European Monitoring Centre for Drugs and Drug Addiction

MINISTERIO DE SANIDAD Y CONSUMO
SECRETARÍA GENERAL DE SANIDAD
DELEGACIÓN DEL GOBIERNO PARA EL PLAN NACIONAL SOBRE DROGAS

2007 NATIONAL REPORT (2006 data) TO THE EMCDDA
by the Reitox National Focal Point

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

REITOX

SUMMARY

The present report on the drug situation in Spain in 2006 has been drawn up by the Spanish Focal Point, the Government Delegation for the National Plan on Drugs (GDNPD), in accordance with the guidelines established by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), as part of the 2006 REITOX grant agreement for an action.

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

Regarding the legal framework, various important provisions with national, regional and international scope were adopted and published in the year 2006.

As far as national regulations are concerned, the Law 29 of July 26, 2006 on guarantees and rational use of medicines and health products establishes the general legal system governing medicines of any type for human use and their various aspects. The law includes provisions on narcotic and psychotropic substances.

Also, within the legal system governing sports, we must point out the importance held by the adoption of ***Constitutional Law 7 of November 21, 2006 on the protection of health and the fight against doping in sports.***

In terms of international cooperation in the fight against illegal drug trafficking, as well as other serious criminal activities and money laundering, we must mention, due to its undisputable importance, the text of ***Law 18, June 5, 2006, for effectiveness in the European Union of the resolutions for seizing and ensuring evidence in criminal proceedings***.

Finally, there have been some reforms of an organizational nature within the General State Administration during said time period, in relation with drug-related issues: ***Royal Decree 991, September 8, 2006, whereby the basic organic structure of the Ministry of the Interior is developed*** and ***Royal Decree 1116, October 2, 2006 whereby the composition and structure of the Inter-ministerial Group for the National Plan on Drugs is determined***.

In 2006, a new National School Drug Survey was conducted. In general, drug use among students between the ages of 14 and 18 years continues to be experimental or occasional, and is linked with leisure time and the weekend. Alcohol and tobacco remain the most commonly used drugs, followed by cannabis. The year 2006 data, however, show very positive developments, with a significant decrease in the use of the most widespread drugs among students.

The results of this Survey show that the drugs most widely used by students between the ages of 14 and 18 years continued to be alcohol, tobacco and cannabis. Of these students, 79.6% had consumed alcoholic beverages ever-in-lifetime, 46.1% had used tobacco and 36.2% had used cannabis. Last year, cannabis use among population 14-18 years is 6.8 points less. For cocaine use, in the last year, figures show a decrease of three points.

In the area of prevention, the actions in priority areas established in the 2005-2008 Action Plan that were set in motion in previous years have been continued and reinforced.

In 2006, the Government Delegation for the National Plan on Drugs presented the "*ITACA pilot programme*" on Actions to Prevent Drug Addiction in Schools, which involves three educational prevention programmes (two universal and one selective) aimed at students of every age group. These programmes are designed to reinforce and increase the efficacy of programmes already operating in schools. The Pilot Programme will be funded by the Ministry of Health and Consumer Affairs through the Government Delegation for the National Plan on Drugs, and has been prepared jointly with the Ministry of Education and Science.

Also, in 2006 the Government Delegation for the National Plan on Drugs has continued working with the Forum *"Society faced with Drugs"* in which the main NGOs of the sector and other social organisations participate, and which helps to support these activities on three different levels: Family, Young People and the Social Media.

Public awareness by mass media campaigns has continued with a special emphasis on cannabis and cocaine. A spot has been shown in TV and disseminated in other media with a wide coverage entitled "Drugs: there are some trains it is better not to catch".

On the supply side, actions against drug trafficking and related crimes have been implemented with efficiency. Routes for drug trafficking are presented and statistics on seizures and arrested persons show a persistence in the high quantities of illicit drugs confiscated in Spain.

1. NATIONAL POLICIES AND CONTEXT

Legal framework

In terms of regulatory activities in the year of 2006, several rules and regulations of great interest were approved and published.

The most notable, first of all, was ***Law 29 of July 26, 2006 on the guarantees and rational use of medicines and health products***, which repealed Law 25 of December 20, 1990. In this new law, which, on a general basis, establishes the general legal system governing medicines of any type for human use and their various aspects, there are also several special provisions, applicable only to those medicines which contain narcotic or psychotropic substances, rounding off the specific legal system for the governmental control of such medicines.

Also involving this topic, we should point out the mandate referring to the need to establish –by way of a regulatory rule– the minimum requirements, characteristics and term of validity of medical and hospital prescriptions, as well as the special requirements on the prescription and dispensation of medicines containing psycho-active substances. Also prohibited is the authorization of free samples of medicines containing these substances which cause dependence. Likewise, in terms of veterinary medicines, the requirement of a veterinary prescription is foreseen when these medicines contain psycho-active narcotic and psychotropic substances. Last of all, the law foresees the prohibition of advertising for all of the medications which contain such substances.

Within the legal system governing sports, we must point out the importance held by the passage of ***Constitutional Law 7 of November 21, 2006 on the protection of health and the fight against doping in sports.***

The intention of this law is, on the one hand, to update the mechanisms for controlling and repressing drug use within the world of advanced competition sports and, on the other, to create a systematic, transversal framework for preventing, monitoring and repressing drug use in general, which is considered a societal threat which jeopardizes the health of both professional athletes and those who regularly or occasionally practice sports.

Among the new features of the aforementioned law, the most notable are as follows: the creation of a new governmental organization which monitors doping, including the creation of the State Anti-Doping Agency; the new configuration of the power to place sanctions in this field, more in accordance with the principle of legal reserve, at the same time harmonizing the law with international regulations; and last of all, the introduction of a new article into the Penal Code, Article 361 bis, the purpose of which is to punish those in the athlete's environment while preserving public health, which is threatened by the commercialization and uncontrolled dispensation of products lacking any guarantees and which are harmful to people's health.

Within the field of psychotropic substance oversight, the most notable event this year was the approval of ***Order SCO/2004/2006, of June 19, which amended Order SCO/469/2002, of February 19, whereby certain active ingredients were included in Annex I of Royal Decree 2829 of October 6, 1977 which regulates psychotropic substances and products.***

With the new Order, GHB esters and ethers were excluded from List IV of Annex I of Royal Decree 2829 of October 6, 1977 –substances not included in List IV of the 1971

Convention on Psychotropic Substances–, while the remaining portion of the system for oversight of that substance and its salts went unchanged by the approval of Order SCO/469/2002.

In terms of international cooperation in the fight against illegal drug trafficking, as well as other serious criminal activities and money laundering, we must mention, due to its undisputable importance, the text of ***Law 18 of June 5, 2006 for effectiveness in the European Union of the resolutions for seizing and ensuring evidence in criminal proceedings***.

The aforementioned law –which includes the provisions contain in Framework Decision 2003/577/JAI of the Council, dated July 22, 2003– has the fundamental purpose of establishing the mechanism through which measures are to be conveyed by Spanish court authorities for seizing goods or securing the evidence decided in criminal proceedings, when the objects, information or documents subject to the measure are located in another Member State of the E.U.; likewise, it determines in what way the Spanish court authorities are to acknowledge and comply with such decisions, when they are issued by a court authority in another Member State.

One of the main innovations in this new law in terms of the aforementioned mechanism is the waiver of requiring control of double incrimination for a series of violations, which include illicit drug trafficking and the laundering of the product of crime, provided that the sentence foreseen for those violations in the issuing State is one of deprivation of freedom for a maximum duration of at least three years, the double definition requirement being maintained in all other cases.

Along with this, another notable new feature is the reform of Article 338 of the Law on Criminal Procedure, and the introduction of a new Chapter II bis, in Title V of Book II thereof.

Within this new chapter of the Law on Criminal Procedure, Article 367 ter.1 now regulates –instead of aforementioned Article 338, in its prior version– the destruction by court order –with a hearing of the Public Prosecutors and the parties– of the toxic drugs seized or apprehended in criminal proceedings, keeping enough samples for later verifications or investigations, though they may be kept in their entirety (when the court deems it necessary to do so). As for new Article 367 sub-section six, it expressly maintains the validity, without amendment, of the legal provisions –on the topic of drug destruction and those of seizure, provisional use, early dispossesion, confiscation and definitive assignment to the State of other properties, effects and earnings seized due to illegal drug trafficking and the laundering of money originating from it– in Article 374 of the Penal Code, and in Law 17 of May 29, 2003.

In another order of affairs, there is notable interest –in terms of re-integration into work and society by people affected by drug addictions– in some of the contents of ***Law 43 of December 29, 2006 on the improvement of and increase in employment.***

More specifically, we must emphasize the provision (foreseen in Article 2.5) in accordance with which those employers who give indefinite employment contracts to workers suffering from a situation of social exclusion –which includes those who suffer from drug addiction or alcoholism and are undergoing a rehabilitation or social re-integration process–, provided that this situation is accredited by the social services or other competent entities, may be awarded monthly rebates on the company's share of the Social Security payment or, where appropriate, by the equivalent daily amount, per hired worker, equal to 50 euros/month (600 euros/year) for 4 years. When involving

temporary hiring, such hiring will entitle the employer to a rebate of 41.67 euros/month (500 euros/year), throughout the duration of the contract.

In terms of the prevention of the laundering of money originating from illegal drug trafficking, as well as other serious criminal activities, three laws were passed in 2006.

The most important of these constitutes the amendment of **Article 2.1** of ***Law 19 of December 28, 1993 on certain measures to prevent money laundering***, as established in Final Provision Two of ***Law 36 of November 29, 2006 on measures to provide tax fraud***, with the purpose of expanding the subjective realm of applicability of the law on the prevention of money laundering to include certain professional groups and business or financial entities that had previously been excluded.

Therefore, after the aforementioned legal reform took effect, both insurance brokers, when they act in relation with life insurance or other services related with investment, and collective investment companies whose management is not the responsibility of a management company, as well as companies which manage venture capital entities or reciprocal guarantee companies, in addition to other operators, in all cases including those transactions which are performed through agents or intermediaries, are now also subject to the fulfillment of the obligations established in aforementioned Law 19 of December 28, 1993.

Along with said rule with the rank of a law, we must also emphasize two regulatory provisions of interest.

First of all, ***Order EHA/1439/2006, of May 3, which regulates the declaration of means of payment transactions within the realm of money laundering prevention.*** In accordance with this Order, the amounts which must be declared have been raised, by legal authorization. They are set at 10,000 euros for entering or exiting across the border and 100,000 euros for transactions within the national territory. Also regulated is the intervention in all means of payment –by implementation of the Regulation of Law 17/2003– when there have been omissions or false statements in the declaration.

Secondly, ***Order EHA/2619/2006, of July 28, which implements certain money laundering prevention requirements for taxpayers who perform the activity of exchanging currency or handling foreign transfers.*** One of the most important aspects of this Order involves providing, to the taxpayers to whom the order is applicable, a set of precise principles with respect to the measures of internal control that they must adopt in accordance with the Law, thereby reducing the margin of uncertainty in the design and implementation thereof.

In terms of the regulations on controlling legal drugs, one must bear in mind the **amendment of Article 4 b) of *Law 28 of December 26, 2005 on health care measures to fight tobacco use and for the regulation of the sale, supply, consumption and advertising of tobacco products,*** in accordance with the provisions of Article Three of ***Royal Decree-Law 2 of February 10, 2006, which modified the tax rates of the Tax on Tobacco Works, established a complementary transitional margin for tobacco and stamp sellers and amended Law 28 of December 26, 2005*** mentioned above.

With this legal reform, newsstands were allowed to continue selling tobacco products through vending machines, provided that they are located inside of the newsstands, in order to avoid –without harming the public's health– the economic damage that could

be produced in the aforementioned sector, whose revenue from tobacco sales have traditionally been quite high.

In addition to the above, we must also point out –with respect to the regulation on tobacco– the tax reform carried out in ***Royal Decree-Law 10 of November 10, 2006 whereby the tax rates of the Tax on Tobacco Works were modified***.

In accordance with this norm, and with the explicit goal of promoting a decrease in the usage of this product by increasing its public selling prices, **Item 5 of Article 60 of *Law 38 of December 28, 1992 on Special Taxes* was modified**, in order to raise to 70 euros, instead of the former amount of 55 euros, the single tax rate per 1,000 cigarettes.

In order to conclude this examination of regulatory activities in 2006, we must necessarily make reference, as well, to the reforms of an organizational nature performed within the General State Administration during said time period, in relation with activities to fight against drugs.

In this sense, we must first of all mention ***Royal Decree 991 of September 8, 2006, whereby the basic organic structure of the Ministry of the Interior is developed***.

The aspects of this reform involve the following factors: attributed directly to the State Secretariat of Security are the tasks of management, promotion and coordination of the activity by said Department in the field of illegal drug trafficking and money laundering related with said trafficking and linked crimes; removed, in accordance with the aforementioned, are both the Office for Analysis and Prospecting of drug trafficking, money laundering and related crimes and the Office for Concerted Action on drug trafficking, money laundering and related crimes, both forming part of said State Secretariat. Last of all, ascribed to the Ministry of the Interior, through the aforementioned State Secretariat, are both the Superior and Advisory Boards for the fight against drug trafficking and money laundering, and the Advisory Board of the observatory on the tracking of the use of new technologies by criminal organization which perform illegal drug trafficking and which launder money originating from this illegal trafficking and other related crimes. A new unit, the Center Against the Organized Crime has been set up for the elaboration of the strategic intelligence for all types of organized crimes and the establishments of criteria for the operative coordination of services.

In addition to the above, in terms of the organic structure of the National Plan on Drugs, we must point out the reform carried out through ***Royal Decree 1116 of October 2, 2006 whereby the composition and structure of the Inter-ministerial Group for the National Plan on Drugs is determined***.

The re-structuring of ministerial departments performed in accordance with Royal Decree 553 of April 17, 2004, as well as the assignment by the Government Delegation for the National Plan on Drugs (the title holder of which is the Secretary of the Inter-ministerial Group) to the Ministry of Health, in accordance with Royal Decree 1555 of June 25, 2004, advised adapting the structure of the Inter-ministerial Group for execution of the National Plan on Drugs, established beforehand in Royal Decree 79 of January 24, 1997, to these changes.

For this reason, the new regulatory provision attributes the presidency of the Group to the Ministry of Health and Consumer Affairs. Moreover, included in said body are the Ministers of Foreign Affairs and Cooperation, that of the Public Administration, and the State Secretary of Security and the General Secretary of Health. Last of all, the norm

also foresees the naming of departmental coordinators, for the purposes of the National Plan on Drugs, in those ministries whose directors are now included in the Group.

Institutional Framework, Strategies and Policies

The data corresponding to the National Strategy on Drugs for 2000-2008, the intermediate evaluation in the National Strategy for 2000-2008 and the Action Plan for 2005-2008 are all included in Structured Questionnaire 32, which was sent to the EMCDDA in 2006.

At present, there are Autonomous Regional Plans in all of the Autonomous Regions. Most of them have approved documents which contain the regional strategy in the field of drug addictions. For instance:

Andalusia: Second Andalusian Plan on Drugs and Addictions (PASDA) 2002-2007.

Aragon: First Autonomous Regional Plan on Drug Addictions and Other Addictive Behaviors, approved in the year of 2004.

Asturias: Regional Plan on Drugs, approved by the Government Council in the year of 2002.

Canary Islands: Second Canary Islands Plan on Drugs for 2003-2008, approved by the Canary Islands Government Council on March 24, 2003.

Cantabria: Regional Strategy of Cantabria on Drugs for 2005-2008, approved by the Government Council on December 22, 2005.

Castile-La Mancha: Plan on Alcoholism and Drug Dependencies of Castile-La Mancha 2006-2010.

Castile and León: Fifth Regional Plan on Drugs for 2005-2008.

Catalonia: Master Plan for Mental Health and Addictions. National Strategy of Prevention for Drug Use and Association Problems for 2006-2012. Special plan for cocaine.

Extremadura: The Health Plan for 2001-2004 includes drug addictions as a health problem. In relation with this Plan, there is an Integrated Drug Dependency Plan.

Galicia: Galician Plan on Drugs for 2000-2004. A new Plan on Drugs for 2007-2009 was drafted and is pending approval.

Balearic Islands: Action Plan on Drug Dependencies and Addictions of the Balearic Islands for 2007-2011.

Madrid: Strategic Plan on Drugs of the Autonomous Region of Madrid for 2006-2009.

Murcia: Third Regional Plan on Drugs, 2007-2010.

Navarre: Autonomous Regional Plan on Drug Addictions, 1993.

Basque Country: Fifth Drug Addiction Plan, 2004-2008.

La Rioja: La Rioja Plan for Drug Dependencies and Other Addictions.

Valencian Community: Strategic Plan on Drug Dependencies and Other Addictive Disorders, 2006-2010.

The requirement placed on local governments (municipalities) to adopt municipal drug addiction plans may be reflected in the Regional Laws on Drug Addiction. These plans must be compliant with the different Autonomous Regional Plans, which, in turn, have objectives coordinated with the National Plan on Drugs. There are already more than one hundred Municipal Plans, and practically all cities have a Municipal Plan.

At the same time, the Government Delegation for the National Plan on Drugs worked throughout the second half of the year 2006 to create the Action Program Against Cocaine for 2007-2010, which was put in practice in early 2007. It sets down a specific strategy to face this problem and foresees four areas of intervention: coordination, decreasing demand, international cooperation and controlling the supply.

Budget and Public Expenditure

See Selected Issue 11: “Public Expenditure”

Social and Cultural Context

The **Center for Sociological Research (CIS)** is an independent entity which forms part of the Ministry of the Presidency, the purpose of which is to study Spanish society, mainly through survey-based research. On a monthly basis, it does a survey which measures the status of Spain’s public opinion in relation with the country political and economic situation, as well as other topics which stand out in society at the current time.

The data from the last survey published in the month of July 2007 put the problem of drugs in ninth place among the list of matters which most concern those people interviewed, behind terrorism, housing, unemployment, immigration, the economic situation and other topics. This position is far lower than that held by drug addictions one decade ago, which means that there has been either a decrease in the perception of risk among the population regarding psycho-active substance use or less visibility of its effects.
In this respect, the results of the National Household of 2005 among the general population aged 15 to 64 years have shown that, as occurs in the rest of Europe, the most commonly used psycho-active substances in our country continue to be alcohol, tobacco, cannabis and cocaine. The ages when people start using these substances are earlier for those which are legal than for illegal drugs, and for all substances there is less usage among women than among men, except in the case of hypnotic sedatives that do not require a medical prescription.

The use of psycho-active substances, whether legal or illegal, in our country is concentrated among people under the age of 35, except in the case of hypnotic

sedatives that do not require a prescription, in which case usage is greater among people from 35-65 years old, and particularly among women. Another characteristic feature that is confirmed is multiple drug use.

At the same time, in the last two years an increase in the perception of risk associated with drug use has been found for all substances, with the exception of hypnotic sedatives that do not require a prescription, though in terms of the perceived availability of illegal drugs, the population believes it is quite easy to gain access to them.

As for the School Survey of 2006-2007 among secondary school students (14 to 18 years old), the survey offers positive results, the most noteworthy of which are a significant decrease in the use of the most widespread and widely used drugs in this population (alcohol, tobacco and cannabis). For the first time since 1994, there has been an inversion in the rising trend maintained in the use of cannabis and cocaine. Moreover, there was an increase in the perceived risk associated with drug use, especially in the case of alcohol and cannabis, along with a decrease in the availability in getting drugs perceived by students.

In relation with the civil society initiatives in the field of drug addiction, we must emphasize the work of the Forum: "Society in the face of drugs," established in 2005 under the presidency of the Minister of Health and Consumer Affairs, which currently has more than 50 cooperating entities. Its goal is to create a platform for the relationship between the Ministry and the civil entities which represent families, youths and the media, making it possible to give civil society a greater role and more ability to participate in everyone's commitment to decrease drug use.

In the last two years, the Forum has created three Work Groups: Youths, Family and Media.

The Youth Work Group is made up of organizations that represent youths, as well as those organizations dedicated to working on different aspects of youth life, such as free time, or their joining the working world. It has reiterated the need to count on the participation of youth entities to develop prevention policies and these entities' desire to get involved. The Group met on four occasions in 2005 and another four times in 2006.

The Family Work Group is made up of organizations that work on prevention and assistance for drug addicts and of parents associations. As a response to the current of "lacking social motivation" also being suffered by families, it is attempting to find a reference framework on new forms of drug use that will allow it to play the preventative role assigned to it and focus "family and drug" problems from a perspective of community intervention, with the involvement of other social agents, especially the NGOs which work in the field of drug addictions, so that they can take on a role of responsibility and leadership. Also proposed was the start-up of specific programs on the basis of the risk levels of the different types of family units that exist today. The group met on three occasions in 2005 and six in 2006.

The Media Work Group has made it possible to create a space for thought between information providers (bodies of the Public Administration, NGOs) and the media. In doing so, it has produced a Good Practices and Recommendations Guide for information professionals, with a decalogue for journalists regarding the rigor and balance necessary for informational coverage of drugs, and another guide for directors, screenwriters and producers who work in the creative processes of fictional series and entertainment works. The Group met on four occasions in 2005 and another four in 2006.

Meanwhile, the Parliament and the members of the Mixed Congress-Senate Commission for Studying the Drug Problem got approved, in June 2005, the establishment of a Presentation for Studying the harmful effects of drugs on youths' health and, most especially those of substances such as cannabis, cocaine and designer drugs. Various experts in the field of drug addictions have testified, contributing different viewpoints, experiences and the latest scientific evidence on the topic, which has led the Commission to draft a report and make a series of recommendation which will be revised and approved by both chambers of Parliament and will therefore entail specific activities that will undergo parliamentary tracking and monitoring.

In the field of prevention and sensitization, the most notable events were the dissemination of the Report on Cannabis produced by the Clinical Commission of the Government Delegation for the National Plan on Drugs and the campaigns carried out in the year 2006 by the National Government (Government Delegation for the National Plan on Drugs), as well as by the Autonomous Regions.

The Government Delegation for the National Plan on Drugs launched a campaign to prevent cannabis and cocaine use with the slogan "There are trains it is better not to get on," because these are the two most widely used drugs in Spain. Furthermore, since 2004 and with the cooperation of the "Ramón Rubial-Spaniards in the World" Foundation, campaigns have been carried out to increase awareness among the general population about the risks associated with drug use and trafficking abroad.

Up to today's date, the Autonomous Regions have reported having carried out the following information and sensitization campaigns:

Aragon
Drug use prevention campaign for youths during night time entertainment by cell phone.

Andalusia
Campaign with the slogan "Use your head. Don't let yourself get carried away. Better without drugs," aimed at preventing drug use among young people.

Asturias
This autonomous region carried out several drug use prevention campaigns.
Campaign with the slogan "There are drinks that are won and others that are lost," for the prevention of alcohol use among youths, of a regional scope.
Campaign with the slogan "Youths, alcohol and traffic" of a local scope.
Campaign with the slogan "Consider yourself informed" aimed at preventing drug use in the general population, of a local scope.
Campaigns related with the celebration of the World Day Without Tobacco, the World Day Without Alcohol and the World Day Without Drugs, of a local scope.
Campaign to provide information on the resources existing for drug addictions, of a local scope.

Canary Islands
Informative prevention campaign for youths based on information and communication technologies (TIC).

Cantabria
Campaign with the slogan "Know how to drink, know how to live," aimed at preventing drug use in the working population.

Castile and León
Campaign with the slogan "Don't get involved," for the prevention of drug use in the general population.
Campaign with the slogan "With alcohol, it doesn't make sense," aimed at preventing alcohol use among youths.

Extremadura
Campaign with the slogan "Make sense: you decide," aimed at preventing drug use mainly among youths.

Galicia
Campaign with the slogan "Take a look at drugs. Certain things you should know," to prevent the use of various substances (cocaine, cannabis, synthesized drugs and alcohol).

La Rioja
Campaign to raise awareness and prevent cocaine use among youths and families in La Rioja.

Madrid
Campaign with the slogan "Cocaine draws you closer to death" to prevent cocaine use among the general population.

Basque Country
Campaign with the slogan "Alcohol for minors? Not a drop" for the prevention of alcohol consumption among minors.

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

Drug Use in the General Population

The information in this Section is included in the 2006 Spanish National Report.

Drug Use in the School and Youth Population

In 2006, a new survey was performed on drugs in the school population. The survey forms part of a series of surveys that have been carried out in Spain once every two years since 1994, with the goal of becoming familiar with the situation and trends in drug use among students between the ages of 14 and 18 years who attend Secondary Schools. The surveys were financed and promoted by the Government Delegation for the National Plan on Drugs and have been provided with the cooperation of the Autonomous Regional Governments (Autonomous Regional Plans on Drugs and Departments of Education) and the Ministry of Education and Science.

The general objective of the surveys is to gather useful information in order to design and evaluate policies aimed at preventing drug use and problems, with a main focus on the family and/or school environments. This information complements that which is obtained using other methodologies, such as drug problem indicators (admittances for treatment, hospital emergency rooms or drug-related mortality), the National Household on Alcohol and Drugs in Spain (EDADES) and the indicators on the drug supply and supply control.

Though changes were made in the questionnaire and in the procedures for gathering data throughout the time period, the methodology remained quite uniform, and therefore the data can be used to observe trends over time. At the same time, the questionnaire and the methodology used are very much similar to those of other countries in the European Union and the United States, which makes it possible to perform quite a few international comparisons. Different versions of the questionnaire in the various languages of Spain were used.

Objectives

The specific objectives of the State Survey on Drug Use in Secondary Schools (ESTUDES) are as follows:

a) To discover the rate of consumption of the various psycho-active drugs.
b) To discover the most important socio-demographic characteristics of drug users.
c) To discover certain relevant usage patterns.
d) To take into account opinions, knowledge, perceptions and attitudes towards certain aspects related with drug abuse (perceived availability, perceived risk given various usage behaviors), and certain factors related with drug use.
e) To estimate the degree of exposure and receptiveness of students to certain interventions.

Methodology

Reference Population and Sample Frame:

The reference population for this series of surveys was all Spanish students between the ages of 14 and 18 years who attend Secondary Schools. The percentage of Spanish youths between the ages of 14 and 18 years who are students in this level of schooling was between 75%-82% during the time period in which the survey was taken.

The basis or sample frame used to select the sample was the population registered in schools or centers of learning with students in Third and Fourth Year Obligatory Secondary Schooling (ESO), First and Second Year of the LOGSE (Law on the General Organization of the Education System), Baccalaureate and Mid-level Training Cycles (Table 2.2.1.). This frame conditions the distribution of the sample by age. In fact, several groups are left outside of the frame. These include students from 14-18 years old who were studying primary or university education, students from 14-18 years old who did not attend school on the date and time when the questionnaire was given (absent), students of General System Schooling included in Social Guarantee Programs and remote schooling, those in Night School Education and Special System Learning. It is quite probable that the bias introduced due to absenteeism and other factors remain relatively constant over the time period, and therefore the effect of this bias on the trends over time and changes in drug use rate and patterns is surely quite small.

Table 2.2.1. BREAKDOWN OF SPANISH STUDENTS IN SECONDARY SCHOOL, BACCALAUREATE AND MID-LEVEL VOCATIONAL SCHOOL TRAINING CYCLES, BY AUTONOMOUS REGION OF RESIDENCE, BY SCHOOL TYPE (PUBLIC OR PRIVATE), AND BY TYPE OF STUDIES. SPAIN, 1994-2006

	Absolute Numbers							Percentage						
	1994	1996	1998	2000	2002	2004	2006	1994	1996	1998	2000	2002	2004	2006
AUTONOMOUS REGION														
Andalusia	471,794	462,498	439,486	402,840	361,512	363,862	326,571	18.4	19.1	19.7	20.8	20.4	20.6	20.5
Aragon	69,699	64,548	58,208	49,597	45,599	44,849	40,860	2.7	2.7	2.6	2.6	2.6	2.5	2.6
Asturias	73,467	67,094	59,379	48,271	42,232	39,752	33,888	2.9	2.8	2.7	2.5	2.4	2.3	2.1
Balearic Islands	39,271	37,441	36,613	34,923	34,408	34,804	31,333	1.5	1.5	1.6	1.8	1.9	2.0	2.0
Canary Islands	113,256	110,955	111,340	96,577	87,248	85,592	74,244	4.4	4.6	5.0	5.0	4.9	4.8	4.7
Cantabria	36,909	34,734	311,64	26,253	23,666	22,473	19,609	1.4	1.4	1.4	1.4	1.3	1.3	1.2
Castile and León	160,256	151,635	137,270	117,058	105,092	102,177	89,776	6.3	6.2	6.2	6.0	5.9	5.8	5.6
Castile-La Mancha	90,837	89,425	85,693	79,729	77,727	78,397	73,297	3.5	3.7	3.8	4.1	4.4	4.4	4.6
Catalonia	384,125	354,024	310,815	262,519	248,490	248,973	236,139	15.0	14.6	14.0	13.5	14.0	14.1	14.8
Valencian Community	251,506	234,037	215,858	190,873	178,801	177,602	160,648	9.8	9.6	9.7	9.8	10.1	10.1	10.1
Extremadura	57,224	59,242	58,622	54,160	51,426	50,791	46,757	2.2	2.4	2.6	2.8	2.9	2.9	2.9
Galicia	182,834	176,703	163,396	134,929	113,916	112,125	94,564	7.1	7.3	7.3	7.0	6.4	6.4	5.9
Madrid	347,417	322,791	292,702	251,754	229,324	231,045	207,926	13.6	13.3	13.1	13.0	12.9	13.1	13.1
Murcia	73,929	71,706	66,423	60,005	55,246	56,305	51,755	2.9	3.0	3.0	3.1	3.1	3.2	3.3
Navarre	32,758	30,589	26,977	22,174	21,103	20,626	19,640	1.3	1.3	1.2	1.1	1.2	1.2	1.2
Basque Country	151,581	136,827	112,596	90,058	82,048	78,790	67,592	5.9	5.6	5.1	4.6	4.6	4.5	4.2
Rioja	17,809	16,224	14,249	11,940	10,928	10,723	9,755	0.7	0.7	0.6	0.6	0.6	0.6	0.6
Ceuta	3,379	3,565	3,724	3,611	3,303	3,433	2,797	0.1	0.1	0.2	0.2	0.2	0.2	0.2
Melilla	2,961	3,136	3,455	3,197	3,244	2,970	2,791	0.1	0.1	0.2	0.2	0.2	0.2	0.2
SCHOOL TYPE														
Public	1,911,828	1,769,080	1,626,084	1,362,588	1,225,988	1,241,521	1,093,906	74.7	72.9	73.0	70.2	69.1	70.3	68.80
Private	649,184	658,094	601,886	577,880	549,325	5,237,68	496,036	25.3	27.1	27.0	29.8	30.9	29.7	31.20
TYPE OF STUDIES														
ESO (Obl. secondary ed.)	237,115	515,206	886,542	953,021	935,678	937,280	891,860	9.3	21.2	39.8	49.1	52.7	53.1	56.09
Baccalaureate	1,510,024	1,261,877	927,249	724,972	614,796	600,389	576,960	59.0	52.0	41.6	37.4	34.6	34.0	36.29
Vocational School	813,873	650,091	414,179	262,475	224,839	227,620	121,122	31.8	26.8	18.6	13.5	12.7	12.9	7.62
TOTAL	**2,561,012**	**2,427,174**	**2,227,970**	**1,940,468**	**1,775,313**	**1,765,289**	**1,589,942**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: State Survey on Drug Use in Secondary Schools (ESTUDES)

Nevertheless, it is advisable to bear in mind that in 2004 the survey was carried out in the months of May and June, whereas all of the other surveys were taken in November and December. This may have influenced students' leisure time habits, such as the frequency of going out at night, or other factors related with drug use, and therefore when comparing the results this must be taken into account. At the same time, there is a problem is under-representation of 18-year-old students in the sample, so it is advisable to stratify certain results by age.

Sample

Two-stage sampling by sets was used, by randomly selecting schools as first stage units and classrooms as second stage units. After this, all of the students in the selected classrooms were included in the sample, in order to simplify the sample design, as well as the execution and analysis of the survey.

The selection of the schools was performed using lists provided by the Departments of Education. In order to select the schools, the sample frame was first stratified by autonomous region (17 strata, plus two strata corresponding to Ceuta and Melilla as of 1996) and school type (two strata, public and private schools). As of the year 2000, all of the schools in each stratum had the same likelihood of being in the sample, regardless of their size. Table 2.2.2. shows the breakdown of the sample by autonomous region, school type and type of studies.

.

Table 2.2.2. BREAKDOWN OF STUDENTS BETWEEN THE AGES OF 14-18 YEARS INCLUDED IN THE ESTUDES SAMPLE, BY AUTONOMOUS REGION OF RESIDENCE, SCHOOL TYPE AND TYPE OF STUDIES. SPAIN, 1994-2006.

	Absolute Numbers							Percentage						
	1994	1996	1998	2000	2002	2004	2006	1994	1996	1998	2000	2002	2004	2006
AUTONOMOUS REGION														
Andalusia	2,469	2,075	1,976	2,372	2,552	2,464	2,750	11.8	10.9	10.9	11.6	9.6	9.7	10.4
Aragon	1,014	941	775	671	2,185	1,757	1,764	4.8	5.0	4.3	3.3	8.2	6.9	6.7
Asturias	993	875	765	661	744	584	1,737	4.7	4.6	4.2	3.2	2.8	2.3	6.6
Balearic Islands	758	661	679	602	1,762	1,795	622	3.6	3.5	3.8	2.9	6.6	7.0	2.4
Canary Islands	880	859	966	739	960	835	2,079	4.2	4.5	5.3	3.6	3.6	3.3	7.9
Cantabria	746	575	722	1,244	1,169	1,478	1,376	3.6	3.0	4.0	6.1	4.4	5.8	5.2
Castile and León	1,356	1,120	1,093	919	1,140	983	1,107	6.5	5.9	6.0	4.5	4.3	3.9	4.2
Castile-La Mancha	893	982	943	1,749	2,501	860	984	4.3	5.2	5.2	8.6	9.4	3.4	3.7
Catalonia	2,304	1,881	1,681	1,552	1,885	2,831	2,177	11.0	9.9	9.3	7.6	7.1	11.1	8.2
Valencian Comm.	1,720	1,466	1,395	2,287	1,685	1,362	1,657	8.2	7.7	7.7	11.2	6.3	5.3	6.3
Extremadura	928	659	718	443	796	1,693	777	4.4	3.5	4.0	2.2	3.0	6.6	2.9
Galicia	1,064	1,436	1,333	1,170	2,108	1,245	2,244	5.1	7.6	7.4	5.7	7.9	4.9	8.5
Madrid	2,123	1,979	1,853	2,929	3,308	3,033	3,055	10.1	10.4	10.2	14.3	12.4	11.9	11.5
Murcia	907	818	813	727	1,394	1,468	1,601	4.3	4.3	4.5	3.6	5.2	5.8	6.1
Navarre	836	659	553	627	530	600	570	4.0	3.5	3.1	3.1	2.0	2.4	2.2
Basque Country	1,293	1,104	1,021	852	806	990	884	6.2	5.8	5.6	4.2	3.0	3.9	3.3
Rioja	647	651	570	462	457	975	525	3.1	3.4	3.2	2.3	1.7	3.8	2.0
Ceuta	0	128	30	323	130	140	289	0.0	0.7	0.2	1.6	0.5	0.5	1.1
Melilla	0	97	199	121	464	428	256	0.0	0.5	1.1	0.6	1.7	1.7	1.0
SCHOOL TYPE														
Public	15,204	13,716	12,766	10,421	14,445	14,889	13,050	72.6	72.3	70.6	51.0	54.4	58.3	49.3
Private	5,727	5,250	5,319	10,029	12,131	10,632	13,404	27.4	27.7	29.4	49.0	45.6	41.7	50.7
TYPE OF STUDIES														
ESO	2,191	5,129	9,560	13,664	14,400	14,415	15,983	10.5	27.0	52.9	66.8	54.2	56.5	60.4
Baccalaureate	13,611	10,495	7,312	5,869	10,733	9,468	8,468	65.0	55.3	40.4	28.7	40.4	37.1	32.0
Vocational School/Training Cycles	5,129	3,342	1,213	917	1,443	1,638	2,003	24.5	17.6	6.7	4.5	5.4	6.4	7.6
TOTAL	**20,931**	**18,966**	**18,085**	**20,450**	**26,576**	**25,521**	**26,454**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

The classrooms were selected once the schools had provided the list of classrooms or groups of students in the school years of interest. The classroom selection was performed with equal probability among all of the classrooms in the school. For economic reasons, the decision was made to select two classrooms in each school.

In each of the surveys, a sample of approximately 20,000-27,000 students was studied (26,454 in 2006), 800-1400 classrooms (1,322 in 2006) and 400-600 schools (577 in 2006) (Table 2.2.3.). In order to ensure at least the minimum accuracy of the estimates by autonomous region, a minimum number of valid surveys was established in each of them. Some autonomous regions finance expansions of the sample.

The percentage of registered students who did not attend class on the date and time of the survey (absent) was between 12% and 17.1% in the various surveys. In 2006, this percentage was 12.1%.

Table 2.2.3. BREAKDOWN OF THE CLASSROOMS AND SCHOOLS INCLUDED IN THE SAMPLE OF THE STATE SURVEY ON DRUG ABUSE IN SECONDARY SCHOOLS, BY AUTONOMOUS REGION. SPAIN, 1994-2006.

Schools	1994	1996	1998	2000	2002	2004	2006
Andalusia	45	45	45	54	60	64	70
Aragon	19	18	18	17	35	32	33
Asturias	19	18	18	17	18	16	29
Balearic Islands	12	12	13	15	32	32	15
Canary Islands	22	23	22	21	23	22	33
Cantabria	13	12	13	28	29	28	28
Castile and León	18	19	27	25	30	27	32
Castile-La Mancha	25	24	17	44	58	22	25
Catalonia	44	38	39	37	43	70	53
Valencian Community	33	33	33	56	37	35	40
Extremadura	16	14	16	10	19	31	19
Galicia	23	26	29	25	36	30	39
Madrid	40	37	40	66	75	71	71
Murcia	16	16	16	17	38	25	25
Navarre	13	13	15	15	14	14	13
Basque Country	26	24	27	21	22	26	28
Rioja	11	12	12	12	12	17	12
Ceuta	_	5*	1	5	3	5	7
Melilla	_	_	3	3	7	6	5
Spain	**395**	**389**	**404**	**488**	**591**	**573**	**577**

Classrooms	1994	1996	1998	2000	2002	2004	2006
Andalusia	92	92	90	108	119	128	139
Aragon	38	36	38	31	101	95	92
Asturias	42	36	36	30	35	32	84
Balearic Islands	29	28	27	24	84	93	30
Canary Islands	44	46	44	41	46	44	98
Cantabria	28	28	28	48	58	84	81
Castile and León	38	40	40	47	58	54	64
Castile-La Mancha	54	55	55	69	116	44	50
Catalonia	88	78	78	74	87	140	103
Valencian Community	68	65	69	90	72	70	80
Extremadura	34	32	53	19	37	92	38
Galicia	56	55	33	43	102	60	116
Madrid	85	80	58	119	144	142	142
Murcia	34	36	79	29	72	74	75
Navarre	30	28	26	22	26	28	26
Basque Country	52	52	33	40	44	51	56
Rioja	25	29	29	20	22	50	24
Ceuta	_	10*	2	15	6	10	14
Melilla	_	_	8	6	22	24	10
España	**837**	**826**	**826**	**875**	**1,251**	**1,315**	**1,322**

* Including both Ceuta and Melilla

Questionnaire and Field Work

A standardized, anonymous questionnaire was used, similar to that used in other surveys completed in Europe and the United States. That used during the period of 1994-2004 was quite similar, but in 2006 changes were introduced to converge more towards international questionnaires, so in certain aspects (not in those involving questions on drug use and perceived availability) it is possible in a certain way that comparability over time may have suffered as a result. In 2006, questions were introduced on GHB consumption and on cocaine base and cocaine in powder form separately, whereas in previous questionnaires they were not included.

The questionnaire states the proposed objectives beforehand and includes questions on: socio-demographic characteristics, drug use, perception of risk from different drug use behaviors, certain aspects related with entertainment, level of perceived availability of different psycho-active drugs, certain social and health-related problems, information gathered on drugs, drug use by friends and classmates, and the attitude of parents regarding drug use.

The linguistic particularities of the various autonomous regions were taken into account. Because of this, different versions of the questionnaire were used in the Castilian, Galician, Basque, Catalan and Valencian languages.

The questionnaire was completed in writing (paper and pencil) by all of the students in the selected classrooms during a normal class (45-60 minutes), in the presence of the teacher (though he or she remains constantly at the lectern).

All of the surveys, except the one in 2004 which was held in spring, were completed in the fall (generally in November and December), though as an exception the year 2006 survey had to be delayed in a few schools until February 2007.

Cooperation by the schools was good. In 2006, the percentage of schools which were replaced was 20.6%, but hardly any refusals were received from schools to cooperate, and in most cases the replacements of schools were due to date-related problems caused by exams or the proximity of vacation times.

At the same time, the degree of cooperation by principals, curriculum directors and teachers at the schools was excellent in all of the surveys. The percentage of students who refused to complete the questionnaire was irrelevant (0.2% in 2006).

In 1994-1998, the sample selection and field work were carried out by the company CUANTER, SA and in 2000-2006 by IPD, SA.

Analysis

The results have been weighted by autonomous region, type of school (public or private) and type of studies (obligatory secondary schooling [ESO], baccalaureate, vocational school/training cycles), to correct the lack of proportionality in the sample with respect to the survey universe. The information on the breakdown of the survey universe by three weighting variables was obtained from the Ministry of Education and Science.

In general, all of the calculations were performed without including those subjects with unknown values for the variables playing a role in each cross tabulation in the numerator and the denominator.

We must point out that the sample is designed to obtain results with acceptable accuracy to estimate the rate of drug use in Spain as a whole, but not in the autonomous regions themselves. Therefore, except in the cases of alcohol, tobacco and cannabis, the estimated rates for the autonomous regions have confidence intervals which are too broad, especially in the autonomous regions with smaller populations, which means that they are highly affected by chance, and when representing the time-based series they may produce saw teeth and deceptive trend lines.

Results

Extension of Drug Use

In 2006, the drugs most widely used by students between the ages of 14 and 18 years continued to be alcohol, tobacco and cannabis. Of these students, 79.6% had consumed alcoholic beverages ever-in-lifetime, 46.1% had used tobacco and 36.2% had used cannabis. The percentage of current users of these substances, or in other words those who had used them in the 30 days prior to the interview, is 58% in the case of alcohol, 27.8% in that of tobacco and 20.1% in that of cannabis.

The use of all other substances (cocaine, ecstasy, hallucinogens, amphetamines, volatile substances, heroin, etc.) is much lower, between 1% and 6% of the students having used them at some time, and between 0.5% and 2.3% those who use them more habitually (Table 2.2.4.).

Separate mention is deserved by the use of tranquilizers. The percentage of students who have taken tranquilizers at some time is 12.6%, whereas those who have used them without a prescription is 7.6%. The current usage thereof (in the last 30 days) has reached 3.6% and 2.4%, respectively.

If we compare these results with those of the previous surveys, we can see a decrease in the use of most of these substances, a decrease which is larger in the case of tobacco, cannabis and cocaine (Table 2.2.4.). These last two substances are, on the other hand, the most widespread drugs, whose use has most increased in recent years.

Table 2.2.4. CHANGES IN RATES OF PSYCHO-ACTIVE SUBSTANCE USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES). SPAIN 1994-2006.

	1994	1996	1998	2000	2002	2004	2006
Ever-in-lifetime use							
Tobacco	60.6	64.4	63.4	61.8	59.8	60.4	46.1
Alcohol	84.1	84.2	86.0	78.0	76.6	82.0	79.6
Hypnotic Sedatives*	6.1	6.1	6.4	6.9	6.5	7.0	7.6
Cannabis	20.9	26.4	29.5	33.2	37.5	42.7	36.2
Ecstasy	3.6	5.5	3.6	6.2	6.4	5.0	3.3
Hallucinogens	5.1	6.8	5.5	5.8	4.4	4.7	4.1
Amphetamines	4.2	5.3	4.3	4.5	5.5	4.8	3.4
Cocaine	2.5	3.4	5.4	6.5	7.7	9.0	5.7
Heroin	0.5	0.5	0.9	0.6	0.5	0.7	1.0
Volatile Substances	3.1	3.3	4.2	4.3	3.7	4.1	3.0
Rate of use in the last 12 months							
Alcohol	82.7	82.4	83.8	77.3	75.6	81.0	74.9
Hypnotic Sedatives*	4.4	4.5	4.7	5.0	4.5	4.7	4.8
Cannabis	18.2	23.4	25.7	28.8	32.8	36.6	29.8
Ecstasy	3.2	4.1	2.5	5.2	4.3	2.6	2.4
Hallucinogens	4.4	5.6	4.0	4.2	3.2	3.1	2.8
Amphetamines	3.5	4.4	3.4	3.5	4.1	3.3	2.6
Cocaine	1.8	2.7	4.5	4.8	6.2	7.2	4.1
Heroin	0.3	0.4	0.6	0.4	0.3	0.4	0.8
Volatile Substances	1.9	2.0	2.6	2.5	2.2	2.2	1.8
Rate of use in the last 30 days							
Tobacco	31.1	32.5	31.9	32.1	29.4	37.4	27.8
Alcohol	75.1	66.7	68.1	60.2	56.0	65.6	58.0
Hypnotic Sedatives*	2.6	2.2	2.3	2.5	2.4	2.4	2.4
Cannabis	12.4	15.7	17.2	20.8	22.5	25.1	20.1
Ecstasy	2.1	2.3	1.6	2.8	1.9	1.5	1.4
Hallucinogens	2.6	2.8	2.0	2.0	1.2	1.5	1.3
Amphetamines	2.3	2.6	2.0	2.0	2.0	1.8	1.4
Cocaine	1.1	1.6	2.5	2.5	3.2	3.8	2.3
Heroin	0.2	0.3	0.4	0.3	0.2	0.4	0.5
Volatile Substances	1.1	1.2	1.8	1.5	1.1	1.1	1.1

Note: These percentages are calculated using the number of cases with information.

(*) Tranquilizers and sleeping peels without a prescription.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

Average Age When Use Begins

Students between the ages of 14 and 18 years begin to use drugs at an early age. In 2006, the substances which they began to use at the earliest age were tobacco, volatile substances (in this case, by a minority) and alcohol, the average age of initiation for which was between 13 and 14 years old. These are followed by tranquilizers and cannabis (14.2 and 14.6 years old, respectively). Cocaine, ecstasy, hallucinogens and amphetamines are the substances which are first used at the latest age (15.4, 15.5 and 15.6 years old, respectively). There are no significant variations in age of initiation in use by sex.

Nor are there significant variations in the age of initiation for most of the drugs compared with previous years, though in the case of tranquilizers, cocaine and volatile substances, their use began a bit earlier in 2006, and that of heroin a bit later (Table 2.2.5.).

Table 2.2.5. CHANGES IN THE AVERAGE AGE OF INITIATION IN THE USE OF PSYCHO-ACTIVE SUBSTANCES AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (AVERAGE AGE IN YEARS), SPAIN 1994-2006

	1994	1996	1998	2000	2002	2004	2006
Tobacco	13.9	13.3	13.2	13.1	13.1	13.2	13.1
Tobacco (daily use)	--	14.6	14.5	14.4	14.4	14.5	14.2
Alcohol	13.5	13.7	13.8	13.6	13.6	13.7	13.8
Alcohol (weekly use)	--	15.0	15.0	14.9	15.0	15.1	15.0
Hypnotic Sedatives*	14.1	14.5	14.8	14.5	14.6	14.8	14.4
Cannabis	15.1	15.1	15.0	14.9	14.7	14.7	14.6
Cocaine	15.6	15.9	15.8	15.8	15.7	15.8	15.4
Heroin	14.3	14.7	14.4	15.4	14.9	14.4	14.7
Amphetamines	15.5	15.7	15.6	15.6	15.6	15.7	15.6
Hallucinogens	15.4	15.6	15.4	15.5	15.5	15.8	15.5
Volatile Substances	13.3	13.6	13.4	13.9	14.3	14.0	13.6
Ecstasy	15.6	15.7	15.5	15.7	15.4	15.6	15.5

Note: These percentages are calculated using the number of cases with information.

(*) Tranquilizers and sleeping peels without a prescription.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

Differences Between the Sexes in Drug Use

The extension of drug use among students between the ages of 14 and 18 years varies quite a bit by sex. Boys use all illegal drugs much more than girls, whereas, on the other hand, the use of tobacco and tranquilizers is more widespread among females. In the case of alcoholic beverages, it is similar for both sexes. Nonetheless, when discussing the intensity of usage, it is greater among males for both tobacco and alcohol.

In the case of illegal drugs, one can observe that the differences based on sex are more notable as drug usage becomes more habitual. In other words, when speaking of usage in the last 30 days, the difference is greater than if we speak of whether they

have used a substance on any occasion. These differences have also been observed in the previous surveys (Table 2.2.6.).

Table 2.2.6. CHANGES IN PSYCHO-ACTIVE SUBSTANCE USAGE RATES AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY SEX (IN PERCENTAGES), SPAIN 1994-2006

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Use ever-in-lifetime														
Tobacco	56.6	65.1	58.9	69.4	57.4	68.5	57.1	66.7	54.6	64.7	56.6	64.1	42.0	49.8
Alcohol	84.3	84.0	84.3	84.1	85.5	86.4	78.2	77.9	75.9	77.2	81.5	82.5	78.4	80.7
Hypnotic Sedatives*	4.8	7.4	4.5	7.6	4.4	8.2	5.2	8.6	5.0	7.9	5.8	8.1	5.8	9.2
Cannabis	23.8	18.0	28.8	24.2	31.6	27.6	36.2	30.1	40.6	34.6	45.3	40.2	38.0	34.6
Ecstasy	4.7	2.5	6.1	4.8	4.0	3.2	7.6	4.8	7.0	5.8	6.0	3.9	4.2	2.5
Hallucinogens	6.7	3.6	8.0	5.6	6.1	5.0	7.2	4.4	5.6	3.4	6.2	3.3	5.7	2.7
Amphetamines	5.3	3.1	6.6	4.1	5.5	3.2	5.7	3.3	6.2	4.9	6.0	3.6	4.2	2.7
Cocaine	3.1	1.9	4.0	2.8	6.5	4.4	8.4	4.5	9.0	6.4	11.3	6.8	6.8	4.7
Heroin	0.7	0.3	0.8	0.3	1.2	0.7	0.8	0.3	0.6	0.5	1.1	0.3	1.5	0.5
Volatile Substances	4.1	2.1	4.2	2.5	5.1	3.4	5.7	3.0	4.8	2.7	5.2	2.9	4.1	2.0
Use in the last 12 months														
Alcohol	82.8	82.7	82.3	82.5	83.0	84.5	77.3	77.3	74.9	76.3	80.6	81.5	73.4	76.3
Hypnotic Sedatives*	3.2	5.6	3.2	5.8	3.3	5.9	3.5	6.6	3.2	5.7	4.0	5.5	3.7	5.8
Cannabis	21.2	15.2	25.9	21.1	28.2	23.5	32.2	25.2	36.2	29.8	39.4	33.7	31.6	28.2
Ecstasy	4.2	2.2	4.8	3.5	2.9	2.1	6.4	3.9	4.7	3.8	3.3	1.9	3.3	1.6
Hallucinogens	5.7	3.1	6.9	4.5	4.8	3.2	5.5	2.9	4.4	2.0	4.4	1.8	4.1	1.6
Amphetamines	4.4	2.5	5.5	3.4	4.5	2.5	4.6	2.4	4.8	3.4	4.3	2.3	3.3	2.0
Cocaine	2.3	1.2	3.3	2.2	5.4	3.6	6.4	3.1	7.5	5.1	9.4	5.1	5.2	3.1
Heroin	0.5	0.2	0.6	0.2	0.8	0.5	0.7	0.1	0.4	0.2	0.8	0.1	1.2	0.3
Volatile Substances	2.5	1.3	2.4	1.7	3.3	2.0	3.3	1.8	3.0	1.5	3.0	1.4	2.6	1.1
Use in the last 30 days														
Tobacco	26.0	36.3	26.2	38.1	25.5	37.6	27.3	37.1	25.0	33.4	32.9	41.9	24.8	30.6
Alcohol	75.3	74.9	66.8	66.7	67.5	68.5	60.4	59.9	56.7	55.4	65.5	65.7	58.1	58.0
Hypnotic Sedatives*	1.9	3.3	1.5	2.9	1.5	3.0	1.7	3.4	1.7	3.1	1.8	3.0	2.0	2.8
Cannabis	15.1	9.8	18.4	13.2	20.3	14.5	24.5	16.9	28.5	19.6	28.3	22.0	22.3	18.0
Ecstasy	2.9	1.4	2.8	1.9	1.9	1.3	3.8	1.7	2.1	1.6	1.9	1.0	2.1	0.7
Hallucinogens	3.6	1.7	3.8	1.9	2.6	1.5	2.6	1.3	1.8	0.7	2.3	0.7	2.0	0.7
Amphetamines	2.9	1.6	3.2	2.0	2.7	1.5	2.6	1.4	2.5	1.5	2.7	1.0	2.0	1.0
Cocaine	1.4	0.7	2.1	1.2	3.2	1.8	3.4	1.5	3.7	2.8	5.1	2.6	3.1	1.6
Heroin	0.4	0.1	0.4	0.1	0.6	0.2	0.5	0.1	0.3	0.2	0.7	0.1	0.9	0.2
Volatile Substances	1.5	0.8	1.5	1.0	2.2	1.5	1.8	1.1	1.5	0.8	1.6	0.7	1.7	0.6

Note: These percentages are calculated using the number of cases with information.

(*) Tranquilizers and sleeping peels without a prescription.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

Differences in Use by Age

Age is a variable which determines the extent of drug use among students. The percentage of youths who are users increases gradually with age, in such a way that usage reaches its maximum level among students between the ages of 17 and 18 years.

The greatest increases in the extent of alcohol, tobacco and cannabis use take place between the ages of 14 and 16 years, whereas with psycho-stimulants such as ecstasy, cocaine and amphetamines this takes place between the ages of 16 and 18 years. As is logical, this has to do with the age at which youths begin to use these drugs, far later with these last substances (Table 2.2.7.).

Table 2.2.7. RATES OF PSYCHO-ACTIVE SUBSTANCE USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY AGE (IN PERCENTAGES). SPAIN, 2006

	14	15	16	17	18
Ever-in-lifetime use					
Tobacco	28.4	41.5	50.7	55.1	61.8
Alcohol	57.1	76.1	86.0	91.2	92.3
Hypnotic Sedatives *	6.3	7.0	7.7	8.4	9.8
Cannabis	14.1	30.0	41.1	48.9	56.9
Ecstasy	0.8	2.0	3.3	4.4	9.3
Hallucinogens	1.1	2.9	4.3	5.9	9.2
Amphetamines	0.7	2.1	3.3	4.8	9.5
Cocaine	1.5	2.9	5.6	8.4	15.9
Heroin	0.6	0.8	1.3	1.0	1.1
Volatile Inhalants	1.5	2.5	3.0	4.2	4.6
GHB	0.4	0.8	1.4	1.6	2.2
Used in the last 12 months					
Tobacco	19.1	30.6	37.6	41.3	47.4
Alcohol	50.9	70.9	82.1	87.4	88.2
Hypnotic Sedatives *	3.8	4.5	5.3	5.1	5.8
Cannabis	11.5	25.2	33.9	40.7	44.9
Ecstasy	0.6	1.6	2.5	3.3	6.0
Hallucinogens	0.8	1.9	3.2	4.0	6.0
Amphetamines	0.5	1.7	2.7	3.7	6.8
Cocaine	1.2	2.3	4.2	5.6	11.1
Heroin	0.4	0.7	1.1	0.8	0.9
Volatile Inhalants	0.9	1.6	2.1	2.3	2.7
GHB	0.4	0.7	1.1	1.0	1.6
Used in the last 30 days					
Tobacco	13.8	24.1	30.6	35.5	42.1
Alcohol	31.7	50.7	65.3	74.2	76.5
Hypnotic Sedatives *	1.8	2.3	2.7	2.6	2.9
Cannabis	7.5	16.6	22.5	27.7	31.5
Ecstasy	0.4	1.0	1.8	1.7	2.4
Hallucinogens	0.5	0.9	1.5	1.9	2.5
Amphetamines	0.3	0.9	1.6	2.1	3.3
Cocaine	0.8	1.2	2.6	3.1	5.9
Heroin	0.2	0.4	0.8	0.5	0.7
Volatile Inhalants	0.6	1.1	1.4	1.1	1.6
GHB	0.4	1.0	1.8	1.7	2.4

Note: These percentages are calculated using the number of cases with information.

* Tranquilizers and sleeping peels without a prescription.

Source: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES)

Tobacco Use

The use of tobacco is fairly widespread among students from 14 to 18 years old, being the second most used substance among them. In 2006, 46.1% of students claimed they had used it at some time, 34% that they had smoked it in the last year and 27.8% in the last month. The percentage of students who smoke on a daily basis was 14.8%, though this percentage rose to 29.6% among students aged 18.

Tobacco use increases with age and is more widespread among girls than among boys (Table 2.2.8. and Figure 2.2.1.) at all ages.

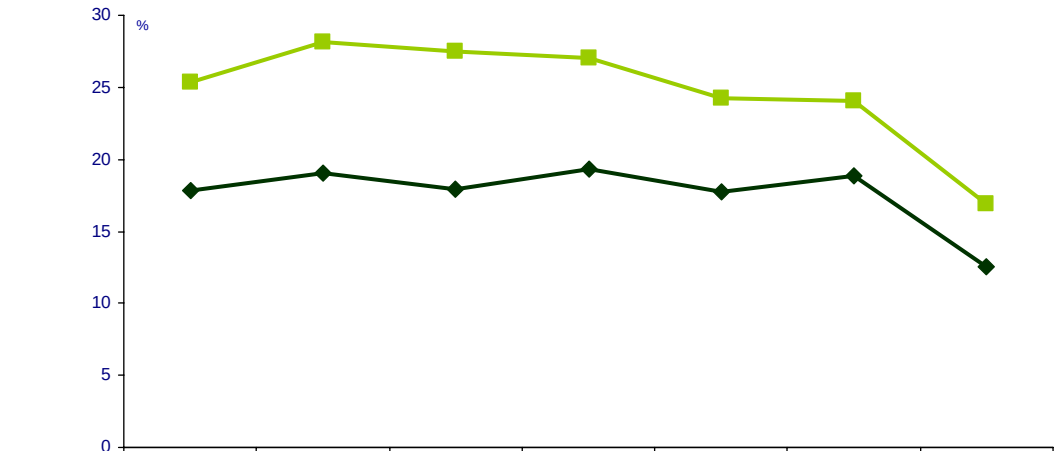
Table 2.2.8. GENERAL FEATURES OF TOBACCO USE AMONG SECONDARY SCHOOL STUDENTS FROM 14-18 YEARS OLD (AVERAGES AND PERCENTAGES), BY SEX. SPAIN 1994-2006

Note: These percentages are calculated using the number of cases with information

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of survey takers	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Rate of tobacco use ever-in-lifetime	56.0	65.1	58.9	69.4	57.4	68.5	57.1	66.7	54.6	64.7	56.6	64.1	42.0	49.8
Average age of first tobacco use among current and former smokers (in years)	13.7	14.1	13.1	13.5	13.0	13.4	12.9	13.2	13.0	13.1	13.1	13.2	13.0	13.1
Rate of tobacco use in the last 30 days	26.0	36.3	26.2	38.1	25.5	37.6	27.3	37.1	25.0	33.4	25.1	32.4	24.8	30.6
Rate of tobacco use on a daily basis	17.8	25.4	19.0	28.1	17.9	27.5	19.3	27.0	17.7	24.2	18.9	24.1	12.5	16.9
Average age when using tobacco on a daily basis began among current and former smokers (in years)	--	--	14.5	14.6	14.6	14.5	14.4	14.3	14.4	14.3	14.5	14.4	14.3	14.2
Number of cigarettes smoked per day														
1-5	37.7	47.3	41.8	50.3	43.8	49.5	44.4	49.0	44.7	46.5	41.6	44.5	61.9	63.0
6-10	33.8	36.8	33.9	34.8	35.2	34.9	34.8	35.2	33.5	36.0	35.7	35.5	22.7	27.2
11-20	26.0	14.9	22.7	13.9	19.6	15.0	20.8	15.8	20.1	16.3	20.9	19.0	13.8	9.3
21 or more	2.5	1.0	1.6	0.9	1.3	0.6	0.0	0.0	1.7	1.2	1.8	1.0	1.5	0.5
Average number of cigarettes per day	9.1	7.2	8.3	6.9	7.9	7.0	7.6	6.8	7.8	7.3	8.1	7.5	5.8	5.3

Note: These percentages are calculated using the number of cases with information.
SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

**Figure 2.2.1. Change in rate of daily tobacco use among secondary school students between the ages of 14-18 years, by sex.
Spain (%), 1994-2006.**



	1994	1996	1998	2000	2002	2004	2006
Males	17,8	19,0	17,9	19,3	17,7	18,9	12,5
Females	25,4	28,1	27,5	27,0	24,2	24,1	16,9

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 1994-2006.

The average age of initiation is the earliest of all the substances (13.1 years) and has remained more or less steady for the last 10 years, staying similar for both sexes. The average age of initiation in everyday use takes place one year later (14.2 years).

Among those who have used tobacco in the last month, the average daily cigarettes smoked are 5.5, a figure lower than that of the year 2004, when it was 7.7 cigarettes, the amount smoked by boys (5.8) being slightly higher than the amount smoked by girls (5.3).

The year 2006 data show a significant decrease in tobacco use compared to prior years (Table 2.2.8.). Daily use decreased from 21.5% in 2004 to 14.8% in 2006. Moreover, as stated above, a smaller quantity is smoked.

The vast majority of students who smoke had thought about quitting on some occasion (72.9%), though those who claim to have used smoking are fewer than half of these (38.6%). The attempt to stop smoking is more common among girls (76.6%) than among boys (67.8%), the percentage of girls who have actually used to do so also being higher (41% compared to 35.4 of boys).

At present, 53.2% of the students who smoke are thinking about quitting (25.9% in the next 30 days and 27.3% in the next 6 months).

Nearly half of all students (48.2%) are very much or quite bothered when people smoke inside of closed places in their presence. The households in which some person smokes on a daily basis are 47.7%, or 10% fewer than in 2004.

Alcoholic Beverage Consumption

Alcohol is the substance whose consumption is most widespread among students between the ages of 14 and 18 years. Of them, 79.6% have used it at some time, 74.9% have consumed it in the last year and 58% in the last month. As their ages rise, the percentage of students who drink goes up, and therefore the percentage of 18-year-old students who have consumed alcohol in the last 30 days is equal to 76.5% (Table 2.2.7.).

Alcohol consumption among students is focused on the weekend. Of the 58% who have consumed alcoholic beverages in the last 30 days, almost all of them (57.7% of those surveyed) did so during the weekend, whereas only 18.8% of students had consumed it on work days. In relation with this frequency, 21.8% of students drink every weekend (24.3% of boys and 19.5% of girls).

In terms of the intensity with which they drink, some data can give us an idea in this respect. Of the students surveyed, 55.3% have gotten drunk at some time, while 25.6% have in the last month (26.5% of boys and 24.8% of girls). The age range for this last figure fluctuates from 10.3% of students at the age of 14 years to 40.3% of those who are 18 years old (Table 2.2.9.). In (Table 2.2.10) you can see the frequency of drunkenness in the last 30 days among those students who consumed alcoholic beverages during that time period. This frequency is similar among boys and girls. This is another indicator which reflects rather well the pattern of consumption characterized by concentration on the weekend, and at the same time intense consumption, which means consumption of 5 or more glasses, beers or drinks on one single occasion. 53.3% (47.3% of girls and 59.8% of boys) of those who have consumed alcoholic beverage during the last 30 days have on some occasion during those 30 days had 5 or more glasses, beers or alcoholic drinks. 17.7% have done so on more than 4 days in the same month.

Table 2.2.9. RATE OF DRUNKENNESS BY SEX AND AGE AMONG SECONDARY SCHOOLS STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY AGE (IN PERCENTAGES). SPAIN, 2006

	EVER-IN-LIFETIME	LAST 12 MONTHS	LAST 30 DAYS
Total	55.3	45.6	25.6
Sex			
Males	53.4	44.6	26.5
Females	57.0	46.5	24.8
Age			
14 years	28.3	22.1	10.3
15 years	46.9	38.0	19.2
16 years	61.7	52.7	30.3
17 years	72.3	59.4	35.1
18 years	78.3	64.7	40.3

Source: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES)

Table 2.2.10. GENERAL CHARACTERISTICS OF ALCOHOL CONSUMPTION AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY SEX (IN PERCENTAGES),. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Rate of alcohol consumption ever-in-lifetime	84.3	84.0	84.3	84.1	85.5	86.4	78.2	77.9	75.9	77.2	81.5	82.5	78.4	80.7
Average and beginning age of alcohol consumption (in years)	13.1	13.8	13.5	14.0	13.5	14.0	13.4	13.8	13.4	13.8	13.6	13.9	13.7	13.8
Average and beginning age of weekly alcohol consumption (in years)	__	__	15.0	15.0	15.0	15.1	14.8	14.9	15.0	14.9	15.2	15.1	15.0	14.9
Rate of alcohol consumption in the last 12 months	82.8	82.7	82.3	82.5	83.0	84.5	77.3	77.3	74.9	76.3	80.6	81.5	73.4	76.3
Rate of alcohol consumption in the last 30 days	75.3	74.9	66.8	66.7	67.5	68.5	60.4	59.9	56.7	55.4	65.5	65.7	58.1	58.0
Rate of alcohol consumption on weekends in the last 30 days	__	__	66.0	66.4	67.0	68.1	60.1	59.8	56.3	55.2	65.1	65.5	57.7	57.7
Rate of alcohol consumption on work days in the last 30 days	__	__	26.8	14.9	26.0	16.1	30.0	16.8	20.8	10.6	26.5	14.1	24.2	13.9
Frequency with which those students who consumed alcohol got drunk in the last 30 days														
Never got drunk	77.7	79.5	75.2	78.8	75.2	76.4	62.1	66.6	62.1	65.8	55.3	59.4	54.4	57.2
Got drunk 1-2 times	14.7	15.2	15.4	16.5	16.4	17.8	23.9	23.7	24.3	24.9	25.6	28.3	28.9	30.7
Got drunk 3-5 times	4.9	4.2	6.8	4.0	5.8	4.9	10.5	7.7	9.8	7.3	12.9	9.8	12.6	10.3
Got drunk + 5 times	2.6	1.2	2.6	0.8	2.6	0.9	3.5	2.0	3.9	2.0	6.2	2.5	4.1	2.3

Note: These percentages are calculated using the number of cases with information
SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES)

Consumption takes place mainly at bars or pubs (73.5% of those who consumed in the last 30 days) in open spaces (streets, city squares, parks, 64.5%) or in discotheques (61.4%). In recent years, there has been a notable increase in consumption in open spaces (37% in 2000, 47.5% in 2004 and 64.5% in 2006).

As a whole, the most commonly consumed drinks are combined drinks/mixed drinks (though on work days the predominant drink is beer (Table 2.2.11 and Fig. 2.2.2.).

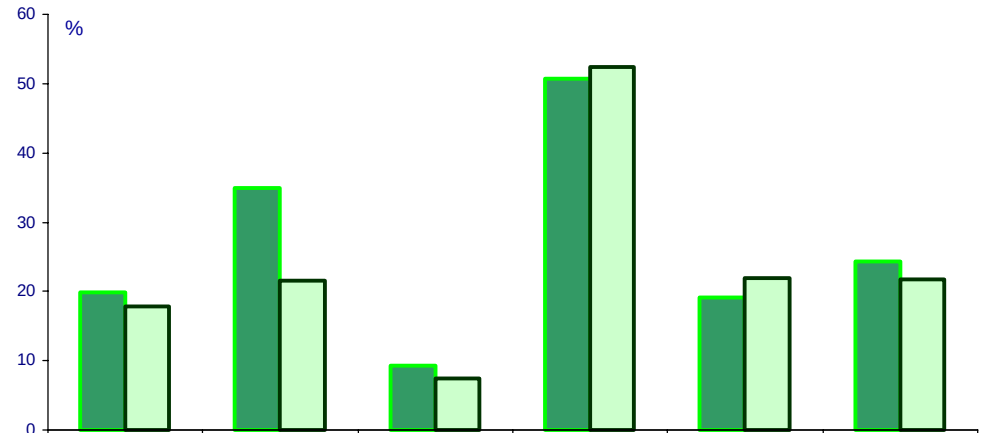
Table 2.2.11. RATE OF CONSUMPTION OF DIFFERENT TYPES OF ALCOHOLIC BEVERAGES ON WORK DAYS AND WEEKENDS DURING THE 30 DAYS PRIOR TO THE SURVEY AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES). SPAIN 1996-2006.

	1996	1998	2000	2002	2004	2006
CONSUMPTION ON WORK DAYS						
On some day from Monday through Thursday in the last 30 days						
Wine	8.1	8.9	8.2	4.9	6.6	5.3
Beer	15.3	14.0	16.2	10.5	14.1	12.8
Aperitifs	3.0	3.2	2.6	1.7	2.4	3.0
Mixed Drinks	5.4	6.4	6.8	5.0	6.8	7.4
Strong Liquors	3.2	3.6	3.5	2.3	3.2	4.6
Fruit Liquors	6.6	7.5	6.2	3.8	4.2	3.5
Every day from Monday through Thursday in the last 30 days						
Wine	0.8	1.0	0.9	0.3	0.7	0.2
Beer	1.7	1.5	2.2	0.9	1.7	0.8
Aperitifs	0.2	0.3	0.3	0.1	0.3	0.2
Mixed Drinks	0.2	0.3	0.6	0.2	0.6	0.4
Strong Liquors	0.1	0.4	0.4	0.1	0.4	0.2
Fruit Liquors	0.3	0.8	0.6	0.2	0.5	0.2
CONSUMPTION ON SOME WEEKEND						
Some day from Friday through Sunday in the last 30 days						
Wine	32.8	32.8	23.7	21.0	27.7	18.8
Beer	46.9	40.7	30.8	27.1	34.1	27.9
Aperitifs	12.0	13.6	9.6	8.0	11.0	8.3
Mixed Drinks	48.8	53.7	49.2	48.2	58.4	51.6
Strong Liquors	24.5	26.7	22.4	22.3	27.8	20.5
Fruit Liquors	36.2	37.1	25.6	22.6	26.0	23.0
Every day from Friday through Sunday in the last 30 days						
Wine	9.6	10.6	8.6	5.9	7.5	3.5
Beer	19.9	17.6	14.4	10.7	13.8	8.6
Aperitifs	2.9	4.2	3.3	2.1	2.7	1.5
Mixed Drinks	19.6	23.5	22.2	18.9	22.5	16.8
Strong Liquors	8.2	10.8	10.1	7.7	9.4	5.5
Fruit Liquors	10.2	12.0	9.0	6.0	6.8	3.8

Note: These percentages are calculated using the number of cases with information.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES).

Figure 2.2.2. Rate of consumption of different types of alcoholic beverages on weekends* among secondary school students between the ages of 14-18 years, by sex (in percentages). Spain, 2006.



	Wine	Beer	Aperitifs	Mixed Drinks	Strong Liquors	Fruit Liquors
Male	19,8	34,9	9,2	50,7	19,1	24,4
Female	17,9	21,5	7,4	52,4	22,0	21,7

(*) Some day from Friday through Sunday in the last 30 days.
SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 2006.

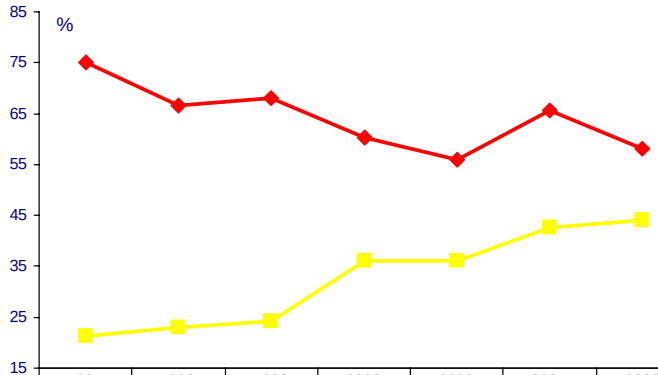
The locations where students most frequency obtain alcoholic drinks are bars or pubs (70.8%), discotheques (59.2%), supermarkets (51.8%) and “hypermarkets” (37%).

As a risk associated with the consumption of alcoholic beverages by youths, importance has been taken on by driving vehicles under the influence of alcohol. Of the students between the ages of 14-18 years, 22% (34.3% of those who are 18) acknowledge that they have been passengers in vehicles driven under the influence of alcohol in the last 12 months.

Of the students between the ages of 14-18 years, 9.8% state that they have driven a vehicle (car, motorcycle) under the influence of alcohol in the last 12 months, a figure which rises to 14.9% among students who are 18 years old.

The proportion of alcohol drinkers dropped, whether using 1994 or 2004 as the point of reference. In fact, the percentage of those who had consumed alcoholic drinks in the last 12 months decreased from 82.7% in 1994 to 81.0% in 2004 and to 74.9% in 2006, and the percentage of students who drank in the last 30 days fell from 75.1% in 1994 to 65.6% in 2004 and to 58.0% in 2006 (Table 2.2.4.). As for the frequency with which students got drunk in the last 30 days, among those who had consumed alcohol during that time period, it went up slightly compared to 2004, continuing the rising trend occurring since 1994. It is of interest to point out that despite the fact that alcohol consumption became less widespread, the most intense consumption among those who do drink went up (Figure 2.2.3.).

Figure 2.2.3. Percentage of secondary school students between the ages of 14-18 years who have consumed alcohol in the last 30 days, having gotten drunk during that time period. Spain, 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
Students who have consumed alcohol in the last 30 days	75,1	66,7	68,1	60,2	56,0	65,6	58,0
% of those who have gotten drunk in the last 30 days	21,4	23,0	24,2	36,1	36,1	42,7	44,1

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 1994-2004.

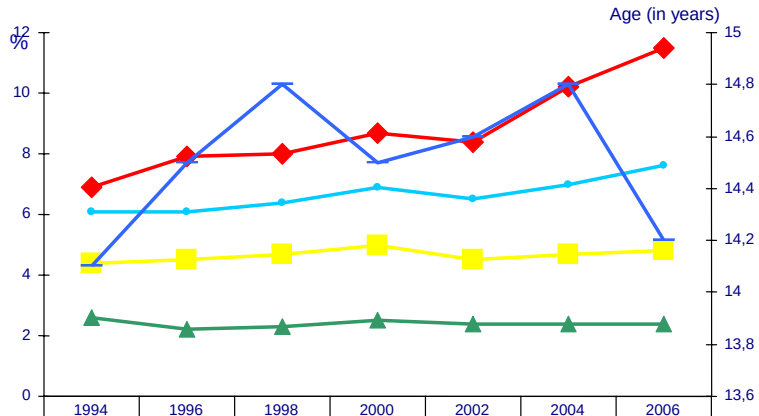
Tranquilizer Consumption

In the questionnaire, the terms “tranquilizers” and “sleeping pills” are used to name a group of medicines which includes sleep inducers, sedatives, hypnotics, “benzos,” Trankimazin (Xanax), Rohypnol (flunitrazepam), Tranxilium (clorazepate), diazepam, valium and barbiturates. In 2006, a question was included on the use of tranquilizers without making any specification regarding the existence or non-existence of a doctor’s prescription, a question which had not existed in prior surveys. The question about whether tranquilizers without a doctor’s prescription were consumed was maintained. Moreover, in another section of the questionnaire, there was also a question about consumption with a doctor’s prescription, though in this case the question referred exclusively to whether such drugs had been consumed ever-in-lifetime and the age of initiation.

In general during 2006, tranquilizers use was 12.6% of students, 7.4% having used them in the last year and 3.6% in the last month. Consumption of tranquilizers without a prescription is somewhat lower, with 7.6% of students ever-in-lifetime, 4.8% those who have done so in the last year and 2.4% in the last month. Just the opposite as what occurs with illegal drugs, their consumption is more widespread among girls than among boys, in the case of both tranquilizers in general (with or without a prescription) and tranquilizers without a prescription (Table 2.2.12.). Experimental or occasional consumption gradually increases with age, though current consumption (in the last 30 days) hardly changes as of the age of 16 years. The age at which students, on average, used tranquilizers for the first time because a doctor prescribed them was 13.8 years, whereas it was 14.2 years when involving tranquilizers without a prescription. The frequency of consumption is sporadic: over half of the students who consumed tranquilizers in the last month did so 1 or 2 times, and the percentage of those did so 10 or more times per month was not greater than 0.2%, among both boys and girls (Table 2.2.12).

In terms of the changes in consumption compared to previous years, a slight increase has been seen since 2002 in terms of consumption ever-in-lifetime, though more recent consumption seems to have stabilized more or less (last 12 months), as has current consumption (last 30 days) (Figure 2.2.4.). These developments have been similar for both sexes (Table 2.2.12).

Figure 2.2.4. Rate of consumption of hypno-sedatives and age of initiation of consumption among secondary schools students between the ages of 14-18 years. Spain (%), 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
With prescription, some time in life	6,9	7,9	8	8,7	8,4	10,2	11,5
Without prescription, last 12 months	4,4	4,5	4,7	5	4,5	4,7	4,8
Without prescription, last 30 days	2,6	2,2	2,3	2,5	2,4	2,4	2,4
Without prescription, some time in life	6,1	6,1	6,4	6,9	6,5	7,0	7,6
Age beginning consumption w/o prescription	14,1	14,5	14,8	14,5	14,6	14,8	14,2

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 1994-2006.
(*) Tranquilizers and sleeping pills.

Table 2.2.12. GENERAL CHARACTERISTICS OF HYPNO-SEDATIVE* CONSUMPTION AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Use of hypno-sedatives with a prescription ever-in-lifetime	5.8	8.1	6.6	9.1	6.4	9.3	7.3	10.2	6.8	9.9	8.1	12.3	9.3	13.6
Use of hypno-sedatives without a prescription ever-in-lifetime	4.8	7.4	4.5	7.6	4.4	8.2	5.2	8.6	5.0	7.9	5.8	8.1	5.8	9.2
Average age at beginning of hypno-sedative consumption (in years) without a prescription	13.6	14.4	13.9	14.8	14.4	15.0	14.3	14.7	14.4	14.8	14.7	14.9	13.8	14.4
Rate of use of hypno-sedatives in the last 12 months	3.2	5.6	3.2	5.8	3.3	5.9	3.5	6.6	3.2	5.7	4.0	5.5	3.7	5.8
Rate of use of hypno-sedatives in the last 30 days	1.9	3.3	1.5	2.9	1.5	3.0	1.7	3.4	1.7	3.1	1.8	3.0	2.0	2.8
Frequency of hypno-sedative use w/o a prescription in the last 30 days														
Never	98.1	96.7	98.5	97.1	98.5	97.0	98.3	96.6	98.3	96.9	98.2	97.0	98.0	97.1
1 to 2 days	1.3	2.1	1.1	1.9	1.0	2.1	1.0	2.2	1.1	2.0	1.0	2.0	1.2	2.0
3 to 5 days	0.3	0.7	0.2	0.7	0.3	0.5	0.4	0.7	0.3	0.6	0.4	0.5	0.5	0.5
6 to 9 days	0.1	0.3	0.1	0.1	0.1	0.2	0.1	0.2	0.1	0.3	0.1	0.2	0.1	0.2
10 to 19 days	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.1	0.0	0.1	0.1	0.1	0.1	0.1
20 to 29 days	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.1	0.1

Note: These percentages are calculated using the number of cases with information.

(*) Tranquilizers or sleeping pills.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006

Cannabis Use

Cannabis is the illegal drug most commonly consumed by students between the ages of 14 to 18 years, with quite a difference between it and all other illegal drugs. 36.2% had an ever-in-lifetime use, 29.8% have used it in the last year, and 20.1% in the last 30 days. Its use is more widespread among boys in terms of all indicators, though this difference is not as great as it is with other illegal substances. However, this difference increases with the intensity of usage. The percentage of students who are daily cannabis users is 3.2%. At this frequency of use, boys (4.2%) use it nearly twice as much as girls (2.2%) (Table 2.2.13).

Cannabis is also the illegal drug that is starting to be used at an earlier age. The average age of initiation in use among secondary school students has reached 14.6 years and is similar regardless of sex, with no significant variations compared to preceding years.

The extent and frequency of cannabis use increases with age from 14 to 18 years. The greatest increase takes place between the ages of 14 and 15 years. At the age of 18 years, one-third of students have consumed in the last month and 11.9% have done so on more than 10 days during that month (Table 2.2.7.).

Nevertheless, in 2006 a significant decrease was seen in consumption after many years of ongoing increases. In fact, there were decreases compared to 2004 in terms of both the percentage who had used it ever-in-lifetime and in those who currently use it (Figure 2.2.5.), and this decrease affected all ages, and both males and females. At the same time, the perception of risk involved in using cannabis has also increased, as we shall see in another section of this report, a factor which is related with the level of use. There may have been an influence by the decrease in the use of tobacco on the use of cannabis, given the relationship existing between the two, given that cannabis is usually mixed with tobacco in order to smoke it

Table 2.2.13. GENERAL CHARACTERISTICS OF CANNABIS USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Ever-in-lifetime use of cannabis	23.8	18.0	28.8	24.2	31.6	27.6	36.2	30.1	46.6	34.6	45.3	40.2	38.0	34.6
Average age upon beginning cannabis use (in years)	15.1	15.2	15.1	15.2	14.9	15.1	14.8	15.0	14.6	14.8	14.6	14.8	14.5	14.6
Rate of cannabis use in the last 12 months	21.2	15.2	25.9	21.1	28.2	23.5	32.2	25.2	36.2	29.8	39.4	33.7	31.6	28.2
Frequency of cannabis use in the last 30 days	15.1	9.8	18.4	13.2	20.3	14.5	24.5	16.9	25.8	19.6	28.3	22.0	22.3	18.0
Never	84.9	90.2	81.6	86.8	79.7	85.5	75.5	83.1	74.2	80.4	71.7	78.0	77.7	82.0
1 to 2 days	6.9	5.1	7.3	7.2	8.4	7.4	8.6	8.8	8.6	9.1	9.4	9.8	7.4	7.4
3 to 5 days	3.0	2.1	4.1	2.7	3.8	3.0	4.7	3.5	4.8	3.8	4.4	4.5	5.3	4.8
6 to 9 days	2.1	1.4	2.9	1.3	3.2	1.9	3.1	1.9	3.9	2.8	3.5	2.6	2.5	1.8
10 to 19 days	1.5	0.6	2.0	1.0	2.1	1.3	3.5	1.3	3.0	1.8	3.5	2.3	2.9	1.8
20 to 29 days	1.5	0.6	2.2	0.9	2.8	1.0	4.7	1.4	5.5	2.1	7.4	2.8	4.2	2.2

Note: These percentages are calculated using the number of cases with information.

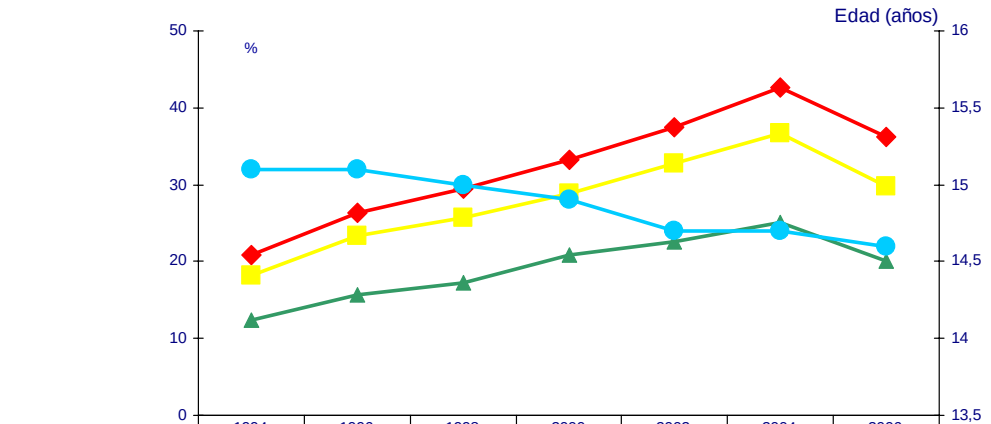
SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

Table 2.2.14. FREQUENCY OF HASHISH USE IN THE LAST 30 DAYS AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY AGE (IN PERCENTAGES). SPAIN, 2006.

Age (in years)	14	15	16	17	18
No days	92.5	83.4	77.5	72.3	68.3
Some day	**7.5**	**16.6**	**22.5**	**27.7**	**31.5**
1-3 days	5.1	8.6	11.3	12.4	12.7
4-9 days	1.4	3.9	5.5	7.2	6.9
10-19 days	0.5	2.1	2.3	3.4	4.4
20 or more days	0.5	2.0	3.4	4.7	7.5

Source: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES)

Figure 2.2.5. Rate of cannabis use and age of beginning use among secondary students between the ages of 14-18 years. Spain (%), 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
Ever-in-lifetime	20,9	26,4	29,5	33,2	37,5	42,7	36,2
Last 12 months	18,2	23,4	25,7	28,8	32,8	36,6	29,8
Last 30 days	12,4	15,7	17,2	20,8	22,5	25,1	20,1
Age of beginning use	15,1	15,1	15	14,9	14,7	14,7	14,6

SOUCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006

Cocaine Use

After cannabis, cocaine is the illegal drug whose use is most widespread among students. 5.7% had an ever-in-lifetime use, 4.1% have used it in the last 12 months and 2.3% have in the last month. This fundamentally involves sporadic usage. In fact, more than half of those who have used it in the last month did so on only one or two days (Table 2.2.15.).

In the ESTUDES 2006 questionnaire, there was a separate question for the first time about the use of cocaine powder (cocaine hydrochloride) and cocaine base (crack). By far, the most widespread form of use among students is cocaine powder (Figure 2.2.6.). The data which we present are those for the two added together in order to make comparisons with the preceding years.

Cocaine use is far greater among males than among females for all three usage indicators (Table 2.2.15), and for all ages, with the exception of the age of 14 years, which is similar for both sexes, though there is little cocaine use at that age, because the expansion of usage takes place between the ages of 17 and 18 years, above all. The average age for beginning cocaine use occurred at 15.4 years in 2006, a bit earlier than in preceding years (Figure 2.2.7.).

The year 2006 data show us that there has been a notable decrease in cocaine use among students between the ages of 14 and 18 years, breaking off the rising trend in recent years. This decrease has mainly taken place at 17 and 18 years, ages at which cocaine use had greatly increased in 2004. As for the age of 14 years, cocaine use went up compared to previous years in 2006. This explains why the average age when cocaine use begins has become earlier than in preceding years, even though there has been a decrease in overall usage (Figure 2.2.7.)

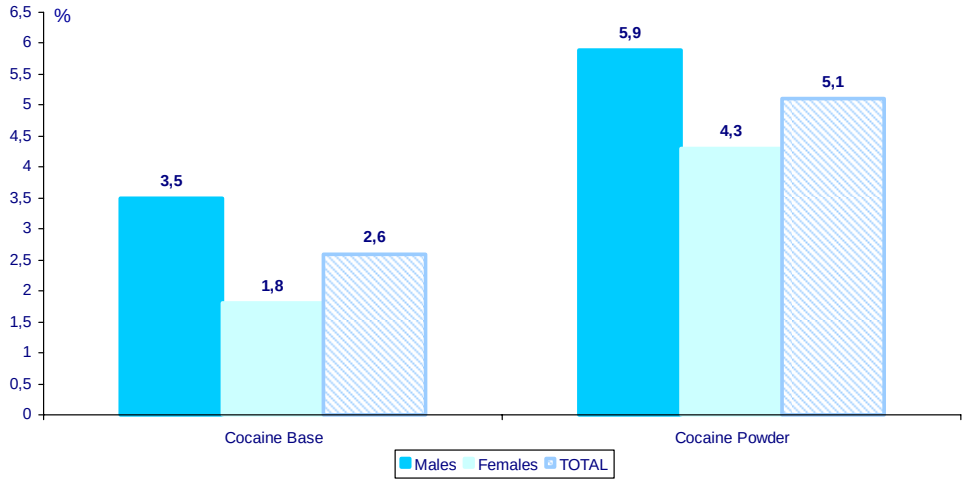
Table 2.2.15 GENERAL CHARACTERISTICS OF COCAINE USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Ever-in-lifetime use of cocaine	3.1	1.9	4.0	2.8	6.5	4.4	8.4	4.5	9.0	6.4	11.3	6.8	6.8	4.7
Average age of beginning cocaine use (in years)	15.7	15.5	15.9	15.9	15.9	15.7	16.0	15.6	15.8	15.6	15.9	15.7	15.4	15.4
Rate of cocaine use in the last 12 months	2.3	1.2	3.3	2.2	5.4	3.6	6.4	3.1	7.5	5.1	9.4	5.1	5.2	3.1
Rate of cocaine use in the last 30 days	1.4	0.7	2.1	1.2	3.2	1.8	3.4	1.5	3.7	2.8	5.1	2.6	3.1	1.6
Frequency of cocaine use in the last 30 days														
Never	98.6	99.3	97.9	98.8	96.8	98.2	96.6	98.5	96.3	97.2	94.9	97.4	96.9	98.4
1 to 2 days	0.9	0.4	1.5	0.8	1.8	1.0	2.5	1.1	2.3	2.1	3.1	1.7	1.6	1
3 to 5 days	0.2	0.2	0.3	0.2	0.6	0.5	0.5	0.2	0.9	0.5	1.0	0.5	0.7	0.3
6 to 9 days	0.2	0.1	0.1	0.2	0.3	0.2	0.2	0.1	0.3	0.1	0.6	0.2	0.3	0.1
10 to 19 days	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.2	0.1	0.2	0.1	0.2	0.0
20 to 29 days	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.1	0.0	0.2	0.1	0.3	0.1

Note: These percentages are calculated using the number of cases with information.

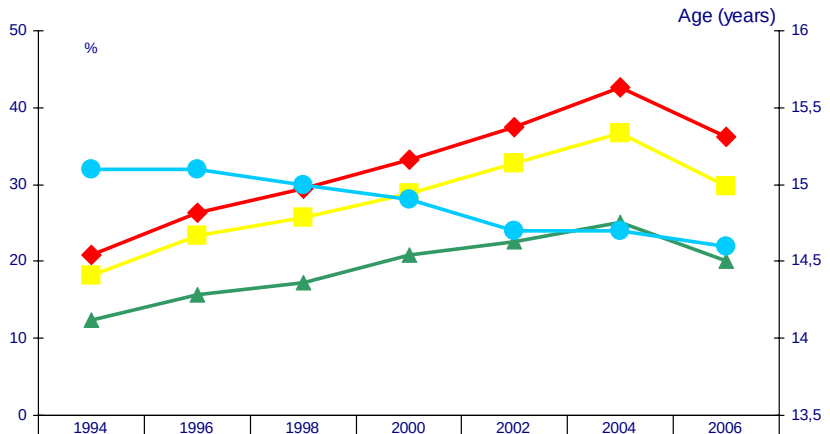
SOURCE: Government Delegation for the National Plan on Drugs. Drug Survey on the School Population (E.D.P.E) 1994-2006.

Figure 2.2.6. Rate of cocaine use (base and powder) at some time in life among secondary school students between the ages of 14-18 years, by sex. Spain, 2006.



SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES) .2006.

Figure 2.2.5. Rate of cannabis use and age of beginning use among secondary students between the ages of 14-18 years. Spain (%), 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
Ever-in-lifetime	20,9	26,4	29,5	33,2	37,5	42,7	36,2
Last 12 months	18,2	23,4	25,7	28,8	32,8	36,6	29,8
Last 30 days	12,4	15,7	17,2	20,8	22,5	25,1	20,1
Age of beginning use	15,1	15,1	15	14,9	14,7	14,7	14,6

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 1994-2006.

Ecstasy Use

Ecstasy is a generic name given to several synthetic stimulant drugs made on the basis of phenylethylamine. In the survey questionnaire, reference is made to these substance with the names of "ecstasy" or other slang names such as "X" (in Spanish, "pastis" or "pirulas"). In 2006, 3.3% of secondary school students had an ever-in-lifetime use, 2.4% had used it in the last year and 1.4% in the last month. As in the case of all other illegal drugs, the percent of users who are males is far greater than the females, and this difference becomes greater when usage frequency is higher (Table 2.2.19). In the last 30 days, the percentage of boys who have used ecstasy is 2.1%, compared to 0.7% among girls. As occurs with cocaine and other psycho-stimulants and hallucinogens, this is mainly sporadic usage in which most of those who have used it in the last month have done so one or two times during that time period. Usage increases with age. In 2006, the increase of ecstasy use had taken place mainly between the ages of 15 and 16 years (Table 2.2.7). The average age for beginning use reached the age of 15.5 years, similar to the age for all other psycho-stimulants. There were no significant variations compared to the previous years (Figure 2.2.8.) or on the basis of sex.

In 2006, ecstasy use continued to fall slightly, especially experimental use among both boys and girls. Current usage (that occurring in the last 30 days) has hardly changed compared to 2004 and even among males it is higher (2.1% in 2006 compared to the figure of 1.9% in 2004).

Table 2.2.16 GENERAL CHARACTERISTICS OF ECSTASY* USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

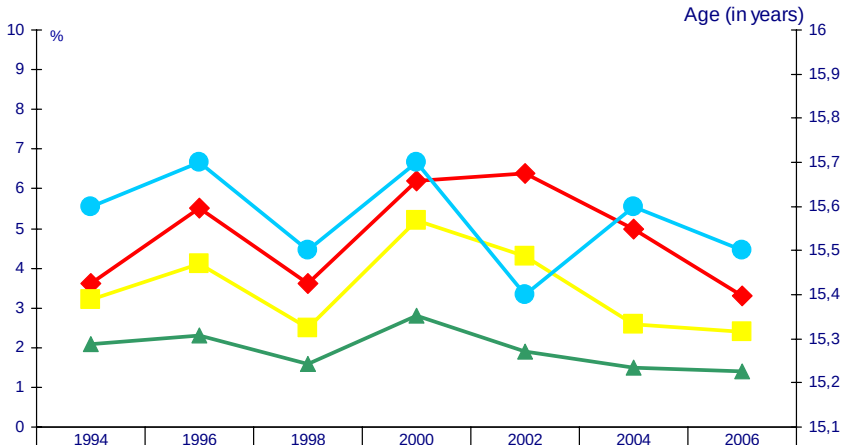
	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Ever-in-lifetime use of ecstasy	4.7	2.5	6.1	4.8	4.0	3.2	7.6	4.8	7.0	5.8	6.0	3.9	4.2	2.5
Average age of beginning ecstasy use (in years)	15.7	15.5	15.6	15.7	15.5	15.5	15.9	15.4	15.4	15.3	15.7	15.4	15.4	15.5
Rate of ecstasy use in the last 12 months	4.2	2.2	4.8	3.5	2.9	2.1	6.4	3.9	4.7	3.8	3.3	1.9	3.2	1.7
Rate of ecstasy use in the last 30 days	2.9	1.4	2.8	1.9	1.9	1.3	3.8	1.7	2.1	1.6	1.9	1.0	2.1	0.7
Frequency of ecstasy use in the last 30 days														
Never	97.1	98.6	97.2	98.1	98.1	98.7	96.2	98.3	97.9	98.4	98.1	99.0	97.8	99.3
1 to 2 days	1.6	1.0	1.3	1.2	1.0	0.6	2.2	1.3	1.6	1.1	1.0	0.7	1.4	0.4
3 to 5 days	0.6	0.2	0.7	0.4	0.3	0.3	1.1	0.4	0.3	0.3	0.3	0.2	0.3	0.2
6 to 9 days	0.4	0.1	0.5	0.2	0.2	0.2	0.2	0.1	0.2	0.2	0.4	0.1	0.1	0.0
10 to 19 days	0.2	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.1	0.0
20 to 29 days	0.1	0.1	0.2	0.1	0.2	0.1	0.2	0.0	0.0	0.0	0.1	0.1	0.2	0.1

Note: These percentages are calculated using the number of cases with information.

(*) Ecstasy or other designer drugs.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006

Figure 2.2.8. Rate of ecstasy use and age of beginning use among secondary school students between the ages of 14-18 years. Spain (%), 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
Ever-in-lifetime	3,6	5,5	3,6	6,2	6,4	5,0	3,3
Last 12 months	3,2	4,1	2,5	5,2	4,3	2,6	2,4
Last 30 days	2,1	2,3	1,6	2,8	1,9	1,5	1,4
Age of beginning use	15,6	15,7	15,5	15,7	15,4	15,6	15,5

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 1994-2006.

Amphetamine Use

In the questionnaire, these substances are referred to with the names of speed, amphetamines, “anfetas,” methamphetamine, “ice” and “crystal.” The extent of use of these psycho-stimulants in 2006 was similar to that of ecstasy. Of students between the ages of 14 and 18 years, 3.4% had an ever-in-lifetime use, 2.6% had used it in the last year and 1.4% in the last month. Usage is more widespread among males and increases with age. In 2006, the greatest increase in use of this substance took place between the ages of 17 and 18 years (Table 2.2.7). It is mostly a sporadic form of use, as well. The age when usage begins has reached 15.6 years and is similar for both sexes, having stabilized more or less in recent years.

Amphetamine use also went down in 2006, continuing the trend which began in 2004 (Table 2.2.17). This decrease took place in all three indicators, mainly among men and, in general, as of the age of 16 years.

Table 2.2.17. GENERAL CHARACTERISTICS OF AMPHETAMINE USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Rate of amphetamine use ever-in-lifetime	5.3	3.1	6.6	4.1	5.5	3.2	5.7	3.3	6.2	4.9	6.0	3.6	4.2	2.7
Average age at beginning of amphetamine use (in years)	15.5	15.4	15.7	15.7	15.7	15.5	15.7	15.3	15.6	15.5	15.8	15.6	15.6	15.5
Rate of amphetamine use in the last 12 months	4.4	2.5	5.5	3.4	4.5	2.5	4.6	2.4	4.8	3.4	4.3	2.3	3.3	2.0
Rate of amphetamine use in the last 30 days	2.9	1.6	3.2	2.0	2.7	1.5	2.5	1.4	2.5	1.5	2.7	1.0	2.0	1.0
Frequency of amphetamine use in the last 30 days														
Never	44.8	49.8	51.8	52.0	51.1	53.1	55.1	59.1	57.9	66.8	97.3	99.0	98.0	99.0
1 to 2 days	32.7	33.6	31.5	29.0	29.5	29.9	31.6	27.4	30.1	23.6	1.3	0.6	1.0	0.6
3 to 5 days	10.6	8.9	8.8	12.5	8.4	8.9	7.0	9.7	5.9	6.1	0.6	0.2	0.4	0.2
6 to 9 days	7.0	3.7	5.5	4.5	5.3	3.9	0.9	1.9	3.7	2.1	0.4	0.1	0.2	0.0
10 to 19 days	3.1	2.3	0.7	0.7	2.8	1.8	4.3	0.5	1.3	1.0	0.2	0.0	0.1	0.0
20 to 29 days	1.8	1.6	1.8	1.3	2.9	2.4	1.1	1.3	1.0	0.4	0.1	0.1	0.3	0.1

Note: These percentages are calculated using the number of cases with information.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

Hallucinogen Use

In the questionnaire, reference is made to hallucinogen use, including with that term a series of substances such as “LSD,” “acid,” “trippies,” “magic mushrooms,” “mescaline,” “ketamine,” “special-K,” “ketolar” and “imalgene.” In 2006, 4.1% of secondary schools students had ever-in-lifetime use, 2.8% had done so in the last year, and 1.3% had in the last 30 days. Its usage is much more widespread among boys, reaching twice the values as for girls (Table 2.2.18). As occurs with all other substances, its usage becomes more common with age. The trend in recent years seems to have been a decrease since the year of 2000, in general terms.

Table 2.2.18 GENERAL CHARACTERISTICS OF HALLUCINOGEN USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Rate of hallucinogen use ever-in-lifetime	6.7	3.6	8.0	5.6	6.1	5.0	7.2	4.4	5.6	3.4	6.2	3.3	5.7	2.7
Average age at beginning of hallucinogen use (in years)	15.4	15.4	15.6	15.6	15.5	15.4	15.6	15.3	15.6	15.4	15.8	15.7	15.5	15.5
Rate of hallucinogen use in the last 12 months	5.7	3.1	6.9	4.5	4.8	3.2	5.5	2.9	4.4	2.0	4.4	1.8	4.1	1.6
Rate of hallucinogen use in the last 30 days	3.6	1.7	3.8	1.9	2.6	1.5	2.6	1.3	1.8	0.7	2.3	0.7	2.0	0.7
Frequency of hallucinogen use in the last 30 days														
Never	96.4	98.3	96.2	98.1	97.4	98.5	97.4	98.7	98.2	99.3	97.7	99.3	97.9	99.2
1 to 2 days	2.4	1.2	2.3	1.4	1.7	1.1	1.7	1.1	1.3	0.6	1.5	0.5	1.2	0.5
3 to 5 days	0.7	0.3	0.9	0.2	0.5	0.2	0.6	0.1	0.2	0.1	0.3	0.1	0.3	0.1
6 to 9 days	0.3	0.1	0.3	0.1	0.2	0.1	0.2	0.0	0.1	0.1	0.3	0.1	0.1	0.1
10 to 19 days	0.1	0.1	0.2	0.1	0.1	0.0	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.0
20 to 29 days	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.3	0.1

Note: These percentages are calculated using the number of cases with information.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

Heroin Use

In the questionnaire, reference is made to heroin use, though in addition to this name, it is also called “caballo” and “jaco.” Heroin is the drug least used by students between the ages of 14 and 18 years. In 2006, 1% had an ever-in-lifetime use, 0.8% had in the last year, and 0.5% had in the last month prior to the survey. Use among boys was far greater than among females. Females had minimal usage levels, 0.5% having used it ever-in-lifetime, 0.3% in the last year and 0.2% in the last month, compared to respective figures of 1.5%, 1.2% and 0.9% among males (Table 2.2.19.). In terms of usage differences based on age, 16 years is the age at which usage is most extensive, not spreading further at the ages of 17 and 18 years (Table 2.2.7.). The average age when usage begins occurs at 14.6 years, a bit later than the age recorded in 2004 (14.4 years), it being slightly earlier for boys (14.5 years) than for girls (14.7). The age at which heroin use begins remains below the ages of initiation of use of other drugs (cocaine, ecstasy, amphetamines or hallucinogens) and has reached the same level as cannabis (14.5 years).

In 2006, one can observe an increase in heroin use compared to preceding years. Upcoming surveys must confirm whether this trend is consolidated.

Table 2.2.19. GENERAL CHARACTERISTICS OF HEROIN USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,415	10,374	8,867	9,668	8,224	9,341	10,147	9,777	12,964	13,946	12,864	13,076	12,598	13,856
Rate of heroin use ever-in-lifetime	0.7	0.3	0.8	0.3	1.2	0.7	0.8	0.3	0.6	0.5	1.1	0.3	1.5	0.5
Average age of beginning heroin use (in years)	14.4	14.1	14.6	15.1	14.0	15.1	15.5	15.1	14.9	14.8	14.2	15.0	14.5	14.7
Rate of heroin use in the last 12 months	0.5	0.2	0.6	0.2	0.8	0.5	0.7	0.1	0.4	0.2	0.8	0.1	1.2	0.3
Rate of heroin use in the last 30 days	0.4	0.1	0.4	0.1	0.6	0.2	0.5	0.1	0.3	0.2	0.7	0.1	0.9	0.2
Frequency of heroin use in the last 30 days														
Never	99.6	99.9	99.6	99.9	99.4	99.8	99.5	99.9	99.7	99.8	99.3	99.9	99.0	99.8
1 to 2 days	0.2	0.0	0.2	0.1	0.2	0.1	0.3	0.1	0.2	0.1	0.2	0.1	0.5	0.1
3 to 5 days	0.0	0.0	0.1	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.2	0.0	0.2	0.0
6 to 9 days	0.0	0.0	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
10 to 19 days	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
20 to 29 days	0.1	0.0	0.1	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.1	0.0	0.2	0.1

Note: These percentages are calculated using the number of cases with information.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

Use of Volatile Inhalants

The questionnaire expressly includes under this name glues, solvents, "poppers," nitrites and "gasoline." Their use is low among secondary school students. 3% had an ever-in-lifetime use, 1.8% have used them in the last year and 1.1% have in the last month. Their use occurs mainly among males and gradually increases with age, though in the current usage one cannot observe usage difference between the intermediate ages (15, 16 and 17 years) (Table 2.2.7.). This use is mainly sporadic, the age of initiation in 2006 reaching 13.6 years, being the earlier drug use initiation age after tobacco, though this age has decrease with respect to those found in 2004 and 2002 (14 and 14.3 years, respectively).

The developing trend in recent years has been quite stable since the year of 2002, when there was a decrease compared to 2000. A slight falling trend has been observed among women (Table 2.2.20).

Table 2.2.20 GENERAL CHARACTERISTICS OF VOLATILES INHALANTS USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), BY SEX. SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10.415	10.374	8.867	9.668	8.224	9.341	10.147	9.777	12.964	13.946	12.864	13.076	12.598	13.856
Rate of volatile substance use ever-in-lifetime	4,1	2,1	4,2	2,5	5,1	3,4	5,7	3,0	4,8	2,7	5,2	2,9	4,2	2,0
Average age when volatile substance use begins (in years)	13,8	12,4	13,9	13,3	13,7	13,0	14,0	13,7	14,3	14,2	13,9	14,1	13,8	13,4
Rate of volatile substance use in the last 12 months	2,5	1,3	2,4	1,7	3,3	2,0	3,3	1,8	3,0	1,5	3,0	1,4	2,7	1,1
Rate of volatile substance use in the last 30 days	1,5	0,8	1,5	1,0	2,2	1,5	1,8	1,1	1,5	0,8	1,6	0,7	1,7	0,6
Frequency of volatile substance use in the last 30 days														
Never	98,5	99,2	98,5	99,0	97,8	98,5	98,2	98,9	98,5	99,2	98,4	99,3	98,2	99,4
1 to 2 days	0,8	0,5	0,9	0,8	1,1	1,0	1,3	0,7	1,0	0,5	0,8	0,4	0,8	0,3
3 to 5 days	0,2	0,1	0,3	0,1	0,5	0,2	0,3	0,2	0,3	0,2	0,2	0,2	0,3	0,2
6 to 9 days	0,2	0,1	0,1	0,1	0,2	0,1	0,1	0,1	0,1	0,1	0,2	0,0	0,2	0,0
10 to 19 days	0,1	0,0	0,1	0,0	0,1	0,0	0,1	0,1	0,0	0,0	0,0	0,0	0,1	0,0
20 to 29 days	0,1	0,1	0,1	0,0	0,2	0,1	0,1	0,1	0,2	0,0	0,3	0,0	0,3	0,1

Note: These percentages are calculated using the number of cases with information.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

Multiple Psycho-Active Substance Use

In general, those students who use drugs tend to use several substances and not just one. This fact can be verified in (Table 2.2.21), in which one can see what percentage of students who have used a substance in the last 12 months have also used other substances, and in Figures 2.2.9a and 2.2.9b., in which one can observe the use of drugs in the last 30 days among those students who have used alcohol, tobacco, cannabis, ecstasy, cocaine and heroin in that time period.

There is a close correlation between alcohol, tobacco and cannabis use by students. Of those who have used tobacco in the last year, 95.7% have used alcohol during that same time period, and 67.6% cannabis. Among those who used cannabis in the last year, 76.8% used tobacco during that time period, 97.7% consumed alcohol and 12.7% used cocaine. There is also a correlation among psycho-stimulants and between psycho-stimulants and other substances (cocaine, ecstasy, amphetamines, hallucinogens). For example, among those who have used ecstasy in the last year, 75.5% have also used cocaine, 58.2% amphetamines, and 52.9% hallucinogens. In terms of the users of cocaine, 44.3% of them have used ecstasy and 44.0% hallucinogens.

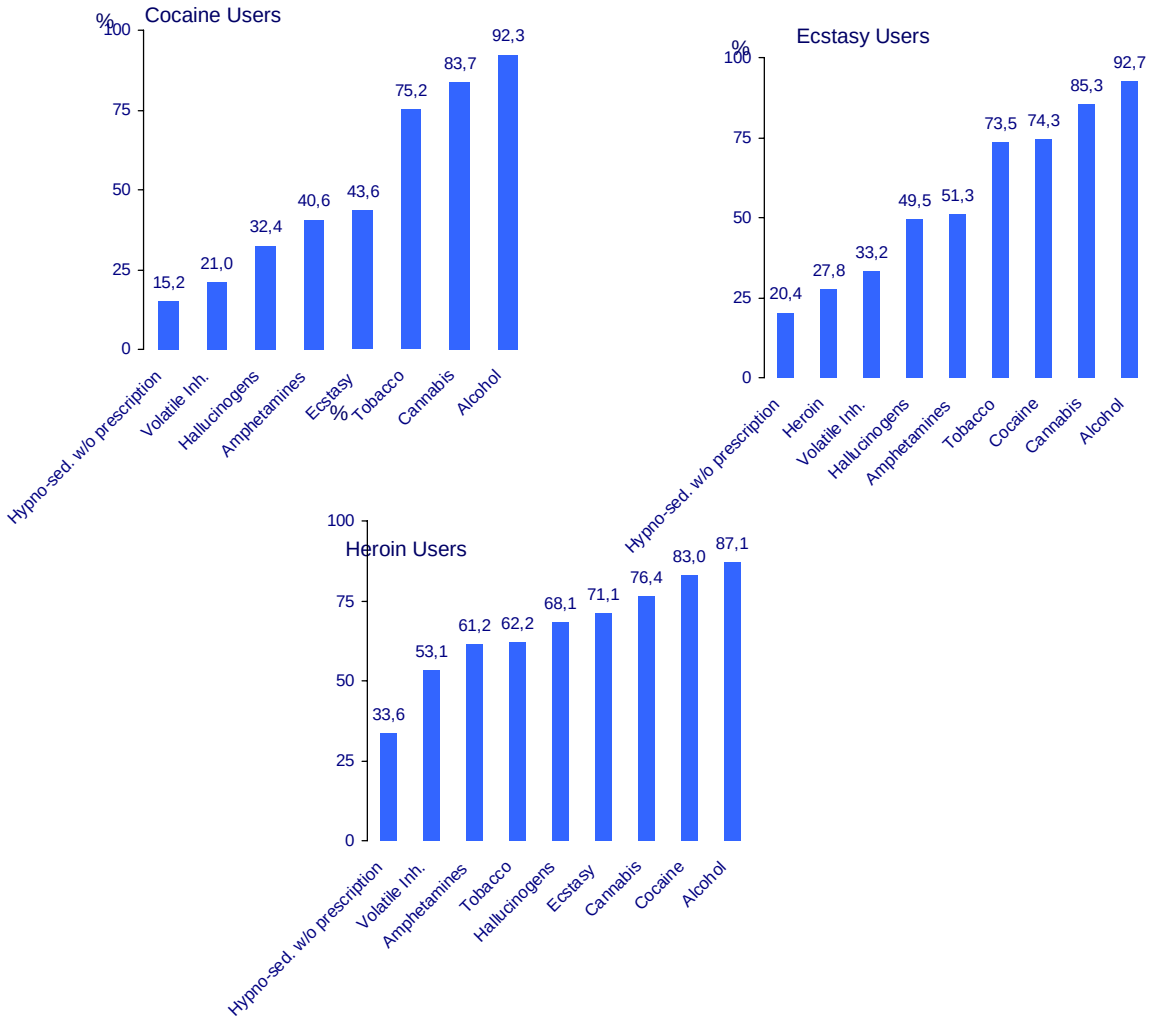
Table 2.2.21 RATE OF USE OF DIFFERENT PSYCHO-ACTIVE DRUGS IN THE LAST 12 MONTHS AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS WHO USED EACH OF THE DRUGS NAMED AT THE TOP OF EACH COLUMN DURING THE SAME TIME PERIOD (IN PERCENTAGES), SPAIN 2006.

Rate of Use	Tobacco	Alcohol	Hypnotic Sedatives*	Cannabis	Ecstasy	Hallucinogens	Amphetamines	Cocaine	Heroin	Volatile Inh.	GHB
Number	8,984	19,817	1,273	7,894	637	746	693	1,085	203	487	236
Tobacco	100	43.4	52.5	76.8	81.3	76.4	78.6	79.6	71.2	65.9	72.1
Alcohol	95.7	100	86.1	97.7	96.8	97.5	98.2	97.5	92.4	94.5	95.4
Hypnotic Sedatives w/o a prescription	7.5	5.5	100	8.0	23.8	21.4	19.0	17.5	31.6	26.0	30.0
Cannabis	67.6	38.9	49.8	100	91.4	89.8	90.9	92.7	86.8	75.5	86.0
Ecstasy	5.8	3.1	11.9	7.4	100	45.2	53.5	44.3	72.2	37.6	82.2
Hallucinogens	6.4	3.7	12.5	8.5	52.9	100	48.9	37.1	68.6	41.6	73.8
Amphetamines	6.1	3.4	10.4	8.0	58.2	45.4	100	44.0	64.6	32.3	74.7
Cocaine	8.5	5.3	14.9	12.7	75.5	53.9	68.8	100	85.0	43.1	83.9
Heroin	1.6	0.9	5.0	2.2	23.1	18.7	19.0	15.9	100	22.4	45.7
Volatile Inhalants	3.6	2.3	10.0	4.7	28.8	27.2	22.7	19.3	53.7	100	44.1

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

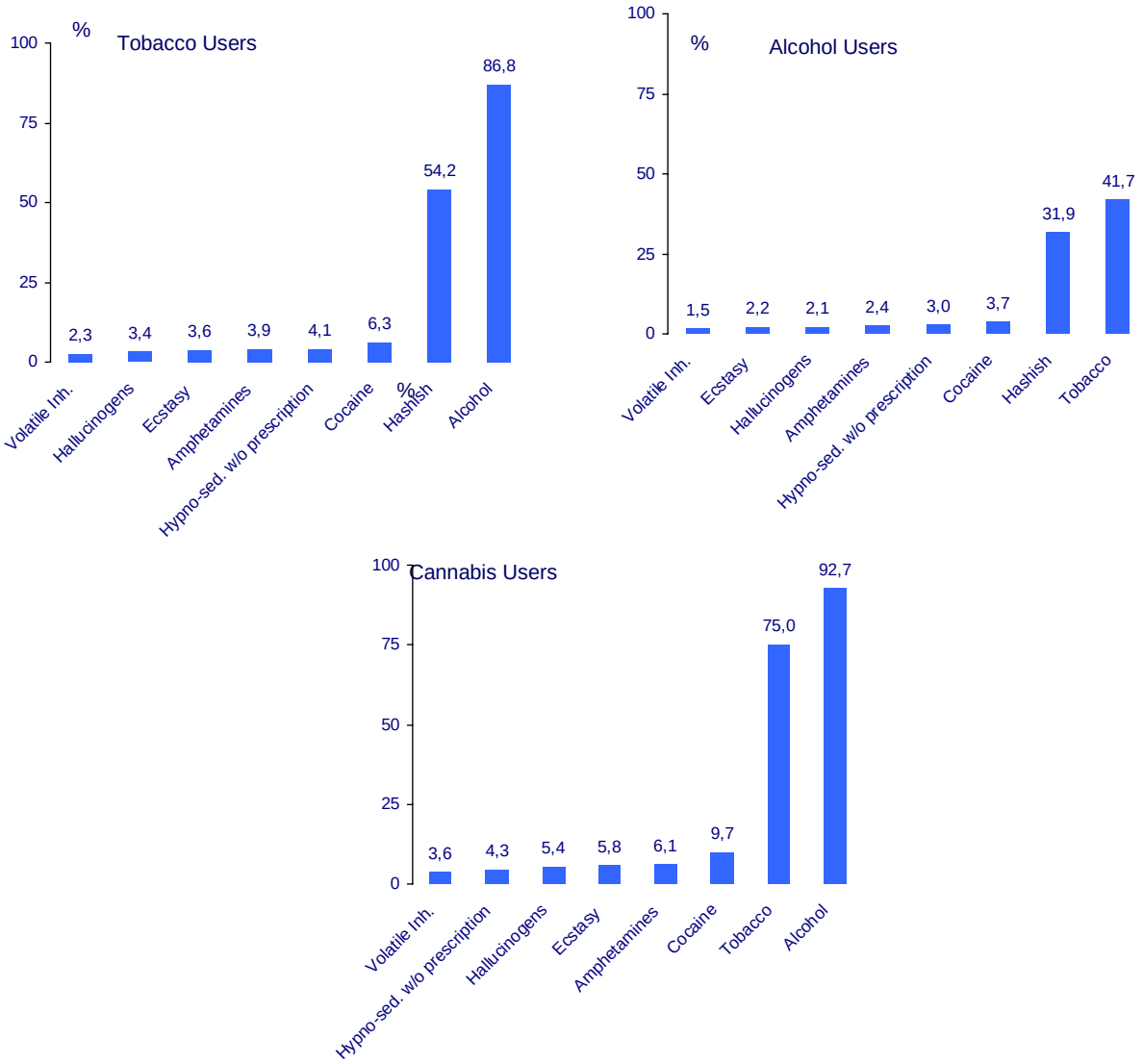
* Tranquilizers or sleeping pills with a medical prescription.

Figure 2.2.9 a. Percentage of drug users in the last 30 days who have used other drugs during that time period, among secondary school students between the ages of 14-18 years (in percentages). Spain, 2006.



SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 2006.

Figure 2.2.9 (b). Percentage of drug users in the last 30 days who have used other drugs during that time period, among secondary school students between the ages of 14-18 years (in percentages). Spain, 2006.



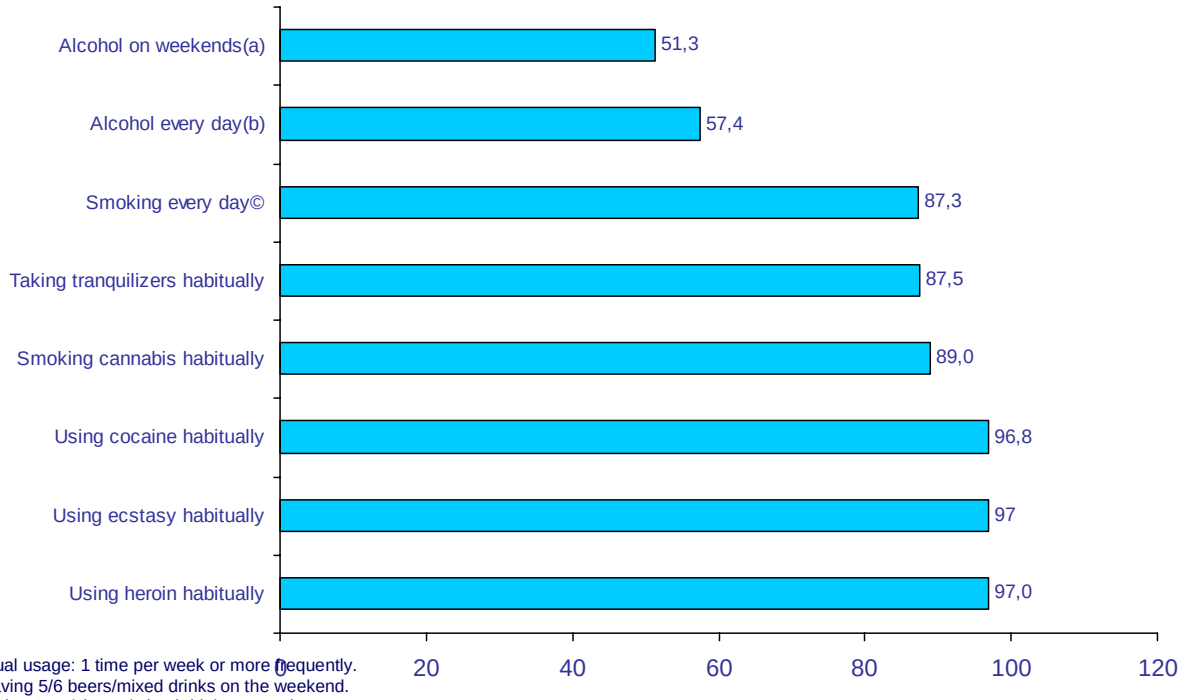
SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 2006.

Perceived Risk of Drug Use

Included in ESTUDES is a set of questions related with the problems that, in the students' judgment, may be caused by the use of the different substances. These questions allow us to survey the perceived risk of different drug use behaviors, which can be an indirect indicator of present or future changes in drug use rates. As the perceived risk of using a drug increases, the extent or intensity of use tends to decrease, and vice versa. Because of this, the percentage of students who perceive high risk from certain usage behaviors is analyzed (the percent who think that a specific behavior may cause quite a few or many problems).

In 2006, the drug use behaviors which secondary school students between the ages of 14-18 years associated with the least risk were having 5 or 6 beers/alcoholic mixed drinks on the weekend, having 1 or 2 beers/mixed drinks every day and taking tranquilizers or sleeping pills sporadically. On the contrary, the behaviors associated with the greatest risk were habitually using (once per week or more frequently) heroin, ecstasy or cocaine (Figure 2.2.10 and Table 2.2.22). The sporadic use of these last three drugs was also associated with a significant level of risk, as well using any illegal drug in general (Table 2.2.23.).

Figure 2.2.10. Percentage of students between the ages of 14-18 years who think that the drug use behavior in question can cause quite a few or many problems (%). Spain, 2006.



Habitual usage: 1 time per week or more frequently.
a) Having 5/6 beers/mixed drinks on the weekend.
b) Having 1 or 2 beers/mixed drinks every day.
c) Smoking a pack of cigarettes per day.
SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 2006

Table 2.2.22. CHANGES IN PERCEIVED RISK ASSOCIATED WITH THE USE OF PSYCHO-ACTIVE SUBSTANCES AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14- 18 YEARS, BY SEX (IN PERCENTAGES), SPAIN 1994-2006.

	1994		1996		1998		2000		2002		2004		2006	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Number of people surveyed	10,416	10,495	9,174	9,738	8,509	9,503	9,949	10,477	12,795	13,781	12,568	12,953	12,598	13,856
Percentage who think that this behavior may cause quite a few or many problems														
Smoking tobacco every day [1]	74.7	79.1	72.8	77.4	75.7	79.9	75.1	79.5	76.7	80.8	78.2	82.3	84.9	89.3
Drinking alcohol on the weekend	39.8	47.7	40.6	49.4	40.3	48.7	41.5	48.3	41.1	48.1	36.8	45.7	48.7	53.6
Drinking alcohol every day [2]	46.3	54.6	43.7	52.9	41.7	49.4	39.4	48.4	38.7	47.9	36.8	45.7	52.3	61.9
Smoking hashish habitually	89.8	93.9	84.9	90.2	82.4	88.8	79.4	86.1	77.5	85.4	81.1	86.2	85.7	91.7
Taking tranquilizers/sleeping pills habitually	89.9	91.3	87.8	89.4	87.5	89.2	86.9	87.9	88.3	89.1	89.8	89.6	86.1	88.6
Using ecstasy habitually	96.6	97.9	96.2	97.9	96.3	97.5	95.0	95.9	96.4	97.1	97.1	97.3	95.8	98.0
Using cocaine habitually	98.1	99.0	96.9	98.3	96.7	98.0	96.3	97.5	96.9	97.8	97.5	98.1	95.6	97.9
Using heroin habitually	98.4	99.3	97.4	98.8	97.5	98.7	97.6	98.8	98.4	98.8	98.5	99.1	95.8	98.1

Note: These percentages are calculated using the number of cases with information.

(ª) Smoking a pack of cigarettes per day.

(º) Having one or two beers/mixed drinks every day.

"Habitually": once a week or more frequently.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 1994-2006.

Table 2.2.23 . PERCEPTION OF RISK FROM DIFFERENT DRUG USE BEHAVIORS AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, (AS A PERCENTAGE OF THOSE WHO THINK THAT THE BEHAVIOR IN QUESTION MAY CAUSE QUITE A FEW OR MANY PROBLEMS), SPAIN 2006

Using cannabis sporadically	70.2
Using tranquilizers sporadically	60.2
Using ecstasy sporadically	91.3
Using cocaine sporadically	90.8
Using heroin sporadically	92.0
Using tobacco daily (one pack per day)	87.3
Drinking alcohol (5 or 6 beers/mixed drinks on the weekend)	51.3
Using alcohol (1 or 2 beers/mixed drinks every day)	57.4
Using cannabis habitually	89.0
Using tranquilizers habitually	87.5
Using ecstasy habitually	97.0
Using cocaine habitually	96.8
Using heroin habitually	97.0

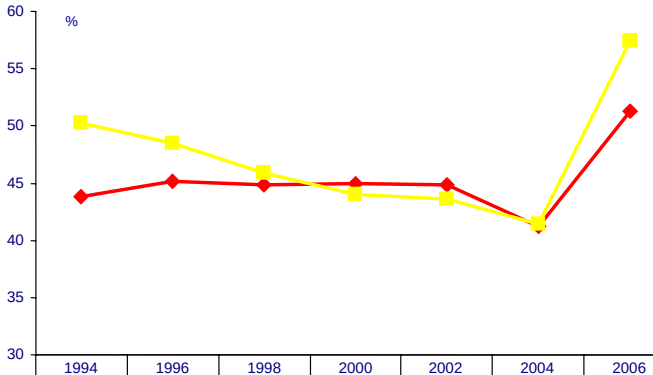
Note: These percentages are calculated using the number of cases with information.
“Sporadically”: once per month or less frequently
"Habitually": once per week or less frequently
SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES) 2006.

Nevertheless, the risk associated with sporadic use in 2006 must be considered with precaution, especially when making comparisons with the preceding years, because there was a change of format in the way of asking the questions compared with previous years, and this affected the responses. In 2006, two questions were posed on risk perception, one in which a question was asked about the sporadic use of different drugs and another different question in habitual usage. In prior years, the two questions formed part of one single question which included both sporadic and habitual usage behaviors. In 2006, a very important increase was observed in the perception of risk in all of the questions related with sporadic use compared to prior years, and above all a small difference in risk perception between sporadic use and habitual use, which may be attributed to the way the question is asked. In previous years, on the contrary, a different risk was attributed to the different usage behaviors, whether sporadic or habitual, but both behaviors were related with each other in the same question, which made it easier to differentiate them when answering the question.

In terms of gender-related differences, in 2006 one can see that the risk perceived by females was greater than that perceived by males, especially regarding the consumption of alcohol and the use of cannabis.

One positive figure found in this survey is that the risk perception regarding daily use of tobacco, alcohol (both on the weekend and with everyday use) and cannabis went up (Figures 2.2.11 and 2.2.12.).

Figure 2.2.11. Changes in perceived risk from the consumption of alcohol on a daily basis and on weekends, among secondary school students between the ages of 14-18 years. Spain (%), 1994-2006.

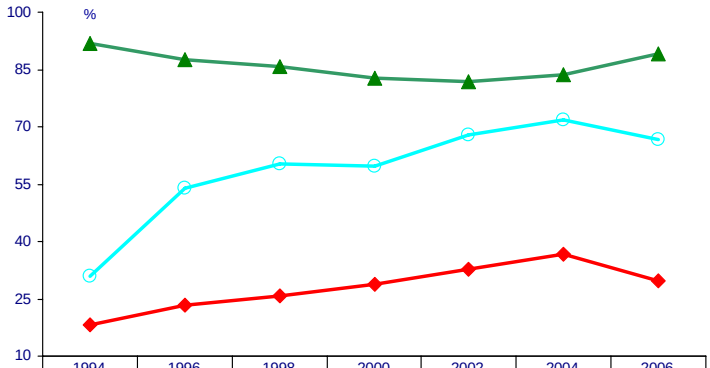


	1994	1996	1998	2000	2002	2004	2006
Having 5 or 6 beers/mixed drinks on the weekend	43,8	45,2	44,8	44,9	44,8	41,2	51,3
Having 1 or 2 beers/mixed drinks every day	50,2	48,5	45,9	44	43,6	41,4	57,4

Perceived Risk: Percentage of students surveyed who think that drinking 5 or 6 beers/mixed drinks on the weekend or 1 or 2 beers/mixed drinks every day can cause many or quite a few problems.

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

Figure 2.2.12. Changes in the rate of cannabis use in the last 12 months, in perceived risk regarding cannabis use and the perceived availability of cannabis among secondary school students between the ages of 14-18 years. Spain (%), 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
Prevalence of use	18,2	23,4	25,7	28,8	32,8	36,6	29,8
Perceived risk of habitual use	91,9	87,7	85,9	82,8	81,7	83,7	89,0
Perceived availability	30,8	53,9	60,4	59,7	67,9	71,8	66,8

Perceived Risk: Percentage of students surveyed who think that habitual cannabis use may cause many or quite a few problems.
Perceived Availability: Percentage of students surveyed who think that it would be easy or very easy to get cannabis if they wanted to.

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES). 1994-2006.

Availability of Drugs Perceived by Surveyed Students

The degree of ease/difficulty in obtaining or getting different drugs, or what we refer to as the perceived availability, in this case by the students, is another of the factors which appears to be related with drug use. The substances which, in the students' judgment, seem to be most available are usually those most commonly used, and vice versa. In actuality, this involves information related with the perception of the supply of drugs, which is of interest.

The indicator used to evaluate this is the percentage of students who think that getting each drug in question is relatively easy or very easy.

In 2006, the drugs perceived by students as being the most available or accessible were those that could be legally purchased and cannabis. In this sense, 91.2% of the students thought that it would be easy or very easy for them to obtain alcoholic drinks if they wanted, 58.9% tranquilizers or sleeping pills and 66.8% cannabis (Table 2.2.24).

In terms of the changes in perceived drug availability over time, from 2004 to 2006 an overall decrease can be observed in the perceived availability of all drugs (Figure 2.2.14.). In the case of certain drugs, such as cannabis and cocaine, the decreases were very important and appeared for the first time after an ongoing increase since 1994 (Figures 2.2.12. and 2.2.13.). In the case of other drugs, such as heroin, amphetamines, ecstasy and hallucinogens, the falling trend that had already started to be seen in 2004 continued. A slight decrease in perceived availability affected alcohol (Table 2.2.24.).

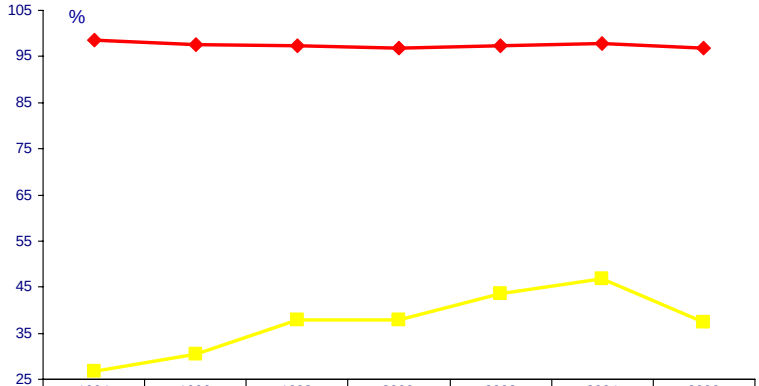
Table 2.2.24. CHANGES IN PERCEIVED AVAILABILITY OF PSYCHO-ACTIVE SUBSTANCES AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS (IN PERCENTAGES), SPAIN 1994-2006

	1994	1996	1998	2000	2002	2004	2006
NUMBER OF STUDENTS SURVEYED	20,789	18,966	18,085	20,450	26,576	25,521	26,454
PERCENT WHO THINK IT IS EASY/VERY EASY TO OBTAIN							
Alcoholic Beverages	93.8	89.0	90.5	91.3	92.0	93.8	91.2
Tranquilizers / Sleeping Pills	55.9	65.9	65.9	67.2	67.6	67.3	58.9
Hashish/Marijuana	30.8	53.9	60.4	59.7	67.9	71.8	66.8
Cocaine	26.7	30.4	37.9	38.0	43.5	46.7	37.4
Heroin	48.0	25.6	29.1	28.1	32.0	30.7	26.1
Amphetamines	43.9	40.1	39.7	40.2	45.4	41.7	32.1
Ecstasy	46.3	42.6	39.8	43.8	50.0	45.1	31.2
Hallucinogens	26.2	40.1	39.2	41.4	45.3	41.9	33.7
Volatile Inhalants	61.4	54.8	54.2	51.6	54.1	51.1	--

Note: These percentages are calculated using the number of cases with information.

SOURCE: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

Figure 2.2.13. Perceived risk of habitual cocaine use and perceived availability of cocaine among secondary school students between the ages of 14-18 years. Spain (%), 1994-2006.



	1994	1996	1998	2000	2002	2004	2006
Perceived Risk	98,5	97,6	97,4	96,9	97,4	97,8	96,8
Perceived Availability	26,7	30,4	37,9	38,0	43,5	46,7	37,4

Perceived Risk: Percentage of students surveyed who think that habitual cocaine use may cause many or quite a few problems.
Perceived Availability: Percentage of students surveyed who think that it would be easy or very easy to get cocaine if they wanted to.

SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2006.

Figure 2.2.14. Percentage of secondary school students between the ages of 14-18 years who think that it would be easy or very easy to get each drug if they wanted to (%). Spain, 2004-2006.

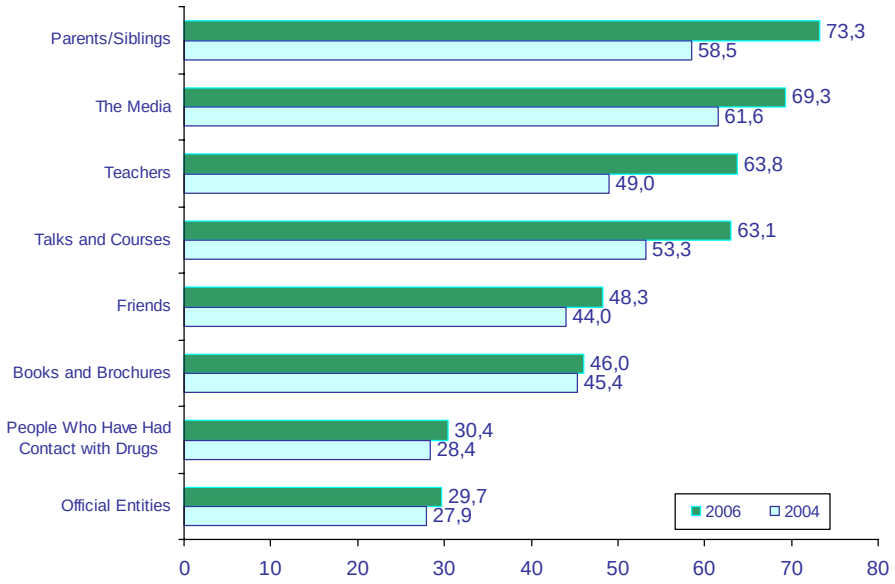
SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 2004-2006.

Information Received on Drugs

The vast majority of students (86.5%) consider themselves sufficiently or perfectly informed about drugs, their effects and the problems associated with them(table). The main channels through which students receive information are their parents, the media and their teachers. A large percentage also state that they have been given talks or courses on the topic (Figure 2.2.15). In 2006, the percentage of students who declare having received information from their parents, siblings and teachers went up compared to previous years. In terms of the last of these, the percentage of students who state they received information through them in 2006 was 63.8%, compared to 49% in 2004. In the same sense, 74.2% of the students claim to have received information on drug use in class, a percentage which surpassed that of prior years (in 2002 it was 65.6% and in 2004 it was 72.5%).

In terms of the preferred channels through which students would like to get information on drugs, the most notable are health care professionals (50.7%), talks and courses on the topic (46.1%) and the people who have had contact with drugs (41.3%).

Figure 2.2.15 Percentage of secondary school students between the ages of 14-18 years who have received information through each of the channels in question. Spain, 2004-2006.



SOURCE: DGPNSD. State Survey on Drug Use in Secondary Schools (ESTUDES), 2004-2006.

Personal and Social Environment of Schoolchildren

Use of Drugs in Peer Groups

Drug use among students is usually performed within the context of leisure time and in peer groups. In the survey, students were asked whether the friends with whom they go out and have relationships with had used the various drugs. Their responses confirm this fact to us. Alcohol, tobacco and, thereafter, cannabis are the substances which the largest percentage of students claim that all or most of their friends have

used. For instance, 54.9% of the students claim that all or most of their friends have had alcoholic beverages in the last 30 days, 33.2% tobacco and 14.7% cannabis. At the same time, usage within the peer group is one of the factors most associated with drug use among students. As can be seen in (Table 2.2.25.), the usage rates of substances among students whose friends (all or most) use them are far greater than for those who claim that only a few of their friends use them.

Table 2.2.25. SUBSTANCE USE ON THE BASIS OF USE WITHIN THE PEER GROUP (IN PERCENTAGES) AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS . SPAIN, 2006

	Most or all of their friends use this substance	None or a few of their friends use this substance
Drinking of alcoholic beverages in the last 30 days	79.4	32.1
Getting drunk in the last 30 days	60.8	16.3
Smoking tobacco in the last 30 days	56.7	13.5
Using cannabis in the last 30 days	66.1	12.1
Using cocaine powder in the last 30 days	36.5	1.4

Time When Returning Home After Going Out and Drug Use

The use of drugs among students occurs mainly within the context of leisure time. The type of entertainment they partake in has an influence on whether they use drugs more or less. Included in ESTUDES is a set of questions on how often students go out at night and the time when the students return home, factors which also appear in prior studies, as did drug use in peer groups, both highly associated with drug use. In 2006, 52.8% of students went out at least once per week. This percentage varied with age, reaching 37.3% at the age of 14 years and 70% at the age of 18 years (Table 2.2.26). The frequency with which they went out at night decreased compared to 2004.

In terms of the time when they return home after going out at night, 16.1% of students got home before midnight, 25.9% after 4 a.m., and 58.1% between midnight and 4 a.m. The time when returning home depends on age. At the age of 14 years, 36.8% of students get home before midnight, whereas only 2.5% of those aged 18 do so by that time. On the contrary, 6% of students at the age of 14 years get home after 4 a.m., a figure which rises to 58.7% at the age of 18 years (Table 2.2.27). In 2006, students got home earlier than in 2004.

Both factors, the frequency of going out at night and the time when returning home after going out, are very much related with drug use. Those students who go out less frequently, as well as those who get home the earliest, use drugs significantly less than those who go out frequently and come home late. In Tables 2.2.28. and 2.2.29., the relationship can be seen between drug use, the frequency of going out at night, and drug use and the time when returning home from going out at night, broken down by age, so that age will not interfere in the analysis, because it is related with both drug use and the frequency of going out, as well as the time when returning home, regardless of whether there may be other factors which play a role.

Table 2.2.26. FREQUENCY OF GOING OUT AT NIGHT IN THE LAST 12 MONTHS, AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY AGE (IN PERCENTAGES). SPAIN, 2004-2006

Age (in years)	Total 2004	Total 2006	14	15	16	17	18
Never	6.1	11.8	26.2	14.3	7.9	4.0	3.4
1-3 days per month	37.3	35.3	36.4	39.8	35.5	32.9	26.7
4 days per month	20.3	18.5	13.2	16.9	20.9	21.2	21.6
More than 4 days per month	36.3	34.3	24.1	29.1	35.8	41.9	48.4

Source: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES)

Table 2.2.27. TIME WHEN RETURNED HOME THE LAST TIME THE STUDENT WENT OUT DURING A WEEKEND, AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY AGE (IN PERCENTAGES). SPAIN, 2004-2006.

Age (in years)	Total 2004	Total 2006	14	15	16	17	18
Before midnight	10.4	16.1	36.8	21.9	12.7	5.2	2.5
Midnight - 2 a.m.	25.2	29.0	41.1	38.8	28.2	19.1	11.1
2 a.m. - 4 a.m.	30.8	29.1	16.1	26.6	33.7	36.7	27.7
After 4 a.m.	33.7	25.9	6.0	12.8	25.4	38.9	58.7

Source: Government Delegation for the National Plan on Drugs. State Survey on Drug Use in Secondary Schools (ESTUDES)

Table 2.2.28. RATE OF DRUG USE AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14-18 YEARS, BY FREQUENCY OF GOING OUT AT NIGHT TO HAVE FUN IN THE LAST 12 MONTHS (%) BY AGE GROUPS. SPAIN, 2006.

	14 years old				15-16 years old				17-18 years old			
	Never	Up to 3 nights per month	1 night per week	2 or more nights per week	Never	Up to 3 nights per month	1 night per week	2 or more nights per week	Never	Up to 3 nights per month	1 night per week	2 or more nights per week
Alcohol[a]	10.6	31.3	37.2	52.1	17.2	52.1	67.4	73.5	19.9	63.0	80.5	85.4
Tobacco[b]	1.6	4.2	2.4	8.2	2.8	9.7	12.9	22.0	2.7	13.9	20.9	34.0
Getting drunk[a]	2.2	8.6	10.9	21.3	4.9	17.4	31.0	36.6	4.3	23.8	36.6	48.9
Cannabis[a]	1.8	7.3	7.7	13.7	4.9	14.2	20.6	30.2	4.0	17.1	25.7	41.0
Cocaine[c]	0.4	0.8	1.2	2.9	0.4	1.4	2.8	6.5	2.3	2.6	6.2	11.9
Ecstasy[c]	0.1	0.4	0.4	1.5	0.4	0.6	1.9	4.4	0.3	1.1	3.3	7.1
Amphetamines[c]	0.1	0.3	0.4	1.2	0.4	1.0	1.8	4.4	0.3	1.0	3.4	8.3
Hallucinogens[c]	0.1	0.5	0.7	1.7	0.5	1.2	2.6	4.7	0.3	0.9	3.3	8.3
Heroin[c]	0.1	0.3	0.1	0.8	0.2	0.2	1.0	1.9	2.0	0.3	0.9	1.1
Volatile Inhalants[c]	0.1	1.2	0.4	1.5	0.6	1.1	1.4	3.4	0.7	0.8	2.1	3.9

a: Used at some time in the last 30 days.

b: Used daily in the last 30 days.

c: Used at some time in the last 12 months.

Source: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory. ESTUDES 2006

Table 2.2.29. RATE OF DRUG USE AMONG SECONDARY SCHOOL STUDENTS, BY TIME WHEN RETURNING HOME AFTER THE LAST TIME HAVING GONE OUT AT NIGHT (%). SPAIN, 2006

	14 years old				15-16 years old				17-18 years old			
	Before Midnight	Between Midnight and 2 a.m.	Between 2 a.m. and 4 a.m.	After 4 a.m.	Before Midnight	Between Midnight and 2 a.m.	Between 2 a.m. and 4 a.m.	After 4 a.m.	Before Midnight	Between Midnight and 2 a.m.	Between 2 a.m. and 4 a.m.	After 4 a.m.
Alcohol[a]	25.7	41.2	58.3	61.3	37.3	55.9	74.2	82.3	40.1	60.7	75.1	88.0
Daily Tobacco	2.3	5.2	8.8	13.8	5.9	10.2	16.8	28.0	7.1	14.1	19.7	33.7
Getting Drunk[a]	7.6	11.8	23.4	30.2	10.9	18.4	32.9	48.9	8.6	17.2	30.7	53.9
Cannabis[b]	3.0	10.7	15.5	26.2	8.5	15.7	25.2	37.1	9.3	14.5	23.6	42.2
Cocaine[b]	0.6	1.4	2.7	4.9	1.1	1.4	3.0	10.3	1.5	1.7	2.6	13.9
Ecstasy[b]	0.3	0.5	1.2	4.4	0.5	0.8	2.2	6.4	1.2	1.1	1.7	7.5
Amphetamines[b]	0.1	0.6	1.2	3.1	1.0	1.1	1.9	6.7	1.2	0.6	1.6	9.0
Hallucinogens[b]	0.3	0.6	2.3	3.1	0.6	1.4	3.1	6.5	0.9	1.3	2.3	8.0
Heroin[b]	0.1	0.4	0.5	2.7	0.3	0.5	0.9	2.4	0.9	0.4	0.6	1.1
Volatile Inhalants[b]	0.5	1.4	1.5	2.7	1.3	1.5	1.9	3.5	1.9	1.2	1.4	3.8

a: Used in the last 30 days.

b: Used daily in the last 12 months.

Source: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory. ESTUDES 2006

Conclusions

- In general, drug use among students between the ages of 14 and 18 years continues to be experimental or occasional, and is linked with leisure time and the weekend.
- Alcohol and tobacco remain the most commonly used drugs, followed by cannabis.
- The year 2006 data, however, show very positive developments, with a significant decrease in the use of the most widespread drugs among students.
- This decrease has been especially large for tobacco, cannabis and cocaine. In the case of the last two, the rising trend found in recent years was put to a stop.
- In terms of alcoholic beverages, the percentage of students who consume them has gone down, as has the intensity of consumption, compared with 2004, though the figures are still higher than in 2002.
- In Spain, psycho-stimulants such as ecstasy or amphetamines, as well as hallucinogens, are less widespread than cocaine (the percentage of students who have used them in the last year is lower than 3% for all three of the aforementioned drugs) and their use has been steadily falling in recent years.

Drug Use among specific groups

No new available data.

3. PREVENTION

In the area of prevention, the actions in priority areas established in the 2005-2008 Action Plan that were set in motion in previous years have been continued and reinforced.

In 2006, the Government Delegation for the National Plan on Drugs presented the "*ITACA pilot programme*" on Actions to Prevent Drug Addiction in Schools, which involves three educational prevention programmes (two universal and one selective) aimed at students of every age group. These programmes are designed to reinforce and increase the efficacy of programmes already operating in schools. The Pilot Programme is funded by the Ministry of Health and Consumer Affairs through the Government Delegation for the National Plan on Drugs, and has been prepared jointly with the Ministry of Education and Science.

These programmes address both legal and illegal drugs, based on the principle that preventing the abuse of any kind of drug, including alcohol and tobacco, among the youngest members of the population is paramount.

These three actions aim to offer a multifaceted response to the current scenario of drug use among very young people, in accordance with prevention recommendations and criteria:

- The voluntary participation of Autonomous Communities and Cities in the design of this pilot programme within the scope of their authority,
- the inter-sectorial application of interventions,
- the continuity of interventions,
- and the evaluation of said interventions in order to determine their efficiency, thus enabling actions taken to prevent drug use in schools to benefit from the implementation of these kinds of activities.

Action A promotes a universal drug use prevention programme aimed at the youngest age group (boys and girls between the ages of 10 and 12) in the shape of a School Competition called "*The Secret to Good Living*."

Action B, known as "*Project Odyssey*," promotes a selective programme to prevent drug use among adolescents between the ages of 16 and 18 enrolled in vocational education programmes, where a high prevalence of substance use has been detected. The action involves special training for teachers and will give them the methodological tools they need to design and implement a prevention programme suited to the specific conditions of the centre where they teach.

Finally, Action C is aimed at primary and secondary school students between the ages of 6 and 16. It consists of a universal joint intervention plan known as the "*Argos Programme*", that promotes the synchronisation of preventive activities carried out by teachers and health professionals, in such a way that the latter can become involved in school prevention programmes and develop methods for the early detection and intervention of drug use.

In 2006 we have continued to work with the *"Society facing the Drugs"* in which the main NGOs of the sector and other social organisations participate, and which helps to support these activities on three different levels: Family, Young People and the Social Media.

In addition, the Government Delegation for the National Plan on Drugs has awarded funding to **non-profit entities** operating on a national level in 2006 for carrying out drug addiction programmes. Two calls for official grant applicants were issued and a total of 3,587,000 € was awarded:

1. The 2006 National Budget allocated a total of 2,987,000 euros for these grants. In the area of prevention and awareness, priority was given to:

   - Programmes to prevent initiation in drug use, particularly alcohol and cannabis, and warning of the risks associated with such use, aimed at young people.
   - Community drug-addiction prevention programmes aimed especially at young people and at-risk or socially marginalised families.
   - Actions for raising awareness among young people in recreational and leisure-related contexts.
   - Actions aimed at increasing the ability of families to actively participate in the prevention of drug addiction.
   - Innovative communication actions designed to raise awareness about problems deriving from drug use.
   - Actions aimed at the workplace.

2. In application of Law 7/2003 of 29 May, the Fund of confiscated assets in relation to drug trafficking and other related crimes, awarded grants amounting to a total of 600,000 €. With regard to drug-addiction prevention programmes, priority was given to non-profit entities for:

   - Programmes to prevent initiation in drug use, particularly alcohol and cannabis, and warning of the risks associated with such use, aimed at young people.
   - Community drug-addiction prevention programmes aimed especially at young people and at-risk or socially marginalised families.

On the other hand, drug use prevention programmes developed by cities subsidize with pursuant to the Action Plan were 2,386,000 € in 2006 by the Government Delegation for the National Plan on Drugs.

Universal prevention

Prevention in Schools

Universal prevention in schools continues to be the preferential sphere of action in every Autonomous Community of the Spanish nation. School prevention has grown both qualitatively and quantitatively in recent years. Autonomous Communities and cities have programmes that their regional plans offer to schools in collaboration with the educational system. There are currently 47 school prevention programmes that have been accredited by the Regional Drug Plans, although the degree of application and continuity varies from one region to another.

In the year 2006, an estimated 1.2 million students in around 9,000 education centres have participated in these kinds of programmes, most of which are aimed at secondary education students. In other cases, interventions are far less developed. In Spain there are relatively few school prevention initiatives aimed exclusively at students

between the ages of 16 and 18, despite the fact that this age group can be considered the most vulnerable in terms of drug use.
In the field of education, as part of the aforementioned *Itaca Programme*, the Government Delegation for the National Plan on Drugs has launched a campaign to raise awareness about school prevention aimed at educational centres. The core of this initiative is a competition based on a CD-ROM game, *"The Secret to Good Living,"* for students at the 5th- and 6th-grade levels of primary education (10-12 years old) and teachers working at these centres. This game is an entertaining and educational tool for boys and girls of an ideal age for taking preventive action (10-12 years old), before they are initiated to drugs, alcohol and tobacco included. It is also designed to inform teachers of the school prevention programmes offered by the Regional Drug Plans. In the 2006-2007 academic year, 80,838 students from 1,128 primary schools in 18 of Spain's 19 Autonomous Communities and Cities participated in this competition.

The halfway-point evaluation carried out by the Government Delegation on the National Drug Plan to determine the degree of compliance with the National Drug Strategy, clearly showed that it is also very important to involve health professionals as well as prevention the academic community in activities, especially primary care providers. Up until now, the health-care sector has not been involved in actions as much as could be desired. For this reason, the second axis of the 2005-2008 Action Plan regarding action, prevention and social awareness, states that one of the priority objectives is the promotion of actions to increase the level of involvement of this important professional sector. To this end, the Government Delegation for the National Plan on Drugs will continue to work on the *"Argos Programme"* described above.

Family Prevention

Family prevention is another area on which a large part of the Regional Drug Plans' efforts are focused.

In general, universal family prevention programmes are less structured than school programmes. The Schools for Parents, educational talks, distribution of materials, orientation and guidance services and informal courses are the most common activities in this area of prevention. Joint interventions with children are not usually part of these activities. Although the most frequent themes addressed in family prevention programmes are generic issues regarding parent-child communication and helping children to avoid drug addiction, specific family programmes for the prevention of certain substances such as alcohol and cannabis are becoming increasingly more prolific and widespread.

The most structured prevention programmes are usually variations on school programmes that are already well established (*Extraordinary, The Adventure of Life, Between All of Us, In the Garden with my Friends, Film in Education* or *Film and Instilling Values).* Universal programmes designed specifically for families are still scarce.

Community Prevention

Alternative leisure programmes

In determining the 2006 recipients of the grants for private non-profit organisations operating on a national level for carrying out programmes related to drug addiction, the Government Delegation for the National Plan on Drugs gave priority to actions for raising the awareness of young people in recreational and leisure-related contexts.
The Government Delegation has doubled the amount of grants allocated to the promotion of development of healthy leisure programmes by local authorities since last

year, providing a total sum of 3.4 million euros. This increase has made possible for the municipal councils of cities with over 100,000 inhabitants that are not provincial or regional capitals, and were consequently not eligible to receive such funding in the past, to apply for such grants and thus reinforce their Municipal Drug Plans. In 2006, a total of 52 programmes developed by town and city councils were granted funding.

These programmes are aimed primarily at minors and young people. Most of the programmes are held in public places (sports centres, schools, community centres, etc.) in afternoons and evenings of weekends or school vacation periods. The majority of activities are recreational and sports-related, and few activities of a cultural nature are offered.

Programmes conducted in habitual places of drug use

This year has witnessed a continuation of informative interventions aimed at young people and designed to reduce the risks and harm associated with recreational drug use. These are normally itinerant actions carried out by peer mediators that work to detect problematic cases and provide information and advice about drugs and their various forms of use in areas around bars, nightclubs, music concerts, etc. They also promote responsible conduct in public places, such as keeping noise levels down in populated areas, picking up trash, etc. Some of these initiatives are "Key Zone," "Energy Control," "Controla Club," "Creative," and "Exeo." Many have their own websites and provide consultation services by telephone and e-mail. There is currently no available data regarding the evaluation of these programmes' processes or results.

In addition to this, most Autonomous Communities have initiatives to minimize the risks associated with the use of alcohol and other drugs while driving motor vehicles, which consist primarily of alternative transportation, encouraging the use of "designated drivers" (which has been quite successful), the implication of driving schools and awareness campaigns. In fact, according to data provided by the General Directorate of Traffic, traffic accidents involving young people between the ages of 18 and 20 have gone down by 15.8% in 2006.

The Media

All Autonomous Communities are currently active in this area with initiatives such as: specific campaigns to celebrate International Days against Drugs, informative audiovisual micro-spaces, advertisements on television and in movie theatres, handing out promotional material (calendars, caps, T-shirts, etc.), brochures and informative DVDs, programmes about drugs broadcast on local radio and TV stations that include reports, debates and interviews, and even schools for mothers and fathers.

There are many websites about drugs aimed at specific sectors of the population (children, young people, parents, educators, etc.), and a large number dedicated to adolescents and young people. These pages offer to the youth information about different kinds of drugs and the most important actions being taken to prevent drug use in the autonomous community.

In 2006, the Government Delegation for the National Plan on Drugs presented its campaign *"Drugs: There Are Some Trains You Shouldn't Catch"* for the purpose of informing and raising social awareness (directed to adolescents between the ages of 12 and 18, as well as at the parents as their guardians and primary educators) about the risks to health and personal development deriving from drug use, especially cannabis and cocaine, the two most popular illegal drugs in Spain.

The campaign, for which 2.2 million euros were allocated, involved the publication of inserts in the press and online, 170 radio spots and more than 1,000 exhibitions of the television advertisement, as well as the placement of 4,452 posters on hoardings, announcement boards and public transport. As in past campaigns promoted by the National Plan on Drugs, over 200 public and private organisations (including town councils, regional authorities, non-profit organisations and companies) altruistically contributed to the dissemination of this important information.

Selective prevention and Indicated prevention

In the case of selective and indicated prevention, interventions in every area are less advanced than in universal prevention. Although all Autonomous Communities have preventive initiatives for at-risk sectors, not all of them have contributed data regarding the scope of said activities.

As part of the "*Itaca Programme*," the Government Delegation for the National Plan on Drugs has launched "*Project Odyssey*," a pilot programme for school prevention aimed at vocational training centres and resources. It consists of applying and evaluating a selective programme that could serve as a model for intervention in these kinds of centres, where initiatives are currently scarce and lack adequate structure.

Prevention among vulnerable population sectors is a priority of the Drug Action Plan (2nd axis, action 8). In fact, the Government Delegation's announcements for grants to private non-profit entities operating on a national level for the implementation of drug-addiction programmes in the year 2006 continue to give priority to community prevention programmes aimed especially at young people and at-risk or socially marginalised families.

Institutional collaboration in this area has improved. In Catalonia, in collaboration with the General Directorate of Juvenile Justice, a project is underway to launch a selective and indicated prevention programme for youth offenders and their families. In Madrid, for example, an initiative for preventive intervention has been introduced in collaboration with the Madrid Institute of Minors and Families (IMFF) for the purpose of extending prevention measures to include minors in the custody of centres in the Network of Residential Foster Care Resources.

A large part of the preventive efforts in this area are focused on underage offenders and/ or minors in foster care facilities. For young people that have been convicted of the use or possession of drugs in public venues, programmes have been designed that offer the possibility of completing a specific information/ reflection course on the substance in question in lieu of paying the corresponding fine. There are also new selective and indicated prevention programmes for at-risk families, former female drug users with children, as well as specific programmes for ethnic minorities aimed at gypsy families and youths with problems related to drug addiction and broken homes as a result of drug use.

Initiatives have been expanded to include training for social mediators, professionals of the judicial system and the police force, day centres and other professionals who work with these at-risk groups to arm them with strategies as agents of prevention. In some cases, these actions involve providing them with educational resources to enhance group interventions with at-risk minors as well as their families.

Many of these programmes are starting to be evaluated, not only terms of the quantity of actions taken or the scope of their reach, but also in terms of the quality of said actions and the results of the same.

Table 3.1. STRUCTURE PROGRAMMES - SCHOOL PREVENTION

Aut. Community	Programme Name	No. of education centres	No. of students	No. of teachers	Intervention level*
ANDALUSIA	Say no	440	22.723	1.858	Universal
ANDALUSIA	Prevent to live	450	86.352	9.906	Universal
ANDALUSIA	What do you think	105	9.291	490	Universal
ANDALUSIA	Train young	404	173.912	7.763	Universal
ANDALUSIA	Smoke-free school	586	64.728	3.264	Universal
ARAGON	“Ordago”	72	14572	623	Universal
ARAGON	The adventure of life	93	9142	434	Universal
ARAGON	Chatting to decide	55	7200	266	Universal
ARAGON	Social skills	2	68		Universal
ARAGON	D-cine programme	25	645	48	Universal
ARAGON	"New challenge" programme	24	592		Universal
ARAGON	"Have a healthy time" programme	3	1500		Universal
ARAGON	School care	42	1566	387	Universal
ARAGON	For your health	1	1187	30	Universal
ARAGON	Illegal drugs programme	2	125	5	Universal
ASTURIAS	Ordago	40	6281	322	Universal
ASTURIAS	The adventure of life	56	4769	300	Universal
ASTURIAS	Film in education	52	8432	217	Universal
ASTURIAS	Between all of us	1	262	10	Universal
ASTURIAS	In the garden with my friends	9	400	24	Universal
ASTURIAS	What are drugs about? What are kids about?	17	2019	96	Universal
ASTURIAS	Prevent to live	1	95	11	Universal
ASTURIAS	Hygiella	5	193	29	Universal
ASTURIAS	The secret to good living	41	2462	320	Universal
ASTURIAS	Film and instilling values	3	180	180	Universal
ASTURIAS	Opening of new centres	220	66500	1940	Universal
CANTABRIA	Ordago	38	5.108		Universal
CANTABRIA	Film in education	90	4.848	297	Universal
CANTABRIA	Prevent to live	68	11.262	539	Universal
CANTABRIA	Smoke-free school	27	2.456	117	Universal
CASTILE-LEON	Discover	107	10.024	187	Universal
CASTILE-LEON	Building health	94	12.594	159	Universal
CASTILE-LEON	The adventure of life	9	765	35	Universal
CATALONIA	The adventure of life	270	20.347	920	Universal
CATALONIA	The sports enthusiasts club	62	20.000	70	Universal
CATALONIA	Ordago	51	6.565	77	Universal
CATALONIA	Health-school	960	96.167	537	Universal indicated
CATALONIA	In full possession of our faculties	6	13.000		Selective /indicated
EXTREMADURA	Prevent to live	224	32360	1828	Universal
EXTREMADURA	What do you think?	47	1620		Universal

EXTREMADURA	The secret to good living	80	5500	550	Universal
EXTREMADURA	What do you feel?	48	500		Universal
MADRID	In the garden with my friends	113	12.690	533	Universal
MADRID	Preventing together	8	458	24	Universal
MADRID	School programme for preventing drug addiction through film	119	18.961	884	Universal
MADRID	School programme for preventing the use of alcohol and other drugs aimed at adolescents in the community of madrid	134	8.614	299	Universal Selective
MADRID	Prevent to live. High coverage prevention programme	195	56.434	2403	Universal
MADRID	School and family programme "between all of us"	23	3.128	126	Universal
MADRID	Project olympus	54	1.871	0	Universal
MADRID	Playing is the alternative	18	875	0	Universal
MADRID	Youth, recreation and health	5	325	0	Universal
MADRID	Programme for the prevention of cannabis use, "let me tell you something about joints"	44	4.050	69	Universal Selective
MADRID	School programme “without”	129	11.248	0	Universal
MURCIA	In the garden with my friends	119	13.656	497	Universal
MURCIA	Building health	55	7.914	160	Universal
MURCIA	Film and instilling values	74	12.325	255	Universal
MURCIA	Ordago	12	2.209	82	Universal
MURCIA	The adventure of life	44	5.059	149	Universal
MURCIA	Values in literature	4	325	3	Universal
MURCIA	Another perspective of youth	10	1.400	61	Universal
MURCIA	I have my place in society. I want to be useful!	14	960	48	Universal
MURCIA	Didactic unit on tobacco	10	876	24	Universal
MURCIA	Drug addiction prevention in professional orientation, workshop-schools and trade houses	32	1.382	18	Universal
MURCIA	Drug addiction prevention workshops in secondary school (i)	133	18.419	354	Universal
MURCIA	Drug addiction prevention workshops in secondary school (ii)	4	992	5	Indicated
MURCIA	Drug addiction prevention workshops in primary school (i)	51	3.229	74	Universal
MURCIA	Drug addiction prevention workshops in primary school (ii)	1	190	1	Indicated
MURCIA	Be yourself	4	570	0	Universal
MURCIA	What do you think?	5	925	20	Universal
MURCIA	Series of university peer talks: alcohol and tobacco prevention	9	379	0	Universal
MELILLA	Prevent to live	10	2045	81	Selective
MELILLA	Film and instilling values	6	850	30	Selective
MELILLA	“Theatre in education: our stage"	3	16		Selective
	TOTAL	**6372**	**920.687**	**40.039**	

Table 3.2. FAMILY PREVENTION						
Aut. Community	**Programme Name**	**Type of Activity**	**Hours of activity**	**No. of mothers/ fathers**	**Includes interventions with child (Y/N)**	**Intervention level**
ANDALUSIA		Day sessions		50 technicians		
ARAGON	Tarazona Family School	Guidance ORIENTATION	40 biweekly sessions	20		Universal
ARAGON	Tarazona Ordago" Parents Programme	Guidance Orientation	20 monthly sessions	172		Universal
ARAGON	Tarazona Family Relations	Orientation	14 weekly sessions	32		Universal
ARAGON	Zaragoza City Council School and Family Programme	School for parents	6 weekly sessions	14500		Universal
ARAGON	Calatayud Drug Prev. for parents	Guidance Orientation	7 week/month	180		Universal
ARAGON	Socio-educational intervention for parents, Solidarity Centre	Orientation Guidance	4 cycles, 16 h monthly	1124		Universal
ARAGON	Valer A.F.A Programme	Talks	10 week/mo	298		Universal
ARAGON	Educating at Home A.F.A	Talks	10 week/mo	341		Universal
ARAGON	Families with Drug Abuse ABAT	Guidance Orientation	18	4		Selective
ARAGON	The job of educating ABAT	Guidance Orientation	9 weekly sessions	97		Universal
ARAGON	Utillas abilities workshop	Guidance Orientation Talks	10 weekly sessions	50		Universal
ARAGON	Family orientation programme, Huesca City Council	Guidance	5h/week monthly	19		Selective
ARAGON	Ibon Colloquium talks	talks	16 h week	21		Universal
ARAGON	"Ordago" parents programme, Cinca Medio region	Guidance	20h monthly	90		Universal
ARAGON	Protego Programme, Jiloca region	Guidance Orientation	12h weekly	50		Universal

ARAGON	Protego Programme, Jaca Town Council	Guidance Orientation	12h weekly	8		Universal
ARAGON	Parental training programme, Teruel Town Council	Talks	8h weekly	12		Universal
ARAGON	Workshop at-risk parents, Cinco villas	Guidance Orientation	12 h weekly	25		Selective
ARAGON	Alcoholic families self-help group, FARA	Guidance Orientation	6 h weekly	206		Selective
ASTURIAS	Ordago	Training talks, workshops	131	2300	NO	Universal
ASTURIAS	The Adventure of Life	Training talks, workshops	84	2150	NO	Universal
ASTURIAS	Drug prevention	Course	88	1750	NO	Universal
ASTURIAS	School for parents	Training talks	294	3200	NO	Universal
ASTURIAS	Alcohol and other drugs	Course	32	640	NO	Universal
ASTURIAS	Tobacco and alcohol	Workshop	45	1122	NO	Universal
ASTURIAS	Tools for educating and preventing	School for mothers/ fathers	8 sessions	9	NO	Universal
ASTURIAS	In the family	School for mothers/ fathers	6 sessions	22	NO	Universal
ASTURIAS	Choosing paths	Seminars (9)	1 and a half	13	NO	Universal
ASTURIAS	Intervention with at-risk families	Orientation, Guidance		25	YES	Selective
ASTURIAS	Preventing the abuse of medications	Workshops	2	23 +16	NO	Selective
ASTURIAS	Preparing a drug-free future	Course	10	115	NO	Universal
ASTURIAS	Educating to Live. School for mothers/ fathers via local TV station	School for mothers/ fathers		45	YES	Universal
ASTURIAS	Prevention and awareness	Workshop (2)	10	40	NO	Universal
ASTURIAS	Drug prevention	Workshop	21	18	NO	Universal
ASTURIAS	Training for parents in the prison population	Employment workshop		50	NO	Selective
ASTURIAS	At-risk women with children	Orientation/Guidance	Year round	34	YES	Indicated
ASTURIAS	Prevention of drug addiction in women	Workshop	9	10	NO	Universal
ASTURIAS	School for Mothers and Fathers	Workshops	4.30 (4 sessions)	18	NO	Universal
ASTURIAS	Emotional and communication skills	Orientation/Guidance	10	16	NO	Universal
ASTURIAS	Prevention of drug addiction in the family	Talk/ Workshop	5	150	NO	Universal

ASTURIAS	Responsible use of medicines	Workshop	5	29	NO	Universal
ASTURIAS	In the family, keys to preventing drug problems	Workshop	10	10	NO	Universal
ASTURIAS	Family information and training	Talks	2	49	NO	Universal
CANTABRIA	FILM IN EDUCATION (PARENTS)	Educational Programme	30	1154	YES	Universal
CANTABRIA	IN THE FAMILY	Educational Programme	10	366	YES	Universal
CASTILE-LEON	Moneo. 4 Sessions	Programme	7 h 30 min	2.552 parents	NO	Universal
CASTILE-LEON	Schools for Mothers and Fathers	Schools	10 h	933 parents	NO	Universal
CASTILE-LEON	Daedalus	Programme	30 h	259 parents & 237 kids	YES	Selective
CASTILE-LEON	Alfil	Programme	24 h	79 parents & 47 kids	YES	Selective
CASTILE-LEON	Project “Identity”	Programme	6- 9 months + follow-up	126 parents & 45 kids	YES	Indicated
CASTILE-LEON	“Lazarillo” Programme	Programme	6- 9 months + follow-up	45 parents & 35 kids	YES	Indicated
CASTILE-LEON	INDICALE Programme, city of Leon	Programme	6- 9 months + follow-up	12 parents & 10 kids	YES	Indicated
CASTILE-LEON	INDICALE Programme, province of Leon	Programme	6- 9 months + follow-up	72 parents & 32 kids	YES	Indicated
CASTILE-LEON	Youth Programme	Programme	6- 9 months + follow-up	51 parents & 27 kids	YES	Indicated
CATALONIA	Connect with your kids	Workshop	Minimum 5 hours	5454	NO	Universal
EXTREMADURA	Programme for prevention in the home	Schools for parents		400	NO	Universal
EXTREMADURA	How to enjoy educating your children	AMPAS	96 hours	565	NO	Universal
EXTREMADURA	Various activities	Schools for parents				Universal
MADRID	Programme for preventing drug addiction in the home	Schools for parents	1.822	3.397	NO	Universal

MADRID	Programme for Selective prevention in the home	Schools for parents	70	83	YES. INTERVENTIONS HELD AT DRUG ADDICTION TREATMENT CENTRES.	Selective
MADRID	Information and Awareness events	Talks	16	619	NO	Universal
MADRID	Hits on educational websites for family prevention online	Information	Time records not kept	35.000	NO	Universal
MURCIA	Programme for preventing drug addiction in the home	Talks and training course.	21	215	NO	Universal
MURCIA	School for parents: Educate to prevent	Talks, preparation and distribution of materials and activities for the home.	6	18	NO	Universal
MURCIA	Educational programme: Educate to Prevent	Talks, preparation and distribution of materials and activities for the home.	6	25	NO	Universal
MURCIA	Educational programme: Educate to Prevent	Talks, preparation and distribution of materials and activities for the home.	6	25	NO	Universal
MURCIA	Educational programme: Educate to Prevent	Talks, preparation and distribution of materials and activities for the home.	6	25	NO	Universal
MURCIA	Drug addiction workshop for parents with adolescent children	Talks, preparation of materials, parent-child meetings and direct orientation and guidance services.	9	24	YES	Universal
MURCIA	Family support programme to prevent drug addiction and risky conduct.	TV programmes, media campaigns, training courses and parent-child meetings.	50	60	YES	Universal
MURCIA	Intervention in our neighbourhoods	Talks, video forum and distribution of material.	68	60	NO	Universal
MURCIA	Educational programme: Educate to Prevent	Talks, preparation and distribution of materials and activities for the home.	8	25	NO	Universal

MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the first cycle of secondary school.	Talks, training courses, preparation and distribution of material, direct orientation and guidance and parent-child meetings.	12	22	NO	Universal
MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the third cycle of primary school.	Talks, training courses, preparation and distribution of material, direct orientation and guidance and parent-child meetings.	10,5	18	NO	Universal
MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the third cycle of primary school.	Talks, training courses, preparation and distribution of material, direct orientation and guidance and parent-child meetings.	12	21	NO	Universal
MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the first cycle of secondary school.	Talks, training courses, preparation and distribution of material, direct orientation and guidance and parent-child meetings.	12	23	NO	Universal
MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the third cycle of primary school.	Talks, training courses, preparation and distribution of material, direct orientation and guidance and parent-child meetings.	12	17	NO	Universal
MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the third cycle of primary school.	Charlas, cursos de formación, elaboración y distribución de material, servicio de orientación y asesoramiento directo y encuentros padres- hijos.	12	15	NO	Universal
MURCIA	Programme for the prevention of drug addiction aimed at mothers and fathers of children in the third cycle of primary school.	Talks, training courses, preparation and distribution of material, direct orientation and guidance and parent-child meetings.	12	19	NO	Universal

MURCIA	Drug prevention programme for preteens and adolescents.	Talks			YES	Universal
MURCIA	Educational programme: Educate to Prevent	Talks, preparation and distribution of material and activities for the home.	8	25	NO	Universal
MURCIA	School and Family Prevention of Drug Addiction	Training courses, talks and video sessions.	10	164	NO	Universal
MURCIA	Programme to prevent the use and abuse of drugs by informing families.	Talks, distribution of material, video forum and video sessions.	36	60	NO	Universal
MURCIA	Workshops for mothers and fathers on "Film and Instilling Values"	Talks, radio programmes, video sessions			YES	Universal
MURCIA	Programme “Valer”	Video sessions, video forum and talks.	10	65	NO	Universal
MURCIA	Educate to Prevent	Talks, preparation and distribution of material and activities for the home.	10	25	NO	Universal
MURCIA	Family support programme to prevent drug addiction and risky conduct.	Training courses, direct orientation and guidance service, distribution of material, activities for the home and video sessions.	10	12	YES	Universal
MURCIA	Schools for Mothers and Fathers	Talks and video forum	12	18	NO	Universal
MURCIA	School for Parents: Educate to Prevent	Talks, activities for the home, preparation and distribution of material.	6	25	NO	Universal
MURCIA	School for Parents: Preventing Drug Addiction in Children	Talks and direct orientation and guidance service.	7,5	20	NO	Universal
MURCIA	School for Parents	Preparation and distribution of material, video forum, video sessions, radio programmes, talks, media campaigns, Parent-Child meetings, direct orientation and guidance service.	11	23	NO	Universal

MURCIA	School for mothers and fathers: Developing contents related to the prevention of drug addiction in their children.	Talks and video forum	11	30	NO	Universal
MURCIA	School for mothers and fathers	Training course, talks, distribution of materials and media campaigns.	50	50	NO	Universal
MURCIA	Healthy Parents, Healthy Children	Training courses, talks, direct orientation and guidance services, preparation and distribution of material, outings and residency programmes.	28	40	NO	Universal
MURCIA	School for Parents	Talks, preparation and distribution of material and direct orientation and guidance service.	6	65	NO	Universal
MURCIA	School for Parents	Direct orientation and guidance service, distribution of material, talks, parent-child meetings, video forum with video sessions, activities for the home.	27	105	YES	Universal
MURCIA	"What Do You Think" Orientation workshops for mothers and fathers.	Talks, preparation and distribution of material and activities for the home.	3	80	NO	Universal
MURCIA	Action prevention programmes for educational centres.	Training courses, talks, direct orientation and guidance service, preparation and distribution of material and video sessions.	20	50	NO	Universal
MURCIA	The Adventure of Life	Parent-Child Meetings, Activities for the home, direct orientation and guidance service, preparation and distribution of material, talks, video sessions.	9	75	YES	Universal

MURCIA	“Carpe Diem III”	Direct orientation and guidance service, activities for the home and talks.	4	350	NO	Universal
MURCIA	Educational Project “Alcalid”	Preparation and distribution of material			YES	Universal
MURCIA	Family training programme “VALER”	Training courses	10	120	NO	Universal
MURCIA	Parental training courses on the prevention of drug addiction and informative brochure.	Training courses, talks, preparation and distribution of material, media campaigns, TV programmes and parent-child meetings.	160	18	NO	Universal
MURCIA	Parental training programme. Course "The Family against Drugs"	Training courses	6	29	NO	Universal
MURCIA	Know more, Live better	Talks, training courses, activities for the home, preparation and distribution of material, direct orientation and guidance service.	120	690	YES	Universal
MURCIA	I know what can harm our children: addictions	Talks, preparation and distribution of material, parent-child meetings and video sessions.	2	421	YES	Universal
MURCIA	School for parents on preventing drug addiction in their children	Talks and activities for the home.			YES	Universal
MURCIA	Drug addiction prevention programme for preteens and adolescents	Talks and activities for the home.	8		NO	Universal
MURCIA	Workshop on drug addiction	Talks	4	53	NO	Universal
MURCIA	"Prevention Education" programme	Video sessions	8	30	NO	Universal
MURCIA	"Women and Life" programme	Talks - workshop on family health and nutrition and on resources and strategies for achieving effective communication in the family.	12	20	NO	Universal
MURCIA	ARCO	Parental training in Parent Associations.	24	40	NO	Universal

MURCIA	ARCO	Telephone consults.	5 hours	58	YES	Selective
MURCIA	ARCO		5 days from January to December			
MURCIA	ARCO	Family programme	18	26	YES	Indicated
MURCIA	Family prevention programme	Orientation and guidance service	2	15	YES	Selective
MURCIA	Psycho-educational course on prevention of drug addiction	Preparation and distribution of material, talks, training courses, activities for the home, radio programmes and direct orientation and guidance service.	32	25	NO	Selective
MURCIA	Programme for preventing drug addiction in at-risk families	Direct orientation and guidance services, parent-child meetings and recreational activities	40	19	YES	Selective
MURCIA	Family Orientation Programme	Preparation and distribution of materials, talks, direct orientation and guidance services, activities for the home, video sessions and video forum.	56	20	NO	Selective
MURCIA	Orientation service for at-risk families	Direct orientation and guidance service, advice on health-care resources and activities for the home.	-	9	YES	Selective
MURCIA	School for Mothers and Fathers	Talks and direct orientation and guidance services.	15	25	NO	Selective
MURCIA	Coexistence talks for the prevention of drug addiction.	Distribution of material and talks.	-	15	NO	Indicated
MURCIA	Prevention of drug addiction in at-risk women with children	Training courses	44	15	NO	Indicated

Table 3.3. AT-RISK MINORS					
Aut. Community	**Programme Name**	**Target group**	**Type of intervention***	**No. hours/ week**	**No. of participants**
ASTURIAS	Key Zone	Young people	Risk minimisation	5 or 6	4825
ASTURIAS	Social community intervention for minors with social and penal problems.	Minors between 14 and 18	Risk minimisation	5	Avilés 10 , Gijón 30 Oviedo 16
ASTURIAS	Street intervention with minors	Minors between ages 12 and 18	Street education	5	29 Castrillón, 8 Avilés
ASTURIAS	Summer workshops	Gypsy children ages 5 to 12	Education-training	2	22 -Cinco Villas
ASTURIAS	Healthy habits	14-18 year-olds	Risk minimisation	4	17-Llanera
ASTURIAS	At-risk adolescents	10 or 18	Education-training	5	28- Mieres
ASTURIAS	Prevention of drug addiction	16-21	Education-training	4	10-Navia
ARAGON	Intervention programme with at-risk minors and families, region of Andorra.	Minors aged 12-16	Orientation, personal development, school enrolment programme	indeterminate	7 minors
ARAGON	Tarabidan Solidarity Centre Programme	Young people aged 14 to 18	Educational programme, alternatives and damage control	indeterminate	126 young people
ARAGON	Information and advice, Town Council of Alcañiz	Young people aged 12 to 18	Educational programme, alternatives and damage control	indeterminate	30 in person, 200 indirectly
ARAGON	Minors programme, Town Council of Huesca	Young people aged 12 to 18	Alternative education programme	10 hours	11 minors
CANTABRIA	Intervention Programme for Adolescents engaged in risky behaviour associated with the use of addictive substances.	Adolescents (12 -18 years old)	Selective/ indicated	16	18
CASTILE-LEON	Burgos Connection Project for street education	Young people with high rates of absenteeism, family problems and drug use problems	Street education		50 young people and 38 families

CASTILE-LEON	Leon programme for street education	At-risk or socially excluded minors	Street education		143
CASTILE-LEON	Salamanca programme for street education	Young immigrants with high rates of absenteeism, school and family problems	Street education		1305 38 immigrants
CASTILE-LEON	Street education programme	Students with high rates of absenteeism and regular users	Street education		50
CASTILE-LEON	Soria programme for street education	At-risk or socially excluded minors	Street education		85
CATALONIA	Selective and indicated prevention programme in the sphere of juvenile justice.	Young offenders. Street Education, Mediation and Guidance Services and Educational Centre professionals.	Education-training	2 hours X 8 sessions	175 young people
MADRID	Social Education Programme for street intervention	Adolescents and young people	Street education, early detection and intervention, training activities	The programme is carried out in 16 towns where a social educator dedicates 21 hours a week over the course of the year.	7.254 participants 16.341 interventions
MADRID	San Cristobal Youth Centre	Adolescents between ages 12 and 18	Education-training programme, alternatives programme, street education, psycho-social intervention with minors and parents.	Monday to Saturday, morning and afternoon throughout the year.	149

MADRID	Youth Day Centre	Adolescents and young people	Education-training programme and alternatives programme.	Monday to Friday, morning and afternoon throughout the year.	60
MADRID	Indicated programme for the prevention of drug addiction in the network of residential foster resources of the Madrid Institute of Minors and Family of the Community of Madrid.	Staff professionals at youth centres (educators, psychologists, social workers) and the underage residents.	Training and advice on the design of prevention projects at centres.	20-hour courses were given, with an additional 20 hours for evaluation and follow-up on each centre's prevention programmes.	480 students
MURCIA	Summer activities programme	Minors aged 6 to 14 in socially depressed areas.	Activities for the community, leisure and free time and personal development.	60	110
MURCIA	La Birlocha	Minors aged 6-12 initiated in drug use, highly conflictive home lives and academic failure and/ or school absenteeism.	School enrolment assistance, leisure and free time, personal development and family activities.	36	84
MURCIA	Programme for the prevention of drug addiction in the Youth Day Centre	Minors under 12 with mental health problems, academic failure and behavioural problems.	Personal development activities.	40	15
MURCIA	Prevention programme for children and adolescents	Minors between the ages of 6 and 14 with mental health problems, experience with drug use and academic failure and/ or school absenteeism.	School enrolment assistance, leisure and free time, personal development and family activities.	1680	40

MURCIA	Leisure and free time project for at-risk minors	Minors under 14 with antisocial behaviour and experience with drug use, highly conflictive home lives, academic failure and/ or school absenteeism and behavioural problems.	Leisure and free time activities.	72	60
MURCIA	"Nuestra marcha"	Minors aged 12-14 with experience in drug use, academic failure and/ or school absenteeism and behavioural problems.	Community activities, leisure and free time and personal development activities.	120	21
MURCIA	Summer School 2006	Minors under 14 in socially depressed neighbourhoods with readily available drugs in the community.	Community activities, school enrolment assistance, leisure and free time and personal development activities.	120	100
MURCIA	Prevention of academic failure and school absenteeism	Minors aged 12 to 16 with academic failure and/ or school absenteeism, behavioural problems and socialisation difficulties.	Activities for personal development, leisure and free time and in the workplace.	10 hours per week	14
MURCIA	Extracurricular activities with minors in the Santiago de Jumilla neighbourhood	Minors aged 6-14 with antisocial behaviour, academic failure and/ or school absenteeism, socialisation difficulties and highly conflictive home lives.	Activities for the community, leisure and free time, personal development and school enrolment assistance.	138	40
MURCIA	Prevention programme for at-risk minors	Minors aged 12-16 with antisocial behaviour, experience using drugs, highly conflictive home lives, academic failure and/ or school absenteeism with behavioural problems and socialisation difficulties.	Activities for the community, leisure and free time and personal development.	810	90
MURCIA	Campaign for the prevention of mental illness and the promotion of mental health: "It Could Happen to You."	Minors aged 14-17 with mental health problems, socialisation difficulties, behavioural problems, antisocial behaviour and academic failure and/ or school absenteeism.	Personal development activities.	40	350

MURCIA	Intervention programme for minors with legal problems to prevent violent conduct related to the use of alcohol and other drugs.	Minors and/ or youths convicted under the terms of Organic Law 5/2000 of January, which regulates the penal responsibility of minors, whose crimes are associated with the abuse of alcohol or other drugs and involve violent behaviour.		3 hours per week	11
MURCIA	Programme for the prevention of drug addiction among at-risk minors in the town and region of Totana.	Minors aged 12-18 with experience using drugs, highly conflictive home life, behavioural problems, antisocial behaviour and academic failure and/ or school absenteeism.	Activities encouraging school enrolment, leisure and free time, personal development, and family activities.	260	153
MURCIA	Youth foster care and assistance centre in El Palmar	Young gypsies between the ages of 16 and 25.	School dropout seminar. Specific pre-working life habits seminar. Social accompaniments and support. Acquiring social habits.	-	25
MURCIA	Educational programme for the prevention of drug addiction in high-risk neighbourhoods, "A tope"	Minors aged 6-12 in socially depressed areas with behavioural problems and antisocial behaviour.	Activities encouraging school enrolment, personal development, and family activities.	-	106
MURCIA	"Alcohol information and guidance centre"	At-risk population, particularly minors	Evaluation and diagnosis interview and assignment to specialised services.	-	8 (2 families)
MURCIA	Drug addiction workshops	Minors aged 6 to 16 with parents addicted to drugs, especially alcohol and cocaine	Personal development and family activities.	10	36 (In two groups, ages 6 to 12 and over 12)
MURCIA	Educational programme for the prevention of HIV and AIDS, other sexually transmitted diseases, unwanted pregnancies and drug addiction in young people.	At-risk population, particularly minors	Education-training programme	4	187 (Workshop Schools: 72 Associations: 42 I.P.: 66 Others: 7)

MURCIA	Individual consultations face-to-face, by phone and online. Tobacco	Young people aged 17 and over who smoke tobacco	Provide information and guidance to quit smoking.	-	92 (Online: 42, In Person: 19, By Phone: 31) 88
MURCIA	Individual consultations face-to-face, by phone and online. Alcohol	Young people aged 17 and over who drink alcohol	Provide information and guidance to recover from alcohol abuse.		88 (Online: 38, In Person: 17, By phone: 33)
MURCIA	ARCO	Minors and young people selected by secondary school and workshop school teachers	Education-training programme	5 hours per week/ 6 weeks	50
MELILLA	“Awareness and prevention of drug use in centres for unaccompanied minors"	Foreign minors residing in foster centres.	Educational programme	4	50

4. PROBLEM DRUG USE AND THE TREATMENT DEMAND POPULATION

Prevalence and incidence estimates of PDU

Estimates of PDU Rates

Nationwide estimates are available for problematic heroin and cocaine use only. Work has recently been undertaken on incidence estimates. For two decades, (primarily intravenous) heroin was the drug which caused most of the social and health problems associated with illegal drug use in Spain, even though the surveys conducted consistently showed that the use of other drugs such as cocaine was more widespread. Heroin is less relevant today, but continues to have substantial social consequences and an impact on public health. Cocaine use, in turn, has become a source of considerable problems. The validity of population survey data on the prevalence of the problematic use of heroin or cocaine is questionable and there is a paucity of indirect information on the subject. In the early 1990's, local estimates of problematic use were calculated in Barcelona and Madrid using the data capture-recapture method; the yearly prevalence figures for the period 1990-1993 among people between the ages of 15 and 54 obtained were 7.2-11.0/1000 for Barcelona and 14.1/1000 for Madrid.

In 1999, an estimate of problematic cocaine use was performed in Barcelona. Capture-recapture with a single source of data was used to estimate rates. All of the Emergency Room episodes in which cocaine use was mentioned were "captured" in the three consecutive four-month periods of the year. Afterwards, log-linear regression models with interaction terms were fitted. It was estimated that there was a total of 25,988 problem cocaine users (95% confidence interval 11,782-58,064), yielding a rate of 31.3 per 1000 inhabitants aged 15 to 54 years (95% confidence interval 14.2-69.9).

Estimates of problematic use of opiates and cocaine for the period from 1999-2002 have been calculated. The demographic and treatment multiplier methods were used to estimate use for the entire country over this time period. The demographic method estimate was obtained by multiplying the number of opiate (or cocaine, as appropriate) users admitted for drug addiction treatment for the first time in their lives in a given year by the average number of years that all persons admitted for addiction to these drugs, whether or not for the first time, had been using opiates (or cocaine). An estimated upper figure was also calculated, taking the average number of years of use to be twice the average number of years of use by those people admitted for treatment for the first time in their lives.

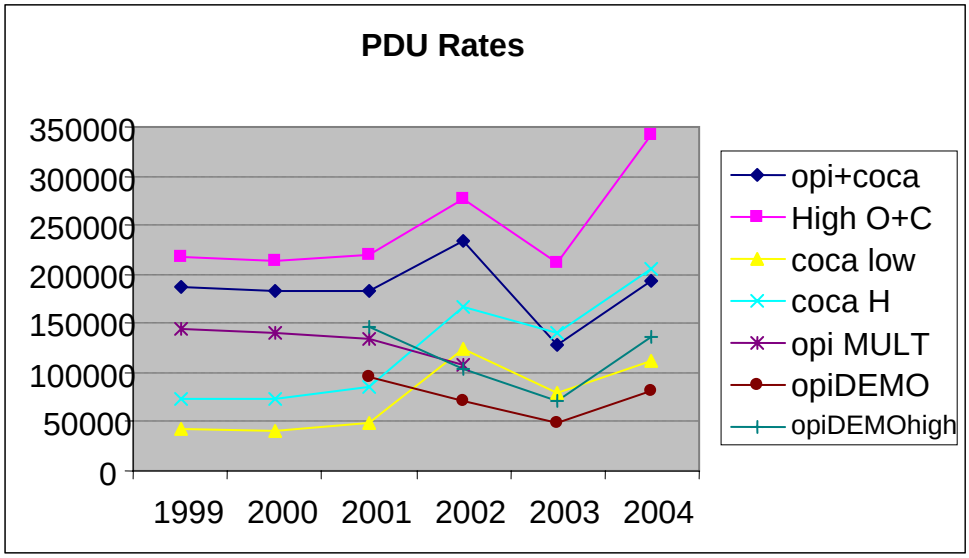
The treatment multiplier method estimate was used until 2002 and was obtained by dividing the number of opiate users admitted for drug addiction treatment in a given year by the rate of persons admitted for opiate addiction treatment in 1996 who had contacted clinics, that had submitted information to the treatment indicator of the National Plan on Drugs in the 12 months prior to admission (26.2%).

After 2002, in relation with rate estimates obtained using the treatment indicator, we can only offer new estimates by using the demographic method. There is no adequate multiplier information on hand yet for opiates or for cocaine. Some questions have been introduced into the new General Population Survey, and we hope that next year we may be able to have a multiplier for each substance and calculate estimates through the treatment multiplier method.

The demographic estimates can be calculated for 2003 and 2004, but raw treatment data for 2003 offer a low count for every substance, and we chose not to provide independent results for 2003. Results for 2004 compared to 2002 show an increase in

the figures on cocaine use, and opiates and cocaine together, as was seen in previous years, whereas for opiates the declining trend seen in the past seems to have changed direction, with stabilization.

Figure 4.1.1. RATE OF PROBLEM OPIOD USE OR COCAINE IN SPAIN, USING THE TREATMENT MULTIPLIER (MULT) AND DEMOGRAPHIC (DEMO) METHODS, 1999-2004.



It will be noted that the demographic method yields lower opiate usage rate figures than the treatment multiplier method. The former may underestimate rates due to a bias possibly introduced by an artifact. In other words, any decrease in the number of patients beginning their first treatment would contradict the stable population assumption inherent to the method. Nonetheless, the estimate of an upper interval figure for this method yields fairly credible figures that are higher than the results obtained using the multiplier method estimate. The demographic method is often criticized and is not, in fact, listed by the EMCDDA among the methods regarded as valid. For the time being, however, no alternative method can be used, because no appropriate treatment multiplier is presently available in Spain.

The treatment multiplier, in turn, involves two types of bias that very likely produce opposite effects. On the one hand, the multiplier may be underestimated because the proportion of users initiating treatment may have increased since 1996, due primarily to the expansion of the methadone treatments which are offered. And on the other, the percentage in question was calculated using a sample of persons captured in centers when they were beginning treatment who were more likely to have initiated another treatment in the 12 preceding months than those users who could be found outside of such institutions. It is difficult to determine which of the two biases has a greater impact and therefore to ascertain how they affect the final prevalence estimate.

Up to this time, no direct estimates have been performed of the rate of problem drug use on the basis of household or school surveys, but in the future some estimates of this type may be performed by introducing scales into the surveys which make it possible to identify the cases in which problem drug use occurs. In this sense, for exploratory purposes and the validation of scales in the Spanish School Survey ESTUDES 2006, three scales were introduced, some of which could be used as a foundation in the future for making problem cannabis use estimates.

Estimate of Changes in PDU Incidence

As part of a study financed by the Health Research Fund (FIS), at the IMIM of Barcelona, it was possible to estimate the changes in problem use incidence for heroin in Spain (new users). To do this, the treatment demand indicator due to psychoactive drug abuse or dependence" was used, from the former State Drug Addiction Information System (SEIT), which has differentiated between the people admitted to treatment for the first time in life (first treatments) and the people who have had prior treatment since 1991. The 152,319 people between the ages of 15 and 54 years who began their first treatment for heroin abuse or dependence from 1991 to 2004 were selected. Each person was classified on a contingency table according to the year when they began using and the latency period (LP) or time which it took for them to begin their first treatment after the beginning of usage. This table was incomplete due to the truncations caused by the data, and it was re-constructed using a log-linear model.

The overall distribution of LP made it clear that 50% of people took 2.5 years to begin their first heroin treatment. Opiate incidence trends were estimated back to 1970, finding a large increase during the seventies until 1980, when a peak of 200 new cases per 100,000 individuals aged 10 to 44 was observed, and then a sharp decrease until the mid-nineties, when a more smoothly shaped curve could be observed (rates coming down from 30 new cases per 100,000 individuals between the ages of 10 to 44 in 1993), followed by a stabilization in the period from 2002-2004, at a rate of approximately 10 new users per 100,000 individuals between the ages of 10 and 44 years.

In terms of the LP distribution by autonomous region, differences were observed overall, Asturias being the region in which, during the time period as a whole, it took the least amount of time to begin the first treatment (50% took 1.5 years), whereas Madrid was the region where people took the longest (50% took 6 years). The estimated incidence rates by autonomous region underwent similar changes in them all, but their magnitudes were different.

This estimated incidence refers to heroin consumers who eventually got treatment or will be treated in a public ambulatory center or one financed with public funds. Even so, this marks the changes in the overall incidence, assuming that the percentage of consumers not observed remains steady. The magnitude of estimated incidence may be biased, because the model used requires that LP remain steady in every study year and the expansion of maintenance programs with methadone in the early nineties must have led to changes in treatment request patterns. Moreover, when the rates are compared among autonomous regions, we must assume that the informational records are consist amongst them, which may not always be true in certain cases.

In any case, this report confirms the decrease in problem heroin use incidence suggested by the indirect indicators. This decrease began in the early eighties. However, until the year 2004 newly beginning users continued to be observed (and the slope of the curve grew flatter).

Treatment Demand Indicator

Methodology

This section summarizes the work protocol for the indicator treatment demand due to psychoactive substance abuse or dependence," the last version of which dates back to 2003. Said protocol included operating criteria for including and excluding episodes, criteria for classifying the different variables, as well as details on the instruments and collection and transmission circuit for information and on coverage of the indicator.

The treatment demand indicator is a record which includes individualized data on admittances for ambulatory treatment due to psychoactive substance abuse or dependence throughout Spain and has existed since 1987. This record forms part of a broader information sub-system developed within the framework of the National Plan on Drugs, with the cooperation of the autonomous regions, and also includes the indicator "hospital emergencies related with drugs" and the indicator "mortality due to acute reaction to drugs." This information sub-system, which was originally called the State Drug Addiction Information System (SEIT) and was later given a different name, came about with the purpose of monitoring changes in and characteristics of problem psychoactive drug use, especially for those which, like opiates or cocaine, usually lead to problems more frequently and are difficult to explore using other methods.

The treatment demand indicator, in its current version (Protocol 2003), is defined as the number of people admitted for ambulatory treatment due to abuse of or dependence on each of the psychoactive substances listed in an annex to the protocol of an autonomous region in one given year. If a person is admitted for treatment more than once in the same year and in the same autonomous region, only the first admittance of that year will be taken into consideration for this indicator, separating into the autonomous regional realm any repeated episodes, with the aid of a personal identification code (PIC) made up of the first two letters of the two surnames, the date and province of birth and sex. The indicator value at the state level is determined by adding together the admittances for treatment recorded in each of the autonomous regions, but because the PICs are not transmitted to the state level, the repeated admittance episodes of the same person during the same year in two or more different autonomous regions cannot be filtered out. Even if the available information indicates that this situation is not very frequent, it can give rise to a small overestimation in the indicator at the state level. To be considered *treatment* is any intervention performed by qualified professionals to eliminate the abuse of or dependence on psychoactive substances or to reduce the intensity thereof. Considered *ambulatory* are those treatments in which the patient does not spend the night at the center or those performed in the drug addiction treatment services of prisons. One must bear in mind that some notifying centers, in addition to ambulatory treatments, may perform treatments with internment or may use mixed systems. However, for the purposes of this indicator, only ambulatory treatments are reported. The diagnostic criteria for dependence and abuse are those which are applied by the professionals who perform the admittance for treatment, though one should tend to apply the criteria of the two main international classifications currently in force (DSM-IV or CIE-10).

Reported as *treatment admittance episodes* are any of the following situations: 1) Admittance for treatment at a center for the first time, this situation being regarded as having taken place the first time a patient is assisted at a specific notifying center, with a clinical record being created (medical, social or psychological) in the presence of a qualified technician (doctor, psychologist, nursing degree holder, social worker, etc.), with the goal of initiating a treatment process for the abuse of or dependence on psychoactive substances, even if that treatment is not the first which is received by that

user in the networks of centers which report the indicator. The admittances for treatment are reported, regardless of their type, including those treatments with substituting opiate substances, whether its goal is detoxification or maintenance. In the case of treatments with substitutes, the one used therapeutically in the maintenance program is not considered the main drug (methadone, for instance), but rather the substances whose abuse or dependence led to the first treatment (in general, heroin). The shift from a maintenance program with substitutes to another "drug-free program" without any interruption of the treatment over time is regarded as one single treatment. 2) Re-admittance for treatment at the same center, defining *re-admittance* as an admittance for treatment to a person who has already undergone one or more treatments at the same center beforehand and has ended them due to therapeutic discharge, expulsion or abandonment. The criteria for therapeutic discharge, expulsion and abandonment are described in the indicator protocol. The patient will be regarded as having *abandoned* the treatment, when the patient goes for 6 months without physically contacting the center, without receiving express instructions from the professionals. 3) The continuation of an indicated treatment, due to reasons related to emergencies or for other reasons, in services which do not report the indicator, such as hospitals, health centers or social assistance centers, and who later go to a reporting center to continue the treatment. 4) Admittance for a treatment involved in a court or administrative situation (conditional remission of a sentence, release from jail to serve a sentence at a treatment center, treatment in replacement of an administrative sanction or treatment of a person on daytime release or furlough from prison).

Not reported as admittances for treatment are: 1) Mere personal contacts or contact by telephone to ask for information or treatment, or those requests which are placed on the waiting list. 2) Contacts made with the sole purpose of asking for aid or social benefits. 3) Those treatments whose sole purpose is to treat the physical complications related with drug use; for instance, the treatment of an overdose, abstinence syndrome or an infection. 4) Those interventions consisting exclusively of exchanging needles or other injection materials, distributing condoms or giving advice on drug use techniques or safe sex. 5) Those treatments with an overnight stay in hospital units, psychiatric hospitals, therapeutic communities, residences, etc.

Though it would be desirable for all of the sites which may potentially provide psychoactive substance abuse or dependence treatments in Spain to report in, the inclusion of them all (primary health care centers, hospitals, private clinics, etc.) is very difficult and costly. Because of this, in practice the subsidized or concerted public or private centers, services or programs that provide ambulatory treatments for psychoactive substance abuse or dependence are included. They may be specific drug addiction centers, centers or services for mental health which provide ambulatory drug dependence treatments (whether independent center or those forming part of general health centers, hospitals or some other type of centers), drug dependence treatment programs in prisons, centers which person complex treatments that include an ambulatory stage or mobile units which provide treatments with opiate substitutes and which have medical and nursing personnel. In general, not included as reporting centers are those which only provide treatment under an admittance or internment system (detoxification units of hospitals, therapeutic communities, certain hospitals or psychiatric services), because it is thought that most of the addicts treated in these centers were sent there from reporting ambulatory centers. Nevertheless, this criterion may be reconsidered in the future. The coverage of the Treatment Indicator with respect to subsidized public or private centers which provide ambulatory treatments for drug abuse or dependence has been practically complete since the indicator was first created, and bearing in mind the characteristics of the health care system in Spain, it is difficult for a significant portion of psychoactive drug treatments to be provided in

exclusively private centers, though the percentage may be greater in the cases of cocaine and cannabis than in the case of opiates.

In terms of the circuit for collecting and transmitting information, the treatment centers select the treatment demand episodes and report them as an individualized record to the autonomous regional units on paper or in an electronic format. They are validated at the autonomous regional units and the data are corrected, selecting those cases which are to be sent to the state unit and filtering out any repeated episodes throughout the year. The electronic file is sent as an attachment. The information is delivered to the central unit, the structure of the files is adjusted since it is not always the same, the data is validated once again and the information is corrected, tabulated and analyzed.

A computer program exists for the indicator and is used by most of the autonomous regions. The program makes it possible to record the data using a series of logical and range-related controls, to filter out repeated episodes and to export the data in a proper format for sending to the state unit.

In order to interpret the indicator data in the proper manner, one must bear in mind that, though it has remained stable in terms of its basic elements throughout its existence, and therefore comparable statistics can be produced over time, the indicator has undergone three modifications since 1987. Until 1990, it only included information on opiates or cocaine. Moreover, it was not possible to know whether the person admitted for treatment had been treated for the same main drug beforehand (the drug leading to treatment) or whether it was that person's first treatment in life, or what the main channel of administration of that drug was. Therefore, in 1991 certain changes were introduced that made it possible to get beyond these last two limitations, and in 1996 others took effect, basically consisting of gathering information on admittances caused by any psychoactive substance (excluding tobacco) and not only for opiates or cocaine, and for the first time included variables to find out the subject's level of studies, main employment status in the last 30 days prior to the treatment, the time which elapsed since the last injection of a psychoactive substance and the HIV infection status. Last of all, in 2003 a new methodological protocol took effect for the indicator "admittances for treatment," produced with the goal of adapting it to the European TDI standard promoted by the European Monitoring Center for Drugs and Drug Addiction (EMCDDA), as well as to correct some of the dysfunctions observed. The main changes were as follows: 1) Five variables of the TDI were added that did not exist in the Spanish indicator (nationality and, referring to the 30 days prior to the admittance for treatment, frequency of main drug use, the person or service who referred the patient for treatment, the type of persons the addict is living with, and the type of lodging). 2) Specific codes were assigned to use for the mix of heroin + cocaine hydrochloride, heroine + base or crack, and heroin + cocaine in the main drug and secondary drug variables, and the decision was made to classify these categories as heroin at the time of analysis. 3) The categories of the "channel/form of administration" variable were modified, grouping into one alone the two categories referring to pulmonary intake: "smoked in cigarettes or a pipe" and "inhaled (including "chasing the dragon" or using aluminum foil)" and labeling the new category as "pulmonary or smoked (inhalation of gases or vapors, "chasing the dragon")". The modification was proposed to eliminate the term "inhale," which is ambiguous with respect to the channel of absorption and was interpreted in different ways by different reporting parties, either as "sniffing powder, intra-nasal channel" or for others "inhaling gases or vapors, pulmonary ingestion." 4) The categories were modified for the variable "maximum level of studies completed," shifting from the 9 categories in the preceding version to 8 in the new version, which is a combination of the National Education Classification 2000 and the classification in the Population and Housing Census of 2001. 5) The categories of "country of birth" were changed, assigning a

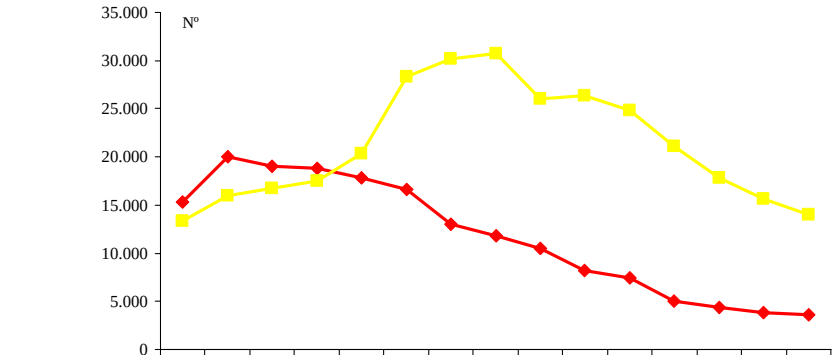
code to each country, in accordance with the system used by the National Statistical Institute. In the prior version, only groups of countries were differentiated. In addition to these modifications, the prior decision was re-affirmed not to record methadone or other opiate substitutes prescribed within the framework of therapeutic programs or as a main or secondary drug. Regarding this matter, the Spanish indicator diverges from the TDI criteria, which establish that opiate substitutes must be recorded as the main drug if they are the drug most commonly used by the subject, whether in a controlled or uncontrolled manner, distinguishing the former *a posteriori* through a new variable that indicates whether, at the time of reporting, the patient was or was not in treatment with substitutes. The adoption in Spain of the TDI criteria would have made it necessary to carry out in-depth change in the traditional way the indicator works, because at the time in which reporting must be performed in theory (when the clinical record is created or the patient is re-admitted for treatment), many times one does not know what type of therapy is going to be assigned to that patient. The TDI criteria require waiting some time to do the reporting, which could lead to a significant risk of delays or forgetting to do the reporting, and of course it would in some way require those autonomous regions that have not implemented a system with individual tracking to perform such tracking, at least for a few months.

Results

From 1998 to 2002, the number of admittances for treatment of psychoactive substance abuse or dependence went down in Spain (excluding alcohol and tobacco), dropping from 54,338 in 1998 (the year with the highest number of admittances) to 46,744 in 2002. However, from 2002 to 2004 it went back up to 52,128 admittances in 2004, then going back down in 2005 (50,630). The decrease from 1998 to 2002 was probably due to the effect of maintenance programs with methadone, which made many heroin users stop rotating through the treatment services. The increase from 2002 to 2004 is surely explained by the large increase in treatments for cocaine and cannabis, especially the former.

The profile of admittances for treatment is rapidly changing, with an ongoing decrease of admittances for heroin and an increase in admittance for cocaine (above all) and cannabis. The number of first admittances for treatment for heroin (first time admitted in life) went down from 1992 (year with the highest number) to 2004, dropping from 20,017 in 1992 to 3,604 in 2005. The number of admittances for treatment due to heroin with prior treatments for that drug always fell as a trend as of 1998 (the year in which it reached the maximum), dropping from 30,756 that year to 14,005 in 2005 (Figure 4.2.1). Starting in 2003, though, a slowdown can be seen in the drop in number of admittances, especially in the case of patients admitted for the first time in their lives.

Figure 4.2.1. Changes in the number of persons treated for heroin abuse or dependence in Spain, 1991-2005.

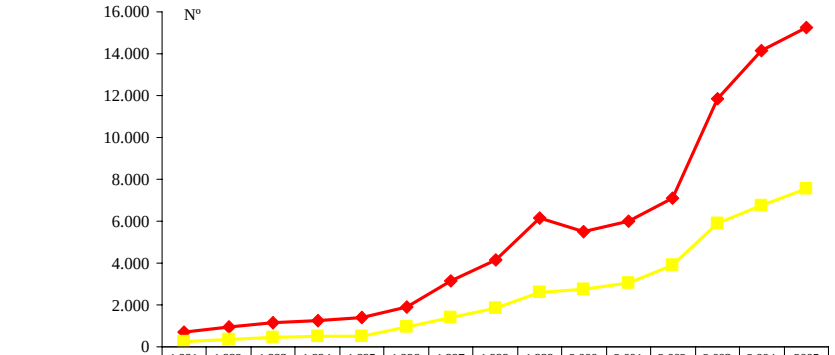


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
First treatments	15.277	20.017	18.977	18.770	17.878	16.647	12.993	11.867	10.473	8.151	7.461	5.051	4.337	3.836	3.604
With prior treatment	13.296	15.956	16.703	17.526	20.369	28.382	30.173	30.756	26.031	26.412	24.844	21.162	17.867	15.617	14.005

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

The number of admittances for treatment due to cocaine have in recent years rapidly increased, though one gets the impression that the rate of increase is beginning to slow down. For instance, the number of first admittances for cocaine rose from 681 in 1991 to 7,125 in 2002, 14,126 in 2004 and 15,258 in 2005. As for the number of admittances for cocaine abuse or dependence with prior treatment for this drug, it also increased ongoingly (Figure 4.2.2).

Figure 4.2.2. Change in the number of people treated for cocaine abuse or dependence in Spain, 1991-2005.

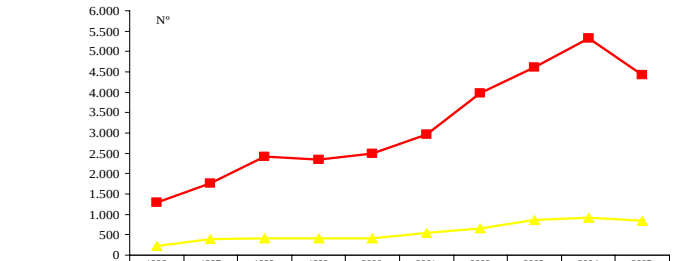


	1.991	1.992	1.993	1.994	1.995	1.996	1.997	1.998	1.999	2.000	2.001	2.002	2.003	2.004	2005
First treatments	681	932	1.146	1.265	1.415	1.892	3.129	4.174	6.126	5.499	5.977	7.125	11.851	14.126	15.258
With prior treatment	262	367	431	491	516	932	1.402	1.838	2.576	2.773	3.046	3.893	5.893	6.747	7.562

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

The number of admittances for treatment of cannabis abuse or dependence increased from 1996 to 2004, but in 2005 it went down, to the detriment mainly of the admittances for treatment for the first time in life. In fact, the number of first admittances went from 1,300 in 1996 to 5,319 in 2004 and 4,426 in 2005, and the number of admittances with prior treatments for this drug went from 230 in 1996 to 1,807 in 2003, then falling to 928 in 2004 and 844 in 2005 (Figure 4.2.3).

Figure 4.2.3. Admittances for treatment due to cannabis abuse or dependence (absolute numbers). Spain, 1996-2005.

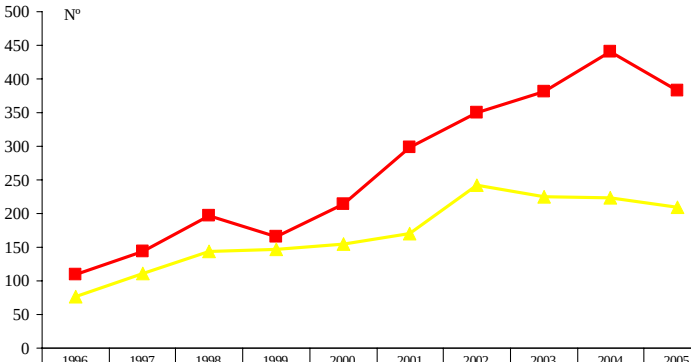


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
First treatments	1.300	1.768	2.412	2.335	2.487	2.966	3.972	4.613	5.319	4.426
With prior treatment	230	387	407	418	408	540	665	871	928	844

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

Other drugs whose admittances for treatment displayed a tendency towards increasing up to 2004 and which had fallen in 2005 are hypnosedatives (tranquilizers, sedatives or sleeping pills). In fact, the number of first admittances went from 109 in 1996 to 441 in 2004 and 383 in 2005, and the number of admittances with prior treatments for these drugs went from 77 in 1996 to 224 in 2004 and 209 in 2005 (Figure 4.2.4).

Figure 4.2.4. Admittances for treatment due to hypnosedative abuse or dependence (absolute numbers). Spain, 1996-2005.

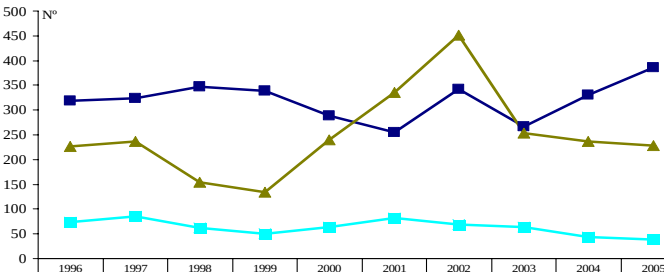


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
First treatments	109	144	197	165	214	299	350	382	441	383
With prior treatment	77	111	143	147	154	170	242	225	224	209

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

All of the other drugs are represented in very low numbers in treatment services. In fact, stimulants other than cocaine (amphetamines, ecstasy and others) only represented 1.9% of first admittances and 1.3% of all admittances in 2005, and they show no signs of increasing. If we compare this with cocaine, heroin and cannabis, it can be seen that in Spain the impact of these drugs in specific drug addiction treatment services is minimal. As for the changes over time, a slight tendency towards increasing can be seen in treatments for cocaine and a decrease in treatments for ecstasy and hallucinogens (Figure 4.2.5).

Figure 4.2.5. Change in the number of people treated for abuse of or dependence on amphetamines, ecstasy and hallucinogens. Spain, 1996-2005.

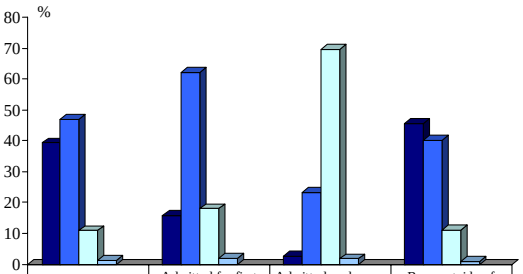


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Amphetamines	319	323	347	339	288	255	342	266	330	386
Ecstasy	226	237	154	135	240	335	452	254	236	229
Hallucinogens	74	85	62	50	64	83	68	63	44	39

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

As can be seen in Figure 4.2.6, in 2005 in Spain cocaine was the illegal drug which led to the highest number of admittances for treatment due to abuse of or dependence on psychoactive substances, at 46.9% of admittances, followed by opiates (39.3%) and cannabis (10.9%). If data on admittances for the first time in life are considered (first admittances), the differences in favor of cocaine are even greater. In fact, in this case cocaine is the drug which led to the most first admittances (62.1%), followed by cannabis (18.0%) and opiates (15.9%).

Figure 4.2.6. Percentage of persons treated for psychoactive substance abuse or dependence in Spain, 2005.



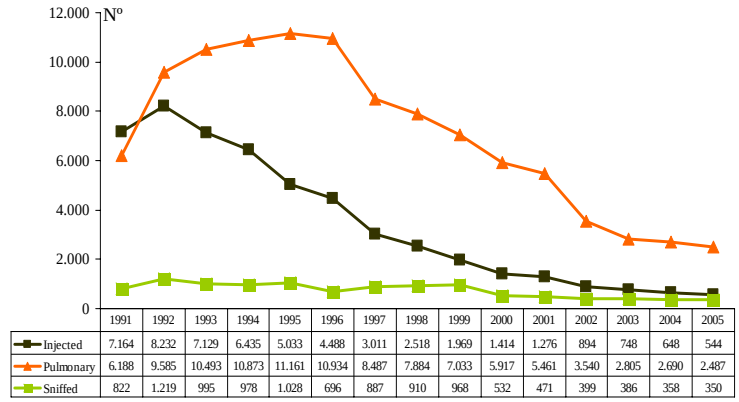
	All admittances	Admitted for first time in life	Admitted under age of 18 years*	Born outside of Spain
Opiates	39,3	15,9	2,7	45,5
Cocaine	46,9	62,1	23,3	40,1
Cannabis	10,9	18	69,7	11,1
Other stimulants (amphetamines, ecstasy...)	1,3	1,9	1,8	1
Number of admittances	50630	24553	1.731	2670

(*) All of the patients admitted for treatment are under the age of 18 years.

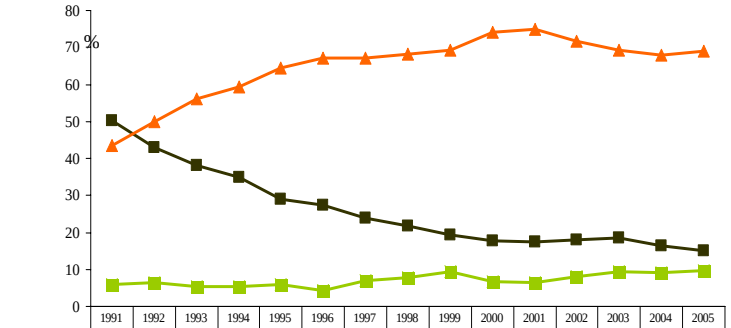
SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

Among those admitted for heroin treatment in 2005, the predominant manner of using this drug during the 30 days prior to the beginning of treatment was pulmonary or smoked ("chasing the dragon"), followed by injection and intra-nasal or sniffed. As of the first half of the eighties, the use of the injected form was practically universal among heroin consumers, but a radical change has taken place in the channel of administration for this drug, injection having been replaced by pulmonary administration. In fact, the number of people admitted for treatment for the first time in life due to heroin abuse or dependence who use injection as the most frequent manner of usage (or the main or preferred manner) for this drug went from 8,232 in 1992 (the year in which the maximum was reached) to 544 in 2005. As for the percentage which these people represented out of the total admittances for heroin, it went from 50.3% in 1992 to 15.1% in 2005 (Figure 4.2.7). It is important to emphasize, however, that after many years of ongoing decreases as of 2003, signs of stabilization are being seen among the patients admitted for the first time in life for heroin treatment in preferential administration by injection, and the percent which injectors represent out of the total has increased.

Figure 4.2.7. Distribution of persons treated for the first time for heroin abuse or dependence, by main channel of administration of said drug (absolute numbers and percentages). Spain 1991-2005.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Injected	7.164	8.232	7.129	6.435	5.033	4.488	3.011	2.518	1.969	1.414	1.276	894	748	648	544
Pulmonary	6.188	9.585	10.493	10.873	11.161	10.934	8.487	7.884	7.033	5.917	5.461	3.540	2.805	2.690	2.487
Sniffed	822	1.219	995	978	1.028	696	887	910	968	532	471	399	386	358	350



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
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
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
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

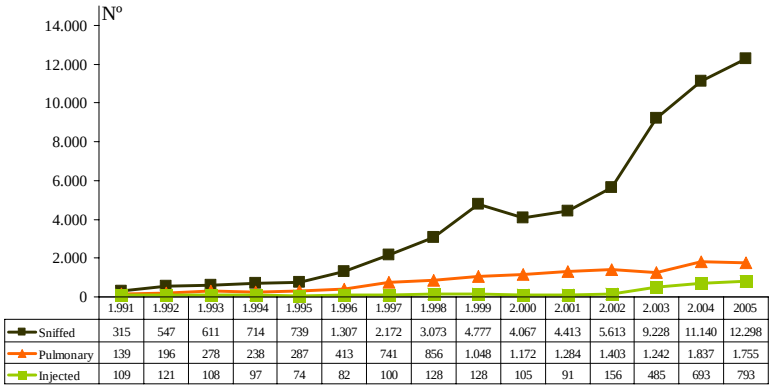
Note: The estimates of the number treated for heroin for all of Spain, by main channel of administration, were calculated by multiplying the number of people treated for heroin throughout Spain by the percentage of persons admitted for each form of administration (percentage was not available for all autonomous region in certain years within the considered period).

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

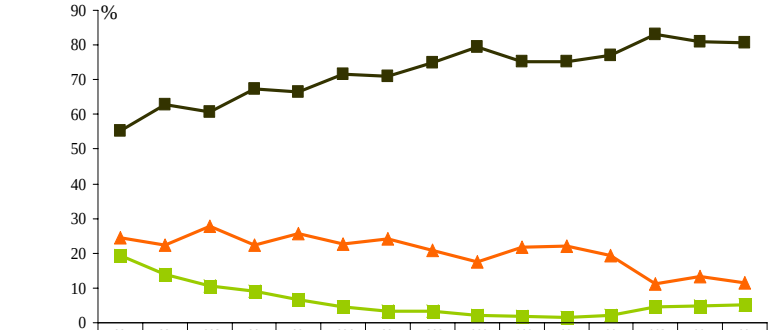
Although the decrease in heroin use by injection is a general trend found in all autonomous regions, there are significant differences between regions in terms of the percentage of people treated for heroin who preferentially use this drug parenterally. For example, in 2005 this percentage was only 1% in Extremadura and 3% in Andalusia, compared to figures of 35.7% in Aragon and 50% in Cantabria.

Among those admitted for cocaine treatment, the predominant form of use is intra-nasal or sniffed (76.7%), followed by pulmonary or smoked (14.3%, depending on the autonomous region), and injected (6.1%). The percent admitted due to cocaine for the first time in life who use injection as the main form of administration of this drug fell from 1991 to 2001, the percentage of those admitted for the first time in life falling from 19.2% in 1991 to 1.6% in 2001, then increasing as of that time to 5.2% in 2005. However, the change in the absolute number of people admitted for cocaine treatment for the first time with this pattern of usage followed a different trend, remaining more or less stable from 1991 (109 people) to 2001 (91 people), then skyrocketing until reaching 793 people in 2005 (Figure 4.2.8). This increase may possibly be reflecting the impact of former injection users who are in maintenance using opiates and are now beginning treatment for cocaine. However, we must pay attention to this phenomenon.

Figure 4.2.8. Admittances for treatment for the first time in life due to cocaine abuse or dependence, by main route of administration of said drug (absolute numbers and percentages). Spain, 1991-2005.



	1.991	1.992	1.993	1.994	1.995	1.996	1.997	1.998	1.999	2.000	2.001	2.002	2.003	2.004	2005
Sniffed	315	547	611	714	739	1.307	2.172	3.073	4.777	4.067	4.413	5.613	9.228	11.140	12.298
Pulmonary	139	196	278	238	287	413	741	856	1.048	1.172	1.284	1.403	1.242	1.837	1.755
Injected	109	121	108	97	74	82	100	128	128	105	91	156	485	693	793



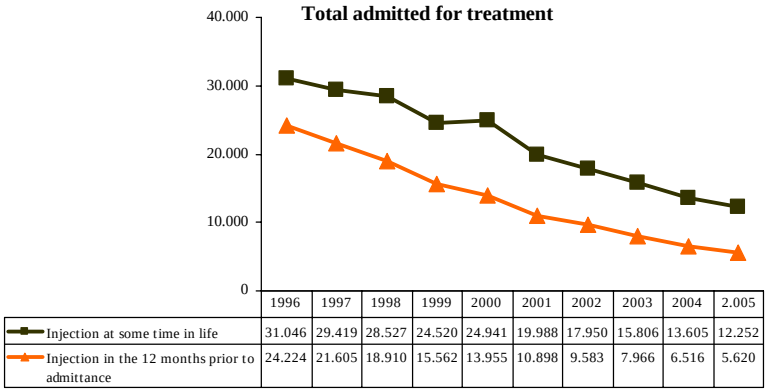
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Sniffed	55,4	62,7	60,8	67,4	66,5	71,7	71	74,8	79,5	75,2	75,2	77	83	80,9	80,6
Pulmonary	24,4	22,5	27,7	22,5	25,8	22,6	24,2	20,8	17,4	21,7	21,9	19,2	11,2	13,3	11,5
Injected	19,2	13,9	10,7	9,2	6,7	4,5	3,3	3,3	2,1	1,9	1,6	2,1	4,4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

Note: The estimates of the number treated for cocaine for all of Spain, by main route of administration, were calculated by multiplying the number of people treated for cocaine throughout Spain by the percentage of persons admitted for each channel of administration (percentage was not available for all autonomous region in certain years within the considered period).

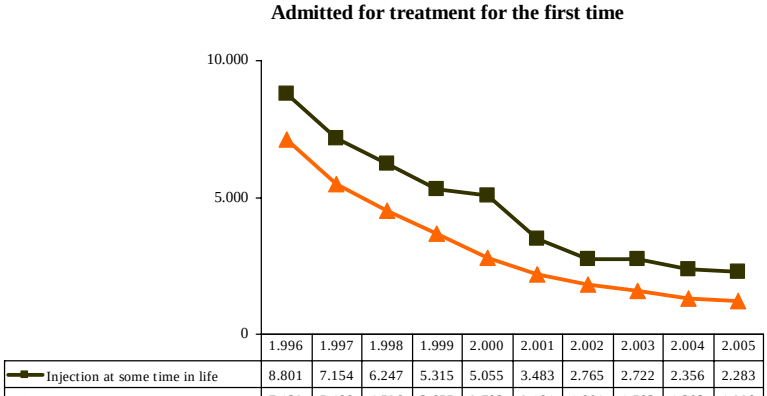
SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

Viewing the use of injection as a whole among those admitted for treatment, it lost importance over the decade of the nineties and until 2005. In fact, the number of persons admitted for any psychoactive drug for the first time in life who had used injection ever-in-lifetime fell from 8,801 in 1996 to 2,722 in 2003 and 2283 in 2005, and the number of those who had used injection in the last 12 months from 7,132 in 1996 to 1583 in 2003 and 1228 in 2005 (Figure 4.2.9).

Figure 4.2.9. Changes in the number of injection users admitted for treatment due to abuse or dependence on drugs in Spain, 1996-2005.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Injection at some time in life	31.046	29.419	28.527	24.520	24.941	19.988	17.950	15.806	13.605	12.252
Injection in the 12 months prior to admittance	24.224	21.605	18.910	15.562	13.955	10.898	9.583	7.966	6.516	5.620



	1.996	1.997	1.998	1.999	2.000	2.001	2.002	2.003	2.004	2.005
Injection at some time in life	8.801	7.154	6.247	5.315	5.055	3.483	2.765	2.722	2.356	2.283
Injection in the 12 months prior to admittance	7.132	5.488	4.526	3.655	2.793	2.181	1.801	1.583	1.303	1.228

Note: The estimates of the number of injection users admitted for treatment for Spain as a whole were calculated by multiplying the number of people admitted for treatment throughout Spain as a whole by the percentage of persons admitted who had injected drugs on some occasion in life or in the 12 months prior to admittance (a percentage which was not available for all of the autonomous regions in certain years during the period considered).

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Treatment Indicator.

In 2005, the vast majority of patients admitted for treatment due to illegal drug abuse or dependence (84.6% of all those admitted and 84.1% of those admitted for the first time in life) continued to be males. The highest proportion of males is found among those admitted for cocaine or cannabis, and the lowest among those admitted for hypnosedatives. The average age of the people admitted for treatment was 31.9 years for all admittances as a whole and 29.2 years for first time admittances. Of all those admitted, 6.5% were born outside of Spain (Table 4.2.1).

Table 4.2.1. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE PEOPLE ADMITTED FOR TREATMENT DUE TO PSYCHOACTIVE DRUG ABUSE OR DEPENDENCE, BY EXISTENCE OR NON-EXISTENCE OF PRIOR TREATMENT AND BY SEX (IN PERCENTAGES). SPAIN, 2005.					
	Total	**Prior Treatment[1]**		**Sex**	
		Yes	**No**	**Men**	**Women**
Number of cases	50,630	23,714	24,553	42,633	7,791
Treated for the first time for the main drug (%)	50.9	-	-	50.6	52.3
Average age (in years)	31.9	34.6	29.2	32.0	31.5
Women (%)	15.4	15.0	15.9	-	-
Highest level of studies completed(%)					
No studies	1.3	1.5	1.1	1.3	1.5
Primary school	43.7	46.3	41.1	44.5	39.1
Secondary school	51.1	48.9	53.5	50.7	53.8
University studies	3.7	3.2	4.1	3.4	5.3
Other	0.2	0.2	0.2	0.1	0.3
Main employment status (%)					
Working	44.6	36.9	52.3	47.0	31.4
Unemployed, never worked	4.6	5.1	4.2	4.0	7.9
Unemployed, has worked	33.5	40.4	27.0	32.9	36.7
Other	17.3	17.6	16.5	16.1	24.0
Born outside of Spain (%)	6.5	6.0	7.1	6.4	7.5
Main source referring person to treatment (%)					
Other drug addiction treatment services	15.0	20.6	9.7	14.6	17.6
General practitioners, primary health care	9.5	5.6	13.2	9.5	9.5
Hospitals or other health services	5.8	4.9	6.7	5.5	8.0
Social services	4.2	5.1	3.3	3.7	7.1
Prisons, closed internment centers for minors	8.6	9.4	7.8	9.1	5.9
Legal or police services	6.3	4.1	8.5	6.7	4.3
Companies or employers	0.5	0.4	0.6	0.4	0.8
Friends or family	17.5	11.6	23.1	17.8	16.0
Own initiative	30.1	36.3	24.3	30.5	28.0
Other	2.5	2.1	2.8	2.4	2.7
Most long-lasting co-habitation in 30 days prior to admittance for treatment (%)					
Alone	12.3	14.4	10.3	12.5	10.9
Only with spouse/significant other	9.9	10.4	9.5	8.9	16.0
Only with children	6.1	5.5	6.6	5.5	9.4
With spouse/significant other or children	15.8	15.2	16.4	15.8	15.9
With parents or family of origin	41.2	36.0	46.1	42.6	32.7
With friends	2.8	3.0	2.7	2.7	3.9
Other	11.9	15.5	8.4	12.0	11.3
Main housing for 30 days prior to admittance for treatment (%)					
House, apartment, flat	84.4	79.2	90.3	84.3	85.3
Prison, closed internment centers for minors	7.1	9.6	4.6	7.6	4.2
Other institutions	1.7	2.3	1.2	1.6	2.2
Guest houses, hotels, hostels	0.8	1.1	0.5	0.7	1.1
Unstable or precarious lodging	2.4	3.5	1.4	2.3	3.2
Other places	3.6	4.4	2.2	3.5	3.9

[1]. The number of cases with or without prior treatment or the number of men plus the number of women may not add up to the total, due to the existence of cases for which these variables are unknown

Source: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory (OED).

The average age of the people admitted for heroin use was 35.6 years, for cocaine 30.5 years and for cannabis 24.0 years.

The level of studies of the patients admitted for treatment has tended to improve slightly over time but continues to display significant variation depending on the drug which leads to the treatment. In 2005, the patients admitted for heroin had been to primary school or a lower level, whereas the percentage of those admitted for cocaine or cannabis treatment with only this level of studies was a minority. As for their employment status, the percentage of employed persons among those treated for cocaine or cannabis was much higher than the percentage of persons employed among those treated for heroin.

In 2003, variables were introduced in relation with housing type, persons co-habitating with the user and the source or service which referred the user for treatment. In Spain, the vast majority of patients admitted for illegal drug treatments live in their family homes (houses, apartments or flats). In 2005, the percentage of people admitted for treatment who lived in institutions was equal to 8.8% and that of those who had precarious or unstable housing (homeless) 2.4%. The most frequent model of co-habitation is that of the family of origin (with parents) or that of the user's own family (with spouse and/or children). There are significant differences in the models of co-habitation and type of housing depending on the main drug for admittance to treatment: living in an institution or having precarious or unstable housing is much more frequent among those admitted for treatment due to heroin (4.5%) than among those admitted for cannabis (1.0%) or cocaine (1.1%). The opposite is true with the percentage of patients who live with their family of origin or on their own. In terms of the service or source which referred the patients for treatment, in most cases the patients began treatment at their own initiative or were spurred by relatives or friends, though the public health system (especially primary care services) leads to treatment for a significant percentage of those admitted for cocaine or cannabis.

Among those admitted for treatment, the multiple drug use pattern is strongly established. Most of those admitted in 2005 had used different drugs other than the one leading to the treatment (secondary drugs) during the 30 days prior to admittance. Among those admitted for heroin, the secondary drugs most frequently reported were cocaine and cannabis, and among those admitted for heroin these were alcohol and cannabis.

For approximately half (50.9%) of those admitted for treatment due to psychoactive drugs in Spain in 2005, it was the first time they received treatment for the same main drug, a percentage which was much lower among those admitted for heroin (20.5%) than among those admitted for cocaine (66.9%), cannabis (84.0%), amphetamines (68.8%) or ecstasy (73.0%).

PDUs from non-treatment sources

Heroin Users Recruited in Community

In 2001-2003, the beginning interview in a study of young heroine user cohorts (*Itínere* Project) carried out in Madrid, Barcelona and Seville (de la Fuente L *et al.* 2005b). The study was financed by several agencies and public institutions which form part of the Ministry of Health and Consumer Affairs (FIPSE, FIS and others) and was directed by researchers working for the Carlos III Health Institute (Luis de la Fuente), the General Department for Drug Dependences and Addictions of the Autonomous Regional

Government of Andalusia (Rosario Ballesta) and the Municipal Government of Barcelona (Teresa Brugal). Current heroine users were found at the age of 30 years or less in the autonomous region through chain sampling techniques. The data were collected by way of a self-administered computer-assisted questionnaire (CASI), with an audio version (Audio-CASI) to explore sexual behaviors. Blood samples were obtained on blotting paper, as well as anthropometric measurements. The participants and survey subject seekers were compensated for their cooperation. The number of participants was 991 (364 in Barcelona, 427 in Madrid and 200 in Seville); most of those recruited were users or former users who did not take part in the study (44.7%) or persons suggested by other participants (39.7%). It was very difficult to recruit the foreseen sample, presumably due to the lack of young heroin consumers. The socio-demographic characteristics of the participants and their involvement in social conflict situations are stated in Table 4.3.1.

Most of the users from the three cities (67%-77.5%) began using heroin at the age of 18 years or less, generally by smoking the heroin in Seville (88.9%) and Madrid (65.6%), and by sniffing (46.6%) or smoking it (39.7%) in Barcelona. Initiation by injection was rare (4%-13.8%). For most, the time between the first usage and the beginning of weekly usage was less than 6 months (61.3%-80.7%). Upon beginning weekly use, the system of smoking continued to predominate in Seville (92.8%) and Madrid (77.7%), whereas in Barcelona the three manners of use mentioned occurred at a similar rate. However, sniffing had lost relevance in favor of injection in Barcelona and in favor of smoking in Madrid. Between 19.1% (Seville) and 54.4% (Barcelona) had ever-in-lifetime changed their habitual or most frequent manner of using heroin, considering only those changes maintained for at least one month. In Barcelona, the change from non-injected to injected forms predominated (87.7%), with the opposite change in Seville (82.2%) and in Madrid with both being of similar importance (Table 4.3.1).

As for recent use patterns (in the last 12 months), between 46.9% of the participants (Barcelona) and 69% (Seville) used heroin daily or almost daily (5-6 days/week). Nonetheless, between 18.5% and 26.9% used it at quite a low frequency (1-2 days/week). As occurred in the first stages of use, the main manner of recent use was quite different, depending on the city: in Madrid (82.9%) and above all in Seville (99%) smoking vastly predominated, and in Barcelona injection did (59.3%), though there are still quite a few smokers (28.3%) and sniffers (12.4%). Also very unequally extended was the use of heroin mixed with cocaine in the same dosage: in Seville, 86.1% had used this mixture always or most of the times that they had used heroin, compared to 34.8% in Madrid and 27.5% in Barcelona. In terms of the type of heroin, almost all of the participants in Madrid (96.9%) and Seville (97.5%) always used brown heroin, whereas in Barcelona many (75.5%) always or mostly used white heroin (Table 4.3.1).

In Madrid and Barcelona, the preferred locations for using heroin were the massive sales and usage zones for drugs, though many cited the place where they live and open spaces (streets, city squares, parks, etc.). On the other hand, the participants in Seville hardly used it in massive sales and usage zones, mentioning as their preferred locations the places where they live, open public spaces and other locations (especially abandoned houses, drug sellers' homes or the homes of friends and boyfriends/girlfriends). Most of the participants (52.5%-70%) usually use heroin in the company of other people, especially close friends, acquaintances or their stable sex partner. The proportion of those who usually use alone was greater in Seville than in Barcelona or Madrid (Table 4.3.1).

Table 4.3.1. PATTERNS OF HEROIN USE AMONG YOUNG USERS IN BARCELONA, MADRID AND SEVILLE. 2001-2003

	Barcelona	Madrid	Seville	Total	p$
	(n=364)	(n=427)	(n=200)	(n=991)	
Age of first use					***
<15	11.5	23.7	27.0	19.9	
15-16	26.1	25.1	22.0	24.8	
17-18	29.4	24.4	28.5	27.0	
19-20	17.9	16.2	11.0	15.7	
>20	15.1	10.8	11.5	12.5	
First way of using					***
Smoked	39.7	65.6	88.9	60.8	
Injected	13.8	9.1	4.0	9.8	
Sniffed powder through the nose	46.6	25.3	7.0	29.4	
Time between first use and weekly use					***
<1 month	22.8	30.8	43.6	30.3	
1-5 months	31.6	26.7	32.6	29.7	
6-11 months	10.8	8.2	8.3	9.2	
12 months or more	34.8	34.2	15.5	30.8	
Usual manner of using at the beginning of weekly usage					***
Smoked	40.8	77.7	92.8	67.2	
Injected	25.2	12.7	5.2	15.8	
Sniffed in powder through the nose	34.0	9.6	2.1	17.0	
Change in habitual manner of usage ever-in-lifetime	54.4	43.2	19.1	42.4	***
Direction of the last change					***
From injected to non-injected	12.3	50.6	82.8	34.3	
From non-injected to injected	87.7	49.4	17.2	65.7	
Frequency of use in the last 12 months					***
Every day	38.7	43.8	61.0	45.4	
5-6 days/week	8.2	14.5	8.0	10.9	
3-4 days/week	26.1	17.8	12.5	19.8	
1-2 days/week or less	26.9	23.9	18.5	23.9	
Habitual manner of usage in the last 12 months					***
Smoked	28.3	82.9	99.0	66.1	
Injected	59.3	16.9	1.0	29.3	
Sniffed in powder through the nose	12.4	0.2	0.0	4.6	
Heroin use alone or mixed with cocaine in the same dosage in the last 12 months					***
Always mixed	7.7	4.1	53.2	14.8	
Mixed most of the time	19.8	30.7	32.9	27.2	
Mixed approximately half the time and alone the other half	8.6	11.2	8.7	98.0	
Alone most of the time	40.4	48.8	2.3	36.9	
Always alone	23.5	5.1	2.9	11.2	
Type of heroin used in the last 12 months					***
Always white	56.0	0.5	0.0	20.8	
White most of the time	19.5	0.0	0.0	7.2	
White approximately half the time and brown the other half	4.9	0.2	0.5	2.0	
Brown most of the time	12.4	2.3	2.0	6.0	
Always brown	7.1	96.9	97.5	64.0	
Most frequency usage location in the last 12 months					***

Houses or lodging where living	26.6	19.4	31.0	24.4	
Public open spaces (streets, city squares, parks, etc.)	15.1	15.7	28.5	18.1	
Massive drug sale and usage areas	49.7	41.5	0.5	36.2	
Cars	1.9	14.3	8.0	8.5	
Somewhere else	6.6	9.1	32.0	12.8	
People with whom usage usually takes place					***
None (consumes alone habitually)	32.1	29.7	47.5	34.2	
Stable sex partners	15.7	22.2	10.0	17.4	
Close friends who are not a stable sex partner	34.9	16.7	26.5	25.4	
Casual acquaintances who are not a stable sex partner	14.0	26.2	11.0	18.7	
With other people	3.3	4.9	5.0	4.3	
$ Level of statistical significance of the comparison between cities, using ji squared: ns= not significant; * p <,0.05 ; ** p<0.01 * ** p<0.001					

The use of drugs other than heroin is shown in Table 4.3.2. The use of cocaine was nearly universal (94.8%-99% had used it at some time in the last 12 months), often in the form of base or crack, or mixed with heroin in the same dosage. However, the extent of the different forms of cocaine varied greatly by city. For instance, the rate of recent usage of cocaine base was higher in Madrid (89.7%) and Seville (85%) than in Barcelona (62%), and the opposite was true with cocaine hydrochloride (cocaine powder). At the same time, differences were find in the same direction in terms of the use of a heroin-cocaine base mixture, and heroin-cocaine powder, the former predominating in Madrid and Seville, and the latter in Barcelona.

TABLE 4.3.2. RATE OF PSYCHOACTIVE DRUG USE AMONG YOUNG USERS IN BARCELONA, MADRID AND SEVILLE. 2001-2003

	Ever-in-lifetime					Last 12 months				
	Barcelona	**Madrid**	**Seville**	**Total**	**p$**	**Barcelona**	**Madrid**	**Seville**	**Total**	**p$**
	(n=364)	(n=427)	(n=200)	(n=991)		(n=364)	(n=427)	(n=200)	(n=991)	
HEROIN										
Heroin+cocaine base mixed in the same dosage	67.3	94.4	98.5	85.3	***	46.1	86.7	97.0	73.9	***
Heroin+cocaine powder mixed in the same dosage	84.1	57.4	48.5	65.4	***	71.4	43.3	34.5	52.0	***
Heroin alone	99.2	99.3	87.0	96.9		98.4	95.3	65.0	90.4	***
COCAINE	100.0	100.0	100.0	100.0	ns	94.8	97.7	99.0	97.5	ns
Cocaine base	85.2	96.0	93.0	91.4	***	62.0	89.7	85.0	78.6	***
Cocaine in powder	97.5	94.6	86.0	93.9	***	89.0	69.1	62.0	75.0	***
OTHER DRUGS										
Ketamine	48.1	10.3	11.0	24.3	***	34.9	4.2	3.0	15.2	***
Ecstasy	83.2	67.9	49.0	69.8	***	50.8	26.5	18.0	33.8	***
Amphetamines	80.5	67.7	37.0	66.3	***	44.1	16.6	11.0	25.6	***
Hypnosedatives	94.5	94.1	78.5	91.1	***	84.3	86.4	66.0	81.5	***
Street methadone[A]	48.9	45.2	70.5	51.7	***	32.0	29.7	57.0	36.1	***
Opiates other than heroin or methadone	78.0	76.3	28.5	67.3	***	54.4	42.2	12.0	40.6	***
Cannabis	98.9	97.4	95.0	97.5	*	93.1	85.7	87.0	88.7	**
LSD	81.3	74.9	50.0	72.3	***	27.8	10.1	10.5	16.7	***
Volatile inhalants	53.8	51.1	20.6	46.0	***	10.7	6.6	4.5	7.7	*
Other	26.6	14.8	7.5	17.7	***					
ALCOHOL										ns
Does not drink	_	_	_	_	_	20.1	16.7	17.1	18	
Less than 50 ml pure alcohol/day	_	_	_	_	_	49.3	49.4	46.2	48.7	
From 50-99 ml/day	_	_	_	_	_	14.5	15.5	20.6	16.2	
100 ml/day or more	_	_	_	_	_	16.2	18.4	16.1	17.1	
TOBACCO										ns
Non-smoker	_	_	_	_	_	1.9	2.6	1.0	2	
<10 cigarettes/day	_	_	_	_	_	15.9	13.6	22.5	16.3	
10-19 cigarettes/day	_	_	_	_	_	57.1	56.6	48.0	55.1	
20 or more cigarettes/day	_	_	_	_	_	25.0	27.2	28.5	26.7	
INJECTION OF DRUGS	80.5	65.1	33.0	64.3	***	75.8	48.9	15.5	52.1	***

$ Level of statistical significance of the comparison between cities, using ji squared: ns= not significant; * p <,0,05 ; ** p<0.01 * ** p<0.001
* p <,0.05 ; ** p<0.01 * ** p<0.001
[A]: This refers to the methadone used outside of the framework of treatment programs.

The study confirms that injecting drugs has ceased to be a universal phenomenon among young heroin users. Even in Barcelona, where injection is still of great significance, nearly 20% have never used injections, and 40.7% habitually use heroin in non-injected forms. Comparing with a similar study from 1995, it can be concluded that the decrease and abandonment of injection has remained study (de la Fuente *et al.* 1997). The greatest drop has occurred in Seville, where injection is now a minority phenomenon, such that 2 out of every 3 young heroin users have never injected drugs, and 99% habitually use heroin in a pulmonary manner. In Madrid, on the other hand, injection as the usual manner of using heroin use has decreased, but not recent injection (in the last 12 months and last 30 days), which suggests that heroin users continue to use injections sporadically.

There are huge differences between Barcelona and the other two cities in terms of the type of heroin circulating in the market. Whereas in Madrid and Seville, almost only brown heroin circulates (heroin base), which is apt for smoking and for using in injections (after acidifying it), in Barcelona white heroin (heroin hydrochloride) continues to predominate greatly. In prior studies, a strong relationship had been found between the type of heroin in circulation and the predominant method for using (de la Fuente *et al.* 1996), so market-related factors may lie behind the resistance to changing methods in Barcelona.

Another relevant finding is the widespread use of cocaine among young heroin users in Spain, very often in the form of base or crack and/or mixed with heroin in the same dose. In fact, in Seville most of the participants (86.1%) always or mostly used heroin and cocaine mixed together. Furthermore, there is a certain tendency towards using heroin and cocaine in the same chemical form and using the same method. For instance, in Seville the use of heroin and cocaine base by pulmonary methods predominated, and in Barcelona the use of injected heroin or cocaine in the hydrochloride form did. At the same time, in addition to cocaine, young heroin users use other drugs in a high proportion, such as tobacco, cannabis, alcohol and hypnosedatives, which may increase the risk of certain acute health problems, especially in the case of hypnosedatives and alcohol, the combined use of which with heroin is an important risk factor for overdosing. There are geographic differences in the use of opiates other than heroin: in Seville, the most commonly used is street methadone (which may have to do with the use of methadone in pill form in maintenance programs), and other compounds in Madrid and Barcelona.

The data indicate that the socio-economic situation of young heroin users continues to be particularly challenging. Their housing conditions usually tend to be precarious, as well: more than 15% (more than 40% in Barcelona) lack a stable home. The breakdown by sex, level of studies and employment status does not differ much from those heroin users assisted in services (Government Delegation for the National Plan on Drugs 2005).

Intensive or frequent patterns of use (when relevant)

Survey of people admitted for treatment due to heroin or cocaine abuse, 2003-2004

The indicator "admittances for treatment" is a record which includes individualized data on the patients who request ambulatory treatment due to abuse of or dependence on psychoactive substances throughout all of Spain. This record, which has been working since 1987, requires ongoing collection and universal geographic coverage, which is why it only encompasses a few essential variables. The "survey" of people admitted for treatment due to heroin or cocaine abuse or dependence in 2003-2004 came in response to a need to complement and expand the information provided by the indicator "admittances for treatment," going further in-depth in terms of the knowledge of the socio-demographic characteristics of users, patterns of use, health problems, risky practices for HIV infections, social support network and the use of health care resources by heroin and cocaine users.

This study also made it possible to find out, by comparing it with another survey taken in 1996, the changes that had taken place in the profile of heroin users.

Those patients admitted for treatment for the first time at the center for which their clinical record was created and those re-admitted for treatment six months after being discharged due to expulsion or abandonment were included.

The patients were included regardless of the assistance program which they were to follow (ambulatory detoxification, drug-free program, maintenance with substitutes, etc.). Excluded were those patients whose main drug of admittance for treatment was something other than heroin or cocaine, even if they also used any of these drugs.

The sample selection was performed by systematic random sampling, in accordance with the order of admittance for treatment (one out of every three patients admitted for heroin or cocaine).

The gathering of information was carried out by giving a questionnaire in a face-to-face interview. Most of the questionnaire is made up of closed and pre-coded questions. Most of the questions in the questionnaire refer to the 12 months or 30 days prior to admittance for treatment. The interview had to be given in the 30 days subsequent to the beginning of the treatment. The questionnaires were completed by the professionals at the centers included in the sample.

The survey was given to a sample of 2,610 people admitted for treatment due to abuse of or dependence on heroin or cocaine or both, at reporting centers from all of the autonomous regions, with the exception of the Basque Country and Navarre.

Socio-Demographic Characteristics (Table 4.4.1)

In the survey taken during the year among patients admitted for treatment due to heroin and cocaine in the year 2003-2004, four out of every five survey takers were males. The average age was 33.7 years for heroin users and 30.1 for cocaine users. 10.0% had no studies, 32.0% had gone to primary school, 52.7% to secondary school and 5.3% more advanced studies. 94.5% were of Spanish nationality.

Nearly half of those admitted for heroin use had been unemployed during the month preceding the treatment, in contrast with those admitted for cocaine, who were more often actively employed and earned money from their own work. In general, those admitted for cocaine had a greater level of independence and economic autonomy due to better social integration.

Though most obtained it from their own work or through their family's help, a significant percentage had obtained income from performing illegal activities during the 12 months prior to admittance. Among those admitted for cocaine, greater importance was held by work in terms of obtaining income, depending less on the family, significant others and social aid. However, this group reported that it obtained income from selling drugs at a high percentage. Many of those surveyed, especially those admitted for heroin use, had been arrested and had been in prison.

Aspects related with social exclusion and drug-related crimes are discussed in further depth in Sections 8.1 and 8.2.

Talbe 4.4.1. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS BY MAIN DRUG LEADING THEM TO BE ADMITTED FOR TREATMENT (IN PERCENTAGES). SPAIN, 2003-2004.				
	Total	**Heroin**	**Cocaine**	**Both**
Number of admittances	2,610	1,225	773	604
Sex (% who are men)	80.3	79.3	84.3	77.5
Average age (DE)	32.7 (7.1)	33.5 (6.7)	30.1 (7.5)	34.4 (6.5)
Spanish nationality	94.5	93.3	95.9	95.4
Marital status				
Single	65.5	68.2	62.2	64.2
Married	18.4	16.0	24.1	15.7
Separated / divorced	15.3	15.0	13.2	18.9
Widowed	0.8	0.7	0.5	1.2
Highest level of studies completed				
No studies	10.0	10.9	5.7	13.0
Primary school	32	31.8	26.1	39.9
Secondary school	52.7	52.1	62.5	41.9
University studies	5.3	5.1	5.5	5.2
Job status in the prior 30 days				
Working	41.6	34.0	62.0	31.3
Unemployed	42.5	47.2	25.3	54.7
Other	15.9	18.8	12.7	14.0
How money is obtained in the last 12 months				
Work	72.0	60.6	88.9	61.8
Money from parents	38.4	40.5	33.9	39.6
Money from spouse/significant other	20.8	21.9	18.1	21.5
Unemployment / social aid	21.5	24.4	15.2	23.6
Theft / selling stolen items	19.4	20.7	12.6	25.5
Prostitution	3.8	4.4	2.3	4.5
Transporting drugs	17.5	16.4	18.3	18.5
Begging in the street	13.3	17.6	4.5	15.7

Drug Use (Table 4.4.2)

- Heroin

Of those surveyed, 75.6% had used heroin at some time in their lives and 60.1% during the month prior to the treatment. The age of beginning use was 20.5 years. The most frequently used methods of drug intake in the last month were pulmonary (60.0%) and injected (19.4%).

One-third of users reported having changed their usual drug intake method at some time for using heroin. The most frequently performed change in method was from injected to “chasing the dragon” (42% of those who changed methods). However, changing from “chasing the dragon” to injection was also frequent (29.9%).

Of all heroin users, 71.4% had gone through some period of abstinence (most between 1 and 3). The average duration of the last abstinence period was one year.

Of all heroin users who had undergone an abstinence period, 57.9% reported having achieved the last abstinence period with the help of professionals (a center) and 28.3% having achieved it on their own. 11.4% had spent their last abstinence period in jail.

- Cocaine

91.5% report having used cocaine powder at some time in their lives, 63.9% during the year prior to treatment, and nearly half during the last month. The average age of beginning use was 19.9 years. The most frequent usage methods in the 30 days prior to admittance for treatment were sniffing (63.6%), injection (21.5%) and smoking (13.8 %).

Of those surveyed, 64.7% had used crack at some time in their lives, nearly half in the year prior to treatment, and a bit more than one-third had in the preceding month. The average age of beginning use was 24.2 years. Crack use was much more frequent among those admitted for treatment due to heroin than among those admitted for treatment due to cocaine.

- Other Drugs

Among those admitted for treatment due to heroin and cocaine, multiple use of other substances in the last month was very common, including tobacco (94.9%), alcohol (70.6%), cannabis (53.4%) and hypnosedatives (40.5%). In the case of ecstasy, designer drugs, LSD, amphetamines and inhalants, many of those surveyed report had an ever-in-lifetime use, but they did not use them frequently.

Table 4.4.2. DRUG USE BY PARTICIPANTS, BY MAIN DRUG WHICH LED TO ADMITTANCE FOR TREATMENT (IN PERCENTAGES AND AVERAGES). SPAIN, 2003-2004.				
	Total	**Heroin**	**Cocaine**	**Both**
Number of admittances	2,610	1,225	773	604
Tobacco and alcohol				
Tobacco	94.9	97.1	90.1	96.9
Alcohol	70.6	65.2	82.6	66.3
Heroin				
Used ever-in-lifetime	75.6	100.0	17.7	100.0
Average age of first use (DE)	20.5 (5.4)	20.4 (5.3)	20.3 (4.8)	20.8 (5.8)
Used at some time in the last month	60.1	83.6	4.6	84.0
Cocaine powder (cocaine hydrochloride)				
Used ever-in-lifetime	91.5	87.2	100.0	100.0
Average age of first use (DE)	19.9 (5.3)	19.5 (4.9)	20.3 (5.7)	20.0(5.3)
Used at some time in the last year	63.9	50.2	93.8	53.0
Used at some time in the last month	48.7	31.6	83.1	39.5
Injection of cocaine powder in the last month	13.2	16.3	4.4	19.1
Cocaine base (crack)				
Used ever-in-lifetime	64.7	74.5	33.0	85.3
Average age of first use (DE)	24.2 (6.7)	24.0 (6.7)	23.6 (6.7)	24.9 (6.9)
Used at some time in the last year	48.0	53.2	21.3	71.3
Used at some time in the last month	36.8	38.6	15.5	60.7
Injection of cocaine base in the last month	6.3	9.0	1.8	6.8
Hypnosedatives				
Used ever-in-lifetime	68.1	79.3	43.6	76.5
Average age of first use (DE)	22.6 (7.1)	22.7 (7.1)	23.1 (7.4)	22.5 (6.9)
Used at some time in the last month	40.5	46.8	25.6	46.5
Opiates other than heroin				
Used ever-in-lifetime	36.1	47.9	8.3	47.4
Average age of first use (DE)	23.1(6.5)	23.1(6.4)	20.3 (5.5)	23.5 (6.6)
Used at some time in the last month	11.5	14.9	2.4	15.3
Cannabis				
Used ever-in-lifetime	90.1	92.7	85.7	90.2
Average age of first use (DE)	15.7 (3.4)	15.5 (3.1)	16.1 (3.4)	15.8 (4.1)
Used at some time in the last month	53.4	55.2	48.8	55.3
Ecstasy or other designer drugs				
Used ever-in-lifetime	44.6	41.2	55.9	37.4
Average age of first use (DE)	20.8 (5.9)	20.7 (5.6)	20.2 (6.1)	21.9 (6.3)
Used at some time in the last month	7.2	4.9	12.4	5.1
Amphetamines				
Used ver-in-lifetime	52.4	54.9	51.9	47.2
Average age of first use (DE)	19.1 (4.4)	18.8 (4.1)	19.3 (4.8)	19.4 (4.5)
Used at some time in the last month	6.4	6.1	7.6	4.7
LSD				
Used ever-in-lifetime	52.2	55.9	48.8	49
Average age of first use (DE)	18.2 (3.7)	18.1(3.5)	18.4(3.5)	18.3(4.1)
Used at some time in the last month	5.4	4.7	5.2	6.4
Inhalants				
Used ever-in-lifetime	17.3	17.8	14	20.8
Average age of first use (DE)	16.5 (4.8)	16.1 (4.5)	17.7 (5.4)	16.1 (4.7)
Used at some time in the last month	2.2	1.7	2.4	3.1

Injection of Drugs (Table 6.2.1)

Of those surveyed, 43.3% had injected drugs at some time in their lives, 23.4% had in the last year, and 17.7% had in the month prior to the treatment. The average age at which they used an injection for the first time was 21.3 years.

The most frequently injected drugs in the month prior to the treatment were, by order of frequency: heroin alone, heroin mixed with cocaine and cocaine alone. Of those who had used injections in the past month, 73% had re-used their own needles.

57.5% of those who had injected drugs in the month prior to treatment had obtained some of their needles for free. The place where they obtained these needles for free most frequently was the needle exchange bus.

Among those users who had used injection in the year prior to treatment, 21.4% had used needles previously used by other persons at some time during that time period, while 22.3% had passed on needles used by them to other people. Though parenteral use was less frequent among those admitted for cocaine, certain risk behaviors like sharing used needles and distributing drugs dissolved inside the syringe were also frequent among injection users in this group.

Other HIV infection risk behaviors and the rate of HIV infection in different groups are discussed to a greater extent in Section 6.2.

Social Environment (Table 4.4.3)

- Relationship and social support

Drug use within the close social environment of the interviewees (siblings, significant other or persons co-habitating with them) was quite frequent (Table 4). The persons mostly chosen by the subjects to speak clearly and sincerely about their problems with drugs and other personal problems was their significant other.

- Social conflicts

Of those surveyed, 63.3% had been arrested at some time in their lives, and nearly one-third had been in prison (Table 4). Their first arrest had taken place, on average, at the age of 21 years. Though social conflictiveness was far greater among those admitted for treatment due to heroin, the percentage of persons arrested and/or subjects who had been in prison was also high among those admitted for cocaine treatment.

Use of Health Care Resources (Table 4.4.3)

- Use of health care and social services

Of those surveyed, 41.9% had gone to an emergency medical service at some time in the last year for some reason, and 10.3% had for an overdose (Table 4). The drug used in the 48 hours prior to the overdose in the greatest percentage was cocaine powder (58.5%), followed by heroin (42.6%) and crack (24.5%). The method of intake most frequently used in cases of overdose was intra-nasal (sniffing), following by parenteral. In most cases, the overdose was taken care of at a hospital.

Of those surveyed, 18.5% had been admitted to a hospital at least once in the year prior to treatment. At the same time, 15.3% had gone to talk with a social worker during the same time period.

Whereas those admitted for treatment due to cocaine had gone more frequently to emergency services, hospital admittances and the use of social resources were more frequent among those admitted for heroin treatment.

Prior Treatments for Abuse of or Dependence on Heroin (Table 4.4.3)

73.7% of those admitted for treatment due to heroin and 78.5% of those admitted for heroin + cocaine had undergone prior treatments to stop using heroin or as a result of dependence on this drug at ambulatory centers or centers with internment. Most of these treatments were provided at ambulatory centers, therapeutic communities or farms. In nearly half of all cases (48.4%), the last treatment given included maintenance with methadone or other opiates, and the treatment ended satisfactorily with the patient's discharge in 20% of all cases.

Prior treatments for abuse of or dependence on cocaine were much less frequent. Among those admitted for treatment due to cocaine, 29.5% had undergone treatment at some prior time, the percentage being similar (30.1%) among those admitted for heroin + cocaine. Most of these treatments took place, as among those admitted for treatment due to heroin, at ambulatory centers, therapeutic communities or farms. The last treatment ended satisfactorily with the patient's discharge in 14.1% of all cases.

44.6% of the subjects who had undergone prior treatment for heroin and 41.8% of those who had done so for cocaine had taken the last treatment at the center where the survey was given. The most frequent reasons for seeking out the treatment were family problems (34.6%) and health (22.8%).

Table 4.4.3. SOCIAL ENVIRONMENT, CONFLICTIVENESS AND USE OF HEALTH RESOURCES AMONG PARTICIPANTS, BY MAIN DRUG LEADING TO ADMITTANCE FOR TREATMENT (IN PERCENTAGES). SPAIN, 2003-2004.

	Total	Heroin	Cocaine	Both
Number of Admittances	2,610	1,225	773	604
Drugs in the social environment in the last 12 months				
Use of heroin by siblings*	11.1	11.9	4.7	17.7
Use of cocaine by siblings*	21.8	19.4	25.3	22.2
Injection of drugs by siblings*	5.2	5.4	1.8	8.3
Use of heroin by significant other*	15.7	23.9	2.1	21.5
Use of cocaine by significant other *	24.7	25.8	23.3	25.1
Injection of drugs by significant other *	5.3	7.9	1.2	6.9
Use of heroin by co-habitating persons*	8.0	10.5	3.1	10.7
Use of cocaine by co-habitating persons *	13.9	12.3	15.6	14.4
Injection of drugs by co-habitating persons *	3.9	5.5	1.7	4.0
The participant has gone out with heroin users	55.0	64.9	28.4	67.6
The participant has gone out with cocaine users	73.0	64.7	90.7	68.6
Social conflictiveness				
Has been arrested ever-in-lifetime	63.3	70.3	40.5	78.1
Has been in prison at some time	32.1	40.2	11.4	41.7
Use of health care resources in the last 12 months				
Has gone to emergency medical services	41.9	41.1	44.8	40.1
Has gone to emergency medical services for overdose	10.3	8.9	15.4	6.8
Has been admitted to a hospital	18.5	19.4	15.8	19.4
Has gone to a social worker	15.3	15.5	10.6	20.9
Prior treatments for abuse of or dependence on drugs				
Heroin				
Some prior treatment for heroin	54.8	73.7	6.2	78.5
Satisfactorily completed the last treatment†	20.0	21.3	28.9	16.8
Took part of the treatment at the last center†	44.6	46.5	31.4	42.6
Cocaine				
Some prior treatment for cocaine use	20.9	10.9	29.5	30.1
Satisfactorily completed the last treatment†	14.1	14.3	16.6	10.9
Took part of the treatment at the last center†	41.8	50.4	36.9	43.4

*Percentages calculated out of the total participants with siblings, with a stable significant other, or with co-habitating persons other than the significant other and siblings, for each of the groups.
† Percentage calculated out of the participants who had undergone a prior treatment for abuse of or dependence on this drug.

5. DRUG-RELATED TREATMENT

PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS and 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS**.**

Treatment system

No new data.

Drug free treatment

These treatments are provided at the following types of centers:

Inpatient Treatments: In Spain, there are two types of centers:

Hospitalised Detoxification Units. In Spain in the year of 2006, 17 Units of these characteristics were running and provided assistance to 941 patients. (PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS and 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS).

Therapeutic Communities. These residential centers also work through an inpatients system. In Spain in the year of 2006, there were 101 of them providing assistance to 3,013 patients. (PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS and 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS).

Outpatient Treatments: In Spain, this type of treatment is provided at the

Outpatient Assistance Centers: In Spain in the year of 2006, there were 211 centers which provided assistance to 21,986 patients. (PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS and 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS).

Pharmacologically assisted treatment

Withdrawal Treatment: Abstinence syndrome treatment is provided through an inpatient program at the Hospital Withdrawal Units, under a non-hospitalization residential system in Therapeutic Communities and under an ambulatory system at the Outpatient Assistance Centers.

Substitution Treatment: The treatment for abstinence syndrome is provided through an inpatient program at the Hospital Withdrawal Units, under a non-hospitalization residential system in Therapeutic Communities and under an ambulatory system at the Ambulatory Assistance Centers.

Centers Which Provide Methadone Maintenance Programs

The purpose of these sites is to provide substitution treatments for opiate dependence syndrome through the therapeutic use of methadone hydrochloride.

In Spain in 2006, the number of people assisted was 33,867 patients. (PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS and 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS).

Clinical tests with heroin

This information is not yet available.

Treatment with buprenorphine

This information is not yet available.

6. HEALTH CORRELATES AND CONSEQUENCES

Drug related deaths and mortality of drug users

Mortality due to Acute Reaction to Psychoactive Substances

The indicator "mortality due to acute reaction to psychoactive substances" of the National Plan on Drugs includes the information on deaths which involved judicial intervention in which the direct, fundamental cause of death was an acute adverse reaction after the deliberate, non-medical use of psychoactive substances.

A case is selected and included in this record if there is evidence of recent use of psychoactive substances (clinical evidence, external physical signs, presence of psychoactive substances or paraphernalia for using them at the place of death, recent use revealed by family members), or if there are positive toxicological tests, compatible anatomical-pathological findings or a coroner's report of death by acute reaction to some psychoactive substance.

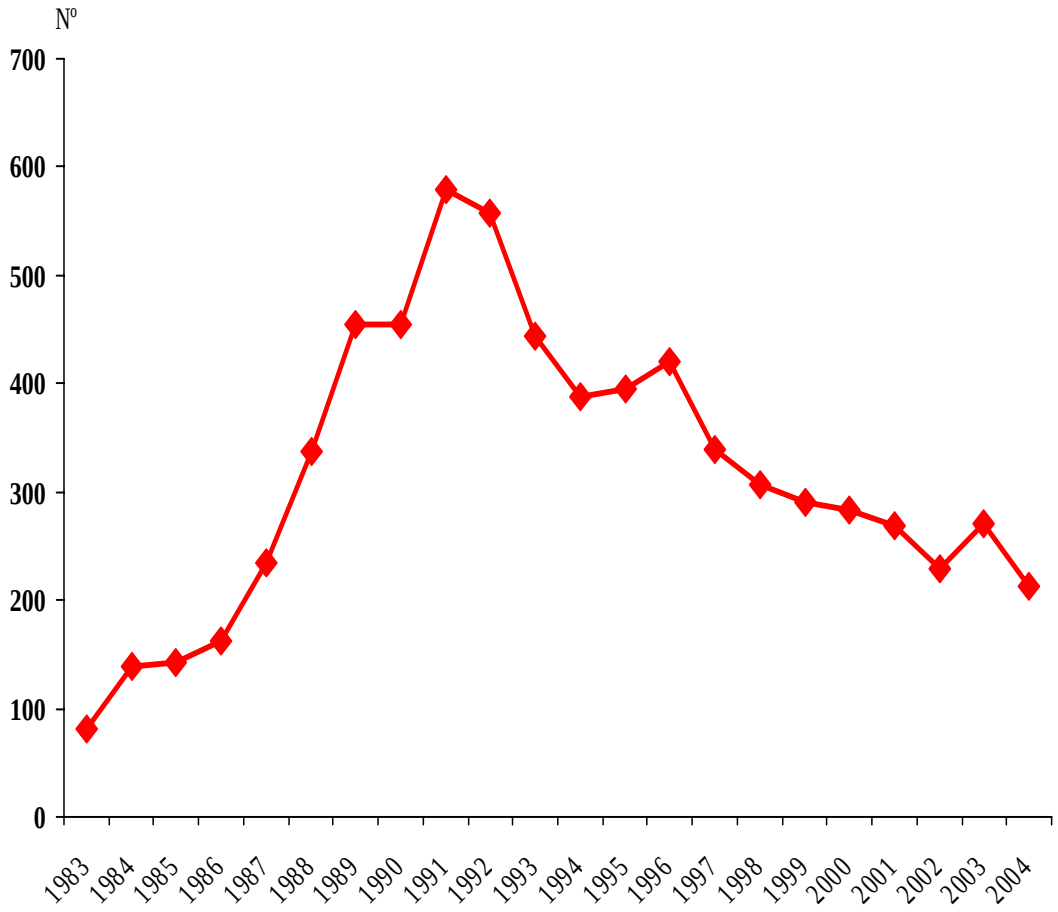
The indicator's use has expanded gradually since 1990 until covering nearly half the population in Spain in 2004, monitoring the largest urban areas and many medium-sized cities. The quality of the information has significantly increased in recent years. In fact, the percentage of cases with available toxicological test results was 65.9% in 1993, 82.1% in 1995, 88.1% in 1998, 97.7% in 2000, 96.6% in 2001, 98.6% in 2002, 99.4% in 2003 and 99.6% in 2004. The indicator detected 493 deaths in 2003 and 468 in 2004. The overall death rate due to acute reactions to drugs in 2004 (calculated for the indicator's coverage area) was equal to 23.4 per million inhabitants.

Of all the deceased, 14.7% in 2003 and 16.1% in 2004 were women, compared to 11.7% in 2002. Their average age was 35.3 years in 2003 and 37.0 years in 2004 (compared with 34.7 years in 2002). Most of those for which there was information on marital status were single (68-69%). 12.1% in 2003 and 8.8% in 2004 showed evidence of suicide. 53.3% in 2003 and 43.0% in 2004 showed recent signs of venipuncture, which suggests that nearly half died after injecting themselves with drugs (though the percentage of unknown results for this variable was very high). 42.7% in 2003 and 40.6% in 2004 of the deceased with serological results for the Human Immunodeficiency Virus (HIV) were HIV-positive, though the percentage of cases for which this variable is not known is also high (Table 6.1.1).

Table 6.1.1. GENERAL CHARACTERISTICS OF THE DECEASED DUE TO AN ACUTE REACTION AFTER USING PSYCHOACTIVE SUBSTANCES, SPAIN, 2003-2004		
	2003	**2004**
Number of deceased	493	468
Females (%)	14.7	16.1
Average age (years)	35.3	37.0
Age group (years)		
15-19	0.8	1.3
20-24	6.7	4.1
25-29	14.6	11.9
30-34	22.6	20.5
35-39	28.2	27.9
40-44	16.9	19.2
>= 45	10.2	15.1
Marital status (%)		
Single	69.4	68.9
Married	19.0	15.6
Separated/Divorced	10.5	14.4
Widowed	1.0	1.1
Origin of corpse (%)		
Home address	54.5	55.2
Hotel-Inn	5.3	5.1
Street	18.5	17.4
Public premises	1.8	1.3
Hospital	10.6	9.5
Prison	1.1	3.5
Other	8.2	8.1
Evidence of recent drug use (%)	85.6	92.6
Evidence of suicide (%)	12.1	8.8
Signs of recent venipuncture (%)	53.3	43.0
Death caused by prior pathology aggravated by psychoactive substance use (%)	35.4	32.6
Anti-bodies to HIV (%)	42.7	40.6
Drugs were found in toxicological analysis (%)	99.4	99.6
SOURCE: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory (OED). Mortality indicator.		

Mortality began to increase drastically between 1983 and 1990, and has decreased significantly from 1991-2004 throughout all of Spain. In recent years, the rate of decrease has slowed down quite a bit (Figure 6.1.1).

Figure 6.1.1. Deaths caused by acute reaction after use of psychoactive drugs in six large Spanish cities (absolute numbers). 1983-2004.



(*) The deaths originate from the ensemble of court records in Barcelona, Bilbao, Madrid, Seville, Valencia and Saragossa. For Seville, the data from the period of 1997-2000 are estimated, and for Saragossa those from the period of 2003-2004. Until 1995, only the deaths due to acute reaction to opiates or cocaine were included.

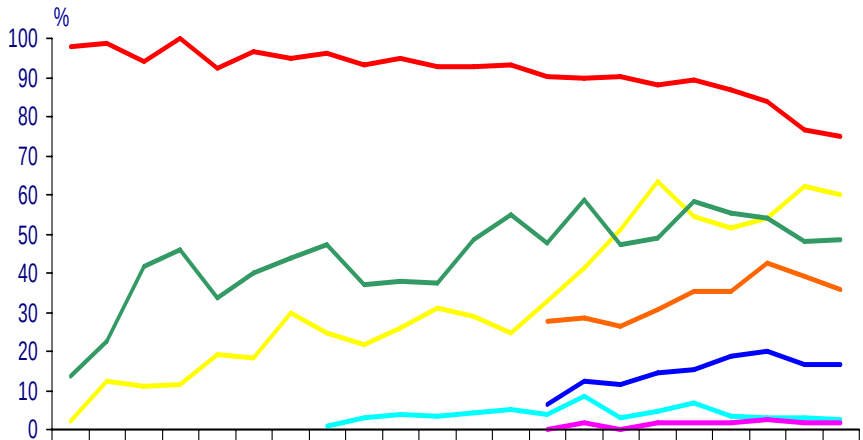
SOURCE: DGPNSD. Spanish Drug Observatory (OED). Mortality Indicator.

As in previous years, in 2003 and 2004 a mix of several drugs were found in most of the deceased, with a predominance of opiates and cocaine (or the metabolites of these substances). In fact, among the cases for which toxicological tests are available, 74.9% were positive for opiates, 60.1% for cocaine, 48.3% for benzodiazepines, 35.8% for alcohol and 16.7% for cannabis. All other drugs had a presence of less than 5%.

The percentage of deaths in which opiates were detected has gradually gone down (Figure 6.1.2). At the same time, and surely due to the increase in polidrug use, the proportion of deaths in which opiates alone are detected has decreased in a much more notable manner, dropping from 21.6% in the period from 1983-1989 to 9.1% in 1998-2001, and 6.4% in 2004 (Figure 6.1.3). In terms of methadone, though its isolated presence remains scarce (0.4% of deaths in 2004), in recent years it is found more frequently in deaths in which opiates or cocaine are found (Table 6.1.2).

Table 6.1.2. PRESENCE OF METHADONE IN DEATHS DUE TO ACUTE REACTION TO PSYCHOACTIVE SUBSTANCES			
	% of deaths in which only methadone is detected	% of deaths with opiates in which methadone is detected	% of deaths with cocaine in which methadone is detected
1996	1.5	15.8	11.9
1997	0.9	15.5	11.2
1998	0.9	18.8	14.3
1999	0.4	26.3	19.0
2000	1.2	28.1	22.5
2001	2.7	40.1	28.5
2002	1.8	41.7	20.2
2003	0.6	59.3	42.3
2004	0.4	53.0	38.6

Figure 6.1.2. Changes in percentage of deaths due to acute reaction to psychoactive substances in which toxicological tests detect each drug (%). Spain* 1983-2004.

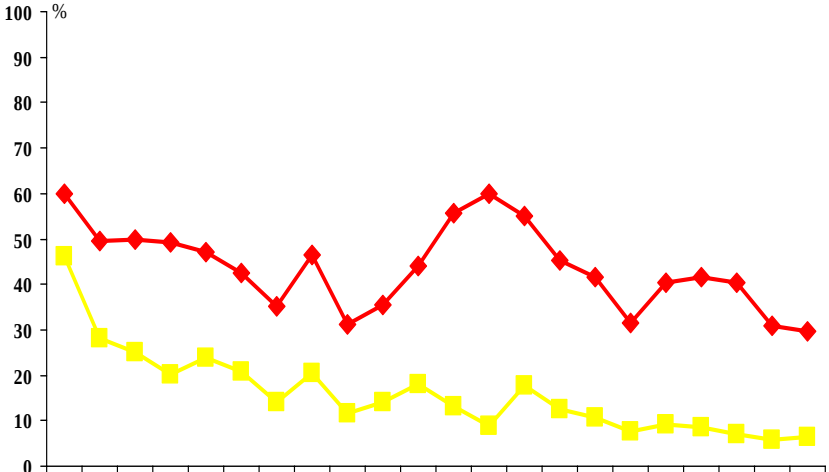


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Opiates	98	98,8	93,9	100	92,4	96,6	94,8	96	93,1	94,9	92,8	92,9	93,4	90,4	89,8	90,1	88	89,4	86,8	83,8	76,7	74,9
Cocaine	2	12,5	11	11,5	19,3	18,4	29,6	24,8	21,6	26	30,9	28,8	24,7	32,7	41,4	51,2	63,3	54,4	51,7	54,2	62,2	60,1
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
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
Cannabis														6,5	12,2	11,3	14,3	15,2	18,7	20	16,7	16,7
MDMA														0,1	1,5	0	1,8	1,6	1,5	2,5	1,6	1,9
Alcohol														27,7	28,6	26,2	30,5	35,5	35,3	42,5	39	35,8

(*) The data from all of the geographic areas monitored by the indicator are included.

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Mortality Indicator.

Figure 6.1.3- Changes in the percentage of deaths due to acute reaction to psychoactive substances in which the toxicological tests detected only opiates or opiates without cocaine (%). Spain*. 1983-2004.



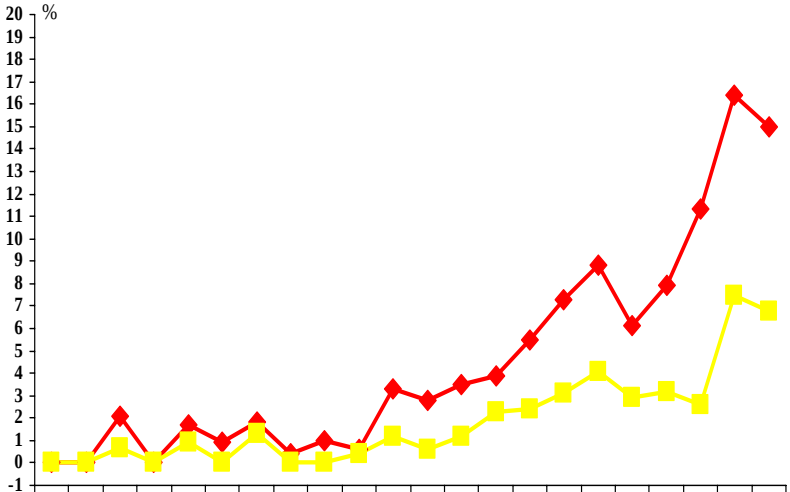
	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Opiates and no cocaine	59,8	49,6	49,7	49,2	47	42,4	35,2	46,6	31,3	35,4	44	55,8	59,8	55,1	45,4	41,7	31,5	40,3	41,7	40,5	30,8	29,7
Only opiates	46,3	28,1	25,2	20,2	23,9	20,8	14,1	20,6	11,5	14,2	18,1	13,1	9	17,7	12,6	10,8	7,6	9,2	8,7	7,1	5,9	6,4

(*) The data from all of the geographic areas monitored by the indicator are included.

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Mortality Indicator.

Just the opposite of what happens with opiates, the percentage of those persons who died due to an acute reaction to drugs in whom cocaine or its metabolic by-products were found has increased considerably since 1983, especially from 1996 (Figure 6.1.2). Likewise, both the percentage of cases in which only cocaine is found (rising from 0.6% in the period from 1983-1989 to 3.2% in 2001 and 6.8% in 2004) and the percentage in which cocaine is detected but not opiates (rising from 1.2% in the period from 1983-1989 to 7.9% in 2001 and 15% in 2004) have increased (Figure 6.1.4). The figures on deaths due to cocaine, however, may not properly represent the actual situation, because a large (and unknown) portion of these deaths may not undergo investigation by the court or coroner.

Figure 6.1.4- Change in the percentage of deaths due to acute reaction to psychoactive substances in which the toxicological tests detected only cocaine or cocaine without opiates (%). Spain*. 1983-2004.



	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
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
Only cocaine	0	0	0,7	0	0,9	0	1,3	0	0	0,4	1,2	0,6	1,2	2,3	2,4	3,1	4,1	2,9	3,2	2,6	7,5	6,8

(*) The data on all of the geographic areas monitored by the indicator are included.

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Mortality Indicator.

The percentage of deaths in which hypnosedatives or their metabolic by-products are detected, most of which are benzodiazepines, has continued to increase slightly, though in recent years it seems to have stabilized (33.8% in 1987, 47.7% in 1996, 58.5% in 2000, 55.2% in 2001 and 48.7% in 2004). As for the percentage in which cannabis was detected, it increased up to 2002, and afterwards gives the impression of having stabilized, as well (6.5% in 1996, 20.0% in 2002 and 16.7% in 2004). The presence of amphetamines or ecstasy is very scarce and no clear trends can be found (Figure 6.1.2).

As for the percentage of deaths due to acute reaction to drugs in which the coroner found signs of recent venipuncture, they went from 89.6% in 1996 to 75.3% in 1999, 55.2% in 2001, 47.2% in 2002 and 43.0% in 2004, though the validity of this indicator is probably not very high. Another indicator which may give us an idea of the behavior of the HIV/AIDS epidemic among injection users is the change in the prevalence of HIV infection among those who died due to an acute reaction to opiates or cocaine (most of whom were injection users), which shows a slight decrease, as could be expected from the developments in the HIV epidemic among drug injection users in Spain. In fact, the figure fell from 52.3% in 1996 to 48.1% in 1999, 47.1% in 2000, 47.3% in 2002 and 40.6% in 2004). However, these figures may be affected by variations in the coverage of the indicator and the percentage of the deceased on whom the test was performed.

Estimate of the Number of Deaths Related with Illegal Drug Use in Spain as a Whole

Illegal drugs may contribute to death through direct or indirect mechanisms. Those deaths directly related with illegal drug use (DRDI), also known as deaths by "overdose," due to an acute reaction or severe intoxication, always occur shortly after drug use, without identifying other problems or pathologies as being directly responsible for the death between the two events. Those indirectly related with drugs, on the other hand, may occur shortly or quite a bit after drug use and are caused directly by problems or pathologies due to the use of drugs, such as accidents, HIV infections, hepatitis or other chronic diseases.

Those deaths indirectly related with illegal drug use (IRDI) are impossible to estimate given the current state of knowledge, because the routine statistics on causes of death are put into various categories (hepatitis B or C, non-alcohol-related cirrhosis of the liver, accidents, etc.), and it is not known what percentage can be attributed to illegal drugs, except in the case of deaths due to HIV, in which the percentage can be estimated on the basis of the National AIDS Registry.

In Spain, the deaths directly related to illegal drug use (DRDI) cannot be calculated directly using the statistics on cause of death obtained from the general mortality registry (RGM) published by the National Statistical Institute (INE) with the name of "Death classification according to their cause," because prior studies indicate that it significantly underestimates them. It was possible to detect this underestimation because a special mortality registry (REM) promoted by the National Plan on Drugs, on the basis of coroner and toxicology reports has been operating since 1983 and is considered to offer higher-quality information than the RGM.

In order to estimate the DRDI deaths for Spain as a whole (Figure 2.4.5), different procedures were used, depending on the time period considered:

1. For 1983-1993, the data from 6 cities were extrapolated (Madrid, Barcelona, Valencia, Seville, Saragossa and Bilbao), to thedata obtained from the REM for Spain as a whole, assuming the hypothesis that both areas have the same mortality rate (De la Fuente *et al.*).

2. For 1994-2004, the annual number of deaths included in a set of selected categories related with drugs from the RGM was multiplied by an underestimation index for this registry. The selected categories were those proposed by the European Monitoring Center for Drugs and Drug Addiction (292, 304.0, 304.2-9, 305.2-3, 305.5-7, 305-9, E850.0, E854.1-2 and E855.2 for CIE-9, and F11-F12, F14-F16, F19, X42, X62 and Y12 for CIE-10) (The DRD-Standard, version 3.0 EMCDDA Scientific Report. EMCDDA/P1/2002, www.emcdda.eu.int), adding E858.9 (CIE-9), or X44 (CIE-10) to adapt to the context of Spain. This last code includes the accidental poisonings due to drug exposure and is widely used in Spain to codify deaths due to "overdosing."

In the case of codes X and Y, the EMCDDA recommends combining them with the T codes (T40.0-.9 and 43.6), which specify the type of drug involved, but unfortunately this is not possible in Spain, because deaths are not coded using T codes.

In order to obtain the underestimation index from the RGM, the number of deaths due to acute reaction to psychoactive drugs taken from the REM was divided by the deaths in the RGM selection, in an area with data from both registries, which covers approximately 44% of the Spanish population. The deaths included in the REM are judicial deaths due to the non-medical, intentional use of psychoactive drugs, whose

coroner and toxicology reports include post-mortem toxicological tests that were positive for illegal psychoactive drugs or other evidence of the recent use thereof, and there is no evidence of any other cause of death. Excluded are deaths due to homicide, accidents or infections in which drugs are detected. From 1994 to 2001, this index was successively 1.64, 1.51, 1.90, 1.59, 1.52, 1.28, 1.44 and 1.38 (Brugal *et al.* Med Clin (Barc) 2004; 123(2):775-777, Government Delegation for the National Plan on Drugs, OED Report for 2004, 2005).

For 2002, it was calculated by using the same procedures as in prior years and was equal to 1.48. In 2003 it was 1.40, and in 2004 it was 1.17.

Upon making the estimate of deaths for Spain as a whole using this procedure, it is assumed that the underestimation level of the RGM in the areas used to calculate the index is similar to that of the rest of Spain.

The HIV-ID deaths were estimated by multiplying the annual number of deaths in the categories CIE-9 and CIE-10 of the RGM in which HIV-related deaths have been coded by an estimate of the percentage of AIDS cases diagnosed during the time period and attributable to the injection of drugs (0.65).

Then the mortality related with illegal drug use throughout Spain is estimated, as well as its impact on the general mortality of the population, exclusively considering DRDI deaths and deaths due to HIV infection related with drug injection (HIV-ID).

The results indicate that, in Spain in 2004, at least 1,836 deaths related with illegal drug use occurred (43.1 per million inhabitants). Of these deaths, it is estimated that 796 (18.7 per million inhabitants) were directly related with these illegal drugs (DRDI) and 1041 (24.4 per million inhabitants) were deaths due to HIV infection in drug injection users (HIV-ID).

The vast majority of the deaths related with illegal drugs took place in the age group of 15-49 years, in which a rate of 71.5 per million inhabitants was found (121.4 per million in males and 23.2 per million among women), and a percentage of mortality attributable to drug use equal to 6.8% (7.9% among men and 3.9% among women). By five-year age groups, the greatest impact of this mortality was reached in the group between the ages of 35-39 years, at a rate of 137.0 per million inhabitants and an attributable mortality percentage of 12.3% (Table 6.1.3).

Table 6.1.3. ESTIMATE OF DEATHS DIRECTLY RELATED WITH ILLEGAL DRUG USE (DRDI) AND DEATHS DUE TO HIV RELATED WITH DRUG INJECTION (HIV-ID). SPAIN, 2004.

	Number			Rate per million inhabitants[c]			Proportional mortality(%)[d]		
	DRDI[a]	HIV-ID[b]	DRDI + HIV-ID	DRDI	HIV-ID	DRD + HIV	DRDI	HIV-ID	DRDI + HIV-ID
Men									
15-19 years	6	0	6	5.1	0.0	5.1	0.9	0.0	0.9
20-24 years	43	4	47	29.7	2.7	32.3	3.8	0.3	4.1
25-29 years	96	18	114	54.1	10.2	64.3	6.2	1.2	7.3
30-34 years	144	81	225	81.2	45.4	126.7	7.6	4.3	11.9
15-34 years	289	103	*392*	*47.0*	*16.7*	*63.7*	*5.5*	*2.0*	*7.5*
35-39 years	171	225	396	99.1	130.2	229.3	6.0	7.9	14.0
40-44 years	127	243	370	77.6	149.1	226.7	3.5	6.8	10.3
45-49 years	46	128	174	31.4	88.0	119.4	0.9	2.5	3.4
15-49 years	633	*699*	*1,332*	*57.7*	*63.7*	*121.4*	*3.8*	*4.1*	*7.9*
50-54 years	19	52	71	14.6	40.4	55.0	0.3	0.8	1.1
55-59 years	9	27	36	7.7	21.8	29.5	0.1	0.3	0.4
60-64 years	4	23	27	3.4	22.4	25.7	0.0	0.2	0.2
15-64 years	665	801	*1,465*	*45.8*	*55.1*	*100.9*	*1.5*	*1.8*	*3.3*
All ages	676	847	***1,523***	***32.3***	***40.4***	***72.7***	***0.3***	***0.4***	***0.8***
Women									
15-19 years	5	1	6	3.9	1.1	5.0	1.8	0.5	2.3
20-24 years	5	3	7	3.1	1.7	4.8	1.3	0.7	2.0
25-29 years	15	7	22	8.1	3.5	11.6	3.0	1.3	4.3
30-34 years	19	28	47	10.0	15.0	25.0	2.6	3.9	6.6
15-34 years	43	38	*82*	*6.7*	*5.9*	*12.6*	*2.3*	*2.1*	*4.4*
35-39 years	26	59	84	14.5	32.9	47.4	2.4	5.5	7.9
40-44 years	22	54	76	13.6	32.8	46.4	1.4	3.3	4.7
45-49 years	5	16	20	3.2	10.8	14.0	0.2	0.7	0.9
15-49 years	96	*166*	*263*	*8.5*	*14.7*	*23.2*	*1.4*	*2.5*	*3.9*
50-54 years	4	7	10	2.8	5.2	8.0	0.1	0.2	0.4
55-59 years	6	3	9	5.0	2.8	7.8	0.2	0.1	0.2
60-64 years	1	5	6	1.2	4.7	5.9	0.0	0.1	0.1
15-64 years	107	181	*287*	*7.2*	*12.3*	*19.5*	*0.6*	*1.0*	*1.6*
All ages	120	194	***313***	***5.5***	***8.9***	***14.4***	***0.1***	***0.1***	***0.2***
Both sexes									
15-19 years	11	1	12	4.5	0.6	5.1	1.1	0.1	1.3
20-24 years	48	7	55	16.1	2.2	18.3	3.2	0.4	3.6
25-29 years	111	25	136	30.5	6.8	37.3	5.4	1.2	6.6
30-34 years	163	109	271	44.7	29.8	74.5	6.3	4.2	10.5
15-34 years	*333*	*141*	*474*	*26.4*	*11.2*	*37.5*	*4.7*	*2.0*	*6.7*
35-39 years	197	283	480	56.2	80.8	137.0	5.1	7.3	12.3
40-44 years	149	297	446	45.5	90.7	136.2	2.9	5.7	8.6
45-49 years	50	144	194	17.4	49.5	66.9	0.7	1.9	2.6
15-49 years	*729*	*865*	*1594*	*32.7*	*38.8*	*71.5*	*3.1*	*3.7*	*6.8*
50-54 years	22	59	81	8.7	23.0	31.7	0.2	0.6	0.9
55-59 years	15	30	45	6.4	12.5	18.9	0.1	0.2	0.3
60-64 years	5	28	33	2.3	13.9	16.2	0.0	0.2	0.2
15-64 years	*771*	*982*	*1,753*	*26.4*	*33.5*	*59.9*	*1.2*	*1.6*	*2.8*
All ages	***796***	***1,041***	***1,836***	***18.7***	***24.4***	***43.1***	***0.2***	***0.3***	***0.5***

a: Estimated deaths, selected from the General Mortality Registry (RGM) of the National Statistical Institute (INE) codes CIE-10 F11-F12, F14-F16, F19, X42, X44, X62 and Y12, and by multiplying the figure obtained by the RGM underestimation index (1.172), calculated by cross-referencing its data with those in the specific registry of the National Plan on Drugs in an area of more than 18 million inhabitants.
b: Estimated deaths, selecting the codes CIE-10, B20-B24, R75, D84.9, D89.8 and D89.9 from the General Mortality Registry (RGM) of the INE.
c: The populations used to calculate these rates were the populations from July 1, 2004, obtained from the Projections based on the Population Census of 2001, scenario 1, INE.

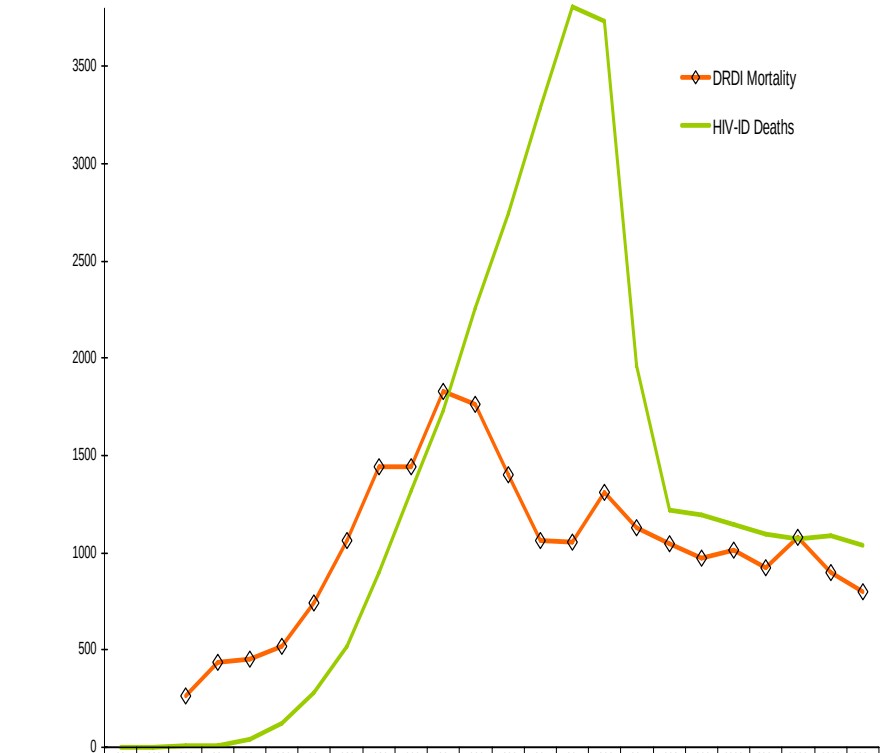
As was indicated, the rate of HIV-ID mortality overall surpassed DRDI, but among the youngest the latter was far greater than the former (26.4 per million compared to 11.2/million among the deceased between the ages of 15-34 years), with even greater differences between the males of that age (47.0 per million compared to 16.7/million).

A second estimate of DRDI mortality was used for the whole of Spain, using only information from the REM of the National Plan on Drugs. To do so, the DRDI mortality rates were calculated on the basis of the REM data in the area covered by this indicator in 2004 (18,559,661 inhabitants, 45.4% of the Spanish population) and it was applied to the Spanish population as a whole. In this case, the DRDI mortality rate was equal to 22.4 per million inhabitants (greater than the figure obtained when the information from the REM and the RGM is combined), thereby calculating 913 DRDI deaths for 2004. This second method, however, probably overestimates the real number of DRDI deaths in relation with the former, for two reasons: a) because, in the REM, the judicial records of the provincial capitals sometimes include the municipality of the capital city and some small towns in their outskirts, and there is not always accurate information for excluding the deaths of those surrounding towns, and b) because the area covered by the REM includes a greater percentage of urban populations (where it is presumed the DRDI mortality rates are higher) than in the Spanish population as a whole.

At the same time, when evaluating the results, one must bear in mind that the DRDI death figures calculated using either of the two methods may be underestimated, because they do not include those deaths related with the illegal drugs that are not recognized or recorded by the doctors on the official death certificates and which are not subject to the judicial or coroner's investigations. These deaths may hold quite a bit of importance in the case of certain drugs like cocaine, for which it is suspected that there is a certain proportion of deaths due to cardiovascular problems among people under the age of 50 years which could be attributed to cocaine if a thorough investigation were carried out, with accurate certification of the cause of death. This under-reporting of DRDI mortality may be on the rise, because it is known that in recent years cocaine-related problems have increased considerably.

In terms of the time-related changes in mortality related with the use of illegal drugs, one can observe that the maximum impact occurred in 1996, then decreasing considerably. The decrease mainly affected HIV-ID mortality, which fell abruptly from 1996 to 1998, years in which high-performance anti-retroviral therapy (TARGA) was widespread implemented (Figure 6.1.5). DRDI mortality reached its maximum in 1991 (when it is estimated that there were 1833 deaths) and has decreased slowly ever since (1310 deaths in 1996, 900 in 2003 and 796 in 2004). The decrease in the impact of illegal drug use on mortality may be due, above all and on the one hand, to the effectiveness of TARGA, which led to a heavy decrease in HIV-ID mortality, and on the other, to the replacement of injected heroin use for smoked heroin or oral methadone and the decrease in the number of heroin users, which contributed to decreasing both HIV-ID and DRDI mortality.

Figure 6.1.5 . Changes in deaths directly related with illegal drugs (*DRDI* or *overdose*) and deaths related with HIV among injecting drug users (HIV-ID) (Absolute numbers). Spain, 1982-2004



	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
DRDI Mortality			266	440	453	516	741	1067	1440	1440	1833	1760	1399	1067	1051	1310	1127	1049	972	1012	923	1079	900	796
HIV-ID Deaths	3	3	7	8	45	123	281	520	896	1321	1727	2260	2748	3288	3807	3737	1962	1221	1199	1149	1094	1074	1086	1041

DRDI Deaths: Deaths directly related with illegal drug use.
HIV-ID Deaths: Deaths due to HIV infection related with illegal drug injection

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Mortality Indicator.

Drug related infectious diseases

Drug Treatment Demand Indicator

The data of the Drug Treatment Demand Indicator of the Spanish National Focal Point show that the percentage of people infected among drug users who had used injections in the 12 months prior to being admitted for treatment (recent injection users) decreased moderately, from 37.1% in 1996 to 33.5% in 2000 and 32.7% in 2005. This decrease affected both men and women and was somewhat less notable among those above 34 (amongst whom the percentage fell from 48.9% to 41.9% in 2005) than among those under 25 (amongst whom it fell from 20.3% to 9.7%). Also as in more recent years, in 2005 those women who had recently used injections displayed a higher prevalence than men (39.5% and 31.2%, respectively). In any case, one must bear in mind when interpreting the data that in 2005 the HIV status was unknown for 31.8% of the 4,358 recent injection users admitted for treatment.

Survey of People Admitted for Treatment due to Heroine or Cocaine (Table 6.2.1)

In the survey of people admitted for treatment due to abuse of or dependence on heroin or cocaine (described more extensively in Section 4.4) taken in 2003-2004, 72.2% of all users had taken a test to detect anti-bodies to HIV before being admitted for treatment. Those admitted for treatment due to heroin had taken the test to detect anti-bodies to HIV much more frequently (83.4%) than those admitted for cocaine treatment (45.8%). Among the patients who had used injections ever-in-lifetime, most had taken an HIV test before being admitted for treatment (91.2%).

The self-reported HIV positive status among those admitted for treatment with information on their HIV status, was 20.5% among those admitted for heroin use and 7% among those admitted for cocaine use. Among those patients who had used injections ever-in-lifetime, the rate of HIV infection was 30.1% among those admitted for heroin treatment and 20.0% among those admitted for cocaine.

The autonomous regions where the greatest rate of HIV infection was found were: Madrid, the Valencian Community, Catalonia, Andalusia and Aragon.

HIV-positive patients report having first revealed their problem to their sexual partner and their mother, who were also the people who had provided the most help in relation with this problem.

1.3% of those surveyed were taking drugs for tuberculosis by the time the survey was being conducted.

Itinere Study

The rate of HIV infection in a group of young heroin users from the *Itinere* Project captured in 2001-2003 in Madrid, Barcelona and Seville (the rate was calculated using analyses performed on capillary blood gathered on blotting paper) was compared with the results of another group captured in 1995, and it was found that among those who had used injections at ever-in-lifetime, the rate had decreased in Barcelona (from 44.1% to 20.8%) and in Seville (from 44.2% to 22.2%). However, in Madrid no relevant decrease was found (from 36.8% to 34.9%), due above all to the behavior of long-lasting injection users. The delay in implementing harm reduction programs, especially in the Methadone Maintenance Programs in Madrid, could be a plausible hypothesis that explains these results (De la Fuente *et al*., 2006).

Records of New HIV Infections and Incidence Studies

To make up for the AIDS registry's shortcomings, several autonomous regions have set up systems for registering new HIV infection cases. The data obtained by these registries indicate that in Navarre and La Rioja the incidence of new infections among drug injection users, after the peak reached in the second half of the 1980's, fell rapidly up to 1996, when signs of stabilization or extremely slow decline began to appear. In 2003-2005, the Records of New HIV Infections covered 8 of 19 Autonomous Regions. On the basis of the data in this new registration system, it has been estimated that, for the entire country, the incidence of new HIV diagnoses in the time period of 2003-05 was 3,182 cases (1,124 in 2003, 1,106 in 2004 and 952 in 2005) (77.8 cases per million inhabitants throughout the entire time period). Of these cases, 16.3% were drug injection users. A gradual decrease is seen in the number and percentage of diagnosed cases which belong to the category of transmission by drug injection users, from 18.6% (n=209) in 2003 to 13.7% (n=130) in 2005. The number of new HIV diagnoses among drug injection users was nearly four times higher in men than in women, and the percentage of injection users out of the total diagnoses for each sex was also higher among men (17.4%) than among women (13.1%) (Table 6.2.1).

Table 6.2.1. DISTRIBUTION OF NEW HIV DIAGNOSES IN DRUG INJECTION USERS BY YEAR OF DIAGNOSIS AND SEX (ABSOLUTE NUMBER AND % OUT OF TOTAL PERSONS NEWLY DIAGNOSED WITH HIV). SPAIN (7 AUTONOMOUS REGIONS), 2003-2005.

	Males		Females		Total	
	n	%	n	%	n	%
2003	170	19.8	39	14.7	209	18.6
2004	134	16.5	45	15.3	179	16.3
2005	109	15.4	21	8.7	130	13.7
Total	413	17.4	105	13.1	518	16.3

Source: National Center for Epidemiology. Carlos III Health Institute.

With regard to the rate of HIV infection status change among persons who show signs of having recently tested negative for the virus, there are hardly any recent studies in Spain. A recently presented cohort study of heroin users under the age of 31 years, performed in Madrid, Barcelona and Seville between the years of 2001 and 2006, indicates that the incidence of HIV infection among injection users was very high (4.5 per 100 persons-year –py-, CI95%: 2.9-6.7, in a very recent report on young injecting heroin users in the *Itinere* Project), which once again suggests that the decrease in HIV linked to injection has mainly been due to the decrease in the number of injection users. Until now, it was believed that HIV infection among heroin users who did not inject was rare, but the latest data from *Itinere* demonstrate a high incidence among young heroin users in Seville (3.4/100 py; CI95%: 0.9-8.7). This confers importance to sexual transmission and the need to place greater attention on couples made up of injection users and HIV-positive persons (Vallejo F *et al*., 2006).

A simulation of the epidemic's behavior using mathematical models makes it possible to estimate that HIV transmission among drug injection users came about suddenly in

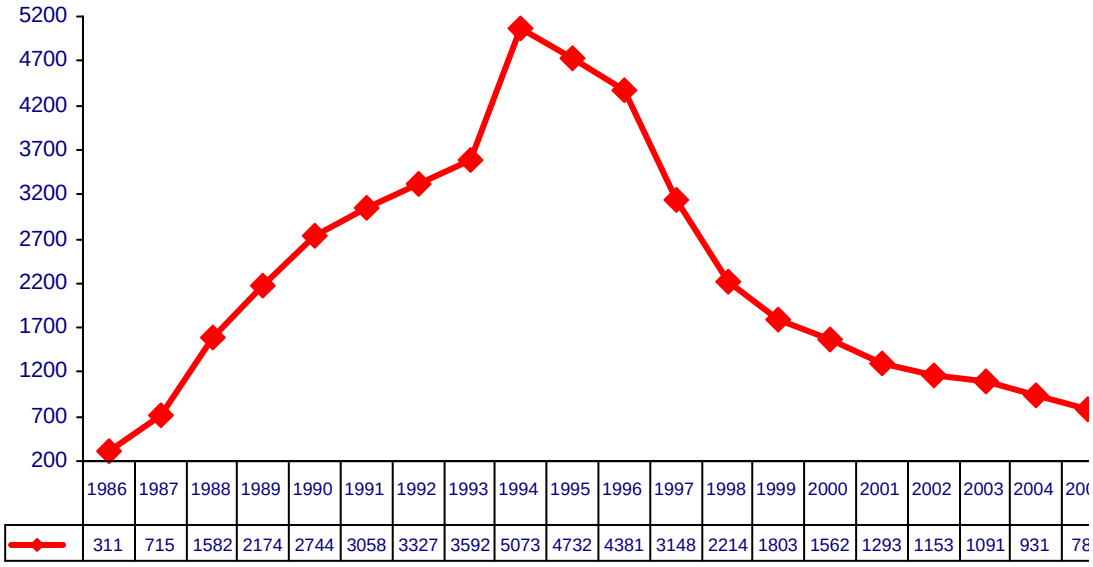
the 1980's (reaching its peak incidence rate between 1985 and 1987, with between 12,000 and 15,000 new infections each year among injection users throughout all of Spain) (Castilla & de la Fuente L., 2000). Since that time, the incidence has greatly decreased in a way that in the late nineties less than 1,000 new infections per year were estimated for Spain as a whole, and at present the extrapolation of data from the registries of new infections mentioned above allows us to estimate a figure of less than 500.

National AIDS Registry

In the last 20 years, AIDS and infection by HIV have been the main health problems associated with drug use in Spain. Since 1981, the year when the epidemic began, to June 30, 2007, a total of 74,885 AIDS cases had been reported, of which 62.3% belonged to the category of transmission by drug injection. In 2006, 1,605 cases were diagnosed (estimate corrected due to a delay in reporting), 43.0% of which were attributed to the use of injected drugs. This percentage has decreased in recent years after the peak reached in 1990 (69.7%), and the percentage belonging to the category of sexual transmission has increased proportionally (National Center of Epidemiology. Carlos III Health Institute, 2007). It is important to point out that since the year of 2003, the number of new AIDS cases among women related with risky sexual practices has been greater than the number of cases related with drug injection. The number of new AIDS cases per year related with drug injection has significantly decreased from 1994 to the present (Figure 6.2.1). This decrease may be the result of several factors which have favored the epidemic's evolution in recent years, factors which include the widespread availability of maintenance treatments with methadone and the notable decrease in injections as the manner of using heroin.

When interpreting the data from the National AIDS Registry, one must bear in mind that it is a cumulative registry, and the number of cases in the most recent years may be caused by a delay in reporting. Moreover, it is important to provide a reminder that it only records the new AIDS cases diagnosed each year and not the new cases of HIV infection. In other words, it does not provide information on the incidence of new HIV infections. This information can be obtained through the system for registration of new HIV infections existing in some autonomous regions.

FIGURE 6.2.1. CHANGES IN AIDS DIAGNOSES ASSOCIATED WITH INJECTED DRUG USE (NUMBER). SPAIN. 1986-2006*.



(*) Updated on June 30, 2007. Data corrected due to delay in reporting. Source: Ministry of Health and Consumer Affairs. National AIDS Registry.
Source: National AIDS Registry. Ministry of Health and Consumer Affairs.

Infections by HTLV

In the samples obtained from the subjects in the *Itinere* Study (described above), antibodies to HTLV were determined. None were positive for HTLV-1 and 27 were positive for HTLV-2. All of those positive for HTLV-2 were injection users in the cities of Madrid and Barcelona. Co-infection with HIV and having used injections in the 30 previous days were strongly associated with infection by HTLV-2 (De la Fuente *et al*., 2006).

Infection by the Hepatitis Virus

The significant consequences to health by HIV infection and the impact of this epidemic among drug injection users has for many years left in the background those problems associated with the very high rates of infection by the hepatitis B and C viruses among those people who inject drugs. The positive changes in the epidemic of HIV infection are making clear the large impact the epidemic of viral hepatitis is having and will undoubtedly have in the future on the morbimortality of these populations.

The rate of infection by the hepatitis B (HBV) virus is, in general, higher among drug injection users or among intense drug users through other channels than in the general population. According to *Itinere,* the rates of infection in 2001-03 among young injection users (18-30 years) in the cities of Madrid, Barcelona and Seville varied between 20% and 35%, and among non-injection users who used heroin between 4.4% and 8.9%. Moreover, despite the recommendation for vaccination among people who perform risky practices introduced in the year of 1982 and the specific vaccination programs against HBV among adolescents begun in 1991-1995, it was observed that

the protection of young heroin users against this virus in these cities was quite low (the prevalence of vaccination was equal to 21.7%, varying from 13.3% in Madrid and 33.2% in Barcelona, and between 23.8% and injection users and 17.9% among non-injection users) and that many opportunities for vaccination were missed at treatment services. In fact, practically all of the susceptible individuals (97.0%) had missed at least one opportunity for vaccination (Vallejo F *et al.*, 2007). Evaluated in this same study was the validity of the vaccine status with respect to hepatitis B reported by the subject himself or herself by comparison with the result of the blood test. A low level of agreement was found (51.9%) between the vaccine status reported by the subject and the vaccine status detected by the blood test (Kappa=0.08).

The rate of infection by the hepatitis C virus is very high among drug injection users throughout the world, and Spain is no exception. In Spain, between 65%-90% of injection users are infected, depending on the geographic area and origin of the sample studied. The data from *Itinere* show that the incidence of HCV among young injection users is extremely high (34.8/100 person-year; CI 95%: 26-46/100). Such a high incidence rate is consistent with the stabilization of the epidemic of HCV infection at the prevalence levels mentioned above, as can be seen in the study performed at a hospital in Barcelona among 2,219 injection users from 1987 to 2001. Moreover, as can be seen in that same report, whereas the prevalence of HCV infection has remained quite stable, the prevalence of HIV infection seems to be decreasing slowly.

Furthermore, another aspect to be taken into account is the high level of co-infection by HIV and HCV. In a recently published study on a sample of 3,247 injection users who went to the AIDS Information and Prevention Centers of the Valencian Community from 1990 to 1996, 45.1% were infected by HCV and HIV. Among the young injection users in Madrid, Seville and Valencia captured in the region from 2001-2003, 26.8% were HCV-negative, 49.8% were infected only by HCV and 23.4% were co-infected by HCV and HIV. Other local studies also confirm the high rates of co-infection. This information is important, because it is known that hepatitis C in patients with HIV has a worse prognosis, with an accelerated progression of liver disease. The worse prognosis of these patients and the foreseeable impact on health services is seen in a study performed at a Madrid hospital where a review of the clinical records of 2,008 persons admitted (84% were drug users) and infected by HIV from 1996 to 2004 showed that the admittances due to decompensated chronic liver disease had gone up from 9% in 1996 to 26% in 2002, then decreased to 20% in 2004.

In Spain, the prevalence of anti-bodies to HCV in the general population fluctuates from 1% to 2.6% (in Madrid and Catalonia it is from 2.5%-2.6%), clearly higher than the rate observed in Central European countries (0.9% in Belgium; 0.6% in Germany; 1% in France), but is similar to or lower than that found in northern Italy (3.2%-4.8%). Predictably contributing to this prevalence in a significant manner is the high rate of infection among drug injection users. In recent years, probably due to the decrease in injected use of drugs, as well as other factors, the incidence of cases of infection has decreased in the population, though it is foreseen that in upcoming years the number of patients with advanced liver disease will go up. In Spain, chronic hepatitis C is the primary cause of cirrhosis of the liver, ahead of excessive alcohol consumption.

Risk Behaviors

- Injection

In the survey of people admitted for treatment due to abuse of or dependence on heroin or cocaine in 2003-2004, 43.3% of those surveyed had used injections ever-in-lifetime, 23.4% in the last year and 17.7% in the last month before treatment. In

Section 4.4, this item is expounded upon extensively (Table 6.2.2). As the treatment demand indicator also shows, among heroin users, the prevalence of injection ever-in-lifetime has also decreased. In fact, if we compare with a similar survey taken in 1996, one can observe that the percentage of people admitted for treatment due to heroin or heroin + cocaine who had used an injection ever-in-lifetime went from 65.1% in 1996 to 57.8% in 2003-2004 and that the percentage of those who had used an injection in the month prior to being admitted for treatment fell from 44.3% to 23.7%. This decrease took place within a context in which both the number of needle exchange points has increased and the number of exchanged needles, as made manifest by Bravo MJ *et al.*[1] in a recent article.

In Table 6.2.2, one can see that the injection risk behaviors (injecting oneself with needles previously used by others, passing on used needles, getting drugs from a needle used by others, and passing drugs on to other persons with a used needle) were quite frequent among injections, both those admitted for heroin treatment and those admitted due to cocaine. At the same time, among the injection users admitted for treatment due to heroin or heroin + cocaine, these risk behaviors of injection have decreased in recent years. In fact, among those who had used injections in the year prior to treatment, the prevalence of previously used by others needle use fell from 34% in 1996 to 21.7% in 2003-2004 and that of taking drugs prepared in needles used by others from 30.6% to 16.3%.

Sexual Behaviors

Of those surveyed in 2003-2004, 41.3% reported having had more than one sex partner in the year prior to the treatment, though the systematic use of condoms in sporadic sexual relations and with the stable sex partner was very low. Somewhat more than half of those surveyed had never received any condoms for free in the year prior to the treatment (Table 6.2.2).

Table 6.2.2. RISK BEHAVIORS AND HIV INFECTION AMONG PARTICIPANTS, BY MAIN DRUG LEADING TO ADMITTANCE FOR TREATMENT (IN PERCENTAGES). SPAIN. SURVEY OF PERSONS ADMITTED FOR TREATMENT DUE TO HEROINE AND COCAINE. 2003-2004.				
	Total	**Heroin**	**Cocaine**	**Both**
Number of admittances	2,610	1,225	773	604
Injection-related behavior				
Injected ever-in-lifetime	43.3	59.4	9.0	54.5
Injection in the last year	23.4	33.0	4.8	27.8
Injection in the last month	17.7	25.2	3.8	20.5
Re-use of needles*	73.0	75.7	64.9	68.9
Obtaining any needles for free*	57.5	56.9	38.9	63.3
Use of needles already used by others†	21.4	21.3	16.9	22.7
Passing used needle on to others†	22.3	23.2	28.3	19.0
Got dissolved drug from a needle used by others †	16.6	18.3	20.4	11.6
Gave out dissolved drug from a needle used by him or herself †	18.9	20.4	24.8	14.1
Sexual behavior				
Vaginal or anal relations in the last year	72.7	70.8	77.8	70.5
Stable sex partner	58.1	53.1	68.6	54.6
Systematic use of condoms in vaginal/anal relations with stable sex partner	10.7	10.7	11.9	9.3
Systematic use of condoms in vaginal/anal relations with sporadic partners	30.2	29.1	28.4	35
More than one sex partner in the last year	41.3	39.8	46.0	38.7
HIV infection among all participants				
Has taken an AIDS test ever-in-lifetime	72.2	82.3	45.8	85.6
HIV-positive results among those who are aware of their HIV status	17.9	19.3	7.0	23.0
HIV infection among injection users ‡				
Has taken an AIDS test ever-in-lifetime	91.2	90.8	92.1	91.7
HIV-positive status among those who are aware of their HIV status	29.4	27.9	20.0	34.9

*Percentages calculated out of injection users in the last month.
† Percentages calculated out of injection users in the last year.
‡ Percentages calculated out of injection users ever-in-lifetime.

Psychiatric co-morbidity (dual diagnosis)

The information in this Section can be found in the 2006 Spanish National Report.

Other drug-related health correlates and consequences

Non-fatal Drug Emergencies

Method

Summarized in this section is the work protocol of the indicator "Hospital emergencies among users of psychoactive substances," the last version of which dates back to 2003. Included in said protocol are operating criteria for including and excluding episodes, criteria for selecting the areas and hospitals monitored, definitions and criteria for classifying the different variables, and details on the instruments and the circuit for collection and transmission of information.

This indicator is an attempt to monitor the characteristics of hospital emergencies related with the non-medical or non-therapeutic use of psychoactive drugs in Spain. It was implemented in 1987, forming part of a broader information sub-system developed within the framework of the National Plan on Drugs, with the cooperation of the autonomous regions, to monitor the changes and characteristics of problem psychoactive drug use, especially of those like opiates or cocaine, which tend to produce problems more frequently and are difficult to explore using other methods.

Unlike the Treatment Indicator, it was never implemented in all of the autonomous regions, and with certain exceptions the areas covered have varied from year to year, as has the number of hospitals monitored in each of them (degree of thoroughness in collection). Moreover, the monitored hospitals' areas of attraction may have varied. At the same time, in 1996 and 2003 there were also two significant modifications of its definition. With this background, from the realm of the State, time and space-based comparisons must be made with great precaution and must only be based on percentage distributions of the characteristics of the emergencies and not only absolute number of population rates.

The Emergencies Indicator, in its current version (Protocol 2003), records all of the hospital emergency episodes in which the non-medical or non-therapeutic use of psychoactive drugs is mentioned (except those in which only the use of alcohol, tobacco or xanthines is mentioned), regardless of whether more than one of them is found in the same person. At the time of testing, though, in order to facilitate comparison with prior years, those episodes in which only hypnosedatives, anti-psychotics or Anti-depressants are mentioned, or any combination of these drugs amongst each other or with alcohol or tobacco, have been excluded, as well.

As the criterion for inclusion of episodes is mentioning the use of psychoactive drugs and the non-relationship of that use with the patient's clinical conditions, the episodes whose clinical history does not contain evidence of a direct relationship with the use of drugs are included as well, such as infectious complications, injuries or trauma due to external causes (accidents, aggressions, self-inflicted injuries). Moreover, as an exception, the episodes involving people who use opiates within the framework of maintenance programs without using other psychoactive drugs are included, as well, provided that the diagnosis is unequivocally related with the use of said opiates, as is the case with overdoses or abstinence syndrome.

The criterion of only requiring that the use of psychoactive substances be mentioned makes it easier to decide which episodes are to be included. However, because it is difficult to know to what degree of thoroughness emergencies without evidence of a direct relationship with use are included in the different areas monitored, the analysis which is provided below has focused fundamentally on those emergencies directly

related with drug use (those in which the doctor includes some evidence of a relationship with drug use in the clinical history), selected with the aid of a dichotomous variable introduced for that purpose on the data collection sheet. In this way, it is also possible to compare the data from 2003 and later with those from prior years, when only those emergencies related with drug use were included.

Since 2003, the emergencies among people from the ages of 15 to 54 years are included, whereas up to that time only those involving people from 15-49 years of age were. Likewise, literally all of the emergency diagnoses mentioned in the clinical history are included, instead of the five large diagnosis groups that had been included up to 2003. However, the information on diagnoses has not been analyzed, as we wait for the development of a standard manual for coding the diagnoses in accordance with CIE-10.

Emergency episodes caused by pregnancy and pregnancy complications are not included, even if the use of psychoactive substances is mentioned. Nor are emergencies due to adverse reactions to medicines (except in the event that opiates prescribed in maintenance programs are mentioned exclusively and the diagnosis is unmistakably related with opiates).

On the record is included the information on the following variables: date of the emergency, sex, age, nationality, patient's legal status (arrested/not arrested), emergency tests (literal), psychoactive substances mentioned in the clinical history (up to 6), the manner of using the aforementioned psychoactive substances, evidence of a direct relationship between drug use and the emergency stated by the doctor in the clinical history, drugs which the doctor relates with the emergency in the clinical history (coded, as with the aforementioned substances, with the help of a coding system developed for that purpose), the most recent manner of using the drugs that the doctor relates with the emergency in the clinical history and the outcome of the emergency.

In accordance with the protocol, when the decision is made to monitor a certain geographic area, all of the relevant hospitals located within that area must be monitored, excluding maternity hospitals, pediatric hospitals and monographic hospitals, but this is not always complied with. Each autonomous region may decide whether it collects the information in an ongoing manner or whether it does so only during one week of each month, to be selected at random in the Central Unit. The protocol also recommends gathering the information actively by selecting those episodes which can be recorded after a thorough review of all the clinical histories from emergency rooms, but this procedure was not always followed, which constitutes yet another argument for avoiding time and space-related comparisons based on the absolute number of emergencies.

Results

In 2004, 8,688 emergency episodes were recorded involving people who had made non-therapeutic and non-medical use of psychoactive drugs (drugs whose sale is illegal, opiates other than heroin or inhalable volatiles). Excluded from this calculation are those episodes in which only alcohol, tobacco, hypnosedatives, anti-depressants, anti-psychotics or any combination of these substances were mentioned. The emergencies came from hospitals in 12 autonomous regions. In most of the monitored areas, the collection of data was limited to one week in each month selected at random, but in others, like the city of Barcelona, ongoing data collection was performed. Of the 8,688 emergencies for which data was gathered, 6,127 were directly related with non-therapeutic use of psychoactive drugs; in other words, evidence was found in the clinical history (expressions of the doctor) which made possible to relate it

with the non-therapeutic use of any of these drugs, and in 6,127 the doctor included in the clinical history evidence relating the clinical condition and the use of drugs.

In 2004, in emergencies directly related with drugs, the substances whose use was mentioned most frequently in the clinical history were cocaine (49.6% of episodes), alcohol (32.4%) –even though they were only included in the analysis when mentioned along with some illegal drug–, hypnosedatives (26.8%) –also only included in the analysis when mentioned along with some illegal drug–,cannabis (25.7%), heroin (23.0%) and other opiates or opiates which are not specified (16.7%) (Table 6.4.1).

Table 6.4.1. GENERAL CHARACTERISTICS OF HOSPITAL EMERGENCY EPISODES AMONG PSYCHOACTIVE SUBSTANCE USERS BY TYPE OF EMERGENCY AND SEX. SPAIN, 2004.

	TOTAL EMERGENCIES AMONG DRUG USERS			EMERGENCIES DIRECTLY RELATED WITH DRUGS		
	MEN	WOMEN	TOTAL	MEN	WOMEN	TOTAL
NUMBER OF EPISODES	6,332	2,324	8,688	4,320	1,787	6,127
AVERAGE AGE (years)	32.2	31.1	31.9	31.4	30.5	31.2
WOMEN (%)	-	-	26.8	-	-	29.3
PSYCHOACTIVE SUBSTANCES MENTIONED (%)[1]						
Heroin	24.7	18.7	23.0	25.0	17.8	22.8
Other Opiates	17.7	14.0	16.7	13.0	9.1	11.8
Cocaine	53.0	41.2	49.6	59.7	43.3	54.8
Amphetamines	2.6	2.0	2.5	3.2	2.0	2.8
MDMA and Derivatives	3.5	2.9	3.3	4.3	3.0	3.9
Hypnosedatives	22.8	38.2	26.8	29.0	45.8	33.8
Cannabis	27.9	20.0	25.7	25.8	17.9	23.4
Hallucinogens	1.1	0.8	1.0	1.1	0.9	1.1
Volatile substances	0.5	0.4	0.4	0.6	0.6	0.6
Alcohol	34.1	28.4	32.4	37.3	30.8	35.3
Other substances	5.2	18.8	9.2	6.7	24.7	11.9
EVIDENCE OF RELATIONSHIP BETWEEN DRUG USE AND THE EMERGENCY (%)	68.2	76.9	70.5	-	-	-
RELATED PSYCHOACTIVE SUBSTANCES (%)[2]						
Heroin	-	-	-	18.1	13.2	16.6
Other Opiates	-	-	-	9.1	7.8	8.7
Cocaine	-	-	-	51.9	37.3	47.5
Amphetamines	-	-	-	2.6	1.5	2.3
MDMA and Derivatives	-	-	-	3.2	2.6	3.0
Hypnosedatives	-	-	-	24.1	44.5	30.0
Cannabis	-	-	-	20.4	13.7	18.4
Hallucinogens	-	-	-	0.8	0.7	0.8
Volatile Substances	-	-	-	0.6	0.6	0.6
Alcohol	-	-	-	33.5	29.0	32.1
Other Substances				4.8	17.9	8.6
ARRESTED (%)	4.6	1.3	3.7	5	1.4	4.0
OUTCOME OF EMERGENCY (%)						
Medical Discharge	82.3	81.6	82.1	81.6	81.3	81.4
Voluntary Discharge	5.0	3.9	4.7	6.0	3.7	5.4
Hospital Admittance	8.6	8.6	8.6	7.7	8.1	7.9
Death in Emergency Room	0.0	0.0	0.0	0.0	0.0	0.0
Moved to another center	4.1	5.9	4.6	4.6	6.9	5.4

1. Includes the substances used habitually or sporadically and the substances related with the emergency.
2. Includes the substances for which the doctor stated that there was a direct relationship with the emergency in the clinical history.
Source: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory (OED). Emergencies Indicator

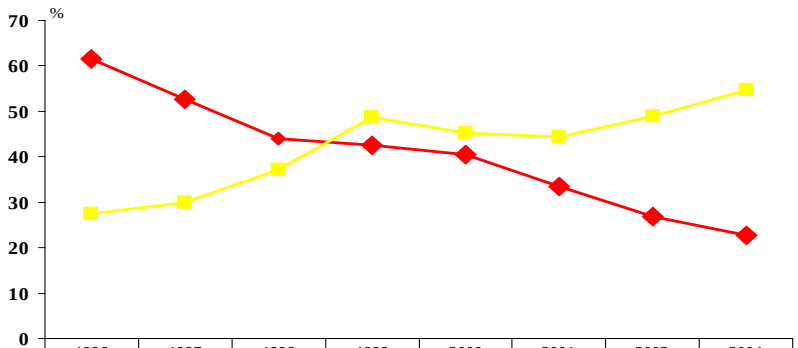
In general, the emergencies involving men mention all types of drugs to a greater degree than those involving women, with the exception of hypnosedatives and the residual group “other drugs” (which includes mainly other psychotropic drugs) (Table 6.4.1), which suggests greater polidrug use among men, and even more so in terms of drugs which are illegal and alcohol. With respect to prior years, one can see a significant decrease in the percentage of mentions of heroin (61.4% in 1996, 40.5% in 2000, 26.8% in 2002 and 22.8% in 2004) and an increase in the proportion of mentions of cocaine, though as of 1999 one can observe a slowdown in the increase in mentions of this drug (27.3% in 1996, 48.1% in 1999, 45.3% in 2000, 49.0% in 2002 and 54.8% in 2004). In any case, as of 1999 heroin gave way to cocaine as the most frequently mentioned drugs in emergencies (Table 6.4.2; Figure 6.4.1).

Table 6.4.2- GENERAL CHARACTERISTICS OF EMERGENCY EPISODES DIRECTLY RELATED WITH PSYCHOACTIVE SUBSTANCE USE (ABSOLUTE NUMBER, AVERAGE AND PERCENTAGES). SPAIN, 1996-2004

	1996	1997	1998	1999	2000	2001	2002	2004
NUMBER OF EPISODES	2,585	1,932	2,099	2,141	2,328	2,145	2,673	6,127
AVERAGE AGE (years)	27.8	28.1	29.1	29.4	30.3	29.8	29.8	31.2
SEX (%)								
Females	21.4%	20.8%	23.1%	23.5%	27.4%	27.1%	27.4%	29.3%
PSYCHOACTIVE SUBSTANCES MENTIONED*								
Heroin	61.4%	52.6%	43.8%	41.9%	40.5%	33.5%	26.8%	22.8%
Other Opiates	17.3%	26.2%	23.3%	23.4%	20.9%	21.9%	17.7%	11.8%
Cocaine	27.3%	29.9%	37.2%	48.1%	45.3%	44.4%	49.0%	54.8%
Amphetamines	3.1%	3.3%	3.4%	2.7%	2.6%	4.6%	3.8%	2.8%
MDMA and Derivatives	1.6%	2.7%	2.9%	3.1%	4.8%	5.2%	6.3%	3.9%
Hypnosedatives	25.7%	21.6%	26.1%	25.1%	30.6%	32.0%	34.1%	33.8%
Cannabis	7.4%	7.3%	11.3%	12.2%	14.8%	19.1%	22.8%	23.4%
Hallucinogens	2.7%	2.2%	2.9%	2.1%	2.9%	2.4%	1.4%	1.1%
Volatile Substances	0.3%	0.1%	0.5%	0.1%	0.3%	0.9%	0.3%	0.6%
Alcohol	13.3%	15.8%	22.9%	22.0%	29.5%	33.8%	39.0%	35.3%
Other Substances	5.1%	3.6%	6.0%	2.0%	0.8%	2.8%	4.5%	11.9%
RELATED PSYCHOACTIVE SUBSTANCES (%)								
Heroin	56.1%	50.9%	38.7%	33.0%	35.3%	29.2%	21.4%	16.6%
Other Opiates	13.5%	17.4%	16.8%	18.9%	18.0%	17.4%	13.1%	8.7%
Cocaine	19.9%	25.0%	31.6%	39.4%	40.9%	40.5%	44.7%	47.5%
Amphetamines	2.2%	2.9%	3.0%	9.8%	2.2%	4.2%	3.4%	2.3%
MDMA and Derivatives	1.3%	2.2%	2.2%	2.4%	4.5%	4.4%	5.3%	3.0%
Hypnotics and Sedatives	23.6%	18.9%	24.3%	23.8%	28.9%	29.2%	30.1%	30.0%
Cannabis	6.2%	6.6%	8.9%	9.3%	12.8%	16.9%	19.9%	18.4%
Hallucinogens	2.1%	1.8%	2.4%	1.7%	2.7%	1.9%	1.3%	0.8%
Volatile Substances	0.2%	0.1%	0.3%	0.1%	0.3%	0.9%	0.2%	0.6%
Alcohol	12.4%	15.2%	22.2%	20.0%	26.8%	29.0%	35.4%	32.1%
Other Substances	4.1%	3.2%	4.9%	1.3%	0.8%	1.6%	1.8%	8.6%
LEGAL STATUS (%)								
Arrested	14.4%	22.4%	11.7%	9.4%	6.4%	5.7%	5.2%	4.0%
OUTCOME OF EMERGENCY (%)								
Medical Discharge	80.5%	82.0%	81.2%	80.9%	78.7%	79.1%	82.1%	81.4%
Voluntary Discharge	7.0%	6.7%	8.8%	8.6%	8.5%	7.5%	7.4%	5.4%
Hospital Admittance	7.6%	7.2%	6.0%	6.5%	8.3%	7.8%	6.3%	7.9%
Death in Emergency Room	0.1%	0.1%	0.0%	0.2%	0.7%	0.2%	0.1%	0.0%
Moved to another center	4.8%	4.1%	3.9%	3.9%	3.7%	5.4%	4.0%	5.4%

1. Includes the substances used habitually or sporadically and those substances related with the emergency.
2. Includes t he substances for which the doctor stated that there was a direct relationship with the emergency in the clinical history
Source: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory (OED). Emergencies Indicator.

Figure 6.4.1. Change in the percentage of emergencies due to acute reaction after using psychoactive substances in which heroin or cocaine are mentioned (%). Spain, 1996-2004.



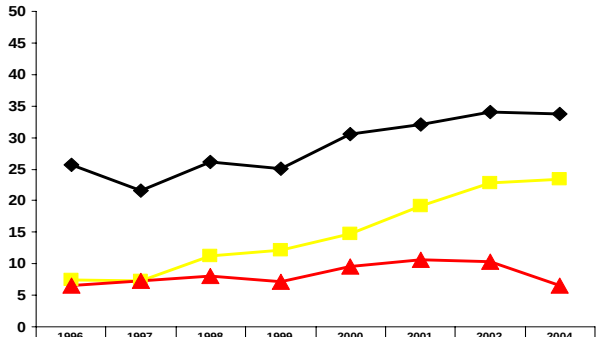
	1996	1997	1998	1999	2000	2001	2002	2004
Heroin	61,5	52,6	43,9	42,5	40,5	33,5	26,8	22,8
Cocaine	27,4	30	37,2	48,7	45,3	44,4	49	54,8

FUENTE: DGPNSD. Observatorio Español sobre Drogas (OED). Indicador Urgencias..

In 2004, even the number of emergencies in which alcohol is mentioned –despite the fact that they are only recorded when there is simultaneous illegal drug use– and which also mention hypnosedatives or cannabis surpass the number of emergencies in which heroin is mentioned. In recent years, there have also been other changes in mentioning drugs in emergency rooms. For instance, from 1996 to 2002 mentioning hypnosedatives became more common, rising from 25.7% in 1996 to 34.1% in 2002, cannabis (from 7.4% in 1996 to 22.8% in 2002) and ecstasy (from 1.6% in 1996 to 6.3% in 2002), which could be explained, in addition to other factors, by a greater tendency towards multiple drug use.

However, from 2002 to 2004 the increase in mentioning hypnosedatives slowed down (33.8% in 2004), as it did for cannabis (23.4% in 2004), and mentions of ecstasy fell (3.9% in 2004) (Table 6.4.2; Figure 6.4.2).

Figure 6.4.2. Change in number of times various substances are mentioned in hospital emergencies due to acute reation to psychoactive drugs (%). Spain, 1996-2004.



	1996	1997	1998	1999	2000	2001	2002	2004
Hypnosedatives	25,7	21,6	26,1	25,1	30,6	32	34,1	33,8
Cannabis	7,4	7,3	11,3	12,2	14,8	19,1	22,8	23,4
Ecstasy, amphetamines or hallucinogens	6,5	7,3	8,1	7,2	9,5	10,7	10,3	6,6

Source: DGPNSD. Spanish Drug Observatory (OED). Emergencies Indicator

When interpreting the above data, one must bear in mind that these are mentions of use of these drugs taken from clinical records and not emergencies that were caused by (or are related with) the use thereof. However, when considering exclusively the

drug which the doctor related with the emergency, the outlook is similar, the substances mentioned the most frequently being: cocaine (47.5% of emergencies), alcohol (32.8%), hypnosedatives (30.0%), cannabis (18.4%) and heroin (16.6%).

Since the same emergency may be related with the use of several substances, the sum may be greater than 100% (Table 6.4.1). Considering the changes throughout the period from 1996-2004, the same trends as in the case of the drugs mentioned in the clinical history can be found (Table 6.4.2).

In 2004, most of the patients in emergencies directly related with drugs continued to be males (70.7%), but the percentage of women increased during the period from 1996-2004 (21.4% in 1996, 27.4% in 2002 and 29.3% in 2004). As in prior years, in 2004 the largest percentage of women were found in emergencies which mention the use of hypnosedatives (38.2%) (Table 6.4.3).

Table 6.4.3. GENERAL CHARACTERISTICS OF DRUG EMERGENCIES BY TYPE OF EMERGENCY AND SUBSTANCES MENTIONED OR RELATED WITH THE EMERGENCY (ABSOLUTE NUMBER, AVERAGE AND PERCENTAGES). SPAIN,2004

	TOTAL EMERGENCIES INVOLVING DRUG USERS										
					SUBSTANCES MENTIONED						
	Heroin	Other Opiates	Cocaine	Amphetamines	MDMA and deriv.	Hypnotics and sedatives	Cannabis	Hallucinogens	Volatile Substances	Alcohol	Other
NUMBER OF EPISODES RELATED WITH EACH DRUG	1,980	1,429	4,304	197	282	1,846	2,197	85	38	2,810	728
AVERAGE AGE (years)	32.9	35.7	31.3	27.5	25.6	32.9	28.4	26.4	26.7	31.9	33.0
WOMEN (%)	21.7	22.7	22.2	22.1	24.1	37.1	21	22.4	23.7	23.5	58.5
DETAINEES (%)	6.3	5.6	3.0	1.5	2.5	4.0	2.5	1.2	0.0	2.3	1.9
OUTCOME OF EMERGENCY(%)											
Medical discharge	79.9	81.5	82.8	81.6	81.0	77.3	84.0	84.8	83.3	82.5	72.7
Voluntary discharge	5.3	5.1	4.8	5.1	4.1	5.3	3.9	3.0	8.3	4.6	3.6
Admitted to hospital	11.0	10.2	8.3	10.8	10.8	9.7	8.9	6.1	0.0	8.3	11.4
Death in ER	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Transferred to another center	3.8	3.1	4.1	2.5	4.1	7.7	3.2	6.1	8.3	4.5	12.3
	EMERGENCIES DIRECTLY RELATED WITH DRUG USE										
					SUBSTANCES MENTIONED[1]						
	Heroin	Other Opiates	Cocaine	Amphetamines	MDMA and deriv.	Hypnotics and sedatives	Cannabis	Hallucinogens	Volatile Substances	Alcohol	Other
NUMBER OF EPISODES RELATED WITH EACH DRUG	1,380	705	3,354	159	230	1,640	1,418	63	36	2,157	668
AVERAGE AGE (years)	33.8	34.2	30.9	27.6	25.5	32.7	28.0	25.6	26.1	31.5	33.2
WOMEN (%)	22.7	22.6	23.1	21	23	38.2	22.5	25.4	25	25.6	60
DETAINEES (%)	7.6	6.8	3.1	1.9	2.2	4.2	2.9	1.6	0.0	2.6	1.8
OUTCOME OF EMERGENCY(%)											
Medical discharge	79.8	81.7	82.4	83.5	82.6	77.4	83.5	82.2	81.8	81.1	72.3
Voluntary discharge	6.3	6.0	5.4	5.0	4.9	5.2	4.1	4.4	9.1	5.7	3.4
Admitted to hospital	9.9	9.7	7.7	8.3	9.0	9.4	8.9	6.7	0.0	7.8	11.5
Death in ER	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Transferred to another center	3.9	2.6	4.5	3.3	3.5	8.1	3.5	6.7	9.1	5.3	12.8
	EMERGENCIES DIRECTLY RELATED WITH DRUG USE										
					SUBSTANCES MENTIONED [2]						
	Heroin	Other Opiates	Cocaine	Amphetamines	MDMA and deriv.	Hypnotics and sedatives	Cannabis	Hallucinogens	Volatile Substances	Alcohol	Other
NUMBER OF EPISODES RELATED WITH EACH DRUG	1,021	527	2,912	131	181	1,552	1,121	44	36	1,973	491
AVERAGE AGE (years)	33.2	34.1	30.6	27.4	25.5	32.5	27.6	25.7	26.2	31.6	33.2
WOMEN (%)	23.2	25.8	22.9	18.5	26	42.3	21.9	27.3	29.7	26.4	60.8
DETAINEES (%)	7.9	8.2	2.9	1.5	1.1	3.4	3.4	2.3	0.0	2.6	1.8
OUTCOME OF EMERGENCY(%)											
Medical discharge	77.6	86.3	83.3	82.2	83.3	78.0	85.0	83.3	90.0	81.8	68.4
Voluntary discharge	7.4	4.7	5.3	5.0	5.9	5.5	4.0	6.7	10.0	5.6	4.0
Admitted to hospital	11.3	5.7	7.3	8.9	8.8	8.7	8.0	3.3	0.0	7.4	12.4
Death in ER	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Transferred to another center	3.7	3.2	4.1	4.0	2.0	7.8	3.1	6.7	0.0	5.2	15.2

2. Includes the substances for which the doctor stated that there was a direct relationship with the emergency in the clinical history.
Source: Government Delegation for the National Plan on Drugs. Spanish Drug Observatory (OED). Emergencies Indicator

In 2004, the average age of the people assisted in emergency rooms due to problems directly related with drugs was 31.2 years (somewhat higher in men than in women), finding a trend towards an increase over the period of 1996-2004 (27.8 years in 1996, 30.3 years in 2000, 29.8 years in 2002 and 31.2 in 2004) (Tables 6.4.1 and 6.4.2). The lowest average age was found in emergency rooms when ecstasy is mentioned (25.5 years), hallucinogens (25.6 years) or volatile inhalants (26.1 years) and the highest were found in emergencies in which heroin (33.8 years) or other opiates (34.2 years) are mentioned (Table 6.4.3).

In 2004, 1.9% of the emergencies directly related with drugs involved foreigners, with the greatest percentage being found in the case of volatile inhalants (20.0%) and ecstasy (3.4%) (Tables 6.4.1 and 6.4.3). 4% of the emergencies directly related with drugs involved arrested persons/detainees (Table 6.4.1), a figure which has decreased noticeably in recent years (14.4% in 1996, 5.2% in 2002 and 4.0% in 2004) (Table 6.4.2). The highest percentage of detainees was found in emergencies in which heroin (7.6%) or other opiates (6.8%) are mentioned (Table 6.4.3).

In 2004, most of the emergency episodes directly related with drugs ended in a medical discharge (81.4%). 7.9% required hospitalization and none caused the death of the patient in the emergency services (Table 6.4.1). No significant changes were found in this percentage over the years, nor were relevant differences found on the basis of the drugs mentioned or sex (Tables 6.4.1, 6.4.2 and 6.4.3).

As for the most frequent behavior of taking the drugs mentioned in emergencies directly related with drugs, one must bear in mind that there is a significant proportion of unknown values, and therefore the results must be considered with caution. In emergencies in which heroin is mentioned, the predominant manner of use was parenteral (68.1%), followed by pulmonary (24.4%), and intra-nasal or sniffed (5.3%), and in emergencies in which cocaine is mentioned, intra-nasal or sniffed (57.8%), injected (21.4%) and pulmonary or smoked (19.5%) (Table 6.4.4).

Table 6.4.4. MANNER OF USING THE DRUGS MENTIONED OR RELATED WITH EMERGENCIES AMONG PSYCHOACTIVE SUBSTANCE USERS. SPAIN, 2004.						
	TOTAL EMERGENCIES AMONG		EMERGENCIES DIRECTLY RELATED			
	DRUG USERS		WITH DRUG USE			
	DRUGS MENTIONED		DRUGS MENTIONED		RELATED DRUGS	
	Nº	%	Nº	%	Nº	%
HEROIN						
Oral	17	1.3%	13	1.4%	20	3.0%
Pulmonary or smoked	325	24.4%	222	24.4%	179	27.2%
Intranasal or sniffed	60	4.5%	48	5.3%	35	5.3%
Injected	917	68.9%	620	68.1%	420	63.7%
Another system	11	0.8%	8	0.9%	5	0.8%
OTHER OPIATES						
Oral	1,344	99.6%	663	99.1%	493	98.0%
Pulmonary or smoked	2	0.1%	2	0.3%	3	0.6%
Intranasal or sniffed	0	0.0%	0	0.0%	2	0.4%
Injected	3	0.2%	3	0.4%	3	0.6%
Another system	1	0.1%	1	0.1%	2	0.4%
COCAINE						
Oral	25	1.3%	19	1.2%	34	2.4%
Pulmonary or smoked	424	21.8%	307	19.5%	269	18.8%
Intranasal or sniffed	1,054	54.2%	910	57.8%	840	58.8%
Injected	440	22.6%	337	21.4%	284	19.9%
Another system	3	0.2%	2	0.1%	1	0.1%
AMPHETAMINES						
Oral	136	91.3%	145	92.9%	99	92.5%
Pulmonary or smoked	1	0.7%	0	0.0%	0	0.0%
Intranasal or sniffed	11	7.4%	10	6.4%	8	7.5%
Injected	1	0.7%	1	0.6%	0	0.0%
Another system	0	0.0%	0	0.0%	0	0.0%
MDMA						
Oral	239	100.0%	198	100.0%	162	100.0%
Pulmonary or smoked	0	0.0%	0	0.0%	0	0.0%
Intranasal or sniffed	0	0.0%	0	0.0%	0	0.0%
Injected	0	0.0%	0	0.0%	0	0.0%
Another system	0	0.0%	0	0.0%	0	0.0%
Hypnosedatives						
Oral	2,103	98.4%	1,880	98.5%	1768	99.7%
Pulmonary or smoked	1	0.0%	1	0.1%	1	0.1%
Intranasal or sniffed	1	0.0%	1	0.1%	1	0.1%
Injected	32	1.5%	26	1.4%	4	0.2%
Another system	0	0.0%	0	0.0%	0	0.0%
CANNABIS						
Oral	44	2.4%	35	3.2%	47	5.2%
Pulmonary or smoked	1,750	97.2%	1,065	96.4%	846	94.1%
Intranasal or sniffed	3	0.2%	3	0.3%	5	0.6%
Injected	4	0.2%	2	0.2%	1	0.1%
Another system	0	0.0%	0	0.0%	0	0.0%
HALLUCINOGENS						
Oral	48	87.3%	34	85.0%	28	90.3%
Pulmonary or smoked	3	5.5%	1	2.5%	0	0.0%
Intranasal or sniffed	4	7.3%	5	12.5%	3	9.7%
Injected	0	0.0%	0	0.0%	0	0.0%
Another system	0	0.0%	0	0.0%	0	0.0%

There has been an improvement in the classification of the form of drug use for emergency episodes in which “inhaled use” was mentioned. Until 2003, they were attributed to pulmonary or smoked use, and with the year 2003 protocol it was seen

that most of these episodes were actually cases of intra-nasal use or sniffing. This improvement in the classification in the case of cocaine creates a significant change, because the most frequent manner of taking drugs in emergencies is no longer pulmonary and has become, by far, intra-nasal, as occurs in the treatment indicator. In the case of heroin, it has been confirmed that the importance of use by injection in emergencies is far greater among the persons admitted for treatment due to abuse of or dependence on this drug, which makes it clear that there is a greater risk of certain acute problems, such as overdoses, among injection users.

The data on manner of use referring to other drugs are concordant with what is known from other sources. In the case of ecstasy, hypnosedatives and opiates other than heroin, their use is almost exclusively oral. In the case of amphetamines and hallucinogens, mostly oral use predominates, with a small percentage of intra-nasal users. And in the case of cannabis, pulmonary use predominates, with a small percentage of oral users (Table 6.4.4).

The comparison of data referring to manner of use with those from prior years must, in principle, be avoided due to the improvement in the classification of the variable, as well as other changes, such as the fact that in 2004 all of the episodes included in the city of Barcelona were included, which have quite a bit of weight in the overall data.

Recently a large study was published on emergencies among cocaine users assisted at the Hospital Clínic in Barcelona from 2002-2004 (Sanjurjo). 745 emergencies were studied in which the patient had used cocaine in the preceding hours and/or had a positive test for this drug (excluding abstinence syndromes and requests for de-toxification). 68% were men, and their average age was 31 years. Most of the episodes took place on the weekend or holidays (53%), and during the night or early morning (53% from midnight to noon). In terms of the reason for cocaine use, in 91.2% of these episodes it was classified as recreational use, and in the rest as attempted suicide (associated with other drugs), except some “body packers.” The way of using the cocaine was mostly sniffing (82%), followed by smoking (9%) and injection (8%). 64% of the persons assisted had used other drugs/medicines (38% alcohol, 13% cannabis, 11% heroin, 9% amphetamines, 8% benzodiazepines, 5% ecstasy). In 70% of episodes, there was evidence in the clinical history of a direct relationship with cocaine use. The most frequent diagnoses were psycho-pathological (54.6%), cardiovascular (25%) and neurological (12%) problems. And the symptoms mentioned most frequently were anxiety/agitation (48%) and chest pain or palpitations (25%). 11% of patients required hospitalization (19 cases in Intensive Care Units, or ICUs), and there were 3 deaths during admittance. The treatments applied most often were benzodiazepines (38%) and neuroleptics (9%).

Driving and Other Accidents

Since 1998, the National Toxicology Institute has performed a yearly study from a toxicology/coroner’s perspective on the drivers and pedestrians who have died in traffic accidents. In 2004, the deaths of 1,349 drivers and 264 pedestrians were investigated. The characteristics of these deaths are shown in Tables 6.4.5-6.4.10.

Nearly 43% of accidents took place on the weekend or on holidays. In most cases, the death, whether of drivers or pedestrians run over, took place at the accident site (more than 85%). The rest received hospital treatment and died a few hours later.

Most of the drivers who died were men (90.6%), as was the case with pedestrians run over (73.8%).

Among the drivers who died in traffic accidents, the majority were between the ages of 21 and 30 years (Figure 6.4.3), whereas those over the age of 61 years predominated among pedestrians who were run over (Figure 6.4.4), with no difference based on sex in either case.

Among the drivers who died in traffic accidents, a positive result was found for any of the investigated toxins (ethyl alcohol, drugs and psychiatric drugs/medicines) in a total of 568 cases (42%), and among the pedestrians who died from being run over in a total of 100 cases (37.7%) (Tables 6.4.6 and 6.4.9). In both cases, ethyl alcohol was the most commonly detected toxin (Tables 6.4.7 and 6.4.10). The positive results of alcohol tests on male drivers amounted to 37.8% of all the males who died and 19% of all the females. In terms of positive alcohol tests among the drivers who died by age group, the highest percentage was found among the group between the ages of 31-40 years (Figure 6.4.5.). As for the pedestrians who died, the greatest percentage of positive alcohol tests was found in the age group of 41-50 years (Figure 6.4.6)

The association of alcohol with certain drugs and/or psychiatric drugs/medications was detected in 7.6% of the cases of deceased drivers. The drug most frequently associated with alcohol use was cocaine, which was detected in 68 cases (5% of the total), followed by cannabis (1.8%) and amphetamine derivatives (0.7%) (Table 6.4.7).

Among the cases of negative alcohol tests or those under 0.3 g/l, there were 81 deceased drivers (6.0%) in which the results of the toxicology tests were positive for some drug and/or psychiatric drug/medication. Appearing among the drugs once again at the top of the list was cocaine with 41 cases, which amounted to 3% of the total number of deceased drivers, followed by cannabis (1.4%).

Among the psychiatric drugs detected in deceased drivers, both those associated with alcohol consumption or used alone, the presence of benzodiazepines in 39 cases (2.8%) was most notable.

Among the pedestrians who died due to being run over and who had negative alcohol tests, the presence of other drugs or psychiatric medications was very low, reaching only 4.1% of all the cases analyzed (264).

Focusing on other sources, a report by the Clinical Commission of the National Plan on Drugs points out that alcohol promotes risky practices which lead to many traffic accidents. Therefore, the likelihood of dying in an accident is five times greater among those drivers and pedestrians who have a blood alcohol level of over 0.5 g/l, such that alcohol use is implicated in 30-50% of all deadly accidents, 20-40% of those accidents with non-mortal victims and 10-30% of the accidents with material damage.

According to a study by the Royal Automobile Club of Catalonia (RACC), motor vehicle accidents are the main cause of death among youths between the ages of 15 and 20, and nearly half of the deadly traffic accidents are caused by alcohol. Every day in Spain, four people between the ages of 15 and 29 years die in traffic accidents. This amounted to 1,387 deaths and 8,000 serious injuries in 2005.

One out of every four deaths in traffic accidents recorded in Spain is of a person under 25 years old, though this population group represents only 17% of all drivers. 32% of the drivers who died in traffic accidents had a blood alcohol level of more than 1 gr./liter, above the authorized legal limit (FAD, 2005).

In a school survey taken in the Valencian Community in 2006 among students between 14-18 years old, 20.0% of those surveyed said they had driven a vehicle on a typical

weekend day. Of these, 45.2% had driven during the night (6:00 p.m. to 10:00 a.m. the next day) after having used drugs or alcohol.

Driving under the influence of alcohol or drugs was most frequent among the oldest students and gradually increased as the night went on. The drug used by drivers changed depending on the time of day. From 6:00 to 8:00 p.m., the most commonly used drug was cannabis. As of 10:00 p.m., the main drug was alcohol. As the night continued, the use of cocaine, ecstasy and other stimulants became more frequent (Figure 6.4.7)

When evaluating the prevalence of traffic accidents among the youths in the sample, it is found that 1.4% of youths have had a traffic accident in which some related substance was involved, while they were driving.

In the sub-sample of drivers, this percentage amounts to 4.4% of youths. The breakdown by gender shows a ratio of 1 to 3, one female for every three males. At the same time, the substances stated by youths who have been in traffic accidents as being related with the accident are in most cases cannabis (29%) and alcohol (52.3%).

Table 6.4.5. GENERAL CHARACTERISTICS OF THE DRIVERS OF VEHICLES WHO DIED IN TRAFFIC ACCIDENTS FOR WHICH TOXICOLOGICAL TESTING WAS PERFORMED (NUMBER AND PERCENT). SPAIN, 1998-2004

	1998	1999	2000	2001	2002	2003	2004
Number of deceased analyzed	1090	1191	1363	1447	1441	1621	1349
Sex (%)							
Men	91.5	91.7	91.3	90.5	89.6	90.1	90.6
Females	8.5	8.3	8.6	9.4	10.3	9.8	9.3
Origin of the body (%)							
Public road/street	-	86	86.2	87.2	90.9	88.2	85.5
Hospital	-	14	13.8	11.1	9.1	11.7	9.1
SOURCE: National Toxicology Institute.							

Table 6.4.6. BREAKDOWN OF A SAMPLE OF DRIVERS OF VEHICLES WHO DIED IN TRAFFIC ACCIDENTS, BY MAJOR OF PSYCHOACTIVE SUBSTANCES (ALCOHOL, OTHER DRUGS, AND/OR PSYCHIATRIC MEDICATIONS) DETECTED IN THE TOXICOLOGICAL TESTS (NUMBER AND PERCENT). SPAIN, 1999-2004

SUBSTANCES USED	1999		2000		2001		2002		2003		2004	
	Nº	%	Nº	%	Nº	%	Nº	%	Nº	%	Nº	%
Ethyl alcohol (alone	378	31.7	492	36	529	36.5	443	30.7	502	30.9	384	28,5
Alcohol and other abused drugs	52	4.3	48	3.5	58	4	77	5.3	83	5.1	80	5,8
Alcohol and psychiatric drugs/medications	11	0.9	16	1.1	20	1.4	15	1.04	15	0.9	16	1,2
Alcohol, other drugs and psychiatric drugs	5	0.4	6	0.4	7	0.4	5	0.3	6	0.3	7	0,5
Drugs other than alcohol	33	2.7	47	3.45	42	2.9	41	2.8	43	2.6	53	3,9
Drugs (not alcohol) and psychiatric drugs	18	1.5	12	0.8	9	0.6	7	0.4	16	0.9	6	0,4
Psychiatric drugs/medications	20	1.6	29	2.1	28	1.9	25	1.7	27	1.6	22	1,6
Sub-total of positive tests	517	43.4	650	47.7	693	47.8	613	42.5	692	42.7	568	42
Analyses with negative test results(*)	674	56.6	713	52.3	754	52.1	828	57.5	929	57.3	781	58
TOTAL BODIES ANALYZED	1,191		1,363		1,447		1,441		1,621		1,49	

* Those in which neither alcohol nor other drugs or psychiatric drugs/medicines were identified.

Table 6.4.7. BREAKDOWN OF A SAMPLE OF DRIVERS OF VEHICLES WHO DIED IN TRAFFIC ACCIDENTS, BY TYPE OF PSYCHOACTIVE SUBSTANCE DETECTED IN THE TOXICOLOGICAL TESTING (NUMBER AND PERCENT). SPAIN, 1999-2004

	1999		2000		2001		2002		2003		2004	
	Nº	%	Nº	%	Nº	%	Nº	%	Nº	%	Nº	%
Ethyl alcohol	446	37.40	562	41.20	614	42.40	540	37.40	606	37.40	487	36.10
Opiates*	29	2.40	31	2.30	17	1.10	19	1.30	16	1.00	8	0.59
Cocaine	62	5.20	65	4.80	60	4.10	76	5.30	110	6.80	68	5.04
Amphetamines	6	0.50	6	0.40	7	0.50	7	0.50	11	0.70	6	0.44
MDMA and derivatives	5	0.40	12	0.90	16	1.10	6	0.40	6	0.40	4	0.30
Cannabis	28	2.50	39	2.90	43	3.00	56	3.90	46	2.80	29	2.15
Barbiturates	1	0.10			2							
Benzodiazepines	41	3.40	50	3.60	44	3.00	40	2.80	50	3.10	17	1.26
Anti-psychotic drugs	0	0.00			1		1		3	0.20		
Anti-depressants	6	0.50	8	0.60	17	1.10	5	0.30	10	0.60	4	0.04
Total Tests	1,191		1,363		1,447		1,441		1,621		1,349	

Included within this group was methadone.

Source: National Toxicology Institute

Table 6.4.8. GENERAL CHARACTERISTICS OF THE PEDESTRIANS WHO DIED IN TRAFFIC ACCIDENTS FOR WHICH TOXICOLOGICAL TESTING WAS PERFORMED (NUMBER AND PERCENT). SPAIN, 1998-2004							
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Number of Tests	155	229	250	288	262	295	264
Sex (%)							
Males	74.80%	91.70%	80.40%	80.20%	75.90%	75.90%	73.80%
Females	25.20%	8.30%	19.60%	19.70%	24.10%	24.10%	26.10%
Origin of the body (%)							
Public road/street		71.20%	74.80%	80.50%	61.80%	79.60%	54.50%
Hospital		28.80%	25.20%	19.40%	38.10%	20.30%	39.00%
Note: The percentages were calculated out of the number of cases with information. The origin of the body refers to the physical site where the death took place.							

Table 6.4.9. BREAKDOWN OF A SAMPLE OF PEDESTRIANS WHO WERE RUN OVER IN TRAFFIC ACCIDENTS, BY MAJOR OF PSYCHOACTIVE SUBSTANCES (ALCOHOL, OTHER DRUGS AND/OR PSYCHIATRIC DRUGS) DETECTED IN THE TOXICOLOGICAL TESTING (NUMBER AND PERCENT). SPAIN, 1999-2004.						
Substances used	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
	Nº (%)	Nº (%)	Nº (%)	Nº (%)	Nº (%)	Nº (%)
Ethyl alcohol (alone)	79(34.5%)	94(37.6%)	101(35.1%)	97(37%)	93 (31.5%)	89 (33.7%)
Alcohol and other drugs	2(0.8%)	4(1.6%)	10(3.5%)	6(2.2%)	11 (3.7%)	5 (1.8%)
Other drugs (alone)	8(3.5%)	6(2.4%)	9(3.1%)	4(1.5%)	5 (1.6%)	6 (2.2%)
Some substances (Sub-totals)	89(39.0%)	104(41.6%)	120(41.7%)	107(40.8%)	109 (37%)	100 (37.7%)
None	140	146(58.4%)	168(58.3%)	155(59.2%)	186 (63%)	164 (62.1%)
Total	229	250	288	262	295	264

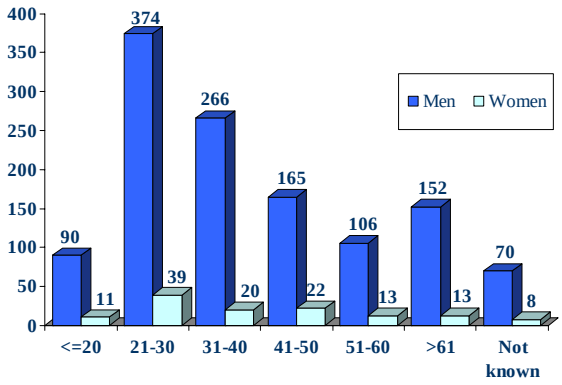
SOURCE: National Toxicology Institute

Table 6.4.10. BREAKDOWN OF A SAMPLE OF PEDESTRIANS WHO WERE RUN OVER IN TRAFFIC ACCIDENTS, BY TYPE OF PSYCHOACTIVE SUBSTANCE DETECTED IN THE TOXICOLOGICAL TESTING. SPAIN, 1999-2004.

	1999		2000		2001		2002		2003		2004	
	Nº	%	Nº	%	Nº	%	Nº	%	Nº	%	Nº	%
Ethyl Alcohol	81	35.4	98	39.2	101	35.1	103	39.3	104	35.3	94	35.5
Opiates*	6	2.6	3	1.2	10	3.5	3	1.1	3	1	1	0.37
Cocaine	7	3.1	6	2.4	10	3.5	6	2.3	11	3.7	5	1.9
Cannabis	2	0.9	2	0.8	5	1.7	4	1.5	5	1.7	6	2.3
MDMA											1	0.37
Total Testing	229		250		288		262		295		264	

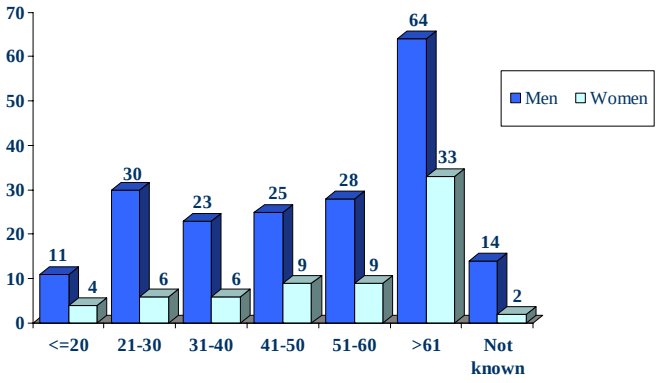
***Also included within this group is methadone.
SOURCE: National Toxicology Institute

Figure 6.4.3 .Breakdown of drivers of vehicles who died in traffic accidents with toxicological testing, by age group and sex. Spain, 2004.



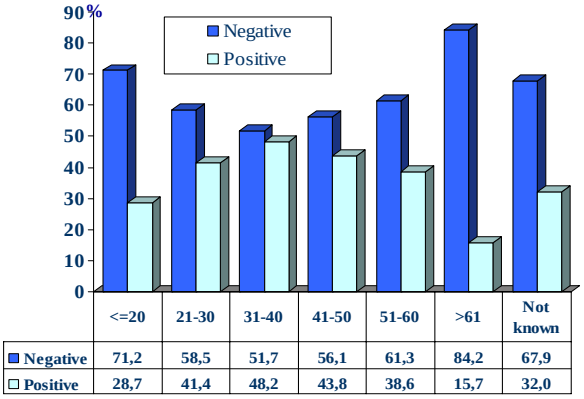
SOURCE: Ministry of Justice. National Toxicology Institute.

Figure 6.4.4. Breakdown of pedestrians who died in traffic accidents in which toxicological testing was performed, by age group and sex. Spain, 2004.



SOURCE: Ministry of Justice. National Toxicology Institute.

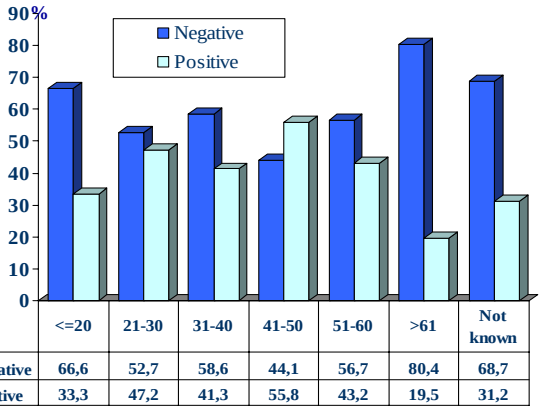
Figure 6.4.5. Percentage of positive and negative alcohol tests among drivers of vehicles who died in traffic accidents with toxicological testing, by age group. Spain, 2004.



	<=20	21-30	31-40	41-50	51-60	>61	Not known
Negative	71,2	58,5	51,7	56,1	61,3	84,2	67,9
Positive	28,7	41,4	48,2	43,8	38,6	15,7	32,0

SOURCE: Ministry of Justice. National Toxicology Institute.

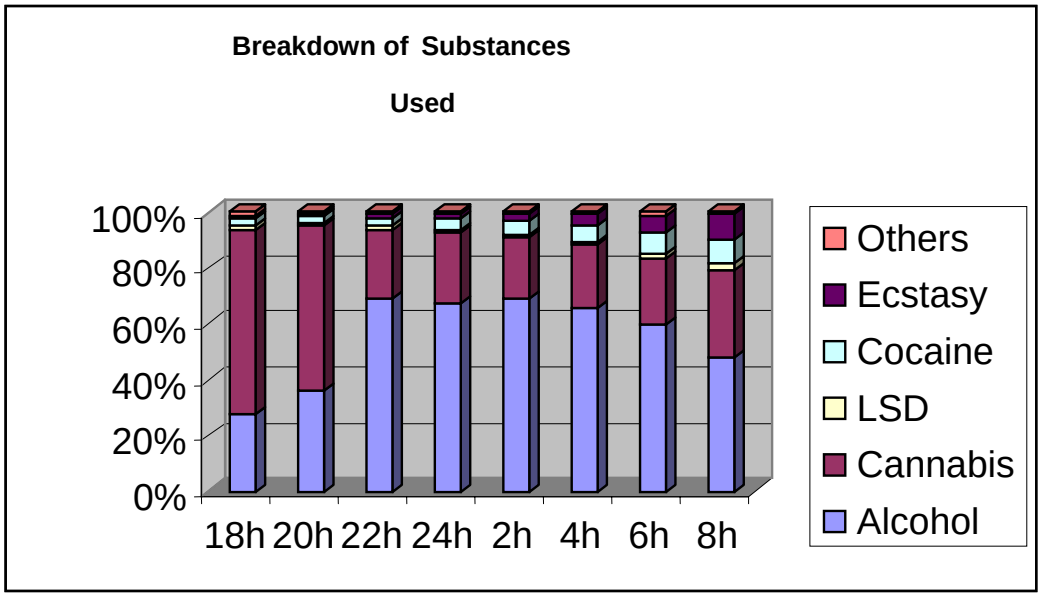
Figure 6.4.6. Percent of positive and negative alcohol tests among pedestrians who died in traffic accidents with toxicological testing, by age group. Spain, 2004.



	<=20	21-30	31-40	41-50	51-60	>61	Not known
Negative	66,6	52,7	58,6	44,1	56,7	80,4	68,7
Positive	33,3	47,2	41,3	55,8	43,2	19,5	31,2

SOURCE: Ministry of Justice. National Toxicology Institute.

Figure 6.4.7. BREAKDOWN OF SUBSTANCES USED BY DRIVERS DURING THE DIFFERENT TIME STRIPE ANALYZED.



7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

Prevention of drug related deaths

No new available data.

Prevention and treatment of drug-related infectious diseases

The harm reduction programs are aimed at active drug addicts, or, in other words at those who continue to use and are therefore not in abstinence. They attempt to minimize the health damages.

Included in these programs are:

The "Social Emergency Centers"

The "Mobile Units"

The "Pharmacies"

The "Safe Injection or Venipuncture Rooms".

The number of these sites and the patients assisted throughout the year of 2006 can be seen in the table (PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS and 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS):

TABLE 7.1. AREA OF INTERVENTION FOR HEALTH CARE
B.1.- HARM REDUCTION PROGRAMS
RESOURCES

1. SPECIFIC RESOURCES	2.-NUMBER OF SITES	3.- USERS ASSISTED
1.4.- Social emergency centers	20	3,157
1.5.- Mobile units	21	5,455
1.6.- Pharmacies offices	465	381
1.7.- Safe injection or venipuncture rooms	0	0
1.8.- Others	2	490

The "syringe exchange programs ('pijs')": In Spain in 2006, these programs were provided at 352 needle exchange points, having assisted 4,592 users and exchange a total of 218,026 needles and/or health kits.

(PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS AND 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS)

Interventions related to psychiatric co-morbidity

In Spain, TREATMENT is provided for psychiatric co-morbidity at both the health care centers for drug addicts and at mental health centers. Furthermore, in 2006 40 "Dual Pathology Care Programs" were carried out, providing help to 4,301 drug-dependent patients with psychiatric co-morbidity.

(PROVISIONAL DATA FROM 9 AUTONOMOUS REGIONS AND 2 AUTONOMOUS CITIES. STILL WAITING TO RECEIVE INFORMATION FROM ANOTHER 8 AUTONOMOUS REGIONS).

Interventions related to other health correlates and consequences

No new available data.

8. SOCIAL CORRELATES AND CONSEQUENCES

Social Exclusion (among drug users and drug use among socially excluded groups)

In the 2003-2004 survey, among the people admitted for treatment due to abuse of or dependence on heroin or cocaine (developed more extensively in Section 4.4), 4.8% of those surveyed had lived in the street or in shelters for the last 12 months, and a further 4.8% had lived in prison. Nearly half of the people admitted for heroin treatment (49.7%) were unemployed, compared to one-quarter of those admitted for cocaine treatment (25.3%).

Of those admitted for treatment due to heroin, 22.3% had obtained money by selling stolen objects, 17.1% from transporting drugs and 4.4% from prostitution. Getting money by selling stolen objects and prostitution was less frequent among cocaine users (12.6% and 2.3%, respectively). However, in this last group, getting money by selling drugs was frequent (18.3%)

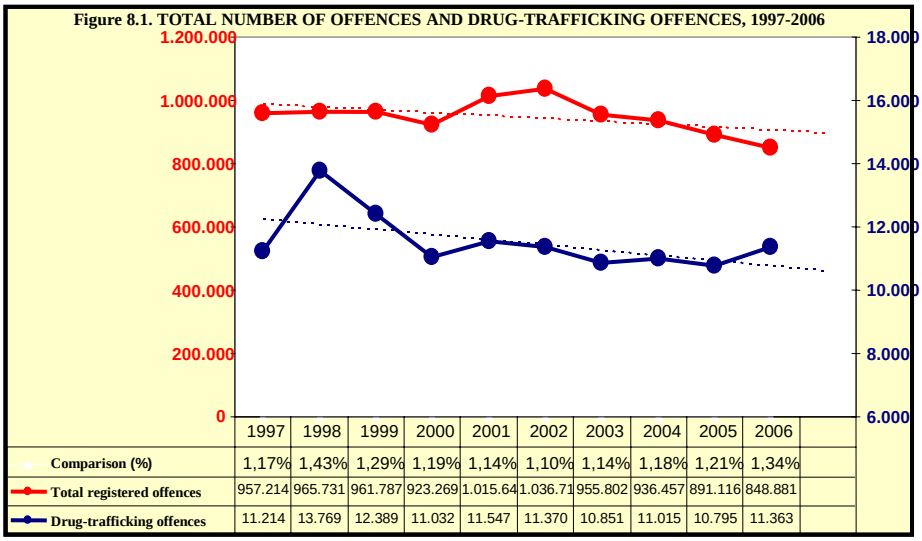
One-fourth of those admitted for treatment due to cocaine reported use of this drug by their siblings and partner in the last 12 months. Among those admitted for treatment due to heroin, 11.9% reported heroin use by their siblings, and 23.9% reported heroin use by their partner. 64.9% of those admitted for treatment due to cocaine and 90.7% of cocaine users had gone out with people who used the same drug which led to the treatment.

Drug related Crime

Evolution of the total number of registered crimes. Evolution of the number of registered drug trafficking crimes

In quantitative terms, drug trafficking offences traditionally represent a small percentage of all crimes. During the studied period, the figures have fluctuated between 1.43% (in 1998) and 1.10% (in 2002); a trend to stabilization has been observed in the last five years, limiting these kinds of offences to an ever narrower interval, between 1.10% and 1.34% of all registered crime.

Figure 8.1. TOTAL NUMBER OF OFFENCES AND DRUG-TRAFFICKING OFFENCES, 1997-2006

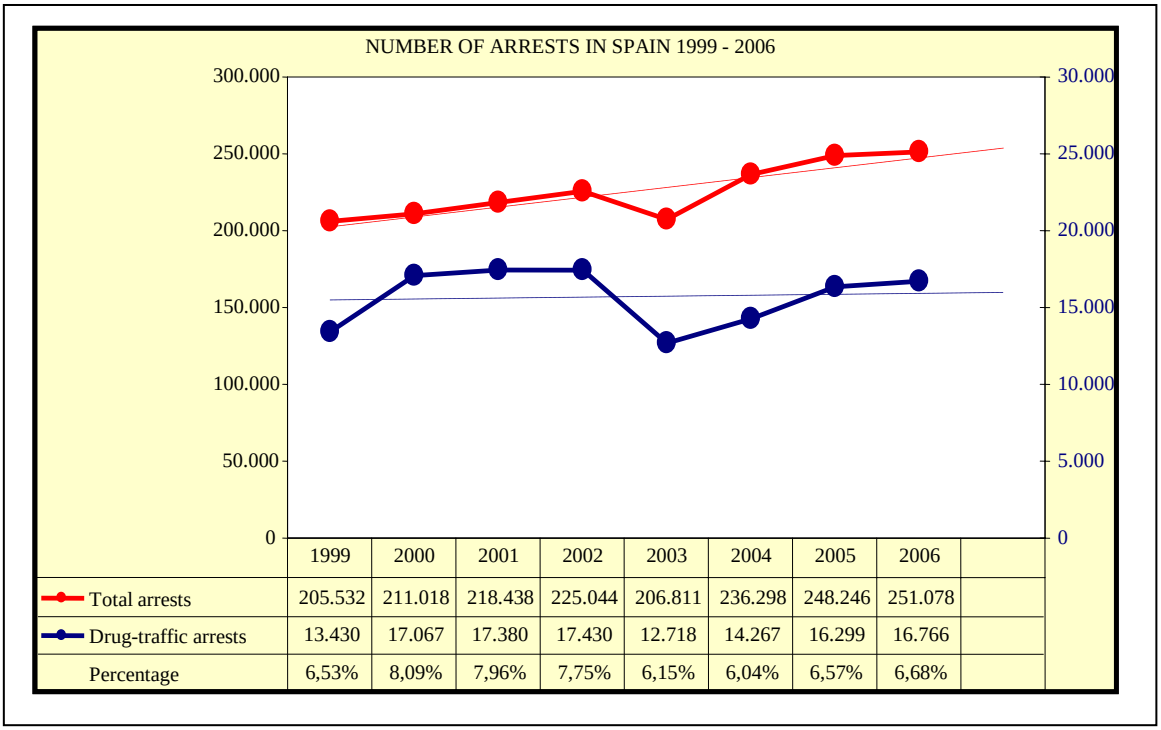


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Comparison (%)	1,17%	1,43%	1,29%	1,19%	1,14%	1,10%	1,14%	1,18%	1,21%	1,34%
Total registered offences	957.214	965.731	961.787	923.269	1.015.64	1.036.71	955.802	936.457	891.116	848.881
Drug-trafficking offences	11.214	13.769	12.389	11.032	11.547	11.370	10.851	11.015	10.795	11.363

General evolution of drug-trafficking arrests

The volume of drug-trafficking arrests over the last eight years has ranged from the maximum in 2000 (8.09%) to the minimum in 2004 (6.04%), considering the total number of arrests for every kind of offence.

In the same period, the relative importance of the number of drug-related arrests as a percentage of all arrests is higher than the relative importance of known drug-related offences as a percentage of the total (between 1.43% and 1.10%).



	1999	2000	2001	2002	2003	2004	2005	2006
Total arrests	205.532	211.018	218.438	225.044	206.811	236.298	248.246	251.078
Drug-traffic arrests	13.430	17.067	17.380	17.430	12.718	14.267	16.299	16.766
Percentage	6,53%	8,09%	7,96%	7,75%	6,15%	6,04%	6,57%	6,68%

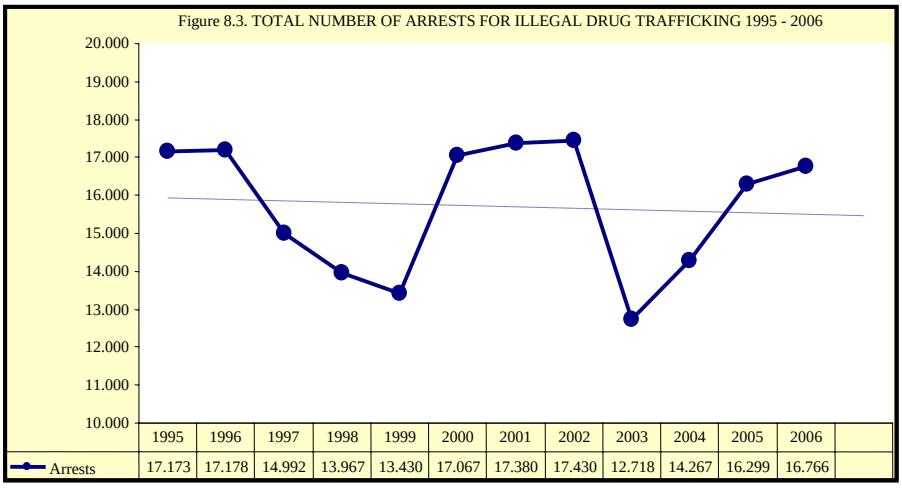
This effect is accompanied by a higher ratio of arrests/offences for variables related to drug trafficking than for variables related to overall offences.

OFFENCES	1999	2000	2001	2002	2003	2004	2005	2006
TOTAL OFFENCES Ratio of arrests – total offences	0.21	0.23	0.22	0.22	0.22	0.25	0.27	0.24
DRUG-TRAFFICKING OFFENCES Ratio of arrests- offences	1.08	1.55	1.51	1.53	1.17	1.30	1.47	1.48

According to the data, in the last eight years between 0.21 and 0.27 arrests have been made for every offence, while between 1.08 and 1.55 arrests have been made for every known drug-trafficking offence in the same period.

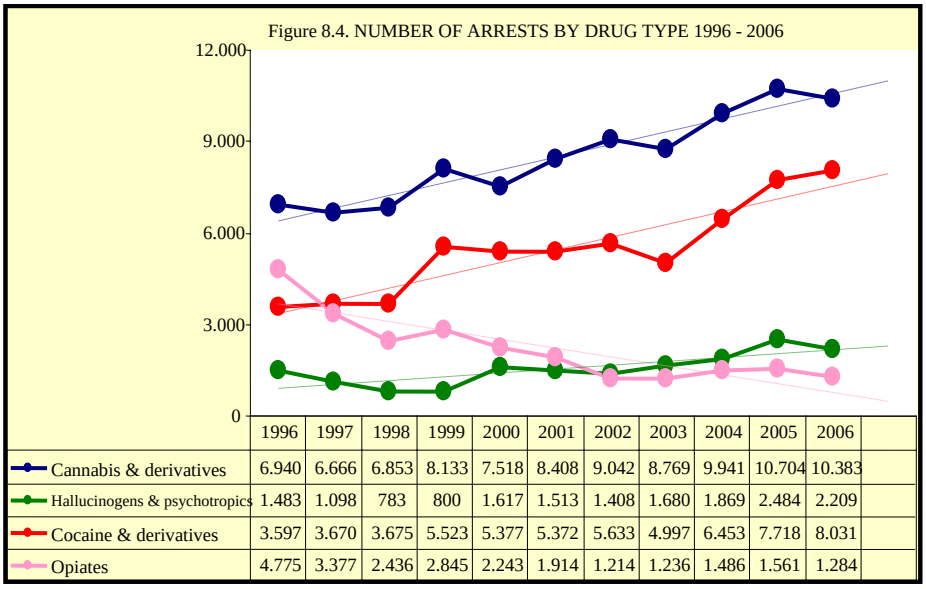
Since 1995, the number of arrests for drug trafficking haS oscillated between the 12,718 arrests made in 2003 and the 17,430 arrests made in 2002 and shows a slight overall downward trend, despite the increases registered from 2000 to 2002 and especially in 2005 (an estimated 14.24% higher than in 2004) and 2006 (up 2.87% from the preceding year).[1]

[1] The drop observed in 2003 is largely attributed to the methodology of data gathering and processing introduced when the new System for Analysis, Evaluation and Application of Data on Drugs (SENDA) was launched.



Evolution of arrests by drug type

The accompanying table and graph show a significant upward trend in the number of arrests for trafficking in every drug type except opiates. However, up until 2002, the number of arrests for traffic in hallucinogens and psychotropic substances did not exceed the number of arrests for traffic in opiates, and the numbers in recent years are still very close.[2]

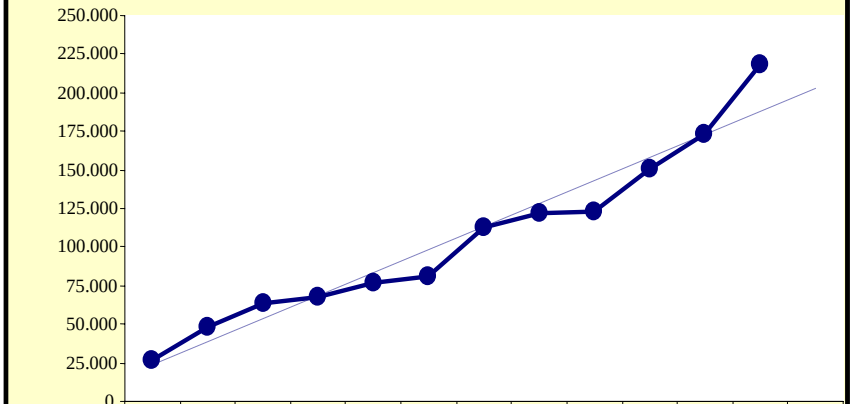


[2] It should be noted that the arrest of an individual resulting in the seizure of more than one kind of substance is recorded as ONE arrest FOR EACH OF THE SEIZED SUBSTANCES. In the same way, some arrests may involve substances not included in the aforementioned categories. This means that the sum of arrests for each drug type may differ from the total number of arrests, although this is not a calculation error. In any case, it would be illogical to add up the arrests for each drug type since the resulting sum will NOT reflect the total number of arrests made and therefore yields no information of interest.

General evolution of charges for the infringement of Organic Law 1/1992 (possession or use of drugs in public venues)

Since 1995, the number of charges filed for violations of OL 1/1992 has risen steadily, showing an almost linear progression along a steep upward incline. In 2006, the number of charges filed reached a record high (up 45.58% over 2004 and 26.32% over 2005). It is important to recall that the Operative Plans on small-scale trafficking and use in recreational places and the vicinity of educational centres were set in motion in 2006, which has resulted in a significant increase in the number of charges filed.

Figure 8.5. CHARGES RELATED TO ORGANIC LAW 1/1992
(POSSESSION & USE OF DRUGS IN PUBLIC VENUES) 1995 - 2006

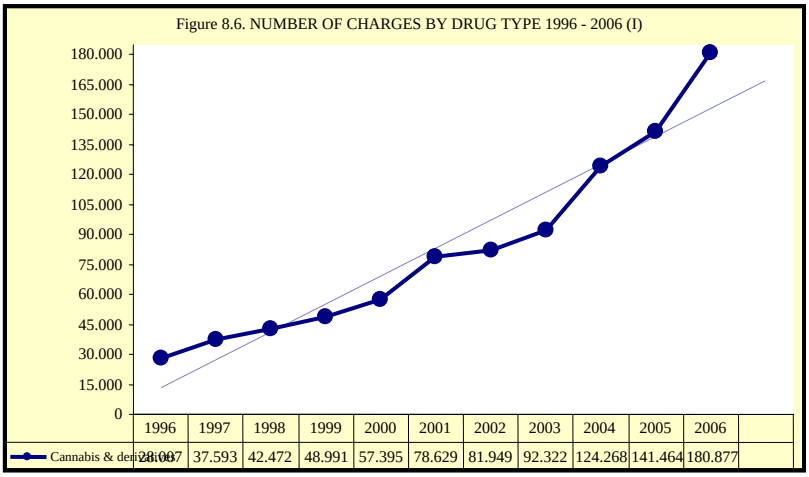


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Charges	27.145	48.529	63.855	67.677	76.564	81.302	112.270	122.285	122.634	150.193	173.096	218.656

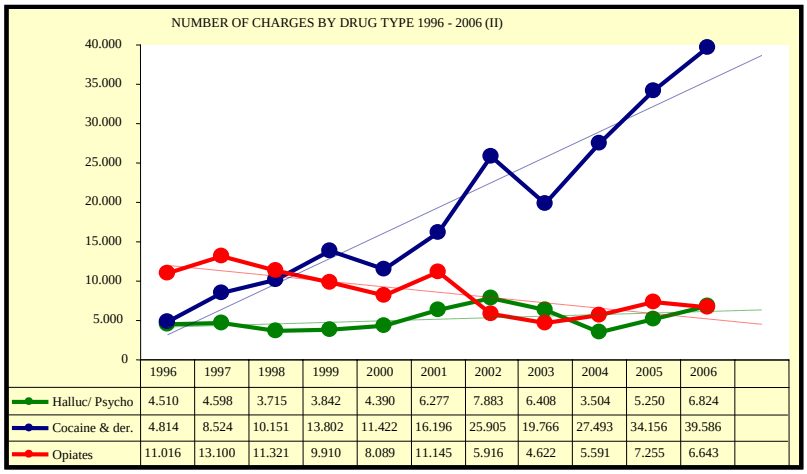
Evolution of charges by drug type

The following table and graph show a marked upward trend in the number of charges related to cannabis and cocaine and their derivatives, similar to their respective curves regarding seizures. This is due to the fact that most drug seizures are carried out in application of Organic Law 1/1992 on Citizen Safety.

Figure 8.6. NUMBER OF CHARGES BY DRUG TYPE 1996 - 2006 (I)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Cannabis & derivatives	28.087	37.593	42.472	48.991	57.395	78.629	81.949	92.322	124.268	141.464	180.877



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Halluc/ Psycho	4.510	4.598	3.715	3.842	4.390	6.277	7.883	6.408	3.504	5.250	6.824
Cocaine & der.	4.814	8.524	10.151	13.802	11.422	16.196	25.905	19.766	27.493	34.156	39.586
Opiates	11.016	13.100	11.321	9.910	8.089	11.145	5.916	4.622	5.591	7.255	6.643

In terms of the relative importance of charges involving each drug type in 2006, cannabis and its derivatives represented 77.34% of the total, followed by cocaine and its derivatives with 16.95%, hallucinogens/ psychotropic substances with 4.76% and opiates with 2.77%.

NB: With regard to the comparative analysis of data on different drug types, it is important to note that the total number of charges is not equal to the sum of charges for each drug type mentioned.[3]

Drug Use in Prison

Statistics: 2006

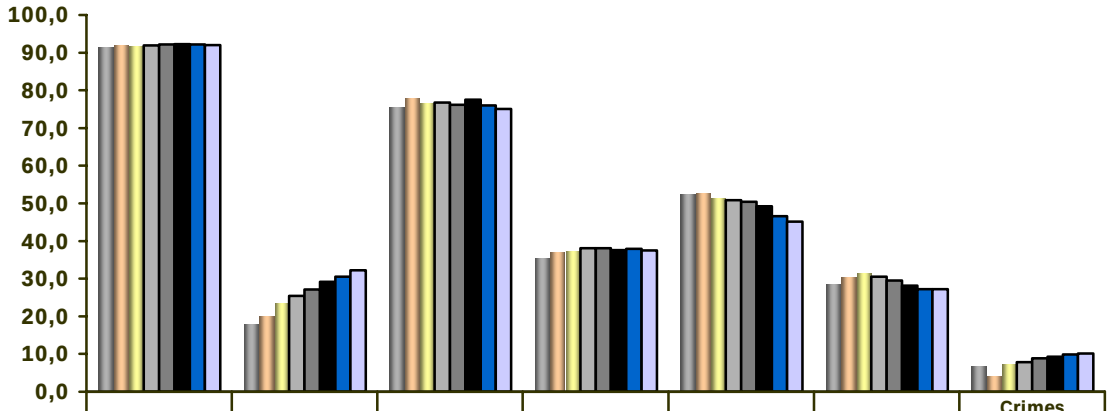
Statistics on the Prison Population. Source: General Department of Penitentiary Institutions. (Data on the prison population in Catalonia are included)

The number of inmates at penitentiary centers has continued to rise. This increase affects both the number of those sentenced and that of preventive detainees. Of the total increase under gone in 2006 with respect to 2005, 68.3% was due to an increase in foreign inmates and 31.7% to Spanish inmates. As of December 31, 2006, there were 64,021 people incarcerated, compared to the 61,054 incarcerated in 2005, meaning an increase of 4.8%. The foreign population underwent a 10.8% increase, and the Spanish population a 2.2% increase.

In Figure 8.7, are shown the characteristics of the imprisoned population in the period from 1999-2006:

[3] This is due to the fact that a charge filed against an individual that involves the seizure of more than one substance is recorded as ONE charge for EACH OF THE SUBSTANCES SEIZED. This means that the sum of arrests for each drug type may be greater than the total number of arrests. Also, the four drug types presented constitute a representative but not comprehensive sample of all illegal drugs seized, and therefore a certain number of charges do not appear in the table. In any case, in light of the preceding facts, it would clearly be illogical to sum up the charges by drug type because the resulting figure does NOT reflect the total number of charges filed and is therefore of no statistical interest.

Figure 8.7.- CHANGE IN THE PROFILE OF THE PRISON POPULATION. SPAIN, 1999-2006 (%).



	Men	Foreigners	Sentenced Criminals	Age: 31-40*	Crimes against property*	Crimes against public health*	Crimes Against People*
1999	91,5	17,9	75,5	35,3	52,4	28,5	6,7
2000	91,9	19,9	77,8	36,9	52,6	30,2	4,2
2001	91,8	23,3	76,6	37,3	51,4	31,3	7,3
2002	91,9	25,4	76,8	38,1	50,9	30,5	7,9
2003	92,1	27,1	76,2	38,1	50,4	29,5	8,9
2004	92,3	29,1	77,6	37,6	49,3	28,1	9,3
2005	92,2	30,5	76,0	37,9	46,6	27,2	9,9
2006	92,0	32,2	75,1	37,5	45,1	27,3	10,2

Note: Crimes against people: homicide and its different forms and injuries; crimes: crimes against property: against assets and of a socio-economic type.
(*) Percentages out of the population sentenced under Constitutional Law 10/1995 and the repealed Penal Code.
Source: Government Delegation for the National Plan on Drugs. Based on the prison statistics of the Ministry of Interior.

- The prison population is predominantly male (92%), with an ever greater increase in foreigners (32.2%). 35.6% of the women are foreign, compared to 31.9% of the men. Likewise, in recent years the inmate population has undergone gradual aging. 63.22% of the prison population of sentenced criminals was between the ages of 31-60 years, compared to the figure of 62.1% within that age group in 2005.

- By type of crime, in the time period from 1999-2006, as can be seen in Figure 1, the persons sentenced for crimes of a socio-economic type fell, whereas those sentenced for crimes against people went up. This fact may be conditioned by the variables of age and repeated violations, because studies point out that as the age of the delinquents increases, there is a shift in the type of crime committed. However, other factors may be involved, as well.

  The predominant types of crime continue to be, first of all, crimes against property (45.14% of sentenced inmates), followed by crimes against public health (27.25% of sentenced inmates). According to the sex variable, 45.78% of the men were in prison for crimes against property, whereas 46.45% of women were in prison for crimes against public health.

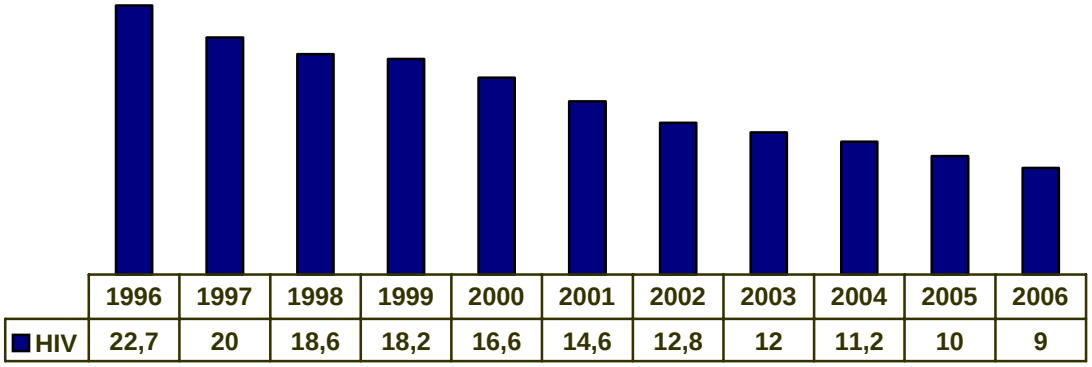
Until now, within the Spanish criminal punishment system, a relationship had been found between heroin use and crimes against property, no violent content of the crimes being emphasized in this group of users.

Statistics: prevalence of diseases associated with drug use in 2006. Source: Health Registries of Prison Health Care. The prison population of Catalonia is not included.

- Rate of HIV: 9.0% of the total prison population dependent upon the General Department of Penitentiary Institutions. The main HIV transmission route is till sharing injection materials for using intravenous drugs among both sexes.

  In accordance with Figure 8.8, the falling trend in HIV rates is continuing in the realm of prisons. The incidence of AIDS has gone down in both sexes, and women continue to have lower rates than men do.

Figure 8.8.- CHANGES IN HIV RATES IN THE PRISON POPULATION. SPAIN, 2001-2006*(%).

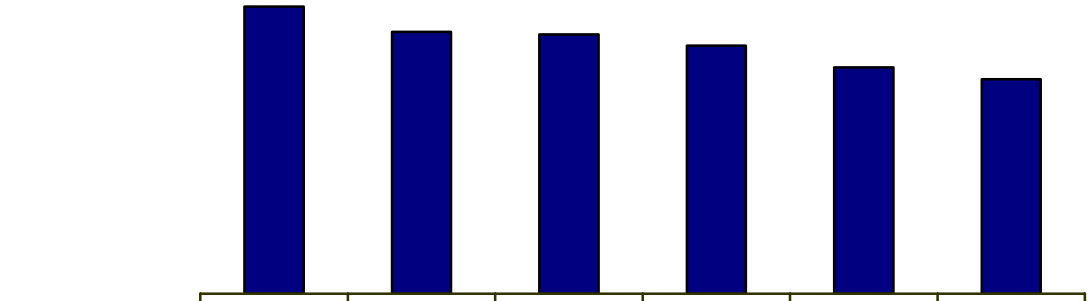


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
HIV	22,7	20	18,6	18,2	16,6	14,6	12,8	12	11,2	10	9

*Catalonia is not included
Source: Government Delegation for the National Plan on Drugs. Data provided by the General Department of Penitentiary Institutions

- Prevalence of hepatitis C: 31.3% of the total prison population dependent upon the General Department of Penitentiary Institutions. In accordance with Figure 8.9, the falling trend in HIV rates is continuing in the realm of prisons.

Figure 8.9.- CHANGES IN HEPATITIS C RATES IN THE PRISON POPULATION*. SPAIN, 2001-2006.



	2001	2002	2003	2004	2005	2006
Hepatitis C	41,9	38,2	37,8	36,2	33	31,3

*Catalonia is not included
Source: Government Delegation for the National Plan on Drugs. Data provided by the General Department of Penitentiary Institutions.

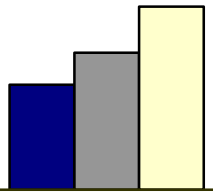
- Percentage of inmates undergoing treatment with antiretroviral medications: 5.6% of the total prison population dependent upon the General Department of Penitentiary Institutions.

- Rate of tuberculosis: 0.21% of the prison population dependent upon the General Department of Penitentiary Institutions is undergoing treatment for the disease of tuberculosis.

- Deaths due to overdose at prison centers, not included the prison population of Catalonia.

  In the year of 2006, 39 inmates died due to overdoses into prisons, 27 inmates from HIV infection and 115 for natural causes not related to HIV (Figure 8.10).

Figure 8.10.- CAUSES OF DEATH IN PRISIONERS*. SPAIN, 2004-2006.



	Natural, no HIV	HIV Infection	Overdose
2004	66	31	40
2005	86	35	43
2006	115	27	39

*Catalonia is not included
Source: Government Delegation for the National Plan on Drugs. Data provided by the General Department of Penitentiary Institutions.

Statistics: State Survey on Health and Drugs Among Inmates in Prison (ESDIP) 2006.

The results of this study were presented in 2006. It is a study financed and promoted by the Government Delegation for the National Plan on Drugs, with the cooperation of the General Department of Penitentiary Institutions (Ministry of the Interior) and the Secretariat of Penitentiary Services of the Autonomous Regional Government of Catalonia. The objectives and methodology of this study were described in 2005 Reitox National Report. The following is a summary of the most significant results in terms of drug use:

- The most widespread psychoactive substances in the prison population were alcohol, cannabis and cocaine. 92.5% of those interviewed had used at least one of the substances about which questions were asked (including alcohol) ever-in-lifetime. Only 7.5% of the sample claimed not to have used any psychoactive substance at any time in life (including tobacco). The greatest rates of use (ever-in-lifetime) were for alcohol (88.3%), cannabis (64.8%) and cocaine powder (53.3%). All of them have been used by more than half of the interviewees on some occasion.

TABLE 8.1.- PSYCHOACTIVE SUBSTANCE USAGE RATES (%). EDSIP, 2006			
Substance	**Ever-in-lifetime**	**Last 30 days on release**	**Last 30 days in prison**
Alcohol	88.3	63.0	3.7
Tranquilizers[a]	32.8	16.4	9.1
Cannabis	64.8	42.7	27.7
Heroin alone	39.0	19.4	4.8
Methadone [a]	9.5	3.4	1.1
Other opiates	14.3	3.5	0.5
Cocaine base	39.0	23.8	2.5
Cocaine powder	53.3	31.1	2.9
Heroin + cocaine	31.4	17.7	1.6
Amphetamines	24.5	4.1	0.3
Hallucinogens	26.2	2.4	0.1
Ecstasy	24.2	4.8	0.3
Inhalants	9.1	0.5	0.2
Heroin[(b)]	41.6	24.3	5.5
Cocaine[(b)]	58.9	40.0	5.0

Note: The percentages are calculated out of the number of cases for which there is information.

a Without a doctor's prescription

(b) In any form

Source: Government Delegation for the National Plan on Drugs.

- The rate of acknowledged use of psychoactive substances in prison (in the last 30 days) is lower than the rate reported while on release. However, more than one-fourth of all the inmates acknowledge having used cannabis during those 30 days at least on one occasion, and nearly one out of every ten used tranquilizers without a prescription. Moreover, heroin and cocaine use in any form took place among 5% of the inmates.

- Tranquilizers (4.3%), heroin alone (3.7%) and cannabis (3.8%) are the substances with the greatest rates of first time use in prison. The remaining substances do not reach 2%.

- Cocaine use alone as the main drug was more frequent among persons under the age of 21 years and fell with age; heroin use alone and mixing heroin and cocaine displayed greater rates in the age group of 31-40 years and decreased with the age of the inmates; last of all, the use of other drugs was more frequent among those under 21 years old. These substance use profiles are repeated for prison inmates. Those over the age of 40 years displayed the lowest usage rates in the last 30 days, whether on release or in prison.

- The rate of drug use was quite a bit higher among men than among women, and among Spaniards than among foreigners. On release, after alcohol consumption, the use of cocaine alone as the main drug was the most frequent among men, whereas among women it was the mixture of heroin and cocaine. In prison, the use of other drugs (tranquilizers and cannabis) was the most frequent for both sexes.

- 25.9% of the inmates recognize that they have injected drugs ever-in-lifetime; 11.7% in the month prior to entering prison, and 1.3% during the last 30 days in prison. Of those who had injected during the month prior to entering prison, 33.8% had done so on a daily basis, while among those who had used injections in prison this figure was only 0.2%.

- 48.5% of injection users had at some time used syringes used by others on release, amounting to 12.3% of the total sample, and 29.2% had on some occasion in prison, amounting to 7.3% of the total sample. The prevalence increases with the age of injection users, the group which displayed the greatest prevalence being that between the ages of 36-40 years.

- 22.3% of the users were in treatment at the time of the interview, amounting to 20.6% of the total sample. Only 11% of the users who were not in treatment wanted to begin a treatment in prison (93.4% wanted to undergo a de-habituation treatment).

Social Costs

No new available data.

9. RESPONSES TO SOCIAL CORRELATES AND CONSEQUENCES

Social Reintegration

The following table provides the data from 2006 corresponding to 9 autonomous communities and 2 autonomous cities.

Table 9.1. SOCIAL REINTEGRATION PROGRAMMES. Type, number of programmes and centres and number of users. Spain, 2006

	Number of programmes and/ or centres	Number of users
Treatment centres with social reintegration activities and/ or programmes	227	-
Social reintegration activity and/ or programme centres (without treatment)	61	-
Residential treatment centres with social reintegration programmes (therapeutic communities)	74	-
Residential care resources	43	484
Educational programmes	179	2.852
Programmes for integration into working life	133	3.259

SOURCE: Government Delegation for the National Plan on Drugs Data corresponding to the Regional Plans on Drugs for all Autonomous Communities and Cities, except: Aragon, Canary Islands, Valencia, Galicia, Madrid, Murcia, Navarra and Basque Country.

This data cannot be compared to the 2005 figures because some of the communities that have yet to submit their data, have extensive networks of social reintegration resources and therefore represent a significant portion of all national users.

As in previous years, the users of centres where reinsertion programmes are carried out were not counted, in order to avoid any possible duplication or overlapping with users of more than one programme.

Prevention of drug related Crime

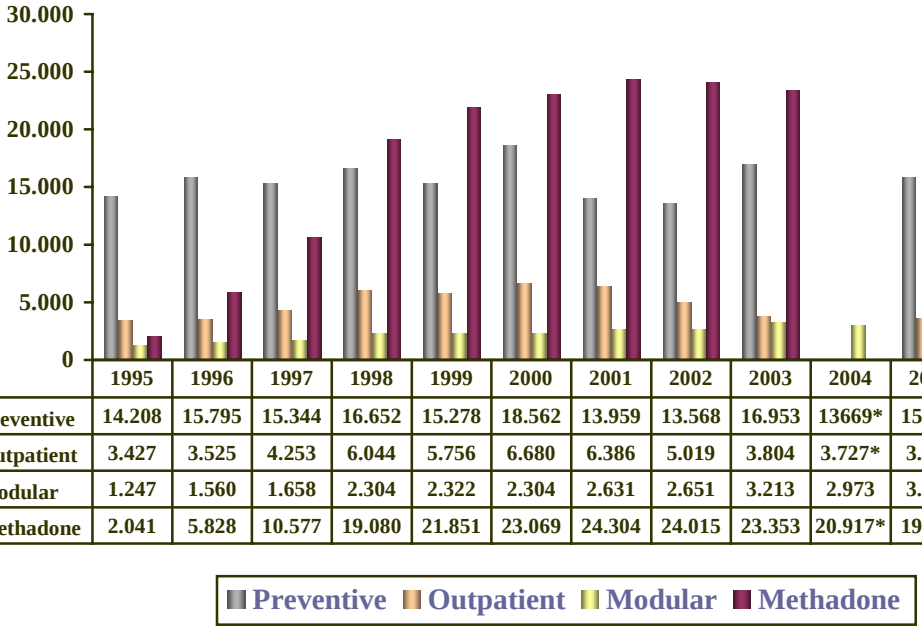
(2005 data, those for 2006 are being elaborated)

Assistance to Drug Users in Prisons

Line 7 of the 2005-2008 Action Plan of the National Strategy on Drugs for 2000-2008 has the goal of "guaranteeing the integrated assistance at prisons for the inmates with drug problems." This goal was implemented concrete through a Cooperation Protocol on drug addiction, agreed between the Ministry of Health and Consumer Affairs (Government Delegation for the National Plan on Drugs) and the Ministry of the Interior (General Department of Penitentiary Institutions) in February 2005.

a) Abstinence-oriented Treatments (de-toxifications, drug-free units, therapeutic communities in prisons). See Figure 9.1

Figure 9.1.- CHANGES IN THE NUMBER OF INMATES IN DRUG ADDICTION PROGRAMS. SPAIN, 1995-2006



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Preventive	14.208	15.795	15.344	16.652	15.278	18.562	13.959	13.568	16.953	13669*	15.804	18831
Outpatient	3.427	3.525	4.253	6.044	5.756	6.680	6.386	5.019	3.804	3.727*	3.557	5759
Modular	1.247	1.560	1.658	2.304	2.322	2.304	2.631	2.651	3.213	2.973	3.631	4.658
Methadone	2.041	5.828	10.577	19.080	21.851	23.069	24.304	24.015	23.353	20.917*	19.010	19.600

*The data on the prison population of Catalonia are not included.
Source: Government Delegation for the National Plan on Drugs on the basis of the data provided by the General Department of Penitentiary Institutions, Autonomous Regional Plan of Catalonia for Drug Addictions.

- De-toxification. De-toxification programs are offered to all of the subjects who are diagnosed as active drug addicts upon entering prison and who have not been included in treatment with methadone. The number of inmates included in patterned de-toxification in 2006 was 1,879 drug-dependent inmates at 59 prisons depending on the Central Administration of the State (Ministry of the Interior, General Department of Penitentiary Institutions). The rate in December 31, 2006 was 0.14% of the prison population.

- Drug-free programs. In 2006, 10,771 inmates were treated through this system of therapy, 9,171 at centers depending on the General Department of Penitentiary Institutions and 1,600 inmates at centers within Catalonia.

- Outpatient detoxification programs. The treated inmates live together with the rest of the prison population and use the general resources of the center. In 2006, 5,392 inmates from 60 prisons depend the General Department of Penitentiary Institutions were included. The rate in

December 31, 2006 was 4.64% of the prison population. And 367 inmates were assisted at 6 penitentiary centers in Catalonia.

- Detoxification programs in a specific therapy premises. These activities are carried out in a specific space within the center, and may be provided in a day center or in a therapeutic module, when the subject spends the night in the module.

  In 2006, 3,425 inmates from 25 prisons depending on the General Department of Penitentiary Institutions received treatment in a therapeutic module, being the rate in December 31, 2006 of 2.53% of the prison population. And treated in the daytime center model were 354 inmates from 9 prisons depending on the General Department of Penitentiary Institutions, being the rate of 0.25% of the prison population. At 8 penitentiary centers in Catalonia, 1,233 inmates were treated through this system.

b) Substitution Treatment

These treatments have been provided in the prison system since 1992, acquired momentum and underwent notable development since 1994, and in 1998 these treatments were extended to all centers.

In 2006, a total of 17,709 inmates from 66 prisons depending on the General Department of Penitentiary Institutions have received treatment with methadone, a rate of 13.75% on December 31, 2006.

At 9 penitentiary centers in Catalonia, 1,891 inmates have been assisted through this system.

c) Harm Reduction Measures

- Provision of blood screening, vaccinations, disinfectants and condoms. At all of the prisons, prevention and heath education programs have been implemented, both through the centers themselves and in coordination with those of the community. These programs are not only intended for drug addicts but also for inmates at risk who may begin to use inside the prison, as well as first-time and the youngest inmates.

  The number of inmates who have gone through this type of programs is 18,831 from all of the prisons in Spain.

  It must be pointed out that these programs achieve special importance within the prison, as a result of the frequent and serious health problems displayed by these persons, a significant percentage of whom make their only contact with the health care system when they go to prison.

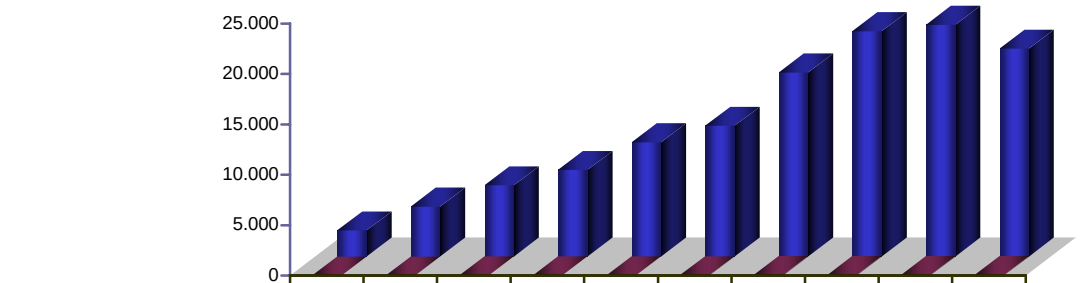
  Preventative activities that are carried out:

  - Strategies to promote health which range from health policies to intervention in the physical and social environment.
  - Supply of bleach and condoms at every prisons. Moreover, at some prisons aluminum foil and smoking filter tips are provided.
  - Health education for disease carriers.
  - Hepatitis B vaccination.

- Hepatitis treatments.
- Implementation of tuberculosis prevention and monitoring program, the fundamental goal of which is the early detection and treatment of both the infection and the disease among the inmates. Application of the Observed Directly Treatment, or DOT.
- Psycho-social support and health groups FOR the prison population infected with HIV or who perform practices that put them at risk OF getting infected.

- Needle and syringe exchange. This program exists at all the prisons depending on the General Department of Penitentiary Institutions. In the year of 2006, there were 43 centers which supplied needles (Figure 9.2) During that same year, 20,626 needles were distributed at centers run by the central administration.

Figure 9.2.- CHANGES IN NEEDLE EXCHANGE PROGRAMS AT PENITENTIARY CENTERS. SPAIN, 1997-2006.

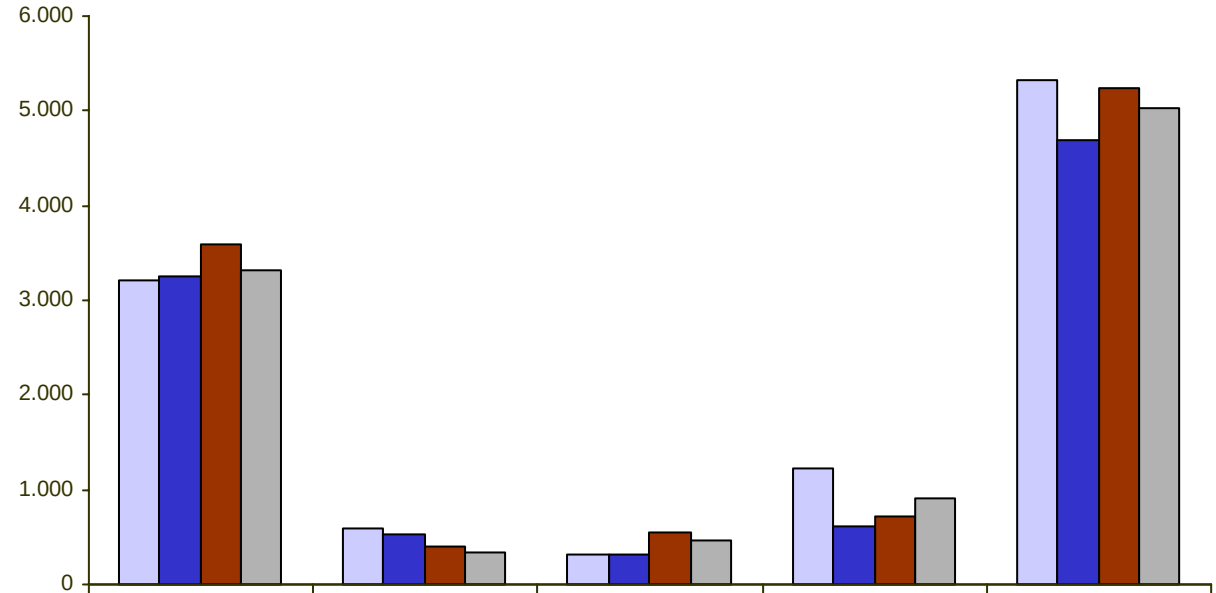


	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Number of centers with users	1	2	4	9	11	27	39	37	40	43
Number of needles distributed*	2.582	4.943	7.056	8.584	11.339	12.970	18.260	22.356	22.989	20.626

* Data from Catalonia are lacking.
Source: Government Delegation for the National Plan on Drugs. On the basis of the data provided by the General Department of Penitentiary Institutions and the Autonomous Regional Drug Addiction Plan of Catalonia.

d) Community links (pre-release, units and release, working with families, throughcare, therapeutic communities for offenders outside the prisons, involvement of community health structures). See Figure 9.3.

Figure 9.3.- DERIVATIONS OF DRUG ADDICTS FROM PENITENTIARY INSTITUTIONS TO COMMUNITY TREATMENT UNITS. SPAIN, 2006



	Treatments with methadone	Therapeutic communities	Others for stopping addiction	Outpatient centers	Total
2006	3.202	596	307	1.216	5.321
2005	3.244	531	314	604	4.693
2004	3.600	393	540	712	5.245
2003	3.323	346	460	908	5.037

* Data from Catalonia are lacking.

Source: Government Delegation for the National Plan on Drugs. On the basis of the data provided by the General Department of Penitentiary Institutions.

- Therapeutic communities for offenders outside the prisons. In 2006, 5,321 inmates were sent for treatment from penitentiary centers dependent upon the General Department of Penitentiary Institutions:

  - A total of 1,216 inmates were sent to external outpatient centers.

  - A total of 3,202 inmates to external methadone programs.

  - A total of 596 inmates to external therapeutic communities.

  - A total of 307 inmates to other detoxification resources.

  It is necessary to emphasize the decrease in the number of inmates assisted in methadone programs, both inside the prisons and in the community resources. This change in the demand for services, coupled with the increase of the number of admittances in drug-free programs, compared with the decrease in inmates in substitution programs, could mean to a change in the inmates' drug

use patterns, a hypothesis which seems to have been confirmed in the last survey carried out in this field.

e) Specific Training

Training for professionals who work in the prison environment. Training courses are given to all the civil servants working at prisons. Subsequently, updating courses are periodically held for the most common pathologies and on the new treatment alternatives.

Moreover, we must point out the following activities promoted and financed by the Government Delegation for the National Plan on Drugs:

- Design and implementation of an online course about drug addictions aimed at doctors for Penitentiary Institutions. In 2006, teaching materials (400 CDs) were presented and given out to the staff members of prisons.

- Design and publication of the guide: "Intervention on Drugs at Prisons" intended for professionals who work at prisons as part of the "Taking Action Is Possible" collection of the Government Delegation for the National Plan on Drugs. Year 2006.

Training aimed at inmates. The ultimate goal of the intervention with drug addict inmates at penitentiary centers is social re-integration, and therefore the activities performed in this realm must first of all be aimed at avoiding the damage associated with drug use, and secondly at the normalization and social integration of the drug addicts. Therefore, the therapy alternatives must not be isolated as a treatment program in and of itself. Instead, they must be integrated into activities which foresee educational and cultural assistance.

In 2006, 10,409 inmates depending on the General Department of Penitentiary Institutions began Professional Occupational Training courses, and 1,112 started Orientation Programs for Employment Integration. It is estimated that 50% of these students were drug addicts.

Alternatives to prison for drugs

2005 data, the data for 2006 are being elaborated.

10. DRUG MARKETS

Availability and supply

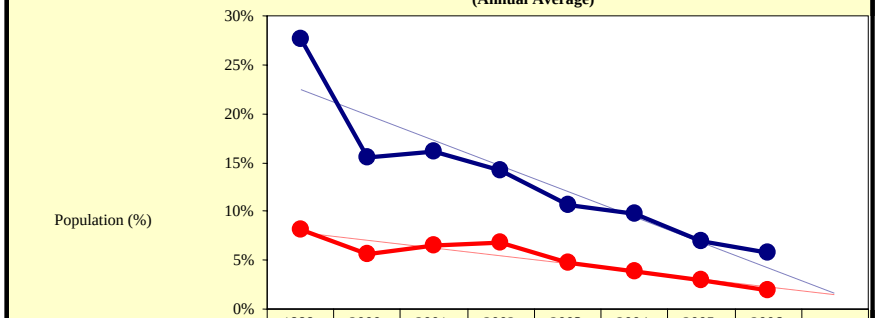
Drugs as a social problem and drugs as a personal problem

The social importance attached to the *drug problem* has diminished appreciably and consistently, going from 27.7% in 1999 to 5.8% in the year 2006.[4]

In comparison with other variables, in 2007 *drugs* were mentioned by citizens as the NINTH most important social problem, having ranked eighth, seventh, fifth and third in preceding years.

Drugs have also lost importance as a personal problem, falling from 8.2% to 1.9%. In 1999, individuals surveyed ranked drugs as their fifth most important personal problem, whereas in 2006 this problem ranked sixteenth on the list.

Figure 10.1. THE "DRUG" VARIABLE AS A SOCIAL PROBLEM AND AS A PERSONAL PROBLEM 1999-2006 (Annual Average)



	1999	2000	2001	2002	2003	2004	2005	2006
DRUGS (Social problem)	27,7%	15,6%	16,1%	14,2%	10,7%	9,7%	7,0%	5,8%
Variable ranking	3	3	3	5	7	7	8	9
DRUGS (Personal problem)	8,2%	5,6%	6,6%	6,8%	4,7%	3,9%	2,9%	1,9%
Variable ranking	5	7	7	7	11	11	13	16

It is possible that the phenomena that determine the citizens' view of drugs as a social problem may also determine their opinion of drugs as a personal problem, and vice versa.

The difference between the degree of importance attached to drugs as a social problem and as a personal problem has dropped from 19.5% in 1999 to 3.9% in 2006, which seems to indicate that people who do not have a personal drug problem tend not to perceive drugs as a social problem.

[4] The information provided in this section was supplied by the opinion polls of the Sociological Research Centre.

Table 10.1. DIFFERENCE BETWEEN PERCENTAGE OF CITIZENS WHO PERCEIVE DRUGS AS A SOCIAL PROBLEM AND THOSE WHO PERCEIVE DRUGS AS A PERSONAL PROBLEM	
YEAR	
1999	19.5%
2000	10.0%
2001	9.6%
2002	7.4%
2003	6.0%
2004	5.8%
2005	4.1%
2006	3.9%

With regard to the statistical analysis of trends, it seems likely that both variables will follow the downward curve of recent years. Therefore, in the near future these percentages are expected to continue their slow yet steady decline, unless a specific incident *reawakens* social interest in *drugs* as a problem.

In any case, the available data shows that social perception of drugs as a problem has declined since 1999 and has been replaced by other recurring issues (housing or job quality, for example), new problems (immigration) and current affairs that capture the public eye for a limited time and later fade into the background or disappear from the headlines altogether (for example, the *mad cow disease* crisis, *Asian bird flu* or rising oil prices). The *social problem of drugs* can be considered a recurring issue that is shifted to one side every time a new problem appears that generates social concern or widespread alarm.

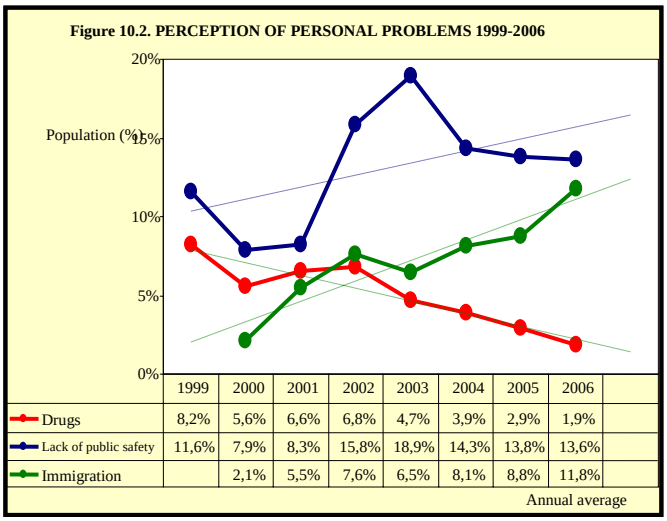
In addition, the data on *drugs as a personal problem* seems to indicate that the number of people who consider it a personal problem is decreasing, although data on drug use indicates that a greater percentage of the population is affected by this problem. The coexistence of these two phenomena can be explained by the development of a process of collective habituation, tolerance or acceptance of the existence of drugs (whether legal or illegal) as an *inevitable* part of social life.

The drug problem and other problems perceived by citizens

Drug use has traditionally been viewed as directly or indirectly linked to the rise of certain criminal behaviours or the existence of certain social minority groups. Although the cause-and-effect relationship between drugs and delinquency, or vice versa, has never been scientifically proven, it is interesting to examine the social perception of these two phenomena.

In the same vein, the importance of foreign drug-related delinquency requires an investigation of the ties between the drug problem and immigration and between delinquency and immigration in the forum of public opinion in order to obtain the most comprehensive overview possible of the characteristics of this arena.

The data shows that citizen concern about immigration as a social problem has grown since 2000, whereas the importance attached to drugs has diminished in the same period. The perceived *lack of public safety* rose between 2000 and 2003 and went down from 2004 to 2006.



With regard to perception as personal problems, the variables have performed in a similar manner: the *drug* variable has risen steadily, the *immigration* variable has also risen and the *lack of public safety* variable has experienced ups and downs although the general trend is downward.

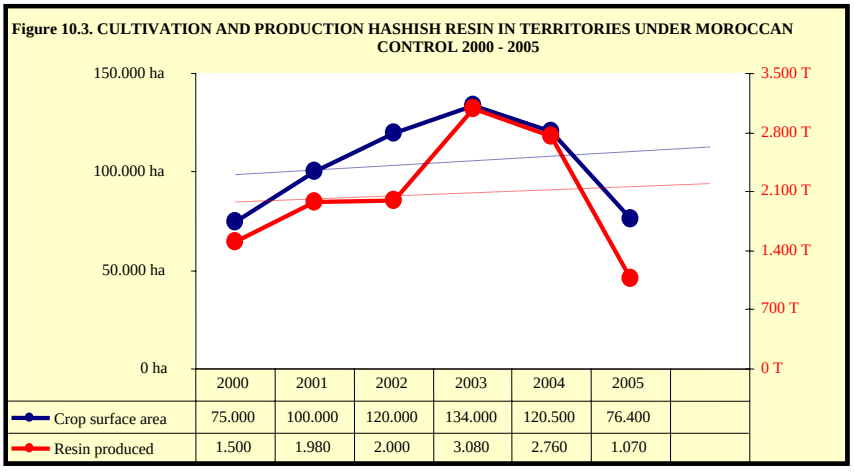
Given this data, it seems that the general population does not view drugs, lack of public safety and immigration as interrelated problems, a perception that is confirmed year after year.

PRODUCTION, SUPPLY SOURCES AND TRAFFIC PATTERNS

HASHISH

Cannabis cultivation and hashish production

An estimated 93% of hashish seized in Spain comes from territories under Moroccan control, where the plants are cultivated and the final product is processed for distribution, primarily in Europe and certain North African countries. Calculations indicate that 70% of cannabis used in Europe and 53% of cannabis seized globally comes from this same region.



In its 2006 report, the United Nations Office on Drugs and Crime (UNODC) indicated that the cultivation of cannabis and the production of hashish in this country decreased by 40% and 61% respectively in 2005.

This decrease is attributed to unfavourable climate conditions and the efforts of Moroccan authorities to eradicate these crops by means of direct intervention, raising awareness among its inhabitants and alterative activities.

According to this report, 72,500 hectares of land were dedicated to such crops in 2005 (compared with 120,500 hectares in 2004) and 1,070 metric tonnes of cannabis resin were produced in the same year (compared with 2,760 T in 2004).

Hashish distribution methods and routes in Spain and Europe

By land
Hashish distribution by land takes advantage of the significant flow of international commercial traffic, especially TIR trucks, between northern Morocco (particularly Tangiers) and the ports of southern Spain (Cadiz, Algeciras, Malaga and Almeria, for example), as well as the border cities of Ceuta and Melilla. The Port of Casablanca is also an important port of origin for shipments to Spain, France and even Italy, whether by direct routes or via Tangiers and Algeciras.

There is evidence of trucks that load hashish in towns far to the south (Agadir, Safi and El Jadida), in areas of fishing and agricultural production with important trade connections to Spain and the rest of Europe, which allows drug traffickers to improve their chances of smuggling their cargo through undetected.

Once in Spain, the hashish is either stored in locations close to the ports of entry or sent along land routes in the same trucks or other modes of transportation to its final destination, whether inland Spain or other countries.

By sea
Traditionally, the most common method of moving hashish from Africa to Europe is on merchant ships, fishing boats or recreational vessels. These crafts are loaded directly on the Moroccan coast or take delivery from other ships acting as go-betweens.

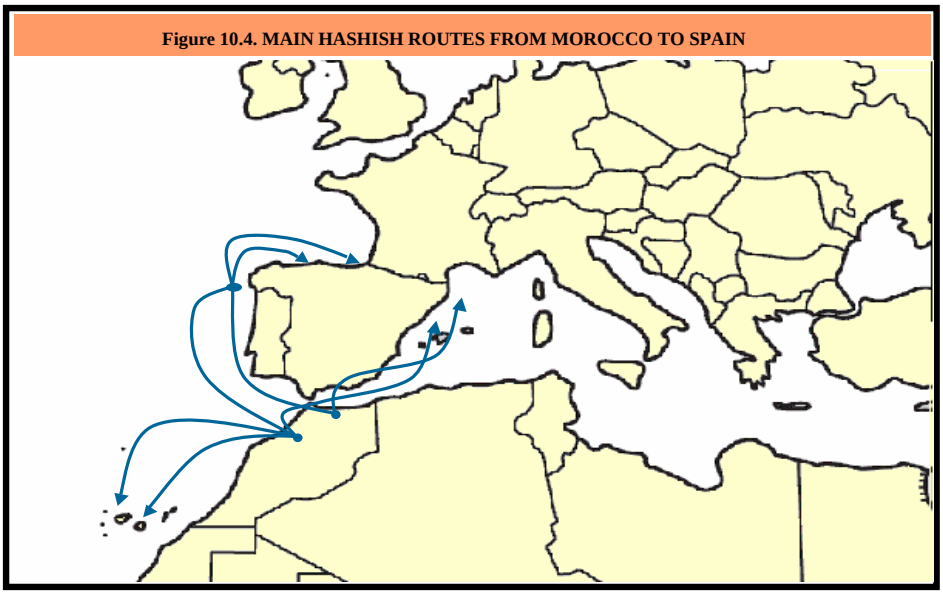
The use of small launches and motorboats to move lesser quantities (between 500 and 1,500 kilos) is also commonplace. Recently, these boats have begun landing at more northern points, reaching as far as the provinces of Tarragona and Barcelona.

The presence of hashish in boats transporting illegal immigrants is still minimal and therefore cannot be considered a new method of distribution.

By air
In the last ten years, authorities have detected the use of small recreational aircraft, crop-dusting planes, microlight aircraft and even helicopters that deliver shipments of hashish by the so-called *bombing* method (tossing out drug packages from the air to be picked up by people waiting on the ground below) or by landing at airstrips with minimal surveillance where cargo can be unloaded without too much difficulty.

Until now it has not been possible to accurately evaluate this method of distribution. Such activities are almost always detected due to aircraft accidents or discoveries made in the course of routine surveillance operations and not as a result of police investigations (only 2 cases were detected in 2006); therefore, it would be advisable to design specific control plans for private and recreational landing strips and establish surveillance of the airspace closer to ground level along the routes regularly used by these kinds of aircraft.

Figure 10.4. MAIN HASHISH ROUTES FROM MOROCCO TO SPAIN

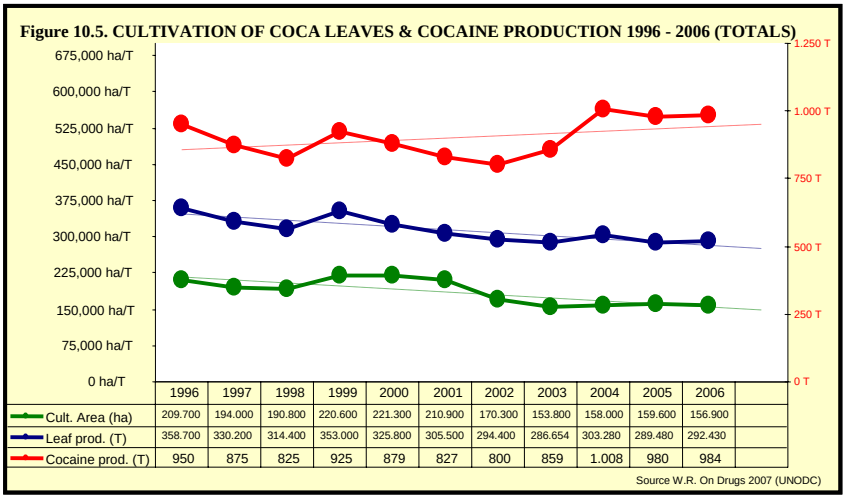


COCAINE

Cultivation of coca leaves and cocaine production

Data regarding the extension of coca crops and the production of dry leaves points to a slight general decline of the two variables, which exhibit similar patterns and trend curves. However, cocaine production does not mimic this pattern due to significant increases in production, particularly in Colombia since 2004.

Figure 10.5. CULTIVATION OF COCA LEAVES & COCAINE PRODUCTION 1996 - 2006 (TOTALS)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Cult. Area (ha)	209.700	194.000	190.800	220.600	221.300	210.900	170.300	153.800	158.000	159.600	156.900
Leaf prod. (T)	358.700	330.200	314.400	353.000	325.800	305.500	294.400	286.654	303.280	289.480	292.430
Cocaine prod. (T)	950	875	825	925	879	827	800	859	1.008	980	984

Source W.R. On Drugs 2007 (UNODC)

Between 1996 and 2006, total cultivated surface area decreased 24.5% and the production of dry coca leaves went down by 18.5%, while total cocaine production increased by 3.60%.

Cocaine distribution methods and routes in Spain and Europe

By sea

In the nineties, European countries cited Spain and the Netherlands as the two main points of entry for cocaine shipments to EU territory. Maritime transport has traditionally been the most common method given its capacity to move large cargos

across the Atlantic. The shipments are redistributed among smaller vessels off the shores of Spain, which in turn smuggle the drugs onshore.

Transport on sea craft

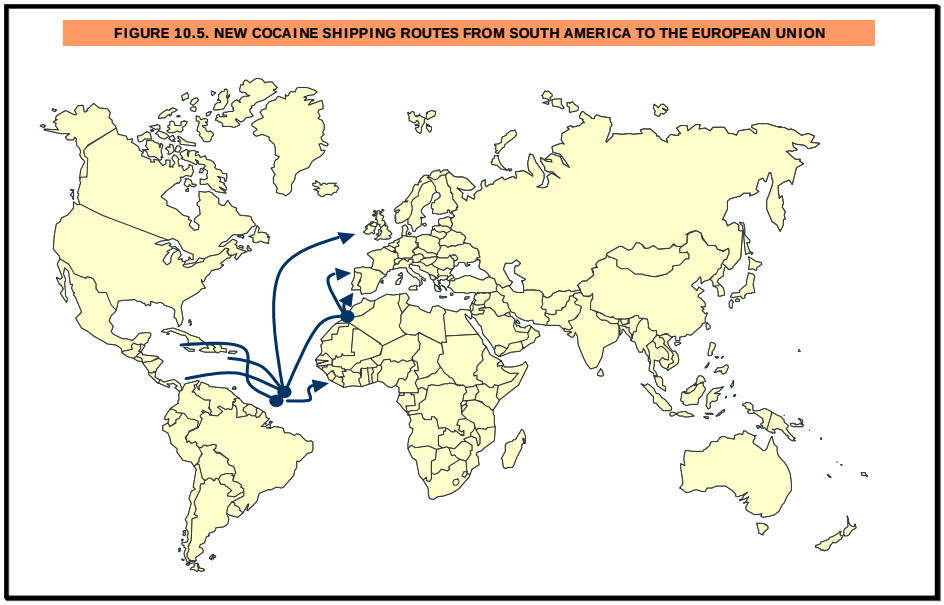
The last several years have witnessed a change in the strategy and structure of drug trafficking organisations, which has led to a change in the *modus operandi* in terms of the mode of transportation and the way in which shipments are loaded and unloaded.

These organisations, probably as a result of pressure from international authorities applied at production sites, along distribution routes and at shipment destinations, are developing safer and more reliable procedures in an attempt to minimise the impact of occasional seizures on their structures, avoiding any possible information leaks and setting up systems to warn their agents of police raids.

In the last two years, authorities have observed that the direct routes between the Caribbean and Spain, aided by the Galician mafias, are being replaced by indirect routes. The shipments are sent to northern Africa and then transported by land on the continent or loaded onto ships that travel from coastal African nations to Spain, either directly or via Morocco.

Another variation in the *modus operandi* affects the way in which trans-Atlantic cargo ships (generally large fishing vessels or whalers) are loaded. Shipments are taken on from other vessels, but now they are also delivered by cargo planes that drop bales of cocaine at predetermined coordinates for the ships to pick up. The bales are attached to buoys fitted with timers that automatically activate after a certain time, causing the packages to rise to the surface just before the ship reaches them. These vessels are usually bound for the Gran Sol area or the Cape Verde Islands, where the cargo is transferred to other smaller craft or to the coast, on its way to any European country.

FIGURE 10.5. NEW COCAINE SHIPPING ROUTES FROM SOUTH AMERICA TO THE EUROPEAN UNION



Transport in containers
This may be the safest and most sophisticated method of transportation given that it allows drugs to be hidden among legitimate trade goods, and due to the fact that the interception of shipments does not affect the traffickers' organisational structure.

These shipments are orchestrated by using a puppet export company controlled by the criminal organisation and another legitimate import company that is unaware of the criminal operation. Companies engaged in legitimate trade may also become tools for such operations, as traffickers often camouflage cocaine in containers or inside the goods themselves.

Transport using drug couriers
Although the quantities seized from passengers on commercial aircraft are not substantial in comparison with the overall quantities, smuggling cocaine on commercial flights is an activity that mobilises an important number of human resources and airport surveillance and investigation specialists.

As opposed to the *maritime strategy* of introducing large shipments via a limited number of landing operations, the so-called *Chinese strategy* focuses on smuggling in a constant stream of small quantities, generally carried by a single person each trip. The individual quantities are insignificant, but the sum of such actions can reach staggering proportions. Moreover, this strategy is extraordinarily efficient in terms of protecting the criminal organisation's structure, since the majority of the couriers are recruited exclusively for this purpose and are generally *sacrificed* when its suits the interests of the organisation. In fact, there is reason to believe that such organisations set up people carrying cocaine with an outward appearance that is bound to attract the attention of customs officials as a distraction, thus allowing others carrying larger amounts in suitcases or even handbags to pass through customs with greater ease.

In general, cocaine is smuggled using commercial aircraft that travel all direct routes between South America and Europe. However, when no direct route exists, it is reasonable to assume that the seizures made in Spain from residents of other nations correspond to quantities that were going to be distributed in their own countries.

Airline passenger inspection results in a large number of seizures – 228 in the course of 2006 – primarily effected at the airports of Madrid and Barcelona, where 2,780 kilos of cocaine were confiscated. The average weight of packages has increased notably and is now around 12 kilos. In 2005, 7 seizure operations confiscated shipments of more than twenty kilos, and in 2006 there were 28 such operations.

Transport using non-commercial aircraft
Although no recent shipments of cocaine using this method have been detected, we must not forget the 2005 intervention at the Fuentemilano Airfield (Segovia) involving a Cessna jet plane from Guinea Bissau where 106 kg of cocaine were seized and ten members of an organisation consisting primarily of Germans and Colombians were arrested. This flight was judged to be an attempt at opening up a new route for transporting cocaine from South America, storing it in the Gulf of Guinea region and subsequently smuggling it into Spain.

Another important operation in 2005 was Operation TACOS, which seized 2,038 kilos of cocaine and 17 million euros in cash. The same operation led to the seizure of two other trans-oceanic aircraft, which proves that drugs are being transported from one continent to another in private airplanes.

SYNTHETIC DRUGS - MDMA

Production of MDMA-ecstasy

The difficulties inherent in gathering reliable data on MDMA production[5] force us to rely on indirect indicators, such as estimated use, the number of seizures and quantities confiscated, or laboratories dismantled.

In 2004 and 2005, 133 ecstasy laboratories were dismantled around the world, especially in economically prosperous regions of developed countries (74 in North America, 33 in Europe and 24 in Australia). Although North America (USA and Canada) accounts for the highest percentage of dismantled laboratories (55.60%), the largest quantities were seized in Europe, where 16.54% of all laboratories dismantled were located in the Netherlands.

According to available data, the European Union is the leading producer of ecstasy, although the relative importance of this area is declining and activity is intensifying in North America, Eastern Asia and Southwest Asia.

Ecstasy distribution methods and routes in Spain and Europe

The ecstasy seized in Spain (in cases where the origin is known) comes primarily from the Netherlands and Belgium. The lack of data on the origin of seized MDMA (around 50% of the total) may be due to problems with information records, but it is also possible that the drugs may come from other more elusive points of distribution, probably in Eastern Europe.

MDMA is usually smuggled into Spain by small groups of people travelling by road, although certain quantities are also brought in by individuals posing as tourists on commercial flights. The airports where the highest volume of traffic in this particular drug has been detected are those in Barcelona, Madrid and Palma, Majorca, as well as the Canary Islands, on direct or indirect flights. The transoceanic distribution of MDMA is usually effected by air.

Many of the most notorious criminal organisations are showing their flexibility and capacity of adaptation by joining in the traffic of MDMA and its derivatives, given that these are often more lucrative and less risky than other drugs. This may be an attempt by heroin distributors to diversify in light of the stagnant and even declining market for their product.

Heroin is being replaced by ecstasy in Europe and Southeast Asia and by cocaine in Europe and North and South America. Authorities have also detected the movement of large quantities of ecstasy pills from Europe through the Caribbean on the way to North America, and large ecstasy laboratories have been dismantled in Eastern Europe.

There is evidence that Spain is being used as a point of departure for airline passengers on the way to distribute ecstasy in America.

[5] The 2005 UNOCD World Drug Report estimates synthetic drug production based on the number of laboratories producing derivatives of amphetamines, methamphetamines and ecstasy. This Report and other police information sources were used to estimate the main centres of MDMA production and distribution.

HEROIN

Cultivation and production of poppy and heroin

The cultivation of poppy plants and the production of opiates are concentrated primarily in three regions of the world, in this order: the *Golden Crescent*, comprising Afghanistan and Pakistan; the *Golden Triangle*, including Myanmar, Thailand, Laos and Vietnam; and Central and South America (Mexico and Colombia).

Most of the world's poppy crops[6] are located in Afghanistan, which accounts for approximately 82% of the total, followed by Myanmar with 10.45%.

Following the 21% decrease in the number of hectares of cultivated surface area detected in 2005, the amount of surface area dedicated to poppy crops increased by 32.67% from 2005 to 2006 due to the significant spread of this practice in Afghanistan. Myanmar's cultivated surface area continued the downward trend begun in 2000.

The invasion of Afghanistan caused a drop in the surface area dedicated to poppy crops and the production of opium in this country, but in 2002 it went back to production levels of previous years and began an upward trend that has continued up to 2006. In this last year, production was over 200% higher than in 1996 and 58.65% higher than in 2005.

Heroin distribution methods and routes in Europe

The shipments of opium, morphine and heroin entering the European Union come primarily from Turkey, which acts as a *way station* for substances produced in the *Golden Triangle* (Myanmar, Thailand, Laos and Vietnam) and the *Golden Crescent* (Afghanistan and Pakistan).

The three main routes along which clandestine drug shipments currently travel are:

BALKAN ROUTE divided into the following branches:

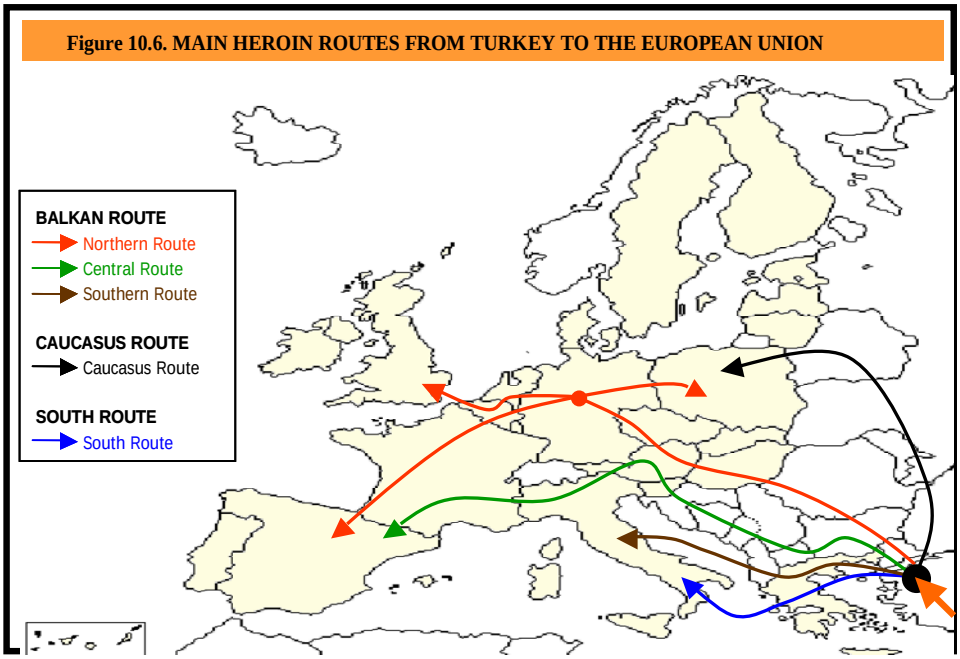
- Northern Route: Turkey, Bulgaria, Rumania, Austria, Hungary, Czech Republic and Germany. 3 sub-routes run from Central Europe: one to the Netherlands and Great Britain, the second to France and Spain, and the third to Poland.
- Central Route: Turkey, Bulgaria, Macedonia, Serbia, Montenegro, Bosnia-Herzegovina, Croatia, Slovenia, Austria, Italy, France and Spain.
- Southern Route: Turkey, Greece, Albania and Italy.

CAUCASIAN ROUTE: Turkey (Black Sea port), Ukraine, Belorussia, Poland and Germany.
SOUTH ROUTE: Turkey, Greece and Italy (by ferry).

According to available data, most of the heroin seized in Spain is of the brown sugar variety, produced in Afghanistan and shipped from Turkey along the Balkan Route. The drugs are smuggled in by Turkish organisations that make use of existing Spanish organisations, generally gypsy mafias, to distribute the heroin to the end user.

[6] 2007 UNODC World Drug Report.

Figure 10.6. MAIN HEROIN ROUTES FROM TURKEY TO THE EUROPEAN UNION



Seizures

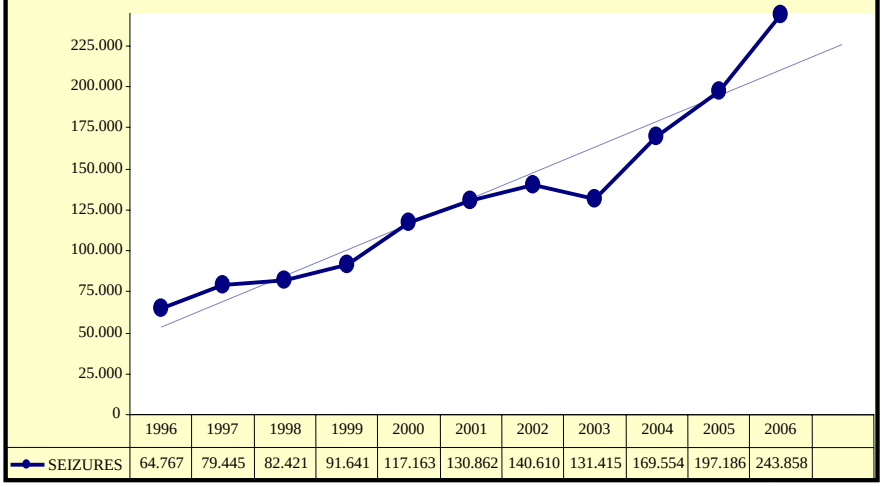
The number of seizures alone is an excellent indicator of the intense efforts of the national security forces to combat illegal drug trafficking.

Over the last ten years, the number of seizures has increased notably in a constant and almost linear trend, indicative of the ongoing efforts against illegal drugs as well as of the increasing availability and visibility of such products.

It is true that most drug seizures were effected in public places from individuals who were using or carrying small quantities of drugs and therefore could not be charged with "*possession with intent to distribute*" under Article 368 of the Spanish Penal Code.

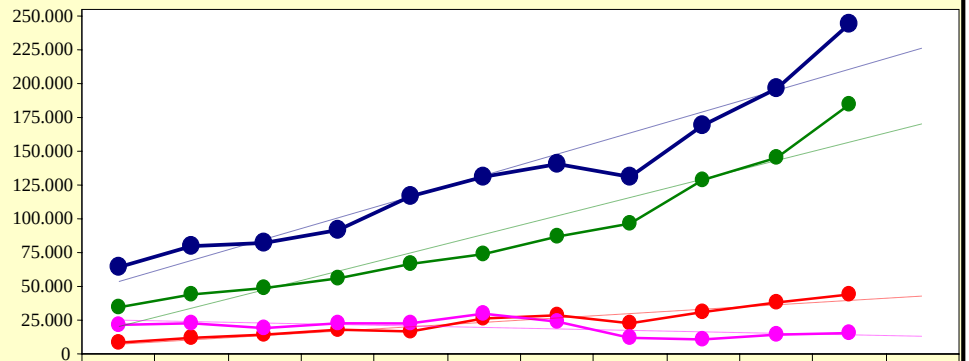
In contrast, operations against drug trafficking networks tend to result in a very small number of seizures involving large quantities of drugs. On numerous occasions these seizures have resulted in the confiscation of several tonnes of drugs in a single raid, particularly in the case of cocaine and hashish shipments. In the year 2006, a total of 243,858 seizures were carried out, 23.67% more than the year before.

Figure 10.7. TOTAL NUMBER OF ILLEGAL DRUG SEIZURES 1996 - 2006



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
SEIZURES	64.767	79.445	82.421	91.641	117.163	130.862	140.610	131.415	169.554	197.186	243.858

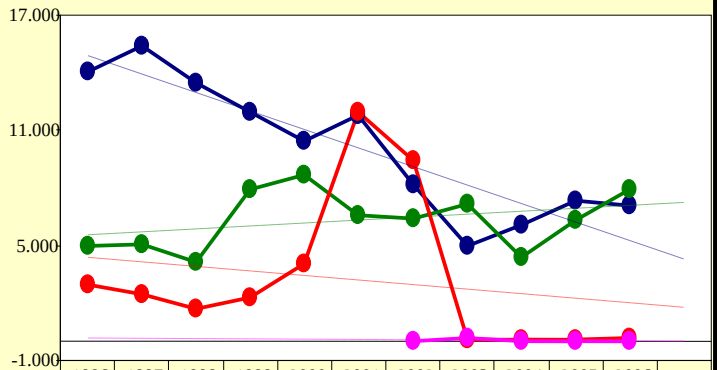
Figure 10.8. EVOLUTION OF NUMBER OF SEIZURES BY DRUG TYPE 1996 - 2006 (I)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
TOTAL	64.767	79.445	82.421	91.641	117.163	130.862	140.610	131.415	169.554	197.186	243.858
Cannabis & derivatives	34.335	44.227	49.117	55.498	66.521	74.391	87.545	96.885	128.461	145.657	184.957
Cocaine & derivatives	8.412	12.276	13.818	18.006	16.140	26.127	29.056	22.048	30.528	37.707	43.794
Rest	21.925	22.913	19.283	22.082	23.151	30.323	24.009	12.482	10.576	13.822	15.107

By substance type, it is clear that most of the seizures involved cannabis and cocaine or derivatives of the same (90.50% in 2003, 93.76% in 2004, 92.99% in 2005 and 93.81% in 2006), with a much smaller number of seizures involving opiates, amphetamine-barbiturates, hallucinogens and other substances.

Figure 10.9. EVOLUTION OF NUMBER OF SEIZURES BY DRUG TYPE 1996 - 2006 (II)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Opiates	14.040	15.399	13.496	11.938	10.465	11.800	8.202	5.012	6.056	7.354	7.039
Amphetamines Barbiturates	4.957	5.040	4.122	7.900	8.678	6.540	6.371	7.181	4.392	6.303	7.887
Hallucinogens	2.928	2.474	1.665	2.244	4.008	11.983	9.420	121	89	135	160
Other substances							16	168	39	30	21

ANALYSIS OF PRIMARY DRUGS

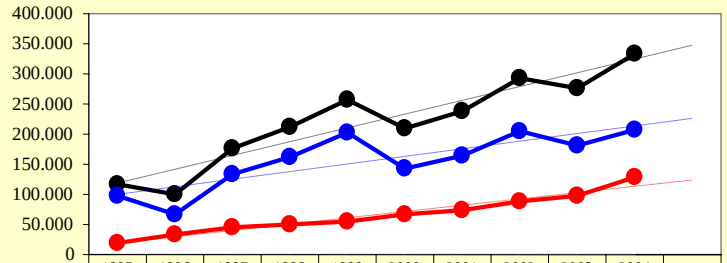
HASHISH

Number of seizures. Evolution in comparison with Europe

In the period analysed, the number of hashish seizures in the rest of Europe followed an upward curve with periodic highs and lows, while the number of seizures in Spain showed a steady upward trend at a steeper rate.

The performance of both variables is reflected in the fact that seizures in Spain now represent a greater proportion of the total number of seizures, rising from 20.67% in 1995 to 62.35% in 2004 in a pattern of steadily increasing numbers almost every year.

Figure 10.10COMPARED NUMBERS OF HASHISH SEIZURES EUROPE-SPAIN 1995-2004

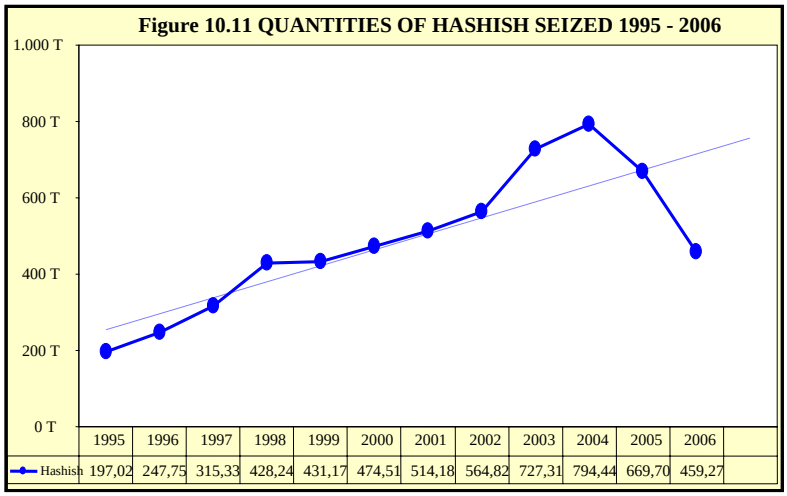


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
EMCDDA total	117.343	100.918	176.835	211.793	258.198	210.064	239.117	292.663	277.295	334.448
SPAIN	20.100	34.355	44.227	49.117	55.498	66.395	74.391	87.169	96.885	128.450
REST of EUROPE	97.243	66.563	132.608	162.676	202.700	143.669	164.726	205.494	180.410	205.998
% SPAIN/TOTAL	20,67%	51,61%	33,35%	30,19%	27,38%	46,21%	45,16%	42,42%	53,70%	62,35%

The correlation coefficients of the statistical variables of the number of seizures carried out in Spain with those in the rest of Europe (0.762550977) and with total seizures (0.912842485) shows a strong correlation, as is to be expected given that 42% of all seizures for the period analysed took place in Spain.

Quantities seized in Spain

The evolution of seized quantities of hashish has followed an almost straight and constant upward line, much of which coincides with the plotted figures up to 2002. From this year to 2004, the quantities experienced a steeper rise and have fallen again in the last two years.



As this graph shows, the total quantity seized in 2004 was just over four times greater than the quantity seized in 1995. In 2005, 15.70% less hashish was seized than in 2004, but in 2006 the numbers dropped even further (31.46% less than in 2005 and 42.22% less than in 2004). This drop may be due to circumstantial factors deriving from the special nature of hashish seizures in Spain, which are predominantly the result of police operations against organised crime, seizures of shipments along the coast and the discovery of large drug shipments in Spanish waters. Consequently, the upward trend of seizures is not expected to change in the short term.

Global comparison

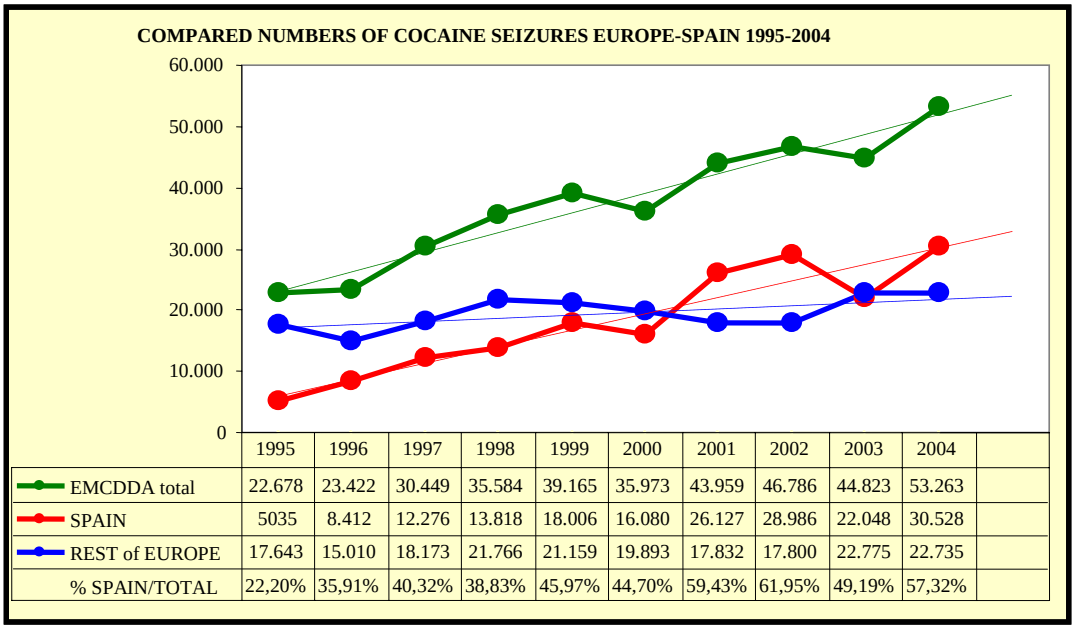
By countries, on a global scale, **Spain** is far and away the highest-ranking nation, accounting for 51.55% of all seizures. Pakistan and Morocco occupy distant second and third places with 7.20% and 7.11% respectively, followed by France (6-43%), Iran (5.30%) and Great Britain (4.78%).

COCAINE

Number of seizures. Evolution in comparison with Europe

In the period analysed, and particularly since 1998, the number of cocaine seizures in the rest of Europe followed a gentle upward curve, while the number of seizures in Spain showed a steady upward trend at a rate very similar to the evolution of the European total.

The performance of both variables is reflected in the fact that seizures in Spain now represent a greater proportion of the total number of seizures, rising from 22.20% in 1995 to nearly 62% in 2002 and 57.32% in 2004, following a pattern of steadily increasing numbers practically every year.

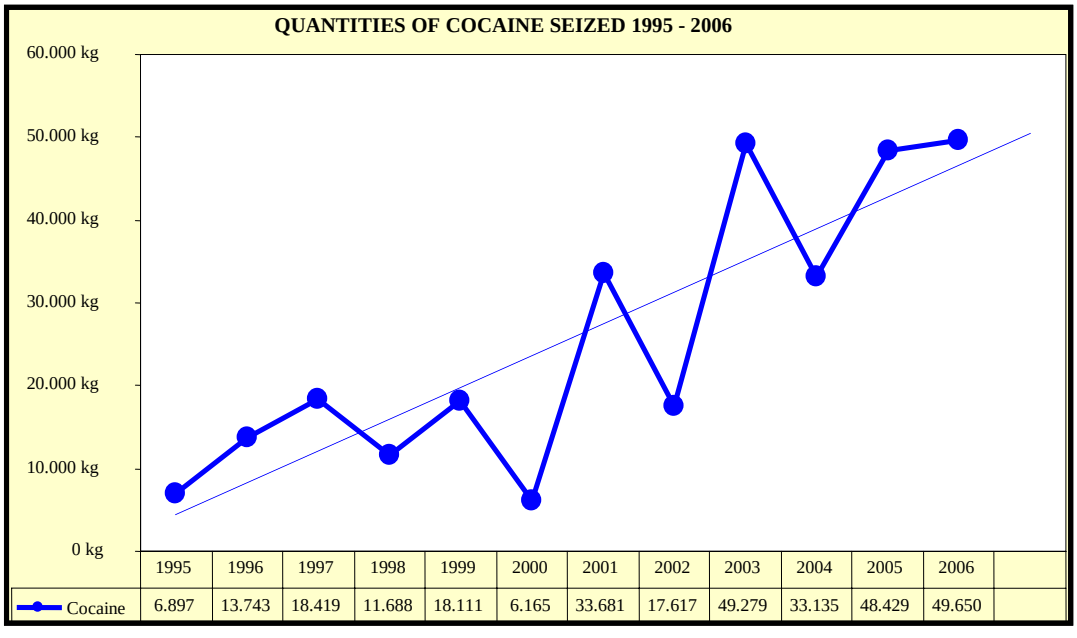


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
EMCDDA total	22.678	23.422	30.449	35.584	39.165	35.973	43.959	46.786	44.823	53.263
SPAIN	5035	8.412	12.276	13.818	18.006	16.080	26.127	28.986	22.048	30.528
REST of EUROPE	17.643	15.010	18.173	21.766	21.159	19.893	17.832	17.800	22.775	22.735
% SPAIN/TOTAL	22,20%	35,91%	40,32%	38,83%	45,97%	44,70%	59,43%	61,95%	49,19%	57,32%

The correlation coefficient (0.427148214) shows a low correlation between the number of seizures in the rest of Europe and the number in Spain, and the coefficient 0.972436514 shows a strong correlation between the number of seizures in all of Europe and the number performed in Spain. This is to be expected, given that Spain has the highest results in terms of successful police operations against cocaine traffickers.

Quantities seized in Spain

The quantities of cocaine seized show a classic sawtooth graph with a marked upward tendency. The distribution of the oscillations is compatible with a context in which new distribution modus operandi are being developed as a reaction to the efficiency of security forces, which elude police pressure until they are detected and immobilised.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Cocaine	6.897	13.743	18.419	11.688	18.111	6.165	33.681	17.617	49.279	33.135	48.429	49.650

Despite the ups and downs, the evolution of seized quantities of cocaine is comparatively higher than that of hashish. In 2006, for the second year running, seizures were 49.84% higher than in 2004 and 2.52% higher than in 2005, setting a new record for cocaine quantities seized in Spain.

Quantities seized. Global comparison

Over the years in the period analysed, more than half of all cocaine seized (55%) was taken in Colombia and the USA.

In 2005, these two countries again topped the list of nations with the highest quantities of cocaine seized (28.5% and 23.21% respectively), followed at a distance by Venezuela with 7.77% and Spain in fourth place with 6.44%.

Spain is followed by three other American nations: Ecuador with 5.76%, Mexico with 4.02% and Peru with 2.98%. Portugal is at the bottom of the list of the eight countries that seized the most cocaine in 2005, with 18,083 kilos representing 2.40% of the global total.

This list includes two of the three cocaine-producing countries (Colombia and Peru), the two countries with the highest prevalence of use (USA and Spain) and the main nations of transit used to reach the largest consumer markets (North America and Europe) which are Venezuela, Ecuador and Mexico.

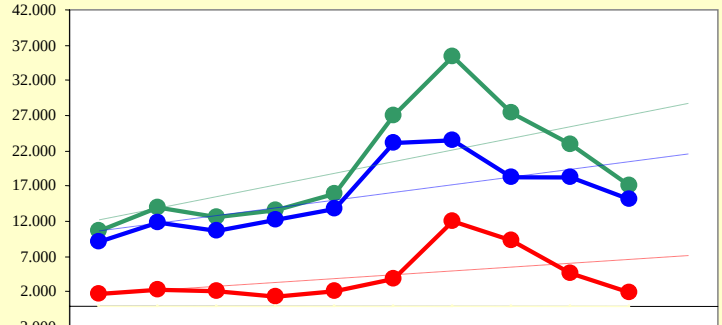
This list has not varied greatly since 1999. Spain ranked fifth in 2000, fourth in 1999, 2002 and 2005, and third in 2001, 2003 and 2004.

SYNTHETIC DRUG – MDMA

Number of seizures. Evolution in comparison with Europe

The number of ecstasy seizures in Spain has evolved similarly to the number of seizures in the rest of Europe and the total figures.

Figure 10. 14 COMPARED NUMBERS OF MDMA-ECSTASY SEIZURES EUROPE-SPAIN 1995-2004



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
EMCDDA total	10.630	13.991	12.546	13.506	15.836	26.945	35.429	27.380	22.977	16.984
SPAIN	1.630	2.242	1.999	1.375	1.995	3.750	11.947	9.180	4.694	1.920
REST of EUROPE	9.000	11.749	10.547	12.131	13.841	23.195	23.482	18.200	18.283	15.064
% SPAIN/TOTAL	15,33%	16,02%	15,93%	10,18%	12,60%	13,92%	33,72%	33,53%	20,43%	11,30%

The correlation coefficients of the number of seizures in Spain with the European total and with the rest of Europe are high (0.906193008 and 0.736587737 respectively). Both figures are compatible with a context in which Europe is making a concentrated

effort to combat ecstasy production and use, and Spain's involvement in this collective effort has resulted in a higher percentage of operations being carried out in our country.

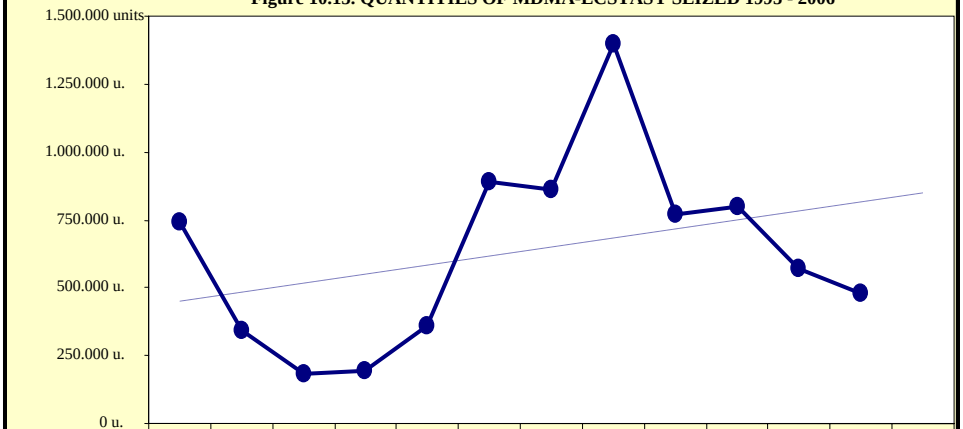
Quantities seized in Spain

The evolution of seizes of MDMA-ecstasy and synthetic drugs in general is influenced by a series of factors that have made it particularly difficult to crack down on the traffic of these substances. In this respect, the accompanying graph can be interpreted in two parts. Between 1995 and 1999, the use of these drugs became progressively harder to detect, after a period in which such substances enjoyed a relatively positive social image that made it more difficult to detect and pursue trafficking activities.

Between 1999 and 2006, institutional procedures of investigation and preventive control improved, and informative campaigns to warn young people of the risks associated with these substances intensified.

Beginning in 2000, the graph starts to follow a pattern similar to that of cocaine, characterised by the sawtooth evolution produced by improvements in security forces operations and the consequent changes in distributors' modus operandi. However, this trend appears to have been disrupted by the low seizure results of the last two years.

Figure 10.15. QUANTITIES OF MDMA-ECSTASY SEIZED 1995 - 2006



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
MDMA-ecstasy	739.511	340.444	184.950	194.527	357.649	891.562	860.164	1.396.14	771.875	796.833	572.871	481.583

The complex nature of the fight against synthetic drugs, from the inclusion of new drugs on the list of controlled substances to the difficulties of locating and neutralising distribution networks, is responsible for the fact that the total quantity of drugs seized in 2006 was 15.94% lower than in 2005 and 39.57% lower than in 2004.

Quantities seized. Global comparison

In 2005, **Spain** seized a total of 572,889 units of ecstasy and occupied the twelfth position in the world ranking. The USA, Australia and Great Britain are at the top of the list, representing 16.47%, 15.53% and 12.55% of the worldwide total respectively.

In Europe, Spain ranks seventh after Great Britain, the Netherlands, Belgium, Germany, Ireland and France.

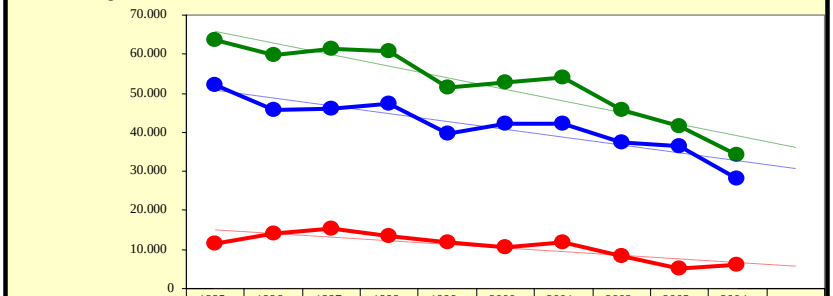
HEROIN

Number of seizures. Evolution in comparison with Europe

In the period analysed, the evolution of the number of heroin seizures has followed a steady downward trend for the three variables assessed. The performance of the three curves exhibits slight oscillations along their downward path.

Spain's contribution to the total number of heroin seizures has always been between 12% and 24%, with 2003 and 2004 registering the lowest figures for the period. This reflects the fact that traffic diminished at the end of the period due to the drop in user numbers registered in drug use surveys.

Figure 10.16 COMPARED NUMBERS OF HEROIN SEIZURES EUROPE-SPAIN 1995 - 2004

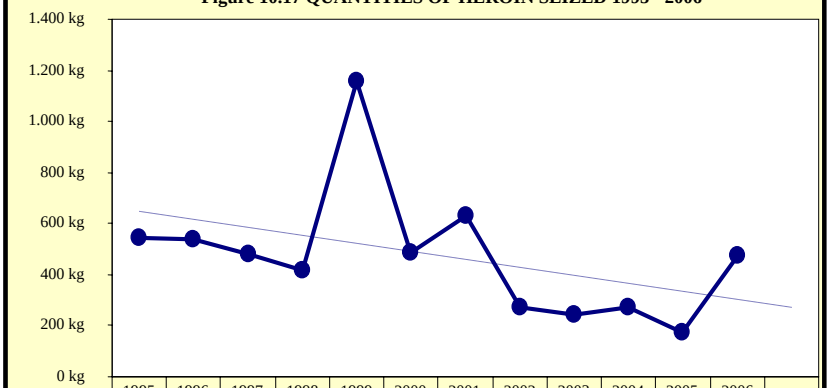


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
EMCDDA total	63.735	59.640	61.279	60.730	51.494	52.658	53.913	45.611	41.595	34.269
SPAIN	11572	14.040	15.399	13.496	11.938	10.410	11.800	8.177	5.012	6.056
REST of EUROPE	52.163	45.600	45.880	47.234	39.556	42.248	42.113	37.434	36.583	28.213
% SPAIN/TOTAL	18,16%	23,54%	25,13%	22,22%	23,18%	19,77%	21,89%	17,93%	12,05%	17,67%

Quantities seized in Spain

The evolution of heroin seizures shows a downward trend that can be attributed to a drop in supply due to the lower rates of use shown by demand indicators.

Figure 10.17 QUANTITIES OF HEROIN SEIZED 1995 - 2006



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Heroin	546,00	537,22	479,45	418,24	1.159,3	484,85	630,58	274,78	242,43	270,95	174,24	472

This downward trend slowed in 2006, with a sharp upturn in seizures. The total volume of heroin seized amounted to 472 kilos, 171.25% more than in 2005 and 74% more than in 2004.

Quantities seized. Global comparison

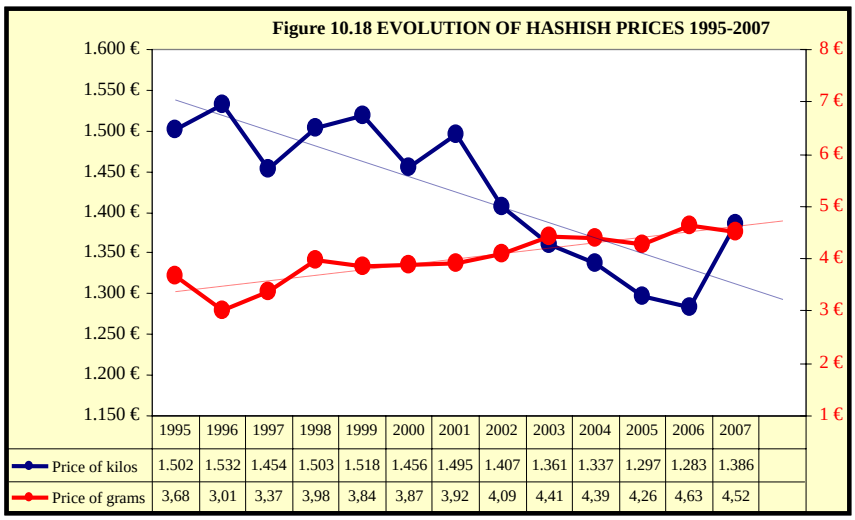
In the global context, the world ranking is headed up by China, Turkey and Afghanistan, which represent 15.30%, 14.03% and 12.18% of all seizures respectively. Spain occupies the thirty-seventh position in this ranking.

Price/Purity

HASHISH

The available data shows a tendency toward price containment with a very slight downward trend of the price per kilo and an equally slight upward trend in the price per gram. However, in a context of increasing demand, it is quite remarkable that the prices have tended to remain stable in absolute terms and are even lower in comparison with the general increase in the cost of living. Thus, according to available data, we are facing a situation of increasing demand and contained prices with stable THC quantities.

Figure 10.18 EVOLUTION OF HASHISH PRICES 1995-2007



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Price of kilos	1.502	1.532	1.454	1.503	1.518	1.456	1.495	1.407	1.361	1.337	1.297	1.283	1.386
Price of grams	3,68	3,01	3,37	3,98	3,84	3,87	3,92	4,09	4,41	4,39	4,26	4,63	4,52

Prices per gram have increased by a total of 22.83% since 1995. The price rose every year consistently until the turning point reached in 2003, and subsequently dropped by 2.5% between 2003 and 2007.

Prices per kilo have experienced an overall drop of 7.62% since 1995. In 2007, prices spiked upwards and experienced an 8.03% increase compared with the average prices per kilo in 2006.

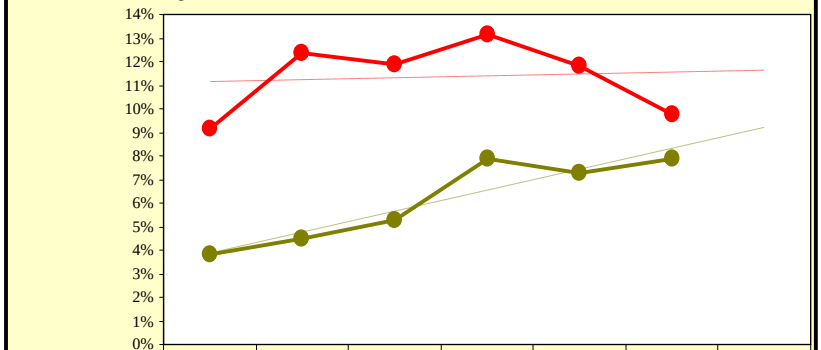
The adulteration of hashish is very rare, although in recent years some samples of hashish resin cut with other resins have been detected. Nevertheless, the highest percentage of adulteration detected does not exceed 0.80%.

The characteristic that modifies hashish's ability to produce effects in the user is the concentration of *Tetrahidrocannabinol* (THC), expressed as percentages, which varies substantially depending on the characteristics of each crop harvested as determined by weather conditions, the land and cultivation techniques used.

Although THC concentration levels do not depend on the trafficker, they may somehow influence the illegal trade of this drug. The annual averages[7] found in the samples analysed have been plotted on the following graph.

[7] 2001-2007 Reports of the Drug Division of the Madrid Department of the National Institute of Toxicology.

Figure 10.19. EVOLUTION OF THC CONCENTRATION IN CANNABIS 2001-2006



	2001	2002	2003	2004	2005	2006
%THC Hashish	9,2%	12,4%	11,9%	13,1%	11,8%	9,8%
%THC Marihuana	3,8%	4,5%	5,3%	7,9%	7,3%	7,9%

The data displayed shows that THC concentration has increased slightly in hashish resin and more sharply in marihuana, undoubtedly due to improved cultivation techniques. The graph presents oscillations with highs and lows that could be explained by the varying weather conditions each year.

An analysis of the hashish market reveals that:

- The prices per gram and per kilo for the period evaluated show a strong inverse correlation – the higher the price per gram, the lower the price per kilo.
- There is no significant relation between hashish prices and the THC levels detected in the samples analysed.

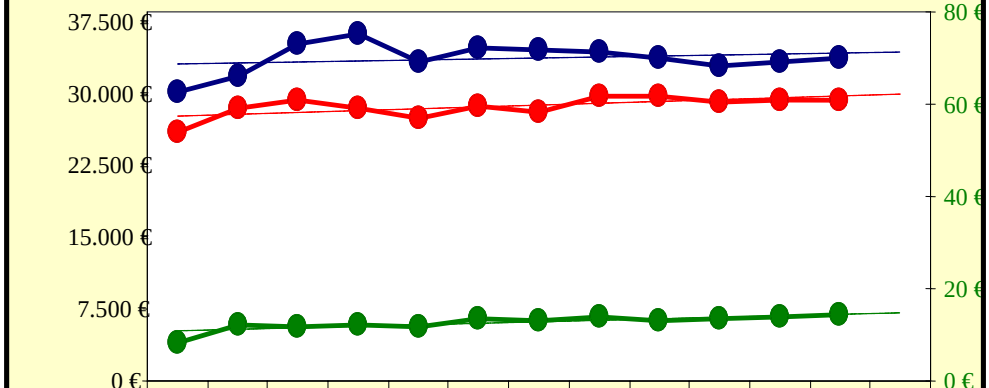
COCAINE

The available data shows a distinct trend of constant price maintenance, with nominal increases that, over an eleven-year period, translate into a 68.49% increase in the price per dose, a 12.31% increase in the price per gram and a 12-38% increase in the price per kilo. These increases are actually lower than the rise in the consumer price index; therefore, the relative prices of cocaine at every level have either remained stable or have dropped in a market of increasing demand, as indicated by the rise in the prevalence of cocaine use and the total number of users.

Prices rose along these same lines between 2006 and 2007, with variations well below the CPI given that the price per dose increased by 0.78%, the price per gram rose by 0.15% and the price per kilo went up by 1.22%.

In the period from 1996 to 2007, the **purity** of cocaine has fluctuated unevenly according to the level of traffic. The purity of cocaine in kilos has decreased by 3.33%, while the purity in grams has increased by 26.25% and in doses by 66%. Looking at data for the last two years, the three variables have experienced more or less pronounced drops. The purity of cocaine in kilos went down by 0.70%, in grams by 6.50% and in doses by 9.80%.

Figure 10.20.COCAINE PRICES PER DOSE, GRAM AND KILOGRAM 1996-2007

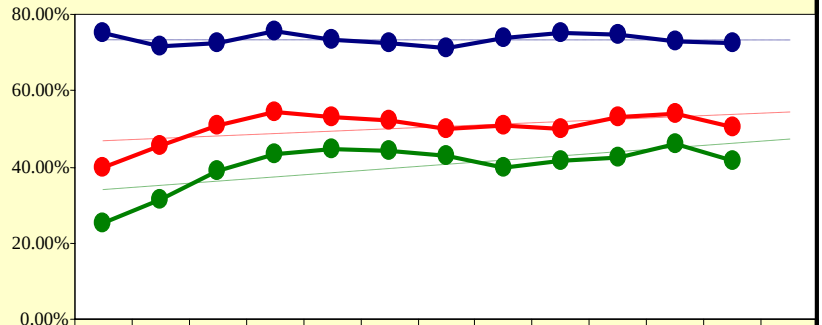


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Per kilo	30.051	31.854	35.159	36.211	33.358	34.640	34.570	34.364	33.653	32.758	33.364	33.771
Per gram	54,09	59,20	60,93	59,05	57,16	59,71	58,30	61,90	61,85	60,58	60,66	60,75
Per dose	8,41	12,32	11,95	12,10	11,70	13,62	13,15	13,93	13,22	13,30	14,06	14,17

Therefore, the data shows that we are facing a situation in which:

- Cocaine production and demand are rising due to the increasing prevalence of the drug and the number of users.
- Cocaine prices are remaining stable in relative terms, and increased in absolute terms from 2006 to 2007, with a notable drop in the price per kilo and a lesser drop in the price per gram.
- The purity at the different stages of distribution is increasingly gradually, although it has decreased slightly in the last year.

Figure 10.21 COCAINE PURITY IN DOSES, GRAMS AND KILOGRAMS 1996 - 2007



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Kilo purity	75,0%	71,5%	72,5%	75,5%	73,5%	72,5%	71,0%	74,0%	75,0%	74,5%	73,00%	72,50%
Gram purity	40,0%	45,5%	51,0%	54,5%	53,0%	52,0%	50,0%	51,0%	50,0%	53,0%	54,0%	50,5%
Dose purity	25,0%	31,5%	39,0%	43,5%	44,5%	44,0%	43,0%	40,0%	41,5%	42,5%	46,0%	41,5%

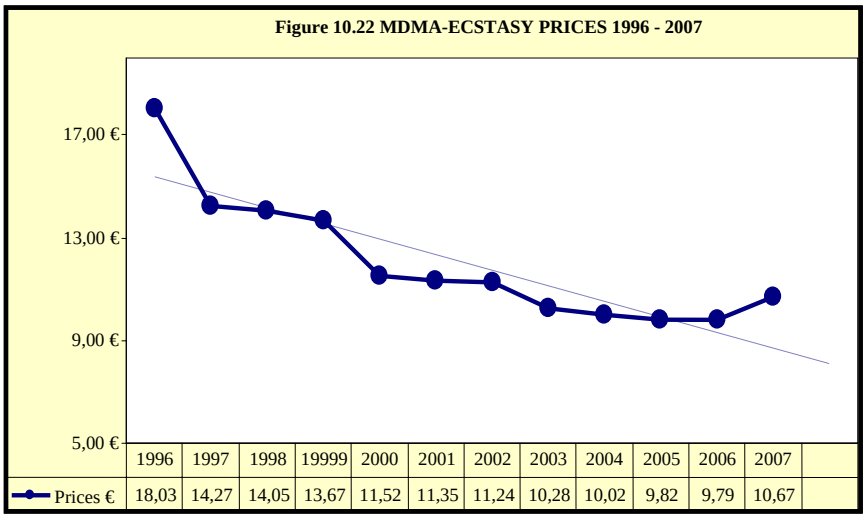
This data suggests the existence of some factor that eludes analysis, given that a reduction of supply and an increase of demand should result in a notable price increase or reduced substance purity, or both.

The calculation of prices, and of purity to a lesser degree, seem the most likely factors requiring a new evaluation, as well as the estimates of total cocaine in circulation, which could be higher than estimated if intensive and more efficient techniques are being used to cultivate crops and thus produce a greater quantity of base cocaine paste than the evidence indicates. This hypothetical greater supply would explain how demand is being met without exerting pressure on prices and purity levels.

SYNTHETIC DRUGS – MDMA

The **price** of ecstasy has shown a steady downward trend ever since records began to be kept in the mid-1990s. From 1996 to 2006, the price dropped by 45.70%, although it did experience a smaller increase of 8.99% from 2006 to 2007.

Figure 10.22 MDMA-ECSTASY PRICES 1996 - 2007



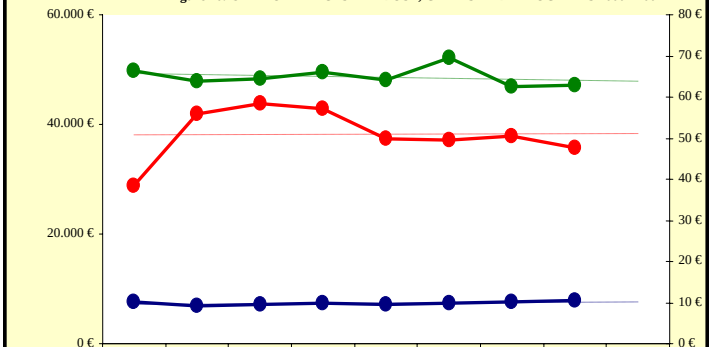
	1996	1997	1998	19999	2000	2001	2002	2003	2004	2005	2006	2007
Prices €	18,03	14,27	14,05	13,67	11,52	11,35	11,24	10,28	10,02	9,82	9,79	10,67

A situation of descending prices is consistent with a drop in demand, but we must keep in mind that the downward trend has been continuous since 1996, regardless of the ups and downs of the prevalence of use. The possible use of adulterating substances or the straightforward substitution of MDMA with other amphetamine derivatives or hallucinogens with similar effects could also be a factor in the price decrease.

HEROIN

The available data shows a price containment trend, particularly since 2004. The last two years have seen a slight downward trend in the price per kilo, also observed in the markets for doses and grams.

Figure 10.23 HEROIN PRICES PER DOSE, GRAMS AND KILOGRAMS 2000 - 2007



	2000	2001	2002	2003	2004	2005	2006	2007
Per kilo	28.727	41.966	43.740	42.885	37.320	37.193	37.756	35.791
Per dose	10,22	9,22	9,52	9,85	9,62	9,85	10,02	10,54
Per gram	66,38	63,96	64,50	66,05	64,15	69,39	62,42	62,81

In relative terms, prices per dose rose by 3.13% and prices per kilo rose by 24.6% between 2000 and 2007, while the price per gram dropped by 5.38% during the same period.

In 2002, the average price of a kilo of heroin was around 43,700€. Since then, the average price has decreased to the current level, 35,791€, which represents an 18.10% drop since 2002.

Although this price decrease may seem dramatic at first glance, it is not so severe if we consider that heroin production has picked up considerably and that the purity, although it is now lower, has not varied significantly. Another mitigating factor is the fact that, in 2000, the average price of one kilo of heroin was 28,727€, which suggests that we could still be in a period of market recovery, although there is not sufficient data to confirm this hypothesis at present.

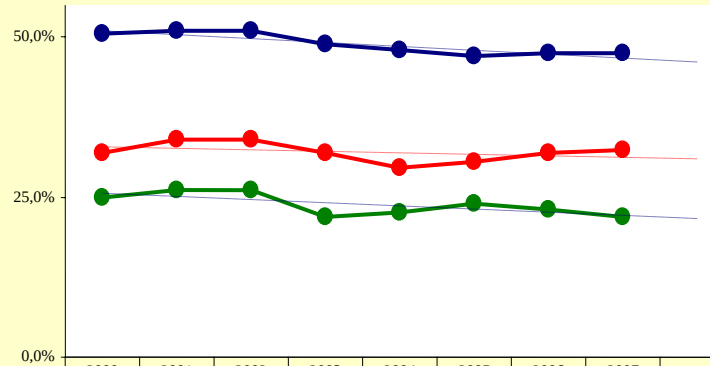
Between 2006 and 2007, the price per dose went up by 5.19% and the price per gram increased by 0.62%, while the price per kilo dropped by 5.20%.

The upturn of prices at the retail level (doses and grams) and the considerable drop in prices at the wholesale level suggests an increase in both supply and demand, although we have not detected an increase in experimental and occasional use and regular use has risen by a mere 0.04%.

With regard to purity levels, the general pattern is a downward trend. In the period from 2000 to 2007, the dose purity dropped by 12% and the kilo purity decreased by 5.94%, while the purity of the gram has increased by 1.56%.

Over the last two years, the dose purity has decreased by 4.35%, gram purity has increased by 1.56% and kilogram purity has remained stable.

Figure 10.24 HEROIN PURITY IN DOSES, GRAMS AND KILOGRAMS 2000 - 2007



	2000	2001	2002	2003	2004	2005	2006	2007
Dose purity	25,0%	26,0%	26,0%	22,0%	22,5%	24,0%	23,0%	22,0%
Gram purity	32,0%	34,0%	34,0%	32,0%	29,5%	30,5%	32,0%	32,5%
Kilo purity	50,5%	51,0%	51,0%	49,0%	48,0%	47,0%	47,5%	47,5%

There is hardly any connection between average prices at the different stages of heroin traffic. The average percentage of purity found at the different traffic stages does show a direct correlation, particularly the kilo in relation to the dose and the gram. Finally, in traffic on a small and medium scale, the markets move independently and separately, and therefore purity and prices have no bearing on each other.

11. PUBLIC EXPENDITURE

Though final figures are not yet available, according to the available data and the changes in spending in previous years, it is estimated that the amount which the National Government and the Autonomous Regional Governments invested in drug addiction policies in the year of 2006 reached the figure of approximately 400 million euros.

Furthermore, a significant number of municipalities in Spain, in general the larger cities, have Municipal Drug Dependency Plans of their own and devote considerable levels of investment to implementing these plans, though these amounts are not included in the already estimated budget.

Not included either are the expenditures made on the social health assistance provided to drug addicts for reasons other than the treatment of the drug addiction itself, because the competences on health care have been devolved from the National Government to the Autonomous Regional Governments. Therefore, it is very difficult to break down the portion of health care spending applied to drug-related pathologies as a part of total spending.

12. VULNERABLE GROUPS OF YOUNG PEOPLE

See information in Chapter 2: “Drug use in the general population and specific sub-groups - Drug use in the school and youth population”.

13. DRUG-RELATED RESEARCH IN EUROPE

Biomedical research and research on health sciences in Spain is an important part of the R+D+I (Research, Development and Innovation) system that is basically implemented within the National Health System, universities and public research entities. Within the field of Science, biomedical research has been one of the most representative forms of research forming part of the scientific boom that took place in the twentieth century. In this sense, we must emphasize the recent passage of the Law on Biomedical Research, which creates a legal framework for performing biomedical research in our country, thereby ensuring safe research that respects the people's rights.

The policy lines of R+D+I (Research, Development and Innovation) are set down in the National Research and Development Plans. The National Plan for Scientific Research, Development and Technological Innovation for 2008-2011 places an emphasis on four large lines of work:

- Generation of knowledge and skills oriented towards training and hiring highly qualified staff members, in both the public and private sectors.
- Promoting and improving the cooperation between public and private institutions, for which they present a new form of cooperation between the State and the Autonomous Regions.
- Promotion of technological innovation.
- The fourth and last line develops five specific strategic activities in different fields, **which include the field of health**.

This new Plan establishes the inter-annual increases in the spending policy dedicated to research, development and innovation in the General State Budget in order to achieve the main objectives with an outlook for 2011. In fact, the R+D+I policy has doubled the financing compared to the preceding year, with investment of more than 47.7 billion euros.

One of the priority areas in the National Research Plan is biomedicine, and mentioned within that field as an important objective is **further exploration into knowledge on addiction neurobiology.** Likewise, the Plan considers it to be of interest to identify behavioral, sociological and environmental risk factors, as well as the interaction among them all. This is what is referred to as community epidemiology. Another relevant aspect which it foresees is the application of "quality" to clinical practice, as well as studying the variability which is produced therein.

RESEARCH STRUCTURES

Drug-related research in national policy

The policy for science and research on addictions in our country follows a set of general lines of action which are carried out through the following:

- The general goal of the National Plan on Drugs is to "improve the objective quality of assistance and the results of treatment programs," for which purpose the **National Strategy on Drugs for 2000-2008** explicitly establishes as one of its large goals: "*The training of technicians and specialists on the various realms of action; training on the programs carried out and the development of lines of research which*

contribute to improving knowledge on the status of the problem and the measures to stem it."

- The Action Plan for 2005-2008 **of the National Strategy on Drugs for 2000-2008** establishes **the Improvement of Knowledge** as its **fourth axis.** This is made up of four parts: research, training for professionals, information systems and the evaluation of programs and interventions.

Actions in research:

- Action 36: Promoting the tasks of the National Institute for Research and Training on Drugs.
- Action 37: Promoting basic and clinical research in relation with the new substances which are most commonly used, new drug use patterns and their effects on health. Meta-analyses will be carried out using the studies on the effects of the various drugs.
- Action 38: Promoting social research on the perception of drugs and drug use among different social agents.
- Action 39: Promoting research in the field of humanities, ethics and culture, and their relationship with the world of drugs.
- Action 40: Stimulating epidemiological research.
- Action 41: Stimulating research on new programs, new forms of organization and new methodological tools to tackle the problems of drug addictions.
- Action 42: Disseminating scientific advancements and making a collection of updated, accessible documents available to all professionals.

Training-related actions:

- Action 43: Developing training programs and updating the proper knowledge for health care personnel, teachers, the staff of penitentiary institutions, social communication professionals and all those who take part in the process of helping people with drug addictions.

Actions in information systems:

- Action 45: Reinforcing the role of the Spanish Observatory on Drugs to improve knowledge of the real situation, to analyze trends, patterns of use, etc.
- Action 46: Building an early detection or alert system, with a simplified Panel of Indicators that makes it possible to monitor traffic, use and effects on health and society.
- Action 47: Further studying and expansion of the National Household.
- Action 48: Re-designing the School Survey.
- Action 49: Taking a specific survey of heroin and cocaine users undergoing treatment.
- Action 50: Carrying out a study on prevalence and associated variables in the prison population.
- Action 51: Carrying out a study on consumption, associated problems and alcohol dependence.
- Action 52: Improving the Indicator System for Problems caused by drug use.

Actions for Evaluation of programs and interventions:

- Action 55: Applying an ongoing evaluation system for the Strategy.

- Action 56: Promoting evaluation systems for Prevention, Treatment, Rehabilitation and Social Integration programs.
- Action 57: Developing an Evaluation system for the professional training programs, for both basic and ongoing training.

Therefore, the two major lines of work of the Government Delegation for the National Plan on Drugs (Government Delegation for the National Plan on Drugs) in the field of research are:

- The research promotion programs aimed at promoting scientific research by subsidizing research projects.

- The training programs which attempt to make it easier to increase awareness about scientific activities (financial support for organizing meetings and publishing scientific publications).

The main weaknesses found in the field of research in our country, in accordance with the needs detected by experts, as well as the data provided through the indicators of the Spanish Observatory on Drugs, are as follows:

Although there are quality research groups, the critical mass continues to be low; many of these groups which have achieved excellence are small. They are fragmented, without much of a relationship amongst each other and with an insufficient endowment of resources.

Non-existence of a unified database containing the research performed in this field. At present, the Action Plan on Drugs regards it as essential to promote research on drugs and to organize it, requiring coordination between government bodies and groups of researchers.

Lack of proper training on research methodology among the professionals in the field of addictions.

The research in the field of social science is difficult to evaluate.

Little ethnographic and criminological research.

Lack of greater empowerment of social agents in the definition of the priority lines of research, which also respond to the specific needs at each given moment.

Actions which are being carried out to correct these deficiencies:

The area of promoting cooperation on R+D is an attempt to do away with one of the endemic weaknesses in our system: the low level of cooperation between agents of different types (especially that of companies with universities and public research centers) and in different geographic locations, in both regional and international frameworks. The new national programs of public-private Networks and Cooperation are intended to promote concerted or cooperative activities so as to guarantee the proper fluid conveyance of knowledge and technology. The Addictive Disorders Network (RTA) is a huge step in this direction, because it takes an inventory of the scientific production teams accredited for drug addiction. This network is made up of 22 research groups.

Promoting, from within the framework of research institutions, a priority line which includes the research planned in the field of drug addictions, taking an inventory of

the research projects carried out in this field in Spain. One first step in this direction has been the report produced by the Spanish Drug Addictions Society on the management of drug addiction knowledge, a report financed by the Government Delegation for the National Plan on Drugs.

Prospecting to discover the needs of research groups: development of work platforms that can be used to create bridges between research and policies.

Studies on improving treatment in terms of cost effectiveness.

Systematic, ongoing evaluation of programs.

Promoting training on research. The Government Delegation for the National Plan on Drugs just financed an introductory manual to drug addiction research. Published by the Spanish Drug Addictions Society, this manual is intended for health care professionals who work in drug addiction clinics.

Relationship research-policy

The basic premise of the National Strategy on Drugs' success lies in the coordination of all the entities working in this field. Different structures and work teams make up platforms which are used to build bridges between research, policies and clinical practice:

- Spanish Observatory on Drugs
- Clinical Commission
- Primary Care Committee

The Spanish Observatory on Drugs.- In Spain, there are technical structures for the monitoring and analysis of epidemiological data in the field of drug addictions. This is the case of the Autonomous Regional Observatories and the Spanish Observatory on Drugs (OED), which each issue their own reports, in addition to a set of research institutions/agencies and universities that contribute to epidemiological research in this field. The OED is a permanent entity which gathers and analyzes the information available from different domestic and foreign sources, making it possible to evaluate the status of drug use and the associated effects at any given time, as well as evaluating them and identifying future trends. All of this information is useful for designing and evaluating policies aimed at preventing drug use and the associated problems. Therefore, this entity, which forms part of the Government Delegation for the National Plan on Drugs, advises different political and institutional bodies on the priorities existing in the field of drugs and the potential measures to be implemented.

The Clinical Commission.- This Commission was created in 2005 as a body to provide support and scientific advice to the Government Delegation for the National Plan on Drugs. It is made up of experts of acknowledged prestige in the fields of Neurology, Psychiatry, Clinical Psychology, Legal Medicine and Public Health. The Commission is working on three lines of work:

The first of them is focused on cannabis use, because it is the substance whose use is most frequent, especially among youths, and it has increased even more in recent years.

The second line of work is dedicated fundamentally to identifying all of the core areas of research, which involves both clinical and epidemiological studies carried out in Spain.

And the third line is focused on the topic of the mortality related with drug use, in terms of the protocols for action to be followed.

Up to this time, its members have produced two reports: the first of them on the effects of cannabis use on health, and the second on the effects of consuming alcohol on health. To do this, more than 165 international publications and studies were reviewed. Both reports are available at the Delegation's website.

Primary Care Commission.- This is a work group created within the Government Delegation for the National Plan on Drugs and is made up of primary care health professionals (representatives of the most important scientific societies in this sector). Its objectives are, on the one hand, to increase awareness among professionals about the important role they play in the early detection of drug use, and on the other hand, in providing keys to intervening in these topics appropriately.

Other work structures which help to increase awareness about the latest scientific advancements in this field are:

The NGO Forum. The National Strategy on Drugs seeks the mobilization of all the Social Organizations in this sector. Therefore, the initiative of the "Society facing the Drugs" Forum is of enormous value, becoming an important ally for prevention and sensitization activities.

The National Commission for the Prevention and Treatment of Drug Addictions in the Workplace gathers representatives of the Administration, Employers' organizations and Trade Unions to focus on the drug use in the workplace.

Main national structures for drug-related research

The structure of management and financing by the State Administration of R+D+I projects is set up through various departments and public entities. The main ministerial departments with competences in the field of R+D+I are the Ministry of Education and Science (MEC), the Ministry of Industry, Tourism and Trade (MITYC) and the Ministry of Health and Consumer Affairs (MSC), which conjointly manage (in the year 2007) approximately 94.0% of the budgeting resources provided through the General State Budget for R+D+I policy. Moreover, there is a wide range of Ministries and entities which manage R+D+I tenders related with their areas of responsibility and action. This diversity of agents makes efforts necessary for additional coordination and policies that facilitate access to the system by the users who are promoted in the new National Research Plan.

The State Administration's management and financing of the R+D+I projects on addictions are carried out through the following departments and public entities:

Ministry of Health and Consumer Affairs:

- Carlos III Health Institute. The program of the Ministry of Health and Consumer Affairs for scientific research on biomedicine and health sciences in 2004-2007 forms

part of the Biomedicine Plan within the National R+D+I Plan. The Carlos III Health Institute is a body for scientific support in the Ministry of Health and Consumer Affairs which manages the following programs in relation with research on addictions:

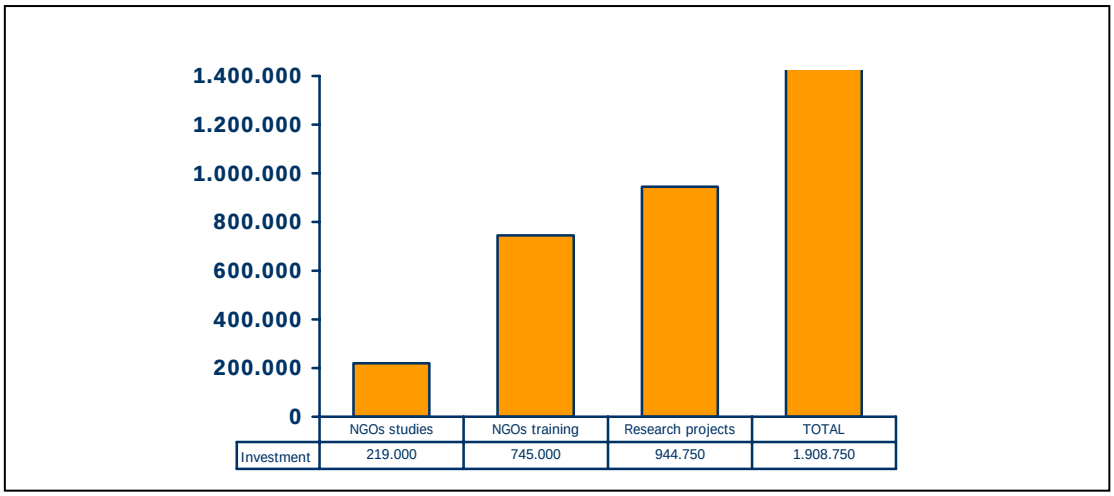
The sector-based program of the Health Research Fund (FIS) is made up of research projects and training for researchers on biomedicine and public health. It includes a specific line of research on drug addictions. In fact, it is the program which has most contributed to the research in this field. The FIS has made significant contributions to the knowledge on opiate and cocaine use rates and monitoring, as well as estimation by capture-recapture.

We must also point out the funding to the Thematic Cooperative Research Networks. This is an initiative similar to those proposed within the Fourth Framework Program of the European Union, the intention of which is to bring three types of research closer to each other and make the incorporation of research results into clinical practice more agile. Through this aid, a thematic cooperative research network was created in 2002, the ***Addictive Disorders Network*** **(RTA),** which came about by taking advantage of a numerous set of addiction research groups of excellence. This thematic network has achieved the following:

1. Creating a map of research projects in each of the three sub-networks (basic, clinical and epidemiological).
2. Creating a training structure based mainly on the start-up of a remote training system on drug addictions.
3. Starting up a system to disseminate information on the network's activities, with the goal of informing society at large and professionals about the status of the addiction problem in Spain, as well as the scientific and therapeutic advancements which have been put into practice.

- Government Delegation for the National Plan on Drugs. The Government Delegation for the National Plan on Drugs establishes activities aimed at promoting the improvement of knowledge in the field of addictions. These activities form part of the Action Plan for 2005-2008 of the National Strategy on Drugs. The Government Delegation for the National Plan on Drugs has several financing instruments for research on addictions (Figure 13.1 and Table 13.1):

FIGURE 13.1.- RESEARCH FINANCING INSTRUMENTS IN THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS. CALL FOR PROPOSALS, 2006 (€)



Source: Government Delegation for the National Plan on Drugs

TABLE 13.1.- INSTRUMENTS FOR FINANCING RESEARCH ON ADDICTIONS AT THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS.

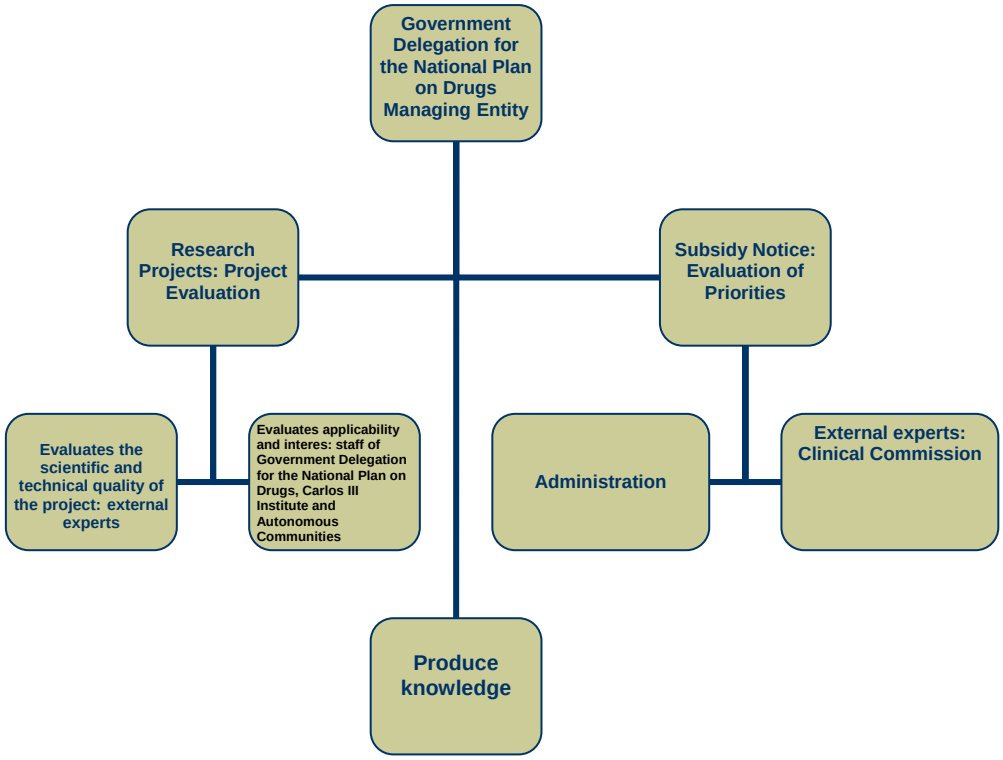
Types of financing	Frequency of public notices for aid	Applicants
Research Projects Call for proposals	Yearly: One notice	Non-profit Research Centers
Prevention programs, training and studies Call for proposals	Yearly: Two notices	Non-profit Entities
Contracts		

Call for proposals aimed at financing research projects submitted by research centers. Since the year of 2000, the Government Delegation for the National Plan on Drugs has issued a call for proposals for research on addictions. The goal of this yearly aid is to promote scientific research in the field of drug addictions to contribute to creating a scientific basis for the objectives and criteria established in the National R+D+I Plan. Research on addictions of a basic, clinical and public health-related nature is financed (Table 13.2), and both the evaluation of priorities and that of projects are assisted through the participation of different social agents (Figure 13.2).

TABLE 13.2.- PRIORITY LINES: CALL FOR PROPOSALS FOR RESEARCH PROJECTS GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS, 2000-2007	
2000	Scientific research projects of an experimental nature or of an observational or differential nature, on any of the different aspects involved in drug addictions, the results of which, whether in the final product or the procedure used, may be published or patented, or which may form part of bibliographic collections of a scientific nature. *No priority lines are specified.*
2001	Scientific research projects of an experimental nature or of an observational or differential nature, on any of the different aspects involved in drug addictions, the results of which, whether in the final product or the procedure used, may be published or patented, or which may form part of bibliographic collections of a scientific nature. *No priority lines are specified.*
2002	They must be projects of basic, clinical, clinical/experimental or public health-related research referring to the different aspects involved in drug addictions , the results of which, whether in the final product or the procedure used, may be published or patented, or which may form part of bibliographic collections of a *scientific nature*. To be considered of priority interest are those research projects which have the most direct applicability for their conclusions and which discuss topics that hold great social relevance, such as: • Projects which deal with the abusive consumption of alcohol by adolescents on weekends and which analyze the behavioral, organic and accident-related repercussions that this abuse entails. Studies on evaluation techniques on the quality of assistance provided to the drug addict in terms of management, treatment and social re-integration.

2003	They must be projects of basic, clinical, clinical/experimental or public health-related research referring to the different aspects involved in drug addictions , the results of which, whether in the final product or the procedure used, may be published or patented, or which may form part of bibliographic collections of a scientific nature. To be considered of priority interest are those research projects which have the most direct applicability for their conclusions and which discuss topics that hold great social relevance, such as: • Projects which deal with the abusive consumption of alcohol by adolescents on weekends and which analyze the behavioral, organic and accident-related repercussions that this abuse entails. • Studies on evaluation techniques on the quality of assistance provided to the drug addict in terms of management, treatment and social re-integration. • Research on the damage caused by the use and abuse of psychostimulants (with the greatest emphasis on syntetic drugs) in recreational environments and studies on the environmental factors which promote their use. • Studies on the features of drug use prevention within the family. Detection of factors which promote the involvement of parents in prevention activities.
2004	• Longitudinal and transversal studies on the social, behavioral and health-related effects of the abusive use of cannabis. • Research projects to evaluate harm reduction programs. • Tracking of users of social re-integration programs. • Evaluation of prevention programs intended for families and alternative leisure and entertainment. • Cocaine and social behavior.
2005	• Projects of basic, clinical, epidemiological or public-health related research on drug addictions, with a special emphasis on cocaine, ecstasy and cannabis. • Meta-analysis with studies on the effects of the different drugs. • Research on the amount of illness cause by drug use. • Social research projects on drug use among youths and adolescents, with a special emphasis on promoting factors such as strategies for the promotion, advertising and marketing of tobacco and alcohol, messages on drugs in movies, television and other media, as well as attitudes and opinions of youths about drugs. • Research on the evaluation of programs and interventions on drugs in the fields of prevention, damage reduction, treatment and social re-integration. • Methodological research aimed at improving the tools used to measure alcohol consumption and the use of other psychoactive drugs, as well as usage patterns and risk behaviors.
2006	Same priorities as in the year of 2006
2007	• Research on psychiatric comorbility and neuropsychological determiners in drug-dependent patients, especially cocaine addicts. • Research on the determining factors which are related with changes in drug use trends, with a special emphasis on cocaine. • Meta-analysis of the studies on the effects of different drugs, with a special emphasis on cocaine. • Social research projects on drug use among youths and adolescents, with a special emphasis on promoting factors such as strategies for the promotion, advertising and marketing of alcohol. Research on the evaluation of programs and interventions on drugs in the fields of prevention, damage reduction, treatment and social re-integration. Methodological research aimed at improving the tools used to measure alcohol consumption and the use of other psychoactive drugs, as well as usage patterns and risk behaviors.

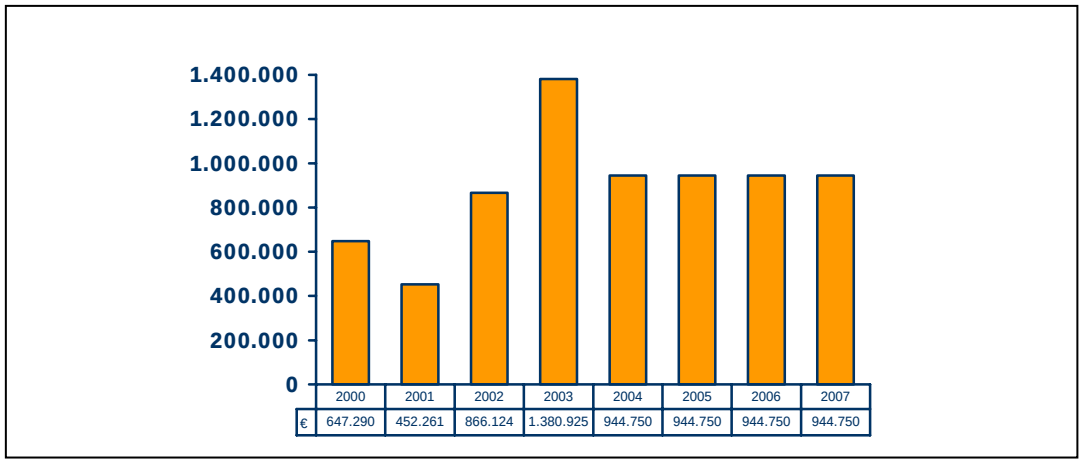
FIGURE 13.2.- MANAGEMENT AND SUPPORT STRUCTURES IN RESEARCH MANEGEMENT OF THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS.



The rules governing the call for proposals states that research projects may last for one, two or three years, within the framework of the National R+D+I Plan. To do so, there is an available credit worth one million euros per year (Figure 13.3). The target population is composed of non-profit research centers (mainly universities, hospitals and foundations).

Calls of proposals for Non-Governmental Organizations. The Delegation also has other funding which is not specific to research for NGOs (two per year). Research projects are subsidized, though with a different design. In the call for proposals 2006, 10 research projects were subsidized after being submitted by NGOs, the total financing of which amounted to 219,000 euros. In general, the goal of these projects is to evaluate projects (Figure 13.3).

FIGURE 13.3.- EXPENDITURES ON DRUG-RELATED RESEARCH. GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS. SPAIN, 2000-2007



	2000	2001	2002	2003	2004	2005	2006	2007
€	647.290	452.261	866.124	1.380.925	944.750	944.750	944.750	944.750

Source: Government Delegation for the National Plan on Drugs

Moreover, the Government Delegation for the National Plan on Drugs enters into agreements with other Units within the Central Administration (National Plan on AIDS, Youth Institute, Institute for Women, National Toxicology Institute, General Department of Traffic, etc.), research centers such as the Superior Council for Scientific Research (CSIC), public and private universities, etc., in order to produce works of scientific relevance and discuss topics which are important or of great practical interest at each given moment.

MAIN RECENT STUDIES AND PUBLICATIONS

Main recent studies since 2000

The Government Delegation for the National Plan on Drugs, during the period from 2000-2007, subsidized 131 projects (Figures 13.4 and 13.5), the main lines of research of which have been:

Problems related with alcohol consumption, especially its effects on the youngest people and on the feasibility of new prevention and rehabilitation strategies. In this sense, we must insist upon the usefulness held not only by research for improving knowledge of these substances and their toxic potential, but also that which contributes to improving the quality of prevention and therapy strategies.

Comorbidity and dependence. There is significant comorbidity of addiction to psychoactive substances and other mental illnesses. The advancements in the treatment and prevention of other mental illnesses may be useful for the prevention and treatment strategies against dependence on substances, and vice versa.

Figure 13.4.- Number of research projects subsidized from the Governement Delegation for the National Plan on Drugs. Years 2000-2007

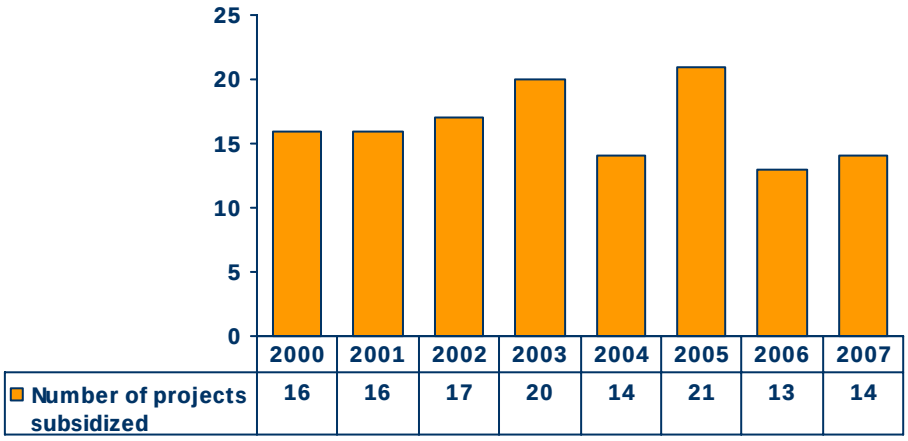
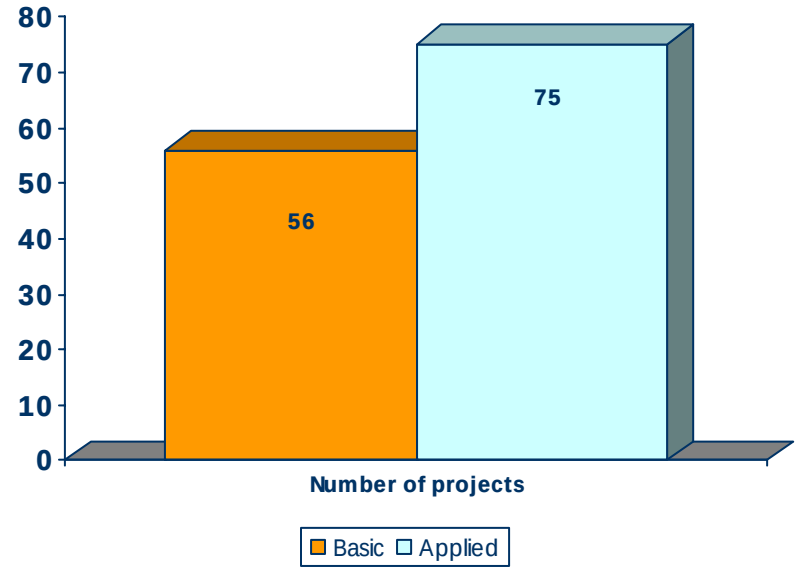


Figure 13.5.- Research projects subsidized by areas by the Government Delegation for the National Plan on Drugs 2000-2007



Source: Government Delegation for the National Plan on Drugs

Evaluation of interventions. Evaluating therapy techniques and treatment programs which are opening up new possibilities in assistance for the persons affected by drug addictions in order to validate their results.

Epidemiology and prevention. The research in this field constitutes a logical nexus of continuity with the development of the Spanish Observatory on Drugs. In recent years, a whole series of information systems and tools with information on drugs have been defined, structured and systematized and have turned out to be indispensable for carrying out any research and training task: home and school surveys are repeated every two years; the Treatment Demand Indicator is consolidated; the survey of heroin users was carried out for the second time and expanded to include cocaine users; a survey was carried out on health care for inmates at prisons, and, throughout the time period studied, the line of research on psychiatric comorbidity among heroin and cocaine users known as the "ITINERE Project" was subsidized (Domingo Salvany A., de la Fuente L, *et al.*).

Neuroscience and addictive behavior, which includes studies on neurobiology, clinical and therapeutic pharmacology, psychiatry, clinical psychology, etc. Neuroscience is a field of scientific research which is undergoing rapid growth. Though the knowledge is far from being complete, there is a considerable amount of useful data, which has an enormous ability to influence policies aimed at reducing the amount of morbility and disability associated with substance use.

Most of these lines of research have been developed by the research groups in the Addictive Disorders Network. This network is made up of 22 groups established in 7 autonomous regions, and a total of 177 researchers (Table 13.3), who perform basic, clinical and epidemiological research on addictions (Table 13.4).

TABLE 13.3.- RESEARCH GROUPS IN THE ADDICTIVE DISORDERS NETWORK, BY AREAS

BASIC	
Group	**Center**
RTA-1	Carlos de Haya Foundation, Málaga
RTA-2	School of Medicine of the University of Seville
RTA-3	School of Medicine of the University of Valladolid
RTA-4	U. Sciences School of the Autonomous University of Barcelona
RTA-5	Health Sciences School of Pompeu Fabra University
RTA-12	School of Psychology of the Complutense University
RTA-13	School of Medicine of the Complutense University
RTA-14	School of Psychology of the UNED
RTA-15	Cajal Institute. CSIC
RTA-16	Cajal Institute. CSIC
RTA-18	Euskal Herrika Unibersitatea
RTA-19	School of Medicine of Miguel Hernández University

RTA-20	School of Psychology of the Universityof Valencia
RTA-21	Cytological Research Institute
RTA-22	Human and Social Sciences School of Jaume I Cajal University. CSIC
CLINICAL	
Group	**Center**
RTA-6	Pharmacology-IMIM Barcelona
RTA-7	IMIM Hospital del Mar, Barcelona
RTA-8	Psychiatric Service. Hospital Vall d´Hebrón
EPIDEMIOLOGY	
Group	**Center**
RTA-9	IMS Epidemiology Service
RTA-10	Hospital German Trias i Pujol
RTA-11	Pharmacology. University of Valladolid
RTA-17	National Center for Epidemiology. ISCIII

TABLE 13.4.- LINES OF RESEARCH OF THE ADDICTIVE DISORDERS NETWORK.

ENDOCANNABINOIDS AND ALCOHOLISM RT1
IMABIS Foundation. Málaga
NEUROBIOLOGY OF OPIODS AND BIOGENIC AMINES RT2
School of Medicine. University of Sevilla
OPIOD ADDICTION RT3
School of Medicine. University of Cantabria
STRESS AND ADDICTION RT4
School of Sciences. Autonomous University of Barcelona
NEUROPHARMACOLOGY OF ADDICTION RT5
Facultad de CC de la Salud. Universitat Pompeu Fabra
CLINICAL PHARMACOLOGY OF ABUSED DRUGS RT6
Pharmacology. IMIM. Barcelona
CLINICAL-EPIDEMIOLOGICAL EVALUATION OF ABUSED DRUGS RT7
IMIM Hospital del Mar. Barcelona
ADDICTION AND DUAL PATHOLOGY RT8
Psychiatric Service. Hospital Vall d'Hebrón

PUBLIC HEALTH IN DRUG ADDICTIONS RT9
Research group of the Public Health Agency of Barcelona
MEDICAL CONSEQUENCES OF DRUG ADDICTION RT10
Hospital Germans Trias I Pujol
EPIDEMIOLOGY OF DRUG USE RT11
Pharmacology. University of Valladolid
PSYCHOPHARMACOLOGY OF ADDICTIVE BEHAVIOR RT12
School of Psychology. Complutense University of Madrid
NEUROTOXICITY OF PSYCHOSTIMULANTS RT13
School of Medicine. Complutense University of Madrid
MECHANISMS OF DEPENDENCE ON PSYCHOSTIMULANTS RT14
School of Psychology. UNED RT15
DOPAMINERGIC RECEPTORS AND ADDICTION RT16
Cajal Institute CSIC
DRUG USE PATTERNS RT17
National Center for Epidemiology. ISCIII
NEUROBIOLOGICAL FOUNDATIONS OF TOLERANCE AND ABSTINENCE RT18
Euskal Herrika Unibertsitatea
NEUROKININS (SUBSTANCE P) AND ADDICTION RT19
School of Medicine. Miguel Hernández University.
PSYCHOBIOLOGY OF DRUG ADDICTION RT20
School of Psychology. University of Valencia
NEUROBIOLOGY OF ALCOHOLISM RT21
Prince Felipe Research Center
Consuelo Guerri Sirera
PSYCHOBIOLOGY OF ALCOHOLISM RT22
School of Human and Social Sciences. Jaume I University

Peer-reviewed scientific journals

In recent years, Spain has seen a significant increase in both research on drug addictions and the completion of cooperative works, becoming one of the most important countries in terms of research in this field. The following are indicators on the drug addiction research carried out in Spain:

Several studies have been carried out which analyze Spain's scientific production on drug addiction (García-López, 1999; Guardiola and Sánchez Carbonell, 1994, 2006). According to the study by Guardiola (2006), Spain's scientific production in the field of drug addiction has increased notably over the course of recent years. Spain is the number three country among producers (in terms of the number of

publication) in the European Union, behind Great Britain and Germany. As of 1990, Spain's production amounts to approximately 10% of the publications in the European Union. This increase may be the result of a growing interest in this field of research, while at the same time drug use has increased, as well as the problems associated with it (Spanish Drug Observatory, 2003). This interest has also been reflected in a percentage increase in the works on drug addiction included in PsycINFO, because scientific production in this field has increased relatively much more than the overall amount in the database.

During the period from 2003-2005, the groups which made up the Addictive Disorders Network published 267 scientific reports with an average impact factor of 3.64 and a global impact factor of 973.15. Moreover, they have developed a corporate image and their own website: http: //www.redrta.net/. (RTA. 2002-2004 Report of the Addictive Disorders Network)

- Journals. The journals which published the most articles by Spanish authors are: *Actas Españolas de Psiquiatría*; *Adicciones*; *Psiquis Revista de Psiquiatría*, *Psicología y Psicosomática* and *Anales de Psiquiatría*. The foreign journals which have published the most articles by Spanish authors are specific to the field of addictions and have high impact factor (Drug and Alcohol Dependence, Addiction, Alcohol and Alcoholism, and Alcoholism Clinical and Experimental Research). (Guardiola 2006).

Main journals specializing in drug addiction published in Spain:

- *Adicciones* (www.adicciones.es), access to complete text of articles published since 1999. Published since 1989 by the Spanish Society for Studies on Alcohol, Alcoholism and Other Drug Addictions (known as *Socidrogalcohol*), it is a member of the ethical guides on publishing addiction journals, the Farmington Agreement, an agreement which governs the process of reviewing works which authors must strictly adhere to. This agreement was created by the International Society of Addiction Journal Editors (ISAJE), of which the journal *Adicciones* is a member.
Adicciones is a publication supported and financed by the Government Delegation for the National Plan on Drugs.
- *Coloquios en drogodependencias* (access to complete text of articles published as of the first issue, from September 1996). Published by the pharmaceutical laboratory Zambon Spain.
www.zambon.es/areasterapeuticas/07otros/01coloquios/index.htm

- *Prevención del Tabaquismo* (http://db.separ.es/ -Publications access point-, access to complete text of articles published in all its issues since June 1994). Published by the Spanish Society of Respiratory Medicine and Thoracic Surgery (SEPAR).

- *RET. Revista de Toxicomanías* (www.cat-barcelona.com/ret/, access to complete text of articles published in all its issues since the first, from the 4th quarter of 1994). Published by Cat Barcelona.

- *Revista Española de Drogodependencias* (www.aesed.com/publicaciones.htm, access to complete text of articles published in its latest issues). Published since 1976 by the Spanish Association of Study on Drug Addictions (AESED).

- *Salud y drogas* (http://inid.umh.es/inicio.asp?mod=revista&ct=portada.asp, access to complete text of articles published in all its issues as of Volume 1, Issue 1 -Year

2001-). Published by the Institute for Research on Drug Addictions of the Miguel Hernández University of Alicante.

- *Trastornos Adictivos* (www.doyma.es -Journals access point-, includes the complete text of articles published as of the first issue in January 1999). Published by Doyma, it is the Official Body of the Spanish Drug Addictions Society (SET). *Trastornos Adictivos* publishes reports involving ongoing training about addictions, its objective being to perform an eminently practical update of topics related with addictive disorders. The originals are produced in accordance with the recommendations of the International Committee of Medical Journal Publishers (Vancouver Group). The reports are subjected to evaluation by the Editing Committee, advisors and external proofreaders; the journal also has an international Consulting Committee. The reports are published in groups in accordance with scientific criteria. The publication includes Editorials, New Technologies, Updates, News from the sector and scientific societies involved and, of course, Scientific Articles, which give the journal greater interest. It includes a self-evaluation system through multiple-choice style questions and later official accreditation by the Ministry of Health, as part of an Ongoing Training Program on Addictive Disorders. *Trastornos Adictivos* is a publication supported and financed by the Government Delegation for the National Plan on Drugs.

- Authors. Of all the works, 74.5% were produced by more than one author, and the cooperation index from 1996-2000 was 3.50.

- Institutions. The university was the most productive institution, followed by hospitals and addiction treatment centers. (Guardiola 2006; FIS 2006) (Table 5).

TABLE 13.5. DRUG ADDICTIONS: SECTOR. BIBLIOMETRIC MAP OF SPAIN, 1996-2004; BIOMEDICINE AND HEALTH SCIENCES, FIS 2006

University	208	950	4.57	25,5%	0.84	10.1%	21.6%
Health Care	125	857	6.86	20.0%	1.05	12.0%	20.0%
OPI	24	246	10.25	12.5%	1.56	16.7%	37.5%
Superior Council of Scientific Research (CSIC)	10	25	2.50	30.0%	0.59	20.0%	50.0%
National Institutes	8	185	23.13	0.0%	2.50	0.0%	50.0%
Carlos III Health Institute	6	36	6.00	0.0%	1.92	33.3%	0.0%
Administration, NOGs and others	22	194	8.82	9.1%	1.11	22.7%	9.1%
Public Administration	22	194	8.82	9.1%	1.11	22.7%	9.1%
Companies	5	42	8.40	0.0%	1.09	60.0%	0.0%
TOTAL	**277**	**1655**	**5.97**	**23.5%**	**0.96**	**9.7%**	**24.9%**

- Main websites which specialize in drug addiction research in Spain:

- DOCUMENTATION CENTER OF THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS. www.pnsd.msc.es. Specialized in drug addictions, with bibliographic collections in different domestic and foreign languages. These bibliographic collections encompass all types of addictive substances (legal and illegal), as well as policies for action, in both Spain and the largest Western countries, in relation with the prevention, treatment, re-integration, etc. of drug addicts and the control of illicit drug trafficking. It also has documentation on the activities carried out by the international entities with responsibilities in this field: United Nations, European Union, Council of Europe, etc.

- SPANISH DRUG ADDICTION STUDY ASSOCIATION (AESED) www.aesed.com/
AESED (which began under the name of *Drogalcohol*) supports the study of, training on and scientific divulgation of studies on alcoholism and other drug addictions. Among its areas of work are the Center for Documentation on Drug Addictions, REDOC, which was officially opened in 1994. The website includes access to a portion of the contents form the last issue of the Spanish Drug Addictions Journal, as well as an index by authors of the articles published since it was created in 1976.

- SPANISH DUAL PATHOLOGY ASSOCIATION (AEPD) www.patologia-dual.com/aepd.htm
Set up in Madrid in 2005, the main goal of the association is to study, research and increase awareness about Dual Pathology, which is defined as the co-existence in the same person of an addictive behavior (alcoholism, drug addictions, behavioral addictions, etc.) and a mental illness.

- CITA, THE CENTER FOR ADDICTION RESEARCH AND TREATMENT. *www.cita.ad/*
Created in 1986 by Dr. Josep María Fábregas, CITA has a great deal of experience in drug addiction treatments.

- FOUNDATION FOR DRUG ADDICTION STUDY, PREVENTION AND ASSISTANCE (FEPAD) *www.fepad.es*
The Autonomous Regional Government of the Valencian Community created this Foundation in 2004 with the objective of improving assistance and prevention for drug addictions and to seek greater knowledge about the social health care situation of drug addictions and their consequences. The activities of FEPAD revolve around carrying out and tracking prevention programs (in schools, families, communities and workplace), and training and research in the field of drug addictions and international cooperation.

- IGIA Group. www.grupigia.com
The IGIA Group is a Non-Governmental Organization of a statewide scope made up of professionals in the field of drug addictions who come from various disciplines (Psychology, Medicine, Law, Anthropology, etc.) that was created in 1983. The IGIA Group attempts to produce, from within an associative context of an interdisciplinary nature, spaces for meeting and tools for reflection and debate about the various aspects related with the phenomenon of drug addictions.

- INSTITUTO BITÁCORA *www.institutobitacora.org*
Instituto Bitácora is a private institution whose headquarters is in Seville, dedicated since 1990 to research, prevention and treatment of problems resulting from alcohol consumption. Given the close relationship that abusive alcohol consumption has with certain mental pathologies and with the use of other substances, the Institute performs research and gives treatments for these

combinations of problems, in order to tackle them in an integrated manner.

- INSTITUTE FOR DRUG ADDICTION RESEARCH (INID) *inid.umh.es/*
The Institute for Drug Addiction Research (INID), attached to the Miguel Hernández University (Alicante), is oriented towards research, training and the application of programs and resources, by providing services and technical consulting to the public and/or private entities which request it, on all the problems related with drug addictions (prevention, assistance and social re-integration). It includes a section with advice for youths on different substances that may be addictive (alcohol, hallucinogens, cocaine, inhalers, marijuana and tobacco). The websites allows for access to the articles published in the journal Salud y drogas.

- DEUSTO DRUG ADDICTION INSTITUTE (IDD) *www.idd.deusto.es/*
The Deusto Drug Addiction Institute is a university entity which forms part of Deusto University (Bilbao). The Institute was created in 1990 with a concern for joining efforts to analyze drug addiction in its different facets through the University. Its main goals are scientific and technical research, teaching activities, organizing symposia and scientific meetings and the training of professionals in the field of drug addictions.

- MEHIB. GOOD PRACTICES IN TREATMENT WITH METHADONE. *www.easp.es/mehib/web/index.asp*
Within the Andalusian School of Public Health, it includes an access point on Mehib (Methadone maintenance and health care for drug users: identifying best praxis), a multi-centered research project carried out by the Andalusian School of Public Health, the University of Bremen and King's College of London, on different aspects of Methadone Treatment Programs (PTM). The objective of the website is to disseminate the results obtained and act as a point for meeting and reflection for professionals interested in this topic.

- ADDICTION DISORDER NETWORK. www.redrta.net/
The RTA Network was created to research the origins of addictive disorders, their clinical manifestations and their social impact with the ultimate goal of providing tools for therapeutic and social intervention which help reduce the impact of addictions. The RTA Network is made up of 22 research teams from 7 autonomous regions (Catalonia, Madrid, Andalusia, Valencian Community, Basque Country, Castile and León, and Cantabria).

- SOCIDROGALCOHOL, THE SPANISH SCIENTIFIC SOCIETY OF STUDIES ON ALCOHOL, DRUG ADDICTIONS AND OTHER ADDICTIONS. *socidrogalcohol.org/*
A non-profit scientific society declared to be of public utility, made up of professionals with different academic degrees. Founded in 1969, it has a national presence, with various autonomous regional delegations. Its main goals are to promote the performance of scientific activities related with drug addictions and to facilitate the relations between scientists dedicated to studying and researching the problems resulting from the abuse of toxic substances. Access to the summaries of those articles published in the journal Adicciones since 1996.

- SPANISH SOCIETY FOR RESEARCH ON CANNABINOIDS (SEIC). *www.ucm.es/info/seic-web/*
Inside the website of the Complutense University of Madrid is information on this scientific society made up of researchers who work in the field of cannabinoids through different disciplines and methodologies. The SEIC attempts to support

these scientists and provide a legal framework that promotes research and advancement in the knowledge on cannabinoids. The website includes access to the programs and summaries presented at its annual meetings, as well as the electronic bulletins that it has been producing since January 2002.

- SPANISH DRUG ADDICTIONS SOCIETY (SET). www.setox.org/ The SET, located in Valencia, is a society of a nationwide scope founded in 1988. Its main objective is to make it possible for professionals to share scientific information (doctors, psychiatrists, pharmacists, psychologists, etc.), thereby promoting the progress of knowledge in the field of drug addictions.

A large number of the reports produced by these associations are financed by the Government Delegation for the National Plan on Drugs, through the aid provided to NGOs. By doing so, financing is given for seminars, congresses, meetings, courses and various publications. The last time aid was given in the year of 2006, different activities were subsidized for training (30 courses and seminars, 2 drug addiction journals, 1 clinical guide, 1 research manual, 1 manual on addiction genetics) and for increasing awareness (4 congresses and 4 publications), the total financing of which amounted to 745,000 euros (Figure 1).

COLLECTION AND DISSEMINATION OF RESEARCH RESULTS

See above.

14. BIBLIOGRAPHY

Alphabetic list of relevant Internet addresses

www.pnsd.msc.es	Government Delegation for the National Plan on Drugs
www.adicciones.es	Adicciones
www.zambon.es	Coloquios en drogodependencias
www.redrta.net	Addictive disorders network
http://db.separ.es	Prevención del Tabaquismo
(www.cat-barcelona.com/ret/	Ret. Revista de toxicomanías
www.aesed.com/publicaciones.htm	Revista Española de Drogodependencias
http://inid.umh.es/	Salud y drogas
www.doyma.es	Trastornos adictivos
www.aesed.com	Spanish drug addiction study association (AESED)
www.patologia-dual.com/	Spanish dual pathology association (AEPD)
www.cita.ad/	Cita, the center for addiction research and treatment.
www.fepad.es	Foundation for drug addiction study, Prevention and Assistance (FEPAD)
www.grupigia.com	Igia Group
www.institutobitacora.org	Instituto Bitácora
inid.umh.es	Institute for drug Addiction Research (INID)
www.idd.deusto.es/	Deusto drug addiction institute (IDD)
www.easp.es/mehib/web/index.asp	EHIB. Good practices in treatment with methadone.
socidrogalcohol.org/	Socidrogalcohol
www.ucm.es/info/seic-web/	Spanish Society for Research on Cannabinoids (SEIC)
www.setox.org/	Spanish drug addictions Society (SET)

15. ANNEXES

List of Graphs used in the text

Figure 10.24	HEROIN PURITY IN DOSES, GRAMS AND KILOGRAMS 2000 – 2007
Figure 13.1	RESEARCH FINANCING INSTRUMENTS IN THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS. CALL FOR PROPOSALS, 2006
Table 13.1	INSTRUMENTS FOR FINANCING RESEARCH ON ADDICTIONS AT THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS.
Table 13.2	PRIORITY LINES: CALL FOR PROPOSALS FOR RESEARCH PROJECTS GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS, 2000-2007
Figure 13.2	MANAGEMENT AND SUPPORT STRUCTURES IN RESEARCH MANEGEMENT OF THE GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS.
Figure 13.3	EXPENDITURES ON DRUG-RELATED RESEARCH. GOVERNMENT DELEGATION FOR THE NATIONAL PLAN ON DRUGS. SPAIN, 2000-2007
Figure 13.4	Number of research projects subsidized from the Government Delegation for the National Plan on Drugs. Years 2000-2007
Figure 13.5.	Research projects subsidized by areas by the Government Delegation for the National Plan on Drugs 2000-2007
Table 13.3	RESEARCH GROUPS IN THE ADDICTIVE DISORDERS NETWORK, BY AREAS
Table 13.4	LINES OF RESEARCH OF THE ADDICTIVE DISORDERS NETWORK.
Table 13.5	DRUG ADDICTIONS: SECTOR. BIBLIOMETRIC MAP OF SPAIN, 1996-2004; BIOMEDICINE AND HEALTH SCIENCES, FIS 2006