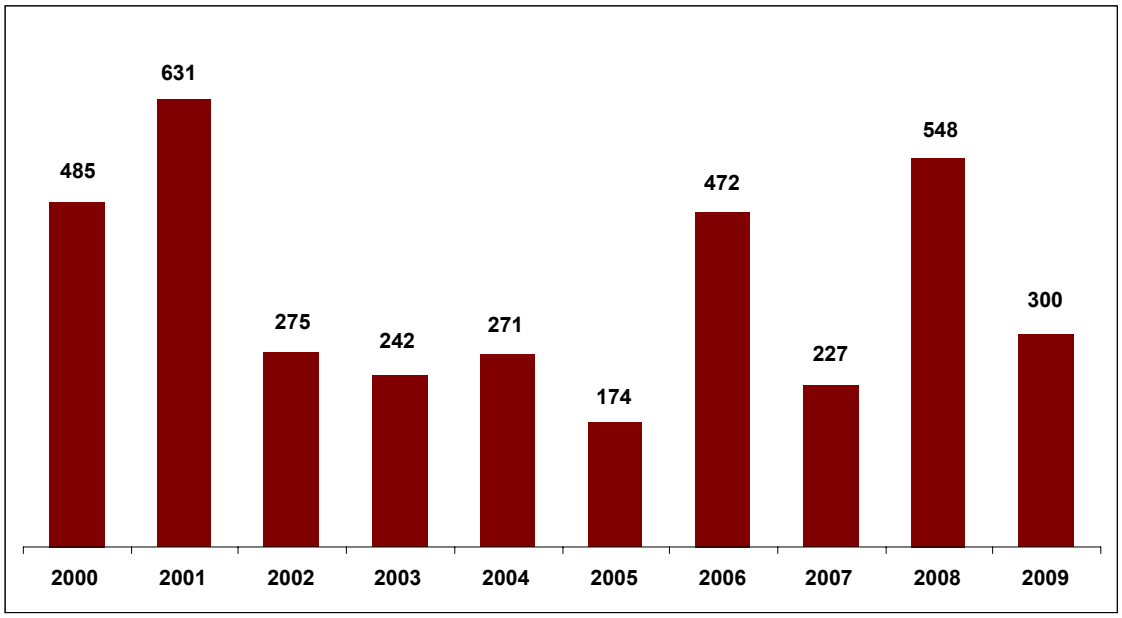
Figure 10.7 shows the number of heroin seizures as having undergone a sustained rise since 2002, having totalled 10,379 in 2009, meaning a 9.83% increase over the previous year.

Figure 10.7. Heroin seizures, 2000-2009



The evolution of the heroin seizures shows a downward trend (Figure 10.8) attributed to a drop in the supply due to the declining use revealed by the demand indicators. This downward trend is however slowing with the seizures recorded in 2006 (472.00 Kg) and 2008 (547.57 Kg) meaning increases of 170.89% and 141.22% compared to the preceding years.

Figure 10.8. Amounts of heroin seized, 2000-2009 (kilograms)



AMOUNTS OF PRECURSORS SEIZED

Only chemical substances catalogued as Category 3 precursors are manufactured in Spain, this category including six very commonly-used chemical products, solvents such as acetone and toluene and hydrochloric and sulphuric acid.

With regard to the seizures made, an increase has been detected in sulphuric and hydrochloric acid, the part used in cocaine-extracting laboratories and, the greatest part related to synthetic psychotropic drug laboratories in which other substances under voluntary control showed up entailing the confirmation of the use of alternative substances not subject to accounting for obtaining drugs.

Table 10.1. Substances and amount seized, 2009

Substances seized	Amount seized
Acetone (cc)	3,776,680
Hydrochloric acid (cc)	229,801
Sulphuric acid (cc)	91,500
Ether (Diethyl ether) (cc)	2,000
Ethyl Ether (cc)	11,000
Methyl-Ethyl-Ketone (cc)	253,000
Toluene (cc)	14,000
Potassium permanganate (gr)	300
Piperidine (cc)	1,000
Ephedrine (gr)	550
Acetic acid (cc)	1,000
Ammonia (cc)	65,800
Sodium hydroxide (gr)	75,100

LABORATORIES DISMANTLED

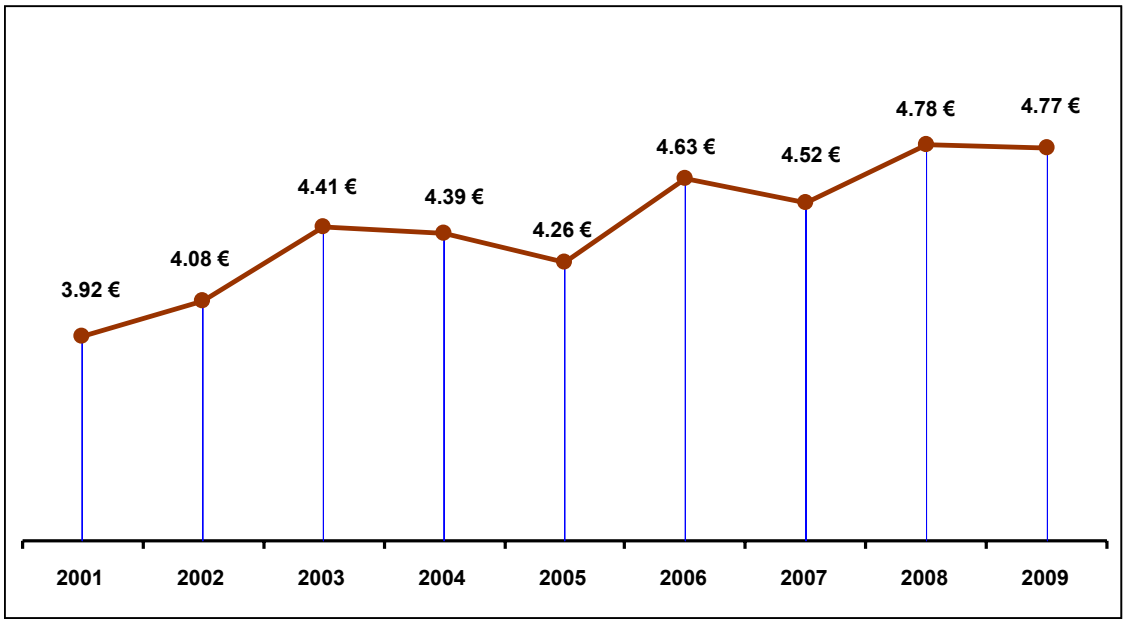
In 2009, a total of 13 laboratories were dismantled in Spain, all of which were very small-scale drug-extracting operations known as "kitchens". Eleven (11) of these laboratories were for extracting secondary cocaine and another (1) for processing. Lastly, yet another amphetamine sulphate (speed)-processing laboratory (1) was also dismantled.

PRICE / PURITY

HASHISH RESIN

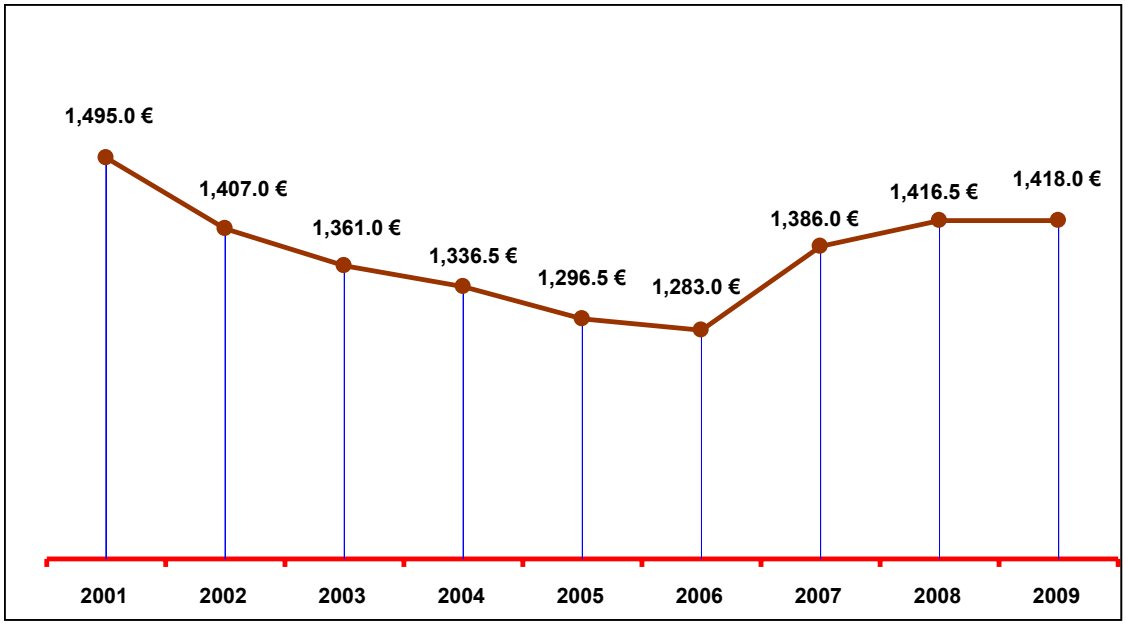
Figure 10.9. shows the trend over the last nine years on the **resale dealer market** to be rising. In 2009, a single gram is now 21.68% higher-priced than in 2001.

Figure 10.9. Hashish resin, price/gram, 2001-2009



On the other hand, Figure 10.10 shows the **wholesale market to be on a downward trend.** Nevertheless, the prices have been rising for three years running, although only very slightly, we therefore possibly finding ourselves confronting a market recovery situation. The price in 2009 was 1,418 € / kilo, which was 0.11% more expensive than in 2008 and 2.31% more expensive than in 2007.

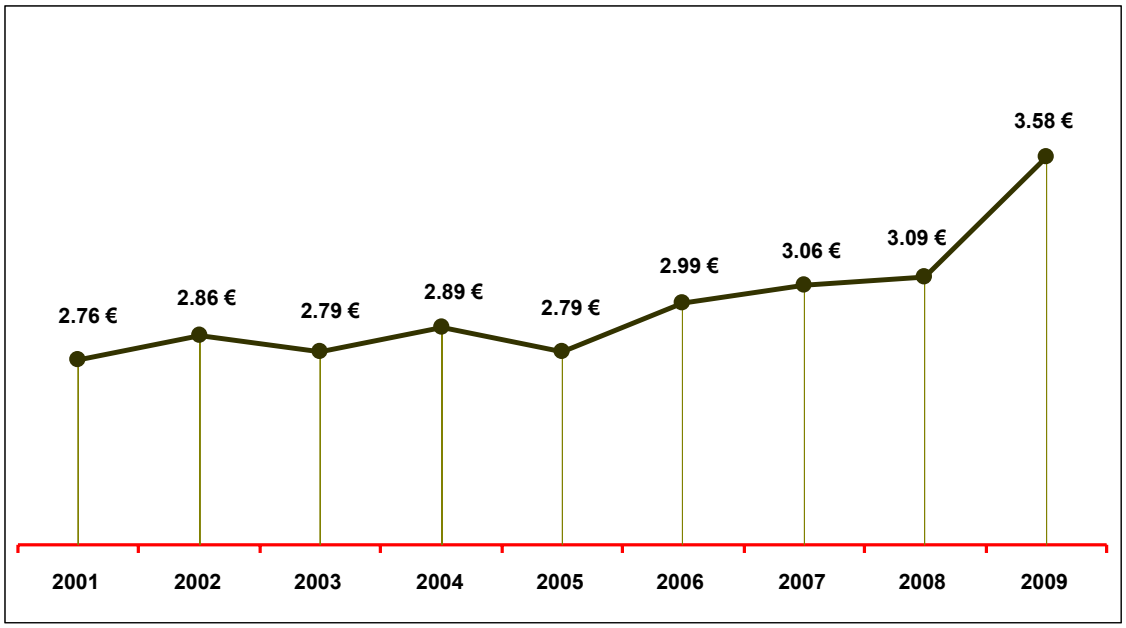
Figure 10.10. Hashish resin, price/kilo, 2001-2009



MARIJUANA

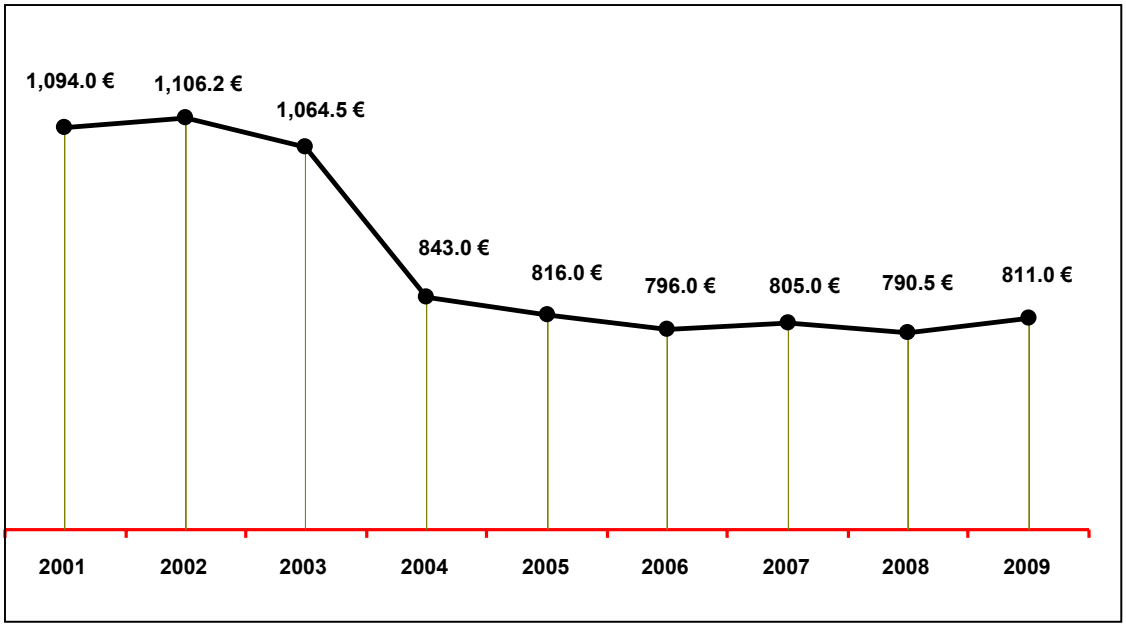
Figure 10.11 clearly shows the **average price per gram of marijuana** to have risen from 2.76 € in 2001 to 3.58 € in 2009 during the time period under study, meaning a 29.71% price rise. The price trend is therefore clearly a **rising trend**, especially as of 2005.

Figure 10.11. Marijuana, price/gram, 2001-2009



On the other hand, Figure 10.12 shows the price per **kilogram** for marijuana to be undergoing a **downward trend** with price moderation. Within the 2002-2009 period, the price of marijuana dropped by 26.67%, by nearly 200 €.

Figure 10.12. Marijuana, price/kilo, 2001-2009

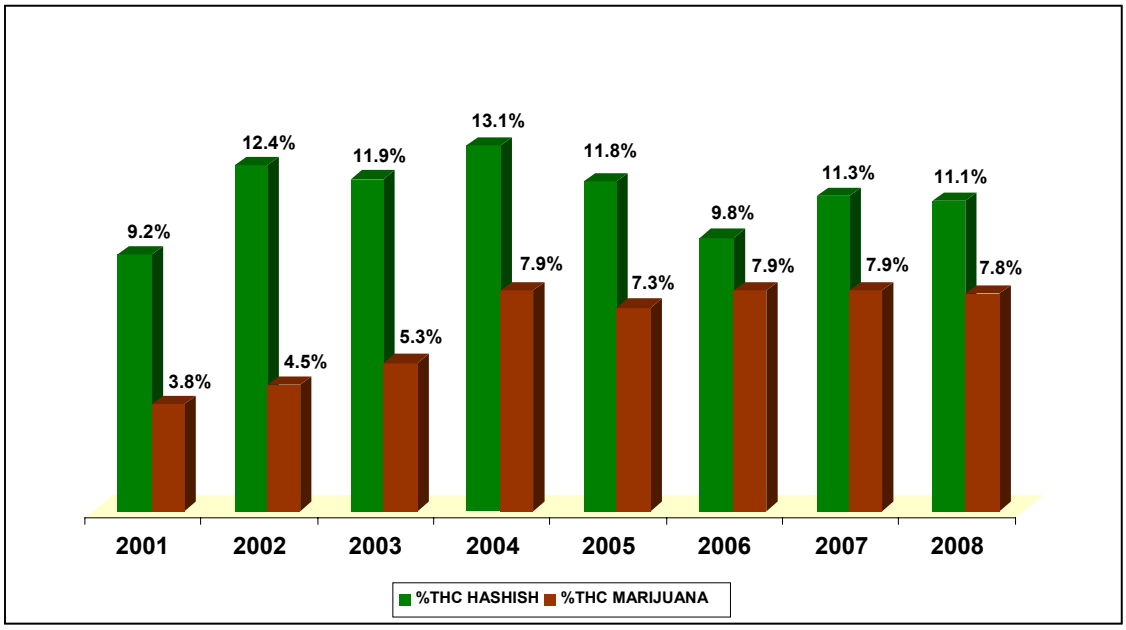


THC concentration

The one property which modifies the ability of hashish to cause effects in users is mainly its *Tetrahydrocannabinol* (THC) concentration, which is stated in percentage form and varies due to the characteristics of the crops, influenced particularly by the selection of seeds, climate, soil quality and cultivation methods employed.

As the aforementioned concentration does not depend on the drug dealer and could have a bearing on the prices in itself, a follow-up has been conducted of the annual averages found in the samples analyzed[10] which are provided in the table in Figure 10.13 below, significantly revealing the **rise in cannabis potency, especially of marijuana.**

Figure 10.13. THC evolution, 2001-2008

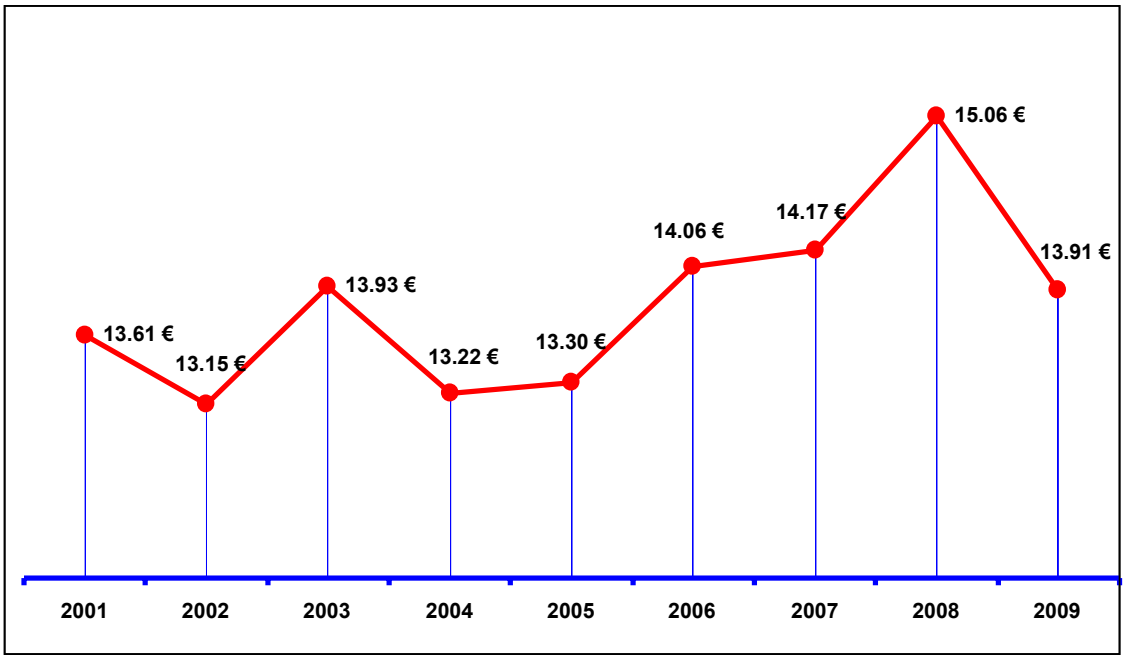


COCAINE

Figure 10.4 shows the price of a single cocaine does to have fluctuated over the last nine year, with a **final rising trend**, due to the major rise it has undergone over the past few years. A single dose of cocaine cost 15.06 € in 2008, having meant a 10.65% rise compared to 2001, nevertheless having dropped by 7.64% in 2009 as compared to the previous year, this price in no way changing the aforementioned trend.

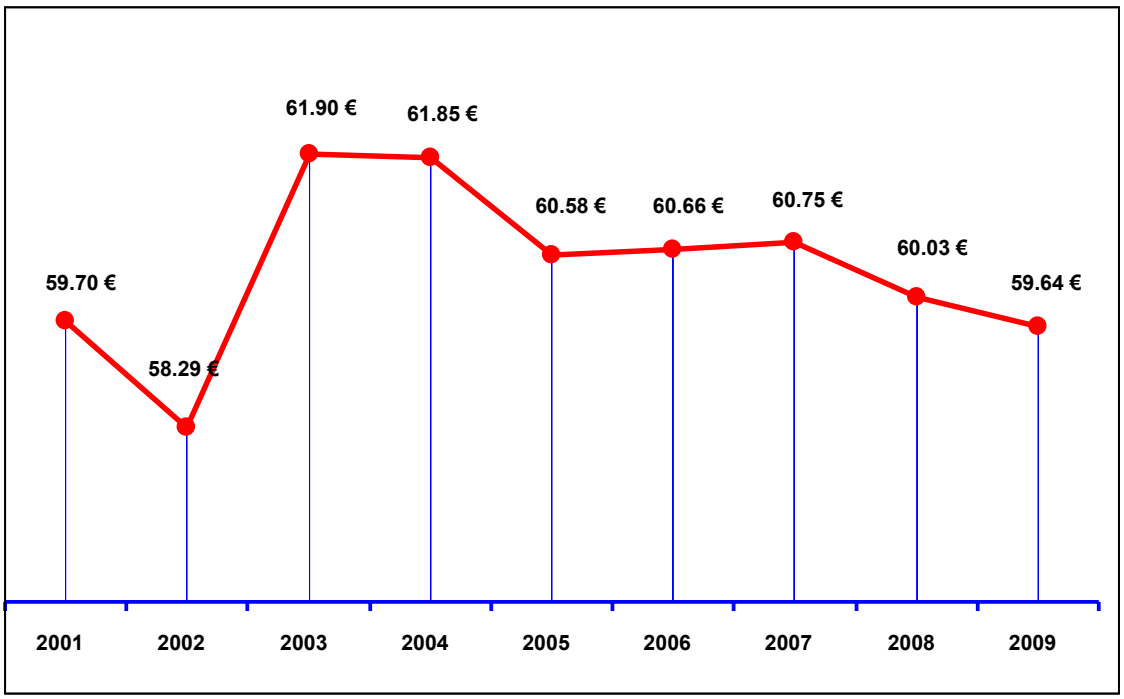
[10] Data furnished by the Drug Service of the National Toxicology and Forensic Science Institute. Madrid Department.

Figure 10.14. Cocaine, price/dose, 2001-2009



As regards the **average price per gram** of cocaine (Figure 10.15), its evolution is showing a **stable** trend. Following the drop in 2002 and the short-lived upward trend the following year, a gradual decline began which has now left the average price in 2009 at 59.64 €/gram, for a difference of only 6 euro cents compared to the price in 2001.

Figure 10.15. Cocaine, price/grams, 2001-2009



As shown in Figure 10.16, for the time period compared, the price per kilogram dropped from 34,500 €/Kilo in 2001 to 32,758 €/Kilo in 2005, having shown a downward trend up until that year estimated at a slightly over 5%. Following two years

of price hikes, he price dropped again in 2008, having finally hit a price of 33,039 € in 2009, thus **continuing on a downward trend**.

Figure 10.16. Cocaine, price/kilo, 2001-2009

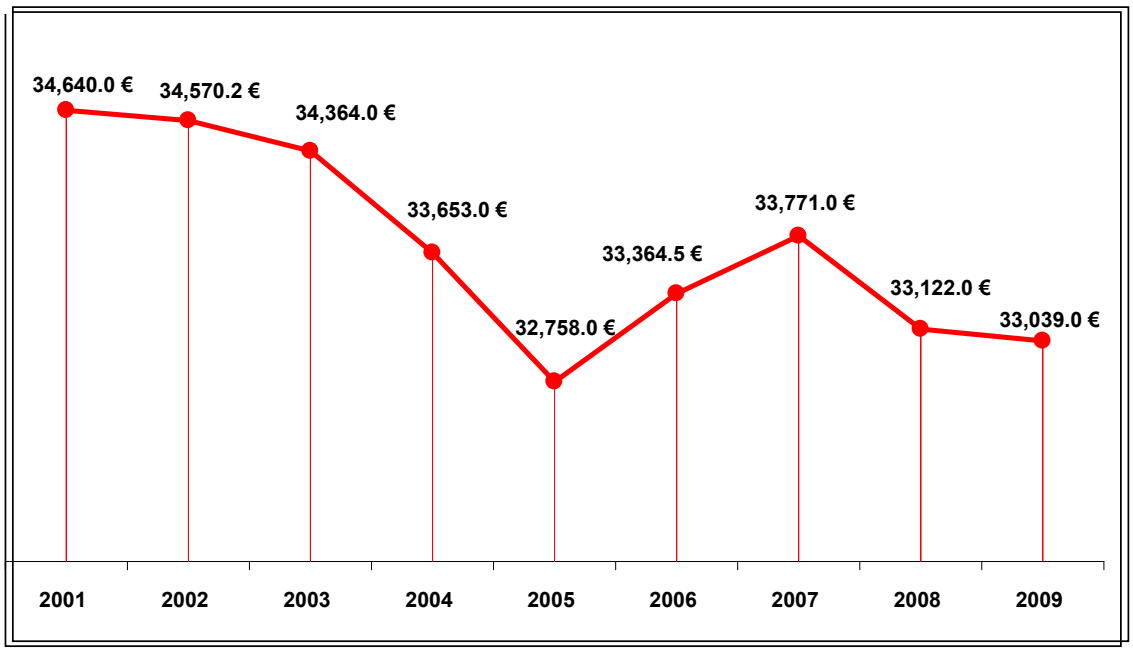
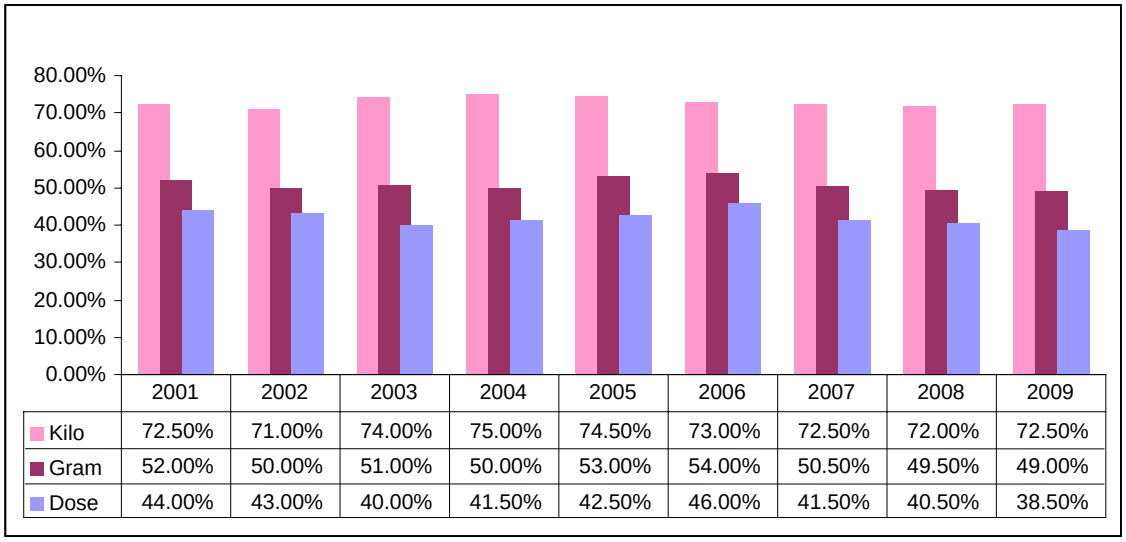


Figure 10.17 shows the **average purity of a single cocaine dose** to have ranged from 44% in 2001 up to 38.50% in 2009. After having reached 46% in 2006, the purity has been dropping continuously since that, having hit the **lowest** degree of purity last year.

Figure 10.17. Evolution of cocaine purity, 2001-2009



	2001	2002	2003	2004	2005	2006	2007	2008	2009
Kilo	72.50%	71.00%	74.00%	75.00%	74.50%	73.00%	72.50%	72.00%	72.50%
Gram	52.00%	50.00%	51.00%	50.00%	53.00%	54.00%	50.50%	49.50%	49.00%
Dose	44.00%	43.00%	40.00%	41.50%	42.50%	46.00%	41.50%	40.50%	38.50%

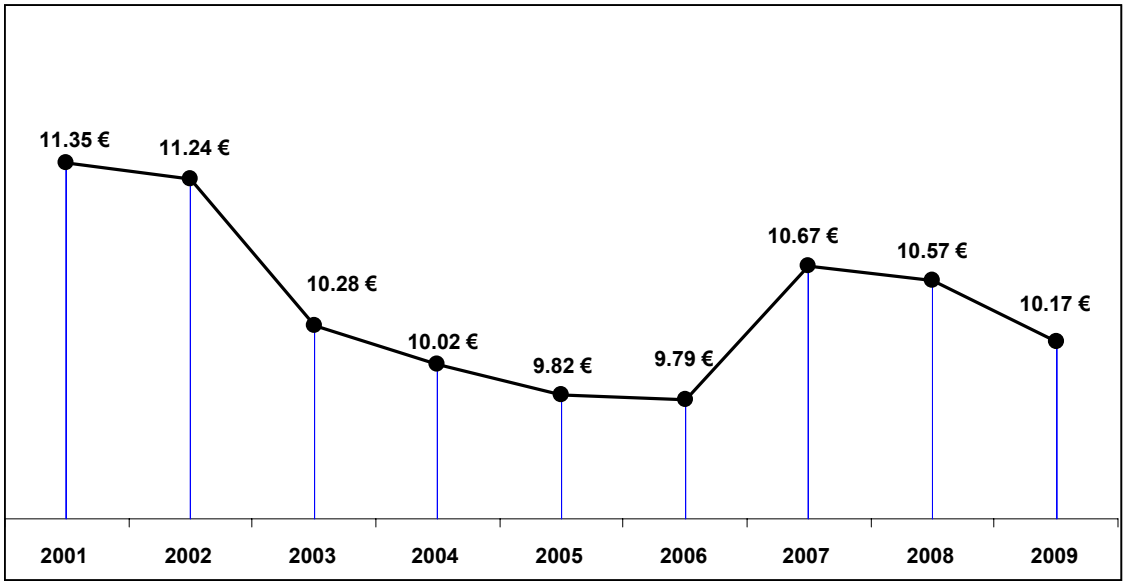
The evolution of the **purity** found in the seizures by **grams** of cocaine is quite similar to that of the doses. Starting out with a greater richness, 52% in 2001, it dropped down to 50% in 2004 to then have started rising again up to the point of totalling 54% in 2006, to then have dropped once again over the last three years down to 49.00%, showing a **slightly downward trend**.

The purity per kilo is currently 72.50%, the same as nine years ago. Although it dropped by one and a half points in 2002, it rose to 75% in 2004 to then continue dropped down to its current level.

MDMA – ECSTASY

Figure 10.18 clearly shows the evolution of the **average price of a tablet of ecstasy** over the last nine years as having been a **downward trend** until 2006. After a short-lived 9% rise in 2007, the per-tablet price has dropped again for the second year running, showing a downward trend.

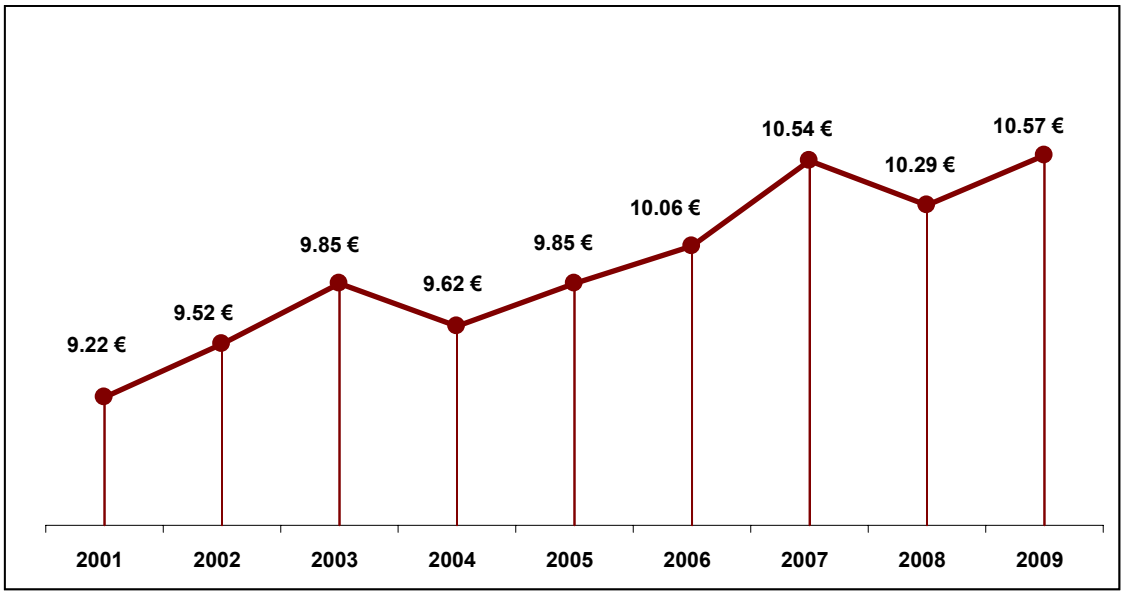
Figure 10.18. Per-tablet price, 2001-2009



HEROIN

Figure 10.19 shows the average **price** of a **heroin dose** in 2009 as being 10.57€ per dose, which is 14.64% higher-priced than in 2001. The evolution of the price of heroin, except for 2004 and 2008, has been constantly on the rise, clearly marking a **rising trend**.

Figure 10.19. Heroin, price per dose, 2001-2009



. Figure 10.20 shows the average price per gram as having been 63.96 euros in 2001. After rising in 2003 by a little over 2 euros per gram, the price started its drop down to 61.79€ on the average which it costs in 2009, which is 3.39% less expensive than in 2001.

Figure 10.20. Heroin, price/gram, 2001-2009

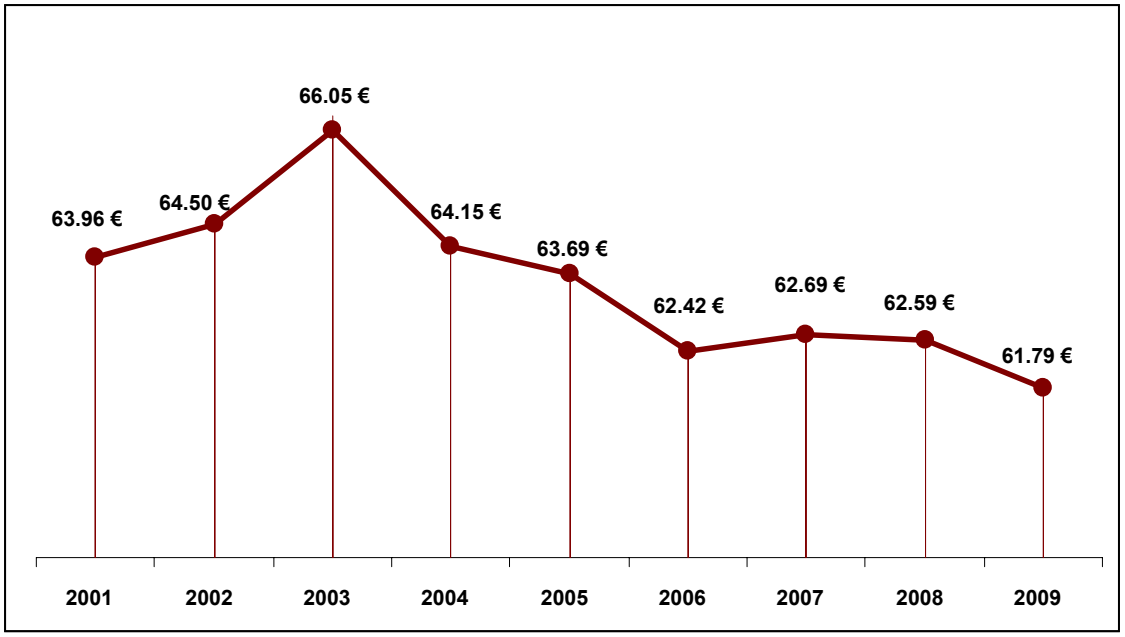
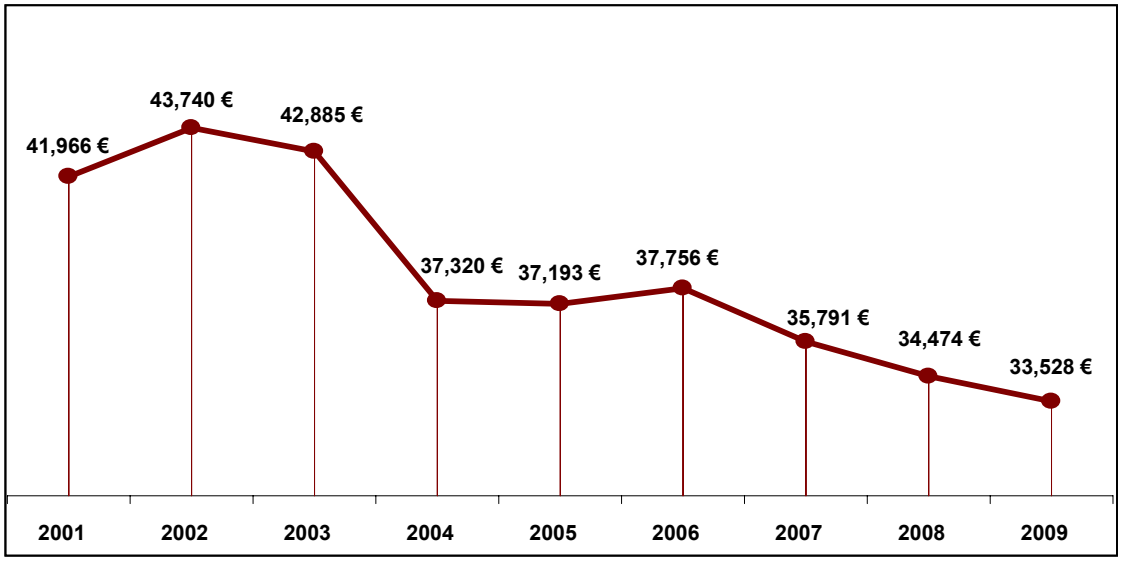


Figure 10.21 shows the **kilo** of heroin as having started the period studied with a rise in 2002, up to 43.740 €/Kg, to then progressively drop down to 33.528 € in 2009, which is a 23.25% drop. This price is 10.212€ lower than in 2001 and 946 € lower than in 2008., thus assuring the **downward trend.**

Figure 10.21. Heroin, price/kilo, 2001-2009

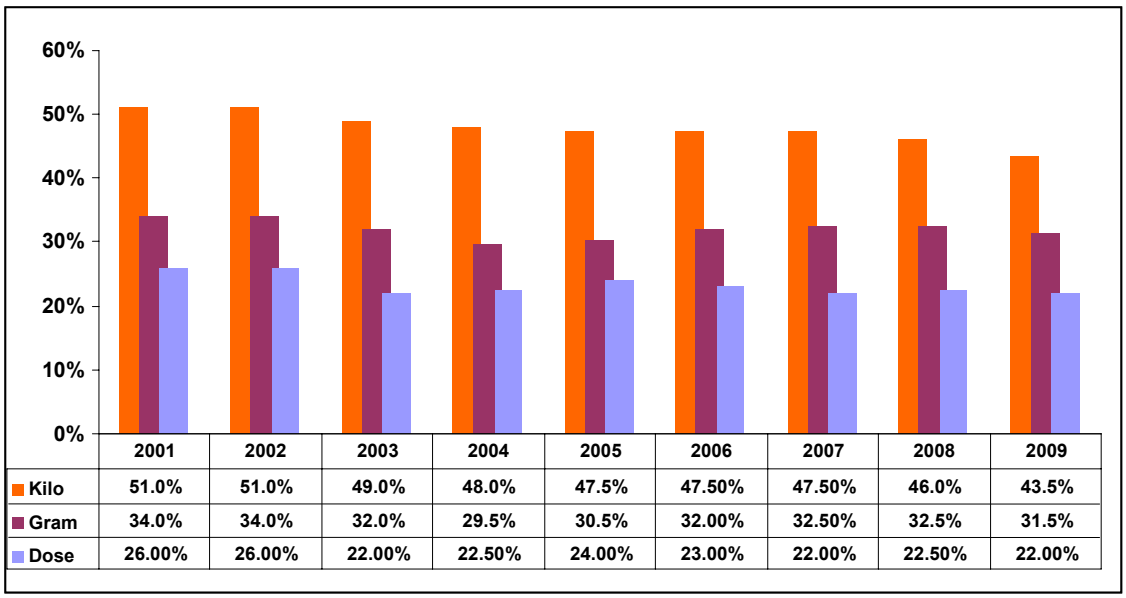


The **average purity** found in the **heroin doses** in 2009 was 22%, meaning that it was 15.38% **lower** than the purity recorded for 2001.

The average purity of a single **gram** of heroin **has also dropped** during the period under study, being 2.5 percentage points lower than the purity for 2001. A gram of heroin is now 7.35% less pure. In 2004, heroin purity per gram reached its lowest point (29.5%), having recouped as of that time up to 32.5% for 2007 and 2008, to then have dropped down to 31.5% in 2009.

Figure 10.22. shows the average purity per kilogram as having shown a sustained downward trend which has been a marked drop over the past few years, having dropped from 47.5% in 2007 to 43.5% in 2009.

Figure 10. 22. Evolution of heroin purity, 2001-2009



	2001	2002	2003	2004	2005	2006	2007	2008	2009
Kilo	51.0%	51.0%	49.0%	48.0%	47.5%	47.50%	47.50%	46.0%	43.5%
Gram	34.0%	34.0%	32.0%	29.5%	30.5%	32.00%	32.50%	32.5%	31.5%
Dose	26.00%	26.00%	22.00%	22.50%	24.00%	23.00%	22.00%	22.50%	22.00%

Data collection methodology (prices and purities)

For determining the prices of the drugs and their purities, the official agency in charge thereof, the Central National Narcotics Office, gathers the data from the Regional Headquarters of each National Police Regional and from the Headquarters of each Spanish Civil Guard Zone.

These Divisions are furnished with all the necessary information from all of the Narcotics Investigation Groups and Sections within the bounds of their authority on the six-month basis (in January and July every year) stipulated, by consulting, if necessary, the respective Citizen Security Divisions or Groups who, due to their everyday contact with the small-scale drug pushers and measures with regard to Citizen Security Law 1/92, are also aware of the evolution of the prices of some narcotic substances in small-scale drug dealing.

As far as the prices are concerned, they are determined from the information furnished by the investigations and the aforementioned measures regarding the subject of the Citizen Security Law. The information regarding the purity of the drugs is taken from the reports issued by the laboratories of the Pharmacy Administration or competent Provincial Agencies following the chemical analysis conducted on each one of the different seizures.

Lastly, based on the reports submitted, the Central National Narcotics Office prepares the official price and purities tables by ruling out the highest and lowest figures.

Part B

SELECTED ISSUES

11. HISTORY, METHODS AND IMPLEMENTATION OF NATIONAL TREATMENT GUIDELINES

HISTORY AND OVERALL FRAMEWORK

Although well-defined drug dependence-related therapeutic intervention programs, including morphine maintenance, have existed since 1932, it was not until 1967 that drug addiction programs linked to the framework of the outpatient centres providing care for alcoholism began being carried out under the National Psychiatric Care Board, Mental Health Services.

Around 1979-1980, several different specific centres providing care were created (DROSS at the "Hospital del Mar" in the City of Barcelona; Red Cross within the Municipal Government of Madrid; Bétera Hospital in Valencia) driven by the unanticipated overwhelming increase in the problems resulting from heroin abuse leading to addiction and the total lack of any Government Agency to suitably intervene. Attempting to achieve a more broad-ranging response from the Central Government, Mental Health was left out of the initiatives undertaken by the Municipal Governments.

In November 1975, studies were begun for preparing a "White Paper" on the part of the Alcoholism and Drug Dependence Services, including a detailed list of social, medical and psychological aspects suitable for dealing with the conflict through the Central Government Administration. It was around this same time that Spain began its transition to democracy, which reached its climax in 1978 with the passage of a Constitution by means of which Spain became a social, democratic State governed by laws, being organized into a State by way of the existence of 17 Autonomous Communities and two Autonomous Cities.

In 1985, the National Plan on Drugs and the Government Delegation to the Plan were created, the objectives of which included coordinating and bostering the drug-related policies carried out through the different Central, Autonomous Community and Municipal Governments and through the social organizations. In this regard, special mention must be made of the fact that a Plan of an Autonomous Community scope exists in each one of Spain's Autonomous Communities and Autonomous Cities. One of the first and most important matters with which the National Plan on Drugs had to deal was the heroin epidemic, which was worsened considerably by its being associated with AIDS.

The professional and administrative structures of the Autonomous Community agencies providing care for drug dependencies have differed in the past and continue to do so today. Currently, most fall within the framework of reference of Public Health and Healthcare, although there are still some systems with intervention models closer to the Social Services. Treatment quality assurance and quality control are in place in all of the National Health System's medical services.

EXISTING GUIDELINES: NARRATIVE DESCRIPTION OF EXISTING GUIDELINES

During the 1986-1992 period, the Government Delegation for the National Drug Plan published the "Community and Drugs" journal, which, in addition to its regular issues, also published a number of Monographic Issues. Original studies on the different areas of intervention in drug dependencies (epidemiology, prevention, treatment, social reinsertion, etc.), recommendations and basic procedures, as well as critical reviews of literature published both in Spain and internationally were featured. It must

nevertheless be said that the different Autonomous Community Plans on Drugs have the authority to prepare their own rules for taking action in regard to providing care and assistance for drug users, although the general guidelines are usually agreed upon within the different bodies coordinating the National Plan on Drugs, in which representatives from these Autonomous Community Plans take part.

The majority of the Good Practices Guides or Manuals have been produced by the Scientific and Professional Societies working in the fields of drugs and alcohol, particularly the Spanish Scientific Society of Studies on Alcohol, Alcoholism and Other Drug Dependencies (SOCIDROGALCOHOL), which, since 1972, has been bringing together physicians, nurses, psychologists, social workers, attorneys, sociologists and any other personnel working on these topics.

This Scientific Society has been publishing a widely-disseminated journal titled "Addictions" since 1989, most of its monographic issues and supplements since 2003 actually being, in practice, good practices or intervention guides which have been widely disseminated and followed. The first issue was devoted to tobacco in 2003.

Mention must be made of one existing precedent. Thus, as of the late 1880's, the Central Government Delegation for the National Plan on Drugs published a total of ten publications in the form of handbooks as part of the "Taking Action is Possible" collection. The major groups of professionals for whom these handbooks were published included primary care professionals, pharmacists, coroners, social workers, etc.

Strictly speaking, the first clinical Guide for the treatment of opiate dependence was published in 2007, as a monographic issue published by the SOCIDROGALCOHOL Scientific Society, under the coordination of Dr. Juan José Fernández Miranda. The latest Guide, available since 2008, is the "Clinical Guide for Psychological Intervention in Addictions" coordinated by Elisardo Becoña and Maite Cortés. SOCIDROGALCOHOL promotes the publication of high-quality monographic studies, the methodological aspects of which are based on the principle of evidence.

Apart from the above, some Professional Associations have been publishing good practices manuals since 2005, such as is the case of the National Council of Professional Social Workers and Case Workers, focusing quite specifically on the social emergency centres.

Within the 1999-2004 period, two Consensus Conferences on Alcohol and Drugs organized by the Spanish Psychiatry Society have also been held, having been well-considered and having included "guideline" criteria for diagnosis, assessing the degree of severity and the treatment-care of alcoholism and other dependencies. Unfortunately, there is sometimes not enough coordination among the Psychiatry networks, the Mental Health Teams and the Drug User Care Teams for the conclusions of any consensus reached to make its way all of the professionals working in these fields.

Within the 1974-1978 period, a break was made with the former tradition of psychiatrists heading the care provided, the bio-psycho-social model then having become almost exclusively a psycho-social gesture, with rigid drug-free programs up until 1995 and the years in following.

The treatment itinerary included many care and treatment variables, having included, sooner or later, a stage involving being admitted to a Therapeutic Community, which

was of extremely prime importance and high effectiveness. The therapeutic communities have been and currently continue to be an irreplaceable link in the chain and have progressively adapted to the change in the population for which they provide care. Many of these Communities are currently admitting patients on methadone maintenance or who have a mental disorder, which were formerly factors determining ineligibility for admission.

Reducing the harm and risk entailed some extremely serious difficulties for carrying them out within the context of drug dependence care networks of a psycho-social rationale, which considered addiction to be a deviated yet voluntary behavior, with almost exclusively cognitive-behavioral programs focusing on the drug-free modality. Being expelled from the program for detected drug use was the general rule, entailing the impossibility of returning to the program until several months later, which gave rise to situations of social exclusion and disadvantage. Keeping the patients in treatment was not considered a priority.

The legal changes having made the methadone maintenance programs possible, with a strict good practices protocol, were first gotten under way in 1990 by way of a bold Decree by the Ministry of Health and Consumer Affairs. This process was undoubtedly facilitated by the major degree to which AIDS was spreading and the determined measures taken in reducing the risk of sero-conversion and infection in all scenarios, including the prison environment.

The implementation of the aforementioned Decree nevertheless met with a major degree of opposition and hindrance on the part of both certain sectors of the public opinion and groups of care associations and some Professional Association, which considered them as being “giving up” or “throwing in the towel”. The methadone maintenance programs were authorized solely in the Government Administration drug user care networks. As of 1997, the development and implementation of these programs was spectacular nationwide in Spain. The number of individuals for whom care was provided in methadone programs throughout Spain rose from 4,718 in 1991 to 84,731 in 2001. These programs were carried out in conjunction with many additional public health, health education and outreach actions plus measures facilitating accessibility to treatment and for keeping in touch with patients.

Around 1996, drug users began being considered as being excluded, delinquent or socially menacing individuals, but rather as recurrently chronically-ill individuals in need of specific treatment and monitoring their own individual health so as to also safeguard public health. Modern, complex Autonomous Community laws were also drafted viewing substance abuse as just one type of addictive behavior, governing the widely-varying modalities of care and treatment.

In Spain, all of the drug dependence treatments carried out by centres and services pertaining to the public sector under any regimen, whether on a hospitalized or outpatient basis, are free of charge and universally available to all, including those for reducing the harm and risk as a whole and admission to specific drug units, hospital detox units or psychiatric treatment on a general hospital or psychiatric ward.

Studies and trials were conducted with LAAM and buprenorphine in those cases in which methadone was not the suitable solution, mostly due to an interaction with anti-tuberculosis or anti-retroviral drugs. In many Autonomous Communities, it was even possible to conduct sequenced blood methadone bioavailability titrations in cases of a poor result from maintenance at extremely high daily doses, despite the appropriate direct supervision of the treatment as a whole. The cost/day of LAAM and

buprenorphine, which is much higher than that of methadone, also led to their use being confined to a residual group of patients. The same criterion has been applied to the naltrexone-buprenorphine combination. LAMM ceased being prescribed when its potential dangerous side effects were published, although no intolerance or complication was recorded in Spain as a result of this combination having been administered.

COMPARISON WITH WHO GUIDELINES

The proposed scheme of comparison regarding the WHO model of treatment for opiate dependence and, in particular, the maintenance programs, would give rise to the ways in which Spain was intervening agreeing totally with those of the U.N. agency. The only discrepancy is related to the fact that, in Spain, both buprenorphine and its combination with naltrexone are currently second-line treatment options when methadone is not the appropriate solution.

Implementing the recommendations of the guides has posed no problem, no response worthy of special note having arisen. It must be said that the intervention models for treating individuals who abuse opiates are totally homogeneous throughout the entire county in Spain.

Exactly the same situation of full agreement applies if a comparison is drawn between the WHO recommendations and those of Spain with regard to prisons. As of the early 1990's, all prisons offer the possibility of undergoing treatment for drug dependence with a wide range of options, from drug-free programs, including prior detoxification, to harm reduction programs, not to mention the needle exchange and health kit distribution programs. Similarly, it is also possible for qualifying eligible prison inmates to start a methadone program.

COST OF DRUG-RELATED TREATMENT IN EUROPE: A COMPARATIVE ANALYSIS

The treatment of drug users in Spain comes under the authority and is carried out mainly by the seventeen Autonomous Communities and the two Autonomous Cities of Ceuta and Melilla of which the State of Spain is comprised, through their respective Autonomous Community Plans on Drugs. This treatment is also provided, to a certain degree, by some municipal and supra-municipal entities (mainly municipal governments of major cities and Regional Government Offices).

In that which will be set out in following, **the term "treatment" is understood not solely as the health care provided to drug users, but also the social reintegration programs**, in other words, any social intervention or combination thereof for the purpose of reintegrating drug users into the community.

The economic resources for carrying out this treatment come mostly from the Autonomous Community Plans on Drugs and, to a lesser extent, from some municipal entities, as previously mentioned. It must however be said that major economic resources are transferred to these Autonomous Community Plans by the Central Government.

The figures detailed in following comprise solely the economic resources contributed by the Autonomous Communities and Autonomous Cities and by the Central Government, given that no data is available on the municipal entities or on the funds of the NGOs working in this area (although those for the treatment provided by these NGOs charged to public funds are indeed included). The data provided has been taken from the Central Government Budget and from the annual reports of the National Plan on Drugs. **The figures provided herein refer to the 2008 fiscal year.**

No data regarding the expenditures made for the treatment of drug users by use-related disorders (including different infectious diseases such as AIDS, hepatitis, etc.) **can be provided**, given that, on the authorities over treatment being transferred over from the Central Government to the Autonomous Community Governments, it is highly difficult to itemize that part of the health care spending allocated to disorders directly related to drug use within the total expenditure invested in treating these disorders and all other disorders.

As far as the Budget managed by the Autonomous Community Plans on Drugs, the figure allocated to treatment (in the sense detailed hereinabove, in other words, including the reintegration programs) totalled the sum of 249.55 million euros in 2008. This sum totals around 75% of the budget which the Autonomous Community Plans allocate to carrying out the drug programs which come under their authority, in the different areas of intervention: prevention, health care and social reintegration, research, training professionals and volunteers. This percentage (75%) has remained stable with slight variations, over the last 20 years. A total of around 13.1 million euros of this 249.55 million euro amount are sums transferred to these Plans by the Central Government so that they may carry out certain treatment programs.

A further 4.47 million euros with which the Central Government funds programs being carried out for supporting the maintenance of the health care and social-employment reintegration resources which are carried out directly by NGOs in the drug dependence area must also be added to this 249.5 million euro figure.

Based on all of the above, the amount which the Central Government and the Autonomous Community Governments have allocated to the treatment of drug users can be estimated as totalling **254.02 million euros**.

Apart from the above, in addition to the previous estimates and **for the purpose of rounding out the contribution of the Spanish National Focal Point on the Selected Issue concerning treatment costs** within the scope of drug dependencies, **a bibliographic search has been run of currently-existing studies on cost analysis and economic assessments in the area of the treatment of drug dependencies in Spain.**

An analysis is made of the research done on illegal drugs in Spain within the **2005-2010** period in those journals published in Spain and internationally which are considered most relevant in the within the specific area of addictions. A study is considered as making an economic assessment if it shows an incremental cost-effectiveness or cost-usefulness ratio, and a cost study if the study provides figures on the cost of the programs. The economic assessments go beyond the cost studies on requiring analysing the benefit, effectiveness and efficacy of the treatments.

The review includes the following publications:

- Drug Dependence

  Published in Spain: Adicciones (ADIC), Revista Española de Drogodependencias (RED) [Spanish Drug Dependence Journal], Health and Addictions (Salud y drogas) (H&A)

  Published internationally: Addictions (ADD)

- Economic assessment-oriented journals

  Published in Spain: Revista Española de Salud Pública (RESP) [Spanish Public Health Journal], Gaceta Sanitaria [Health Care Gazette], Gestión Clínica y Sanitaria (GCS) [Clinical and Health Care Management], Presupuesto y Gasto Público (PGP) [Government Budget and Spending]

  Published internationally: Health Economics (HE), Journal of Health Economics (JHE), European Journal of Health Economics (EJHE).

Twenty-one (21) articles were identified which deal with the assessment of different aspects of illegal drugs in Spain: 7 in ADIC, 6 in ADD, 2 in GS, 2 in RESP, 2 in H&A, 1 in PGP and 1 in RED. **No study was however found which included a complete economic assessment, and solely one (Oliva and Rivera, 2006) on costs related to illegal drug use in Spain**.

The 2006 Oliva and Rivera study uses the information provided by the mechanisms integrated into Autonomous Community of Galicia the drug dependence network. In 2003, this network was comprised of 41 centres, at which 3,429 admissions to treatment took place and a total of 10,923 patients (9,095 males) were treated. A total of 89.5% of the admission were due to illegal drug use, 6.9% to alcohol, 2.5% to tobacco and the remaining 1% to problem gambling. These figures thus confirm the major relative importance illegal drugs entail in the costs of these care networks.

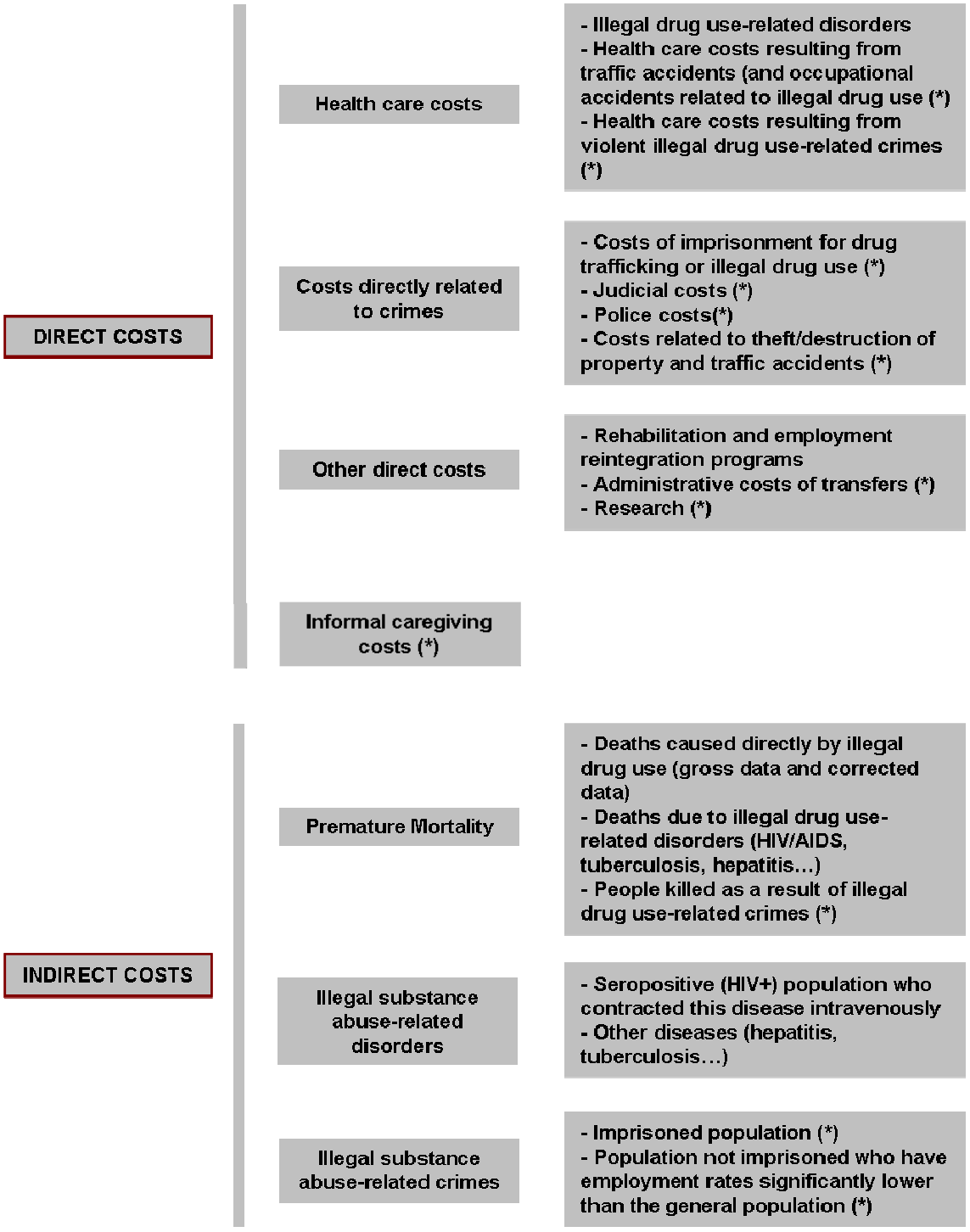
In addition to the data provided by the Galician Health Service, the authors use other sources, such as, for example, the Structural Wage Survey (National Institute of Statistics, Spain) for calculating average earnings, or the Death Statistics by Cause of Death (Eurostat) and the list of Drug-Related Deaths (European Drug and Drug Addiction Monitoring System) for calculating the Potential Years of Life Lost (PYLL)

The Autonomous Community of Galicia has a population of approximately 2,800,000 inhabitants (National Institute of Statistics, Spain, 2009), totalling somewhat more than 6% of Spain's entire population and a total area of approximately 30,000 km^2.

It must nevertheless be taken into account that each one of Spain's 17 Autonomous Communities and 2 Autonomous Cities have their own individual drug dependence treatment network set-up, and although they share many aspects in common, the results of this study are not extrapolatable to the other Autonomous Communities and Autonomous Cities, nor to Spain as a whole.

The Oliva and Rivera study shows health care costs to be the most important costs, yet not the only costs. To favour a precise calculation of the costs, they set out an initial classification of two major divisions: direct and indirect costs.
The direct costs of this disease include the health care costs, the costs of rehabilitation and employment reintegration programs, the research-related costs, the costs related to crimes and the costs of informal caregivers. The indirect costs are usually related to the health condition of the person having addiction-related problems and are related to the disorders not resulting directly from the use of the addictive substance in question, although this substance has indeed played a major role in setting off or worsening the disorder. In the case, for example, of a person who contracts an HIV infection and develops AIDS as a result of using a contaminated needle when using intravenous drugs. The cause of the disease is blood contagion, but this contagion took place due to drug use, the disease in question therefore being an indirect cost of drug use.

The authors include a diagram concerning the different types of costs assessed, in which the items which have been observed as well as those it was not possible to observe - which, when omitted, entail an obvious underestimation of the total cost - are stated.



Source: Oliva and Rivera, 2006
(*) Not quantified

In all, **the overall annual cost attributable to illegal drug use in the Autonomous Community of Galicia is estimated at 129-133 million euros. It is of interest to note the major relative importance of the indirect costs (nearly 70% of the total**

costs) in this study, given that costs of this type are usually neither perceived nor estimated and, if fact, the authors specify all those items which could not be quantified. As previously mentioned, the health care costs totalled nearly all of the direct costs. Once again here, major items of the direct non-health care costs could not be quantified (imprisonment, judicial, police, research, informal caregiving costs, etc.), the costs of the rehabilitation and employment reintegration programs having mainly been used.

Although not related to the time frame for which the bibliographic search was run, worthy of mention is the study conducted by García-Altés et al (2002) which estimated the costs incurred as a result of illegal drug use in the Autonomous Community of Catalonia and nationwide in Spain (estimates for 1997).

Drawing a comparison among the results of the different studies is complicated, given that different populations are studied, besides the costs being calculated differently. Thus, for example, the García-Altés et al. study takes in the direct costs related to crimes, whilst these costs are not calculated in the Oliva and Rivera study.

Some comparative data of the two studies is provided in Table 12.1:

Table 12.1 Comparison of illegal drug use-related costs (Oliva and Rivera, 2006 vs. García-Altés, 2002)

Author/Location/ Year estimate	Total Direct Costs	Health Care Cost	Direct Crime-Related Costs[a]	Others[b]	Total Direct Costs	Total Indirect Costs	Total Costs
García-Altés *et al*. (2002) Spain Estimate year: 1997	Direct Costs	65.50%	24.20%	10.31%	100.00%	--	--
	Total Costs	49.49%	18.28%	7.79%	75.57%	24.23%	100.00%
García-Altés *et al*. (2002) Catalonia Estimate year: 1997	Direct Costs	78.61%	16.37%	5.02%	100.00%	--	--
	Total Costs	44.70%	9.31%	2.85%	56.85%	43.15%	100.00%
Oliva and Rivera (2006) Galicia Estimate year: 2003	Direct Costs	98.50%	--	1.50%	100.00%	--	--
	Total Costs	31.03%	--	0.50%	31.53%	68.47%	100.00%

Source: Oliva and Rivera (2006). Modified by Gil Lacruz, A (University of Zaragoza, Spain) and Sánchez Iriso, E (Public University of Navarre, Spain).
[a] Includes court costs, costs of imprisonment, police costs, property destruction
[b] Includes employment reintegration programs, administrative costs of transfers, research, traffic accidents

The results of the bibliographic review conducted are highly revealing of the **complexity involved in assessing the costs resulting from treating drug dependencies** in general and, **in particular, in the case of Spain due to** the diversity of organizational setups and the functioning of the drug dependence care networks of the different Autonomous Communities and Autonomous Cities as a result of the **characteristics of the administrative organization of the State of Spain.**

Part C

BIBLIOGRAPHY AND ANNEXES

LIST OF TABLES AND GRAPHS USED IN THE TEXT