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DELEGACIÓN DEL GOBIERNO PARA EL PLAN NACIONAL SOBRE DROGAS

2005 NATIONAL REPORT (2004 data) TO THE EMCDDA
by the Reitox National Focal Point

"SPAIN"

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

REITOX

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Summary

The present report on the drug situation in Spain in 2004 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 2005 REITOX grant agreement for an action.

The 2005 report addresses the drug phenomena in Spain and gives an overview of the most relevant developments regarding the institutional and legal framework, the supply control, the epidemiological situation and the drug demand reduction interventions that have taken place during the reporting period. The report also provides in depth information on three selected issues: gender differences, European drug policies: extended beyond illicit drugs and developments in drug use within recreational settings.

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

Regarding the legal framework, various important provisions with national, regional and international scope were approved and/ or published in the year 2004.

Within the sphere of national regulations, primary mention must be made of the important change in organisational and jurisdictional matters that was brought about by ***Royal Decrees 553/2004, 17 April, which restructured Ministerial departments***, and ***562/2004, 19 April, which adopted the basic organisational structure of Ministerial departments***. In accordance with these decrees, the Government Delegation for the National Plan on Drugs is no longer attached to the Ministry of Interior as Under Secretariat, and now answers directly to the Ministry of Health and Consumers Affairs, where it has been included as a General Directorate.

On penal law, ***Royal Decree 1774/2004, 30 July, approves the Regulations of Organic Law 5/2000, 12 January, which regulates the criminal liability of minors***, develops the legal provisions regarding the application of therapeutic confinement measures, when the minors exhibit problems of addiction to alcohol, narcotic and psychotropic substances.

On prevention area, special interest had the approval, as a further development of Organic Law 10/2002, 23 December, on the Quality of Education, of several pieces of legislation that regulate the curricula of the various educational levels: ***Royal Decrees 115/2004, 23 January, which establishes Primary Education curricula, 116/2004, 23 January, which further develops established legislation and determines Obligatory Secondary Education curricula, and 117/2004, 23 January which further develops established legislation and determines Baccalaureate curricula***, lay down specific provisions on matters regarding the prevention of drug addictions.

During the year 2004, the Government Delegation for the National Plan on Drugs has actively promoted the implementation of a data gathering and analysis process in order to obtain precise knowledge of the evolution of drug addiction and the degree to which the National Drug Strategy's objectives are being attained during the first four years of its effectiveness. All authorities comprising the NDP, from both the private and public sectors, and especially the Regional Drug Plans have participated in this process, which culminated in the publication of the 2003 Evaluation of the National Drug Strategy.

According to this Evaluation, the best results have been obtained in the areas of assistance and harm reduction, in addition to satisfactory results obtained in other areas such as research and education, international co-operation and supply reduction.

In 2004, it has been carried out a new School Survey in order to obtain a general overview of drug use among secondary school students between the ages of 14 and 18, as well as drug use trends and certain other related issues.

Its results show that in 2004 the drugs of abuse most widely used by 14 to 18-year-old secondary school students in Spain were alcohol and tobacco and the substances used at the earliest age were also tobacco (average age 13.2), alcoholic beverages (13.7) and inhalants (14).

Cannabis is the illegal drug most widely used by secondary school students between the ages of 14 and 18 in Spain followed by cocaine.

Risk was perceived to be greater for routine than sporadic use, but the differences were much more significant for cannabis or sedative-hypnotic drugs than for ecstasy, cocaine or heroin.

Prevention continues being a priority for the National Plan on Drugs. In Spain the approach to the development and structuring of prevention varies greatly from one autonomous region to another, although their activities all tend to focus on schools, families and the media. The tendency to apply structured programmes in sessions in schools and families with additional resources continues. With regard to the media, most actions are campaigns used by the media as an informative prevention technique, although the media is becoming more and more involved as a collaborator in the effort to spread awareness about drugs. Regarding to the scope of the school programmes, the available data shows that 6,840 educational centres, 18,381 teachers and 965,682 students participated in 2004. In the scope of family programmes, a total of 90,685 fathers and mothers have participated in these programmes which is an amazing increase compared to previous years.

In the supply control section, the available data shows a steady and rising evolution of hashish seizures in Spain over recent years; in the opposite side the quantities confiscated and the number of seizures of heroin in our country went down about 45%. Relating to cocaine, the data on prices, availability, demand, use and seizures seems to indicate that the cocaine market is clearly on the rise.

The last section of the Spanish Report analyses the three selected issues focused this year on gender differences, European drug policies: extended beyond illicit drugs and developments in drug use within recreational settings.

Concerning the first selected issues, gender differences have been analysed from four different points of view: the use of different drugs, treatment, crimes and arrests and specific prison responses.

One on the main conclusions is that prevalence of use of the main illegal drugs (cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin) is several times higher among men than among women, both in the general population living in family residences (15-64 years old) and in secondary school students (14-18 years old). So, health and social consequences of drug use continue to principally affect males.

The second selected issue analyses the Spanish policy regarding tobacco and alcohol both endorsed by the 2000-2008 National Drug Strategy and the 2005-2008 Action Plan that refer to alcohol and tobacco as substances regulated by legislation in all areas covered by drug-addiction legislation (prevention, treatment, assistance) based on the fact that these substances create the greatest number of addictions in Spain.

Law in Spain does not regulate compulsive gambling and it is not considered an addiction; it has to be mentioned as well that Spain has a specific regulation dealing with doping, although it is not considered an addictive behaviour and is not included in the National Drug Strategy.

Finally, this section shows one of the most important changes in the Spanish legislation that was started on 1 December 2004: Law Project on health measures on tobacco; the Draft established limitations on the sale and supply of tobacco products, on its consumption at the workplace and other settings and on tobacco publicity, advertising and sponsorship. It also contained a list of sanctions.

The Ministry of Health and Consumer Affairs not only intends to guarantee the rights of the non-smoking population to breath clean air but also to design informative and assistance strategies to prevent on the health risks associated with smoking and make quitting easier for those who wish to do so.

The last selected issue deals with developments in drug use within recreational settings and try to reflect the situation in Spain during the last years especially regarding alcohol use and the implementation of the Law 1/1992, on the Protection of Citizen Safety.

Regarding preventive responses to drug use in recreational venues, the Spanish Drug Action Plan, approved by the Ministry of Health and Consumer Affairs in March 2005, dedicates the second of its six axis to prevention and social awareness. Among the specific actions included in this axis are related to create extracurricular informative, educational and alternative recreation programmes, with well-organized activities, specifically aimed at young people, socially depressed individuals and at-risk groups.

The Government Delegation for the National Plan on Drugs has been financing some programmes directed to promote healthy activities as alternatives to the drugs' use during young people's free time, mainly weekends and vacation periods. The programmes are aimed at minors and at-risk adolescents, offering them the opportunity to participate in recreational, sports, cultural and social activities, in an attempt to avoid, reduce or replace the participation of these young people in activities related to drug use.

Part A: New Developments and Trends

Part A: NEW DEVELOPMENTS AND TRENDS

1. National policies and context

- **Legal framework**

With regard to regulation activities, various important provisions with national, regional and international scope were approved and/ or published in the year 2004.

Within the sphere of national regulations, primary mention must be made of the important change in organisational and jurisdictional matters that was brought about by ***Royal Decrees 553/2004, 17 April, which restructured Ministerial departments***, and ***562/2004, 19 April, which adopted the basic organisational structure of Ministerial departments***. In accordance with these decrees, the Government Delegation for the National Plan on Drugs is no longer attached to the Ministry of Interior as Under Secretariat, and now answers directly to the Ministry of Health and Consumers Affairs, where it has been included as a General Directorate.

After the approval of the abovementioned provisions, other regulations of the same status have enacted the indicated changes.

Royal Decree 1555/2004, 25 June, which enacted the basic organisational structure of the Ministry of Health and Consumer Affairs , assigns duties on drug –related matters , and Article 13 further establishes the jurisdictional powers granted to the Government Delegation for the National Plan on Drugs, under the General Secretary of Health .Other body assigned to the Government Delegation is the Distribution Co-ordination Board, established by Law 17/2003, of 29 March, which regulates the Fund of confiscated assets from illegal drug trafficking and other related offences.

Royal Decree 1599/2004, 2 July, which enacted the basic organisational structure of the Ministry of Interior, establishes provisions in matters of public safety and police activities related to the National Drug Plan. The State Secretary of Security (article 2 f) is responsible for directing, enacting and co-ordinating the Ministry of Interior's activities in matters of illegal drug trafficking , money laundering on drug related trafficking and other related offences. The State Secretary of Security is also responsible on administrative legislation regarding the control of chemical precursors.

In the matters related to the control of narcotic substances, a relevant development is the approval of ***Mandate SCO/190/2004, 28 January, which determines the list of plants whose sale to the public is prohibited or restricted due to their toxicity***. The annex of this mandate specifically includes all parts of the plant *cannabis sp*.; consequently, the sale of this plant or of its derivatives to the public is prohibited due to its toxicity, and usage and marketing of the same is restricted to the creation of special pharmaceuticals, magistral formulas, officinal compounds, homeopathic stock and to research.

Regarding the control of psychotropic substances, in accordance with decision 2003/847/JAI, of the Council of the European Union, 27 November 2003, ***Order SCO/2359/2004, 2 July, which modifies Annex I of Royal Decree 2829/1977, 6 October, which regulates psychotropic substances and products***, includes in list I of the abovementioned Annex I the substances 2C-I, 2C-T-2 and TMA-2, together with their stereochemical variants, racemates and salts. Consequently, the use, fabrication, importation, transportation, trade and possession of said substances and all compounds containing them are strictly prohibited.

Changes made in 2004 to the internal legislation scheme in effect (in addition to changes in international legislation, which will also be addressed herein) have also affected the control of chemical precursors, following the decision adopted in March 2001 by the United Nations Commission on Narcotic Drugs to include acetic anhydride and potassium permanganate in Table I of the 1988 United Nations Convention against Illicit Trafficking on Narcotic Drugs and Psychotropic Substances, and the subsequent adoption of Commission Directive 2003/101/CE, of 3 November 2003, in compliance with which Annexes I and II of Directive 92/109/CEE were replaced by the new Directive, adapted to comply with the UN's decision.

In order to comply with the abovementioned international regulations , ***Royal Decree 293/2004, 20 February, which modified Annexes I and II of Law 3/1996, of 10 January, on measures for controlling catalogued chemical substances liable of being diverted to the illicit manufacture of drugs***, modified Annexes I and II of the abovementioned Law. In the first case, to include potassium permanganate in category 2 (removing it from category 3); and in the second, to increase the quantitative limit of acetic anhydride and also to include the first of the cited substances together with its corresponding limit.

On prevention area, special interest had the approval ,as a further development of Organic Law 10/2002, 23 December, on the Quality of Education, of several pieces of legislation that regulate the curricula of the various educational levels: ***Royal Decrees 115/2004, 23 January, which establishes Primary Education curricula, 116/2004, 23 January, which further develops established legislation and determines Obligatory Secondary Education curricula, and 117/2004, 23 January which further develops established legislation and determines Baccalaureate curricula***, lay down specific provisions on matters regarding the prevention of drug addictions.

On penal law, ***Royal Decree 1774/2004, 30 July, approves the Regulations of Organic Law 5/2000, 12 January, which regulates the criminal liability of minors***, develops the legal provisions regarding the application of therapeutic confinement measures, when the minors exhibit problems of addiction to alcohol, narcotic and psychotropic substances. In these cases, the legislation foresees the establishment of a treatment programme by professionals with the recommended social and health guidelines and controls that will guarantee a correct monitoring of the programme, which will in turn be part of an individualised programme for the execution of these measures. And, on the other hand, this legislation prohibits alcoholic beverages, narcotics and psychotropic substances in all confinement centres for minors; the introduction, possession and use of all of the above are classified as extremely serious violations.

To conclude the overview of national legislation, mention must be made of ***Law 1/2004, 21 December, on Commercial Opening Hours***, whose third additional Provision authorises the Autonomous Communities to adopt rules that grant Municipal Authorities the power to close down individual establishments that sell alcoholic drinks in order to maintain public order.

In the area of regional legislation, the most important issue has been the approval of ***Law 7/2004, of 30 September, second modification of the Law on Drug Addiction Prevention, Assistance and Reinsertion***, of the Basque Country Autonomous Community, in accordance with which the regional drug-addiction plans of said region now remain effective over a five-year period.

Finally, the overview of drug-related legislative output in the year 2004 would not be complete without mentioning several international laws and regulations.

First of all, within the EU sphere and by virtue of its enormous importance for the harmonization of the various Member states' internal criminal laws as they pertain to this

topic, we must note the adoption of ***Council Framework Decision 2004/757/JAI, of 25 October 2004, laying down minimum provisions on the constituent elements of criminal acts and penalties in the field of illicit drug trafficking.***

In this respect, although Spanish law is already in compliance with the majority of this community provision's contents.

Secondly, it is also necessary to keep in mind the new legal regime of precursors control that has been imposed on all EU Member states, as a result of the adoption of ***Regulations (CE) 273/2004 of the European Parliament and of the Council on drug precursors*** (most of whose precepts will not enter into effect until 18 August 2005, and which abrogates Council Directive 92/109/CEE and other subsequent directives on this subject, as well as (CE) Council Regulations 1485/96 and 1533/2000) and ***111/2005 of the Council, of 22 December, laying down rules for the monitoring of trade between the Community and third countries in drug precursors*** (which will also not become effective until 18 August 2005, except for a few provisions, and which abrogates Regulation (CEE) 3677/90 as of the same date). The entire contents of these regulations shall be obligatory and directly applicable in each member-state.

In Spain's case, this constitutes a tacit modification of internal legislation in this area as established in Law 3/1996, of 10 January, and its regulatory provisions for further development, although the abovementioned Communitarian legislation on drug precursors continues to recognise the capacity of the different States to determine the penalties applicable for infractions of the new regulations.

Also of interest within the scope of the EU is the approval and/or publication of the following provisions: ***Council Decision 29 April 2004, on the conclusion, on behalf of the European Community, of the United Nations Convention Against Transnational Organised Crime***; ***Council Decision 2 June 2004, concerning the conclusion of the WHO Framework Convention on Tobacco Control***; and two ***Council Resolutions 27 November 2003***, one ***on combating the impact of psychoactive substances use on road accidents***, and the other ***on the importance of the role of families in preventing the use of narcotics by adolescents*** (both published in Official Journal C97, 22/04/2004).

Lastly, this year has witnessed the publication of various bilateral agreements ratified "*ad referendum*" by the Kingdom of Spain and other States, on co-operation in the area of preventing use and illicit trafficking of narcotics and psychotropic substances (with the **Republic of Colombia**, signed in Bogotá on 14 September 1998, effective as of 5 March 2004; with the **Federative Republic of Brazil**, signed on 11 November 1999, effective as of 13 July 2004) and on co-operation in the fight against organised crime and illicit trafficking of narcotics, psychotropic substances and precursors (with the **Republic of Latvia** , signed in Madrid 24 November 2003, effective as of 24 December 2003).

- **Institutional framework, strategies and policies**

The National Drug Strategy is in effect for a period ranging from 1 January 2000 to 31 December 2008. The years 2003 and 2008 have been established as dates of reference for completing a partial and complete evaluation of its results.

During the year 2004, the Government Delegation for the National Plan on Drugs (DGPNsD - Spanish acronym) has actively promoted the implementation of a data gathering and analysis process in order to obtain precise knowledge of the evolution of drug addiction and the degree to which the National Drug Strategy's objectives are being attained during the first four years of its effectiveness. All authorities comprising the NDP, from both the private and

public sectors, and especially the Regional Drug Plans have participated in this process, which culminated in the publication of the 2003 Strategy Evaluation.

According to this Evaluation, the best results have been obtained in the areas of assistance and harm reduction, in addition to satisfactory results obtained in other areas such as research and education, international co-operation and supply reduction. However, the need to intensify efforts in the area of prevention is markedly clear, since the key objective – that is, reducing drug use – has not been attained according to the results of the latest surveys.

As a consequence of the results described in said Evaluation, in March 2005 the Ministry of Health and Consumers Affairs approved an Action Plan, effective from 2005 through 2008, which was presented before the Spanish Parliament and favourably received by all political groups represented therein. The Plan's main goal is to mobilise resources and initiatives to advance and revitalise the National Drug Strategy, and is organised into six axis of work and 68 specific actions. The axis are:

- Co-ordination
- Prevention and social awareness
- Comprehensive care
- Improvement of knowledge
- Supply reduction
- International co-operation

- **Budget and public expenditure**

Although the total sum invested by all the Autonomous Communities of the Spanish State is not exactly known as of yet, statistics that are currently available and data on progress in past years provide a basis for estimating that the Central Government and Autonomous Communities have invested a total of 302 to 325 million euros in drug addiction policies during the year 2004.

- **Social and cultural context**

The evolution of the profile of drug-users and they way they see this usage has changed noticeably over the past twenty years. In the 1980s, a large proportion of these users adopted an attitude towards society that could be classified as rebellious and counter-cultural, and, at the same time, fought for a kind of social marginalisation. Today, the use of certain drugs (cannabis, cocaine, ecstasy and alcohol) are considered ways to achieve group and social integration, as well as actively participate in a culture of leisure and recreation, by a significant portion of the younger population.

As the data provided by surveys demonstrates, recent years have seen an increase in the number of users (some sporadic, others habitual) of substances such as those mentioned above. These users are very young in some cases, which make the perspective and forecast for this drug use all the more serious.

The downward trend among the number of heroin users, observed over the past several years, is also confirmed. Trends in heroin administration methods have also undergone notable changes, and a significant group of long-time users continue to demand serious reinforcement of material and human resources.

Alongside these changes in the patterns of use and the profile of users, a change in the way society perceives the importance of drug use has also come about.

This change has been showed in two ways. On one hand, the importance that society gave to the drug issue and the problems deriving from drug use throughout the 1980s declined over the following decade. Fifteen or twenty years ago, Spaniards ranked drugs in second or third place on the list of their most significant problems; whereas today, drugs have dropped down to sixth or seventh place, well behind issues such as unemployment, terrorism, housing availability or economic problems.

On the other hand, this change is also apparent in the perceived risk linked to drug use of the drug users themselves. Different surveys show that drug users, especially the youngest ones, are ever less conscious of the risks involved in using substances like cannabis or cocaine. For example, the percentage of 14 to 18-year-old students who believe that consuming cannabis once per month or less may cause several or many problems dropped from 60% in 1994 to 36.9% in 2004. As for cocaine, this percentage (also among 14 to 18-year-old students) went from 78.5% to 70.6% over the same period.

Finally, according to a survey done of the adult population in 2004 (15-64 years old), on a danger scale of drugs, alcohol and tobacco were considered more dangerous than cannabis. On a scale of 1 to 5 (1: not very dangerous; 5: very dangerous), the ranking was as follows: heroin (4.86), cocaine (4.74), amphetamines/ hallucinogens/ ecstasy (4.53), alcohol (3.76), tobacco (3.71) and cannabis (3.69).

2. Drug Use in the Population

- **Drug use in the general population**

Prevalence of drug use

In 2003, the psychoactive substances of abuse most widely used by the Spanish population between the ages of 15 and 64 were alcohol and tobacco. Of the illegally marketed drugs, the ones most widely used were cannabis derivatives, cocaine and ecstasy, all with use rates in the last twelve months of over 1% (11.3% for cannabis, 2.7% for cocaine and 1.4% for ecstasy). The use of other illegally marketed drugs was less common, with prevalence ranging from 0.6% to 0.8% in the last twelve months for speed/amphetamines and hallucinogens and under 0.2% for heroin, free base cocaine or crack and inhalants. One particularly striking finding was the prevalence of over-the-counter sedative-hypnotic drugs, which at 3.1% in the last twelve months was only exceeded by alcohol, tobacco and cannabis consumption (Table 2.1, Annex 1).

Average age of initiation

In 2003, the age of initiation into drug use varied substantially with the type of drug. The substances used at the earliest age were legal drugs such as tobacco (average age 16.5), alcoholic beverages (16.7) and inhalants (17.5). Cannabis was among the illegally marketed drugs used earliest (18.5). Over-the-counter sedative-hypnotic drugs, in turn, were the substances with first use occurring latest in life (30). All other drug use began, on average, between the ages of 18 and 22 (Table 2.2, Annex 1).

Differences in drug use by sex

Except in the case of over-the-counter (OTC) sedative-hypnotic drugs, substance use was visibly higher among men than women, particularly in the case of illegally marketed substances, where male prevalence is often several-fold greater.

The same qualitative differences were observed among teenagers and young adults from 15 to 34 years old, although the width of the gap in the case of alcohol and especially tobacco is much narrower. In 2003, for instance, the prevalence of daily smokers among men in this age group was 40% and among women, 36.8%.

Differences in drug use by age

Except in the cases of alcohol, tobacco and OTC sedative-hypnotic drugs, in 2003 psychoactive substance abusers were predominantly young people between the ages of 15 and 34 (Table 2.4, Annex 1).

The highest prevalence of recent use (last 12 months) of cannabis, ecstasy, amphetamines and hallucinogenic drugs was found among people between 15 and 24, for cocaine between 15 and 34 and for heroin between 25 and 34. Alcohol consumption, fairly even between the ages of 15 and 54, declined slightly in the older age groups. Smoking prevalence dropped substantially after the age of 44. Finally, the prevalence of OTC sedative-hypnotic drugs was fairly even across all the age groups, with the highest rate among people between 35 and 44.

Smoking

In 2003, 36.7% of Spaniards between the ages of 15 and 64 had smoked daily in the last 30 days (42% of the men and 31.3% of the women), while prevalence was slightly higher in the 30 days and 12 months prior to the survey (Table 2.5, Annex 1). The daily smoking rate was

somewhat higher among young people between 15 and 34 (38.5%) than among the other age groups (35-64 – 35.3%). By age group and sex the highest prevalence of daily smokers was found among men between the ages of 35 and 64 (43.7%) and the lowest among women in the same age group (27%).

In terms of intensity of use, the average number of cigarettes smoked daily by daily smokers was 15.7 (46.1% smoked 20 cigarettes/day or more). The average age of initiation into smoking was 15.8 for men and 17.3 for women (Table 2.5, Annex 1).

The prevalence of daily tobacco use has been observed to rise in recent years, particularly among women, with 31.3% of daily smokers in 2003, up from 27.1% in 1997 (Table 2.5, Annex 1). By age group and sex, taking 1997 as the reference year, the greatest increase was seen among women between 35 and 64, with the rate rising from 19.1% in 1997 to 27% in 2003 (Figure 2.1, Annex 2).

Alcoholic beverages

Alcohol is by far the psychoactive substance of abuse most widely consumed by the Spanish population. In 2003, 48.2% had consumed alcoholic beverages at least once a week in the 12 months prior to the survey, 75% had had a drink on more than eight of the preceding 30 days and 14.1% on a daily basis in the last month. With regard to indicators of more problematic drinking, 21.2% had been drunk at least once in the 12 months prior to the survey, and 5.3% were “drinkers at risk”, i.e., men consuming 50 cubic centimetres (cc) of pure alcohol/day or more and women consuming 30 cc/day or more in the preceding 30 days. Drinking was considerably more common among men than women, in terms of sporadic, regular and risky consumption (Table 2.6, Annex 1). Certain substantial differences were also observed by age group. Sporadic drinking was more widespread among young people from 15 to 34, and episodes of drunkenness much more common (Table 2.7, Annex 1).

The proportion of weekend consumers in the population aged 15 to 64 was higher than weekday drinkers. In the 30 days prior to the survey, 63.8% of the population had consumed alcoholic beverages on the weekend (Friday, Saturday or Sunday), whereas only 51.8% had had a drink on weekdays (Monday through Thursday). The beverages most widely consumed were beer/cider, wine/champagne and mixed drinks, in that order, both on weekends (42.2%, 31.5% and 28%, respectively) and during the week (27.4%, 22.3% and 5.8%, respectively). Appetizers/vermouth and hard liquor/liqueurs were consumed by far fewer people, and mostly on weekends (Figure 2.2, Annex 2). Substantial differences are observed between young people and the rest of the population in terms of type of beverage and timing patterns (Table 2.8, Annex 1). Consumption is much more common on weekends than during the week for any type of alcoholic beverage among both age groups. The highest rate of weekend drinking was found in the 15 to 34 age group, for mixed drinks and hard liquor (Table 2.8, Annex 1). Finally, the figures on drinking by sex, type of beverage and timing pattern show that men drink more of any given beverage than women, with the exception of fruit-based liqueurs on weekends (Figure 2.2, Annex 2).

Regular drinking, measured in terms of the prevalence of alcohol consumption on more than 8 days in the last 30 (44.6% in 1997 and 47.8% in 2003) and the prevalence of intoxication in the last 12 months (19.2% in 1997 and 21.2% in 2003) followed an upward pattern from 1997 to 2003. These increases were observed in all age groups and both sexes, but drunkenness was more intense among people between 35 and 64, particularly among men (Figure 2.3, Annex 2). By type of beverage, the prevalence of mixed drinks and beer followed a clear upward tendency both on weekends and during the week (Table 2.8, Annex 1).

Cannabis

Cannabis derivatives (hashish, marihuana) are the most widely used illegally marketed drugs in Spain. In 2003, 29% of Spaniards between 15 and 64 had used them at least once in their lives; 11.3% in the last twelve months, 7.6% in the last 30 days and 1.5% daily in the last month (Figure 2.4, Annex 2). Cannabis was found to be consumed primarily by young people according to each and every one of these indicators (Table 2.9, Annex 1).

They also consistently showed the use of the drug to have risen steeply between 1995 and 2003 (Table 2.9, Annex 1 and Figure 2.4, Annex 2).

Cocaine

The following discussion refers to powder cocaine, with only a brief remark on free base cocaine at the end of this section.

Powder cocaine is clearly the second most commonly used illegally marketed drug in Spain, after cannabis. In 2003, 5.9% of the population between the ages of 15 and 64 had used the substance at least once in their lives, 2.7% in the last 12 months and 1.1% in the last 30 days. Consumption was found to be normally sporadic, with only a small percentage of people reporting regular use. Only 0.2% had consumed cocaine weekly in the last 30 days.

The indicators also show a substantial rise in prevalence in the period 1995-2003, although the prevalence of recent use (last 30 days) declined slightly with respect to 2003 (Figure 2.5, Annex 2).

As noted earlier, in addition to the conventional powder, cocaine can also be found in Spain in the form of free base, which is generally inhaled (smoked). Free base cocaine consumption continued to be uncommon among the general population between the ages of 15 and 64. Only 0.5% had used it at least once in their lives and 0.1% in the last 12 months.

Ecstasy

“Ecstasy” is a generic, popular term for a series of phenylethylamine-base synthetic stimulants. There is evidence that users often take amphetamines thinking they are taking “ecstasy”. In 2003, 4.6% of the population between the ages of 15 and 64 had used ecstasy at least once in their lives, 1.4 in the last 12 months and 0.4% in the last 30 days (Figure 2.6, Annex 2). Consumption was more sporadic than for conventional cocaine. Only 0.1% had consumed it weekly in the last 30 days and no daily users were identified.

Use of these drugs is nearly exclusively restricted to young people. In 2003 while only 0.1% of the population from 15 to 64 had used them in the last 12 months, the percentage was 2.9% among people in the 15 to 34 age group.

Consumption patterns over time followed a spiked or wavy curve, with a decline in the prevalence of total and recent consumption (last 12 months and last 30 days) from 1995 to 1999, a rise between 1999 and 2001 and a further decline after the latter year.

Amphetamines

In 2003, 3.2% of the population had consumed amphetamines at least once in their lives, 0.8% in the last 12 months and 0.2% in the last 30 days. As in the case of ecstasy, consumption was found to be very sporadic, with less than 0.1% reporting weekly use in the last 30 days. The prevalence of use in the last 12 months was considerably higher among men (1.1%) than women (0.5%). Furthermore, again as with ecstasy, consumption is

restricted nearly entirely to people between 15 and 34, among whom the prevalence of use in the last 12 months was 1.6%, compared to a very low prevalence among the population between 35 and 64 (0.2%). Prevalence trends for consumption in the last 12 months, in turn, remained essentially flat (Figure 2.7, Annex 2).

Hallucinogens

In 2003, 3% of the Spanish population between the ages of 15 and 64 had used hallucinogens at least once in their lives, 0.6% in the last 12 months and 0.2% in the last 30 days. As in the case of ecstasy and amphetamines, hallucinogen consumption was observed to be very sporadic, with less than 0.1% reporting weekly use in the last 30 days. The rate of use in the last twelve months declined slightly between 1995 and 2003 (from 0.8% to 0.6%), although with such low figures it may be rash to venture any firm conclusions.

Heroin

Surveys are not generally regarded to be a good method for estimating heroin use. In 2003, 0.9% of Spaniards between 15 and 64 had used heroin at least once, 0.1% in the last 12 months and a smaller proportion in the last 30 days. Conclusions cannot be readily drawn about consumption trends, although the rate of use in the last 12 months appears to be holding steady or sloping slightly downward.

Opiates other than heroin

Experimentation with these substances is scant among Spaniards. In 2003, 0.4% of the population had used such substances at least once in their lives, 0.1% in the last 12 months and 0.1% in the last 30 days. No clear trends could be discerned either in terms of prevalence or age of initiation.

Over-the-counter sedative-hypnotic drugs

In 2003, 3.1% of Spaniards between the ages of 15 and 64 had used OTC sedative-hypnotic drugs in the last 12 months, with women (3.3%) showing a slightly higher rate than men (2.0%) and prevalence in the population between 35 and 64 (3.6%) somewhat greater than in the younger age groups (25-34; 2.5%). Rate of use in the last 12 months was observed to rise in the period 1997-2003, from 2.3% in 1997 to 3.1% in 2003. This increase was recorded primarily among the population in the 35 to 64 age groups and was slightly more intense among women.

Inhalants

In 2003, 1% of Spaniards had used inhalants (glue, solvents, volatile nitrites and so on) at least once, 0.1% in the last 12 months and a smaller proportion in the last 30 days. By age, use was virtually absent in the population between 35 and 64. The prevalence of use at least once was observed to rise slightly over the period 1995-2003 (from 0.7% to 1%).

Polydrug use

People using a given substance in a certain period of time (last 12 months, last 30 days) fairly frequently also used other drugs in the same period, a phenomenon usually going by the name of *polydrug use.*

As Figure 2.9 (Annex 2) shows, people who had used any kind of illegally marketed drug in the last 12 months consumed drugs other than the one in question in a higher proportion than the population at large during the period considered. Users of illegally marketed drugs

were nearly universally smokers and drinkers and the use of cannabis was likewise generalized (prevalence of over 70%) among this population. Similarly, the use of powder cocaine was universal among heroin or free base cocaine users and widely extended (prevalence of over 60%) among people using amphetamines, hallucinogens, inhalants and ecstasy; in other words, among nearly all users of illegal drugs, except cannabis consumers. Finally, the use of free base cocaine (crack) was relatively widespread (31.8%) among heroin consumers. The association between the use of these two drugs was further corroborated by the fact that 47.1% of the people who had consumed free base cocaine in the last 12 months had also used heroin.

Perceived risk of drug use among the population at large

The analysis discussed below focuses on the proportion of people who reported perceiving a high risk in connection with a given use behaviour, defined to be the proportion of people who believed that such behaviour may occasion a fair or even a large number of problems. In 2003 the psychoactive drug use behaviour that the Spanish population between 15 and 64 associated with the lowest risk was drinking five or six beers during the weekend, followed at some distance by the sporadic use (once or month or less) of cannabis or sedative-hypnotic drugs. The behaviour associated with the highest risk, on the contrary, included the use on a regular basis (once a week or more) of ecstasy, cocaine or heroin. The sporadic use of ecstasy or cocaine was likewise associated with substantial risk (Figure 2.10, Annex 2).

The proportion of people perceiving high risk in regular use of a given drug was somewhat greater than those who saw a similar risk in its sporadic use, for all drugs except cannabis and sedative-hypnotic drugs, where substantial differences were recorded. The greatest differences in perceived risk were not found with respect to the sporadic-regular use pattern (frequency of use), however, but in connection with the type of drug used. Figure 2.10 (Annex 2) shows that in 2003 the proportion of people perceiving high risk in the sporadic use of ecstasy, hallucinogens or cocaine was substantially greater than the percentage perceiving high risk in smoking a pack of cigarettes every day or drinking five or six beers/other alcoholic beverage. Moreover, the sporadic use of cannabis was perceived to entail greater risk than drinking five or six beers on the weekend. In this regard, the use of legally marketed drugs (alcohol, tobacco and sedative-hypnotic drugs) was clearly perceived to involve less risk than the use of illegally marketed drugs (Figure 2.10, Annex 2).

Nonetheless, between 1997 and 2003, the perceived risk of smoking daily or the sporadic use of sedative-hypnotic drugs grew, while the risk associated with the daily consumption of alcohol and on the weekend declined, along with the perceived risk of sporadic and regular use of cannabis. The risk associated with the consumption of all other psychoactive drugs remained essentially constant (Table 2.10, Annex 1, Figures 2.11 and 2.12, Annex 2).

Perceived availability of illegal drugs

The availability indicator used was the proportion of people believing that a given type of drug could be relatively or very readily obtained. In 2003 the illegal drug most readily available or accessible for the Spanish population continued to be cannabis (hashish and marihuana). In fact, 59.2% of the respondents believed that they could be relatively or very readily obtained. Cocaine and ecstasy ranked next on the scale of availability, followed at some distance by LSD and heroin. In any event, over 39% of the population between 15 and 64 believed that any of the illegal drugs considered (cannabis, ecstasy, LSD, cocaine or heroin) could be readily or relatively readily secured (Table 2.11, Annex 1).

The pattern of perceived availability showed a considerable increase in the percentage of people believing that such substances could be readily or very readily obtained in 2001.

Perceived availability declined somewhat in 2003, although this slide was nearly negligible in the case of cannabis and hashish (Table 2.11, Annex 1, Figures 2.11 and 2.12, Annex 2).

Visibility of factors related to problematic drug use and supply

In 2003, the problematic use of illegal drugs was "invisible" for most of the Spanish population, at least in terms of the visibility in their immediate surroundings – neighbourhood or town where they live – of the problems related to the use of heroin or injected drugs, which is the visibility explored to date by the household survey (proportion of Spaniards from 15 to 64 who frequently see used syringes on the ground, people injecting drugs, people sniffing or snorting drugs off aluminium foil or people under the influence passed out on the ground). This "invisibility" means that problematic use takes place in private or in space-time scenarios out of sight of most of the population.

In any event, visibility declined substantially between 1995 and 2003 (Figure 2.13, Annex 2), a finding consistent with the trends revealed by drug problem indicators from other sources (treatment, hospital emergency statistics and mortality). As in the case of the visibility of use of heroin and drug injection, the visibility of drug supply, measured by the percentage of people from 15 to 64 approached by dealers, was low in 2003 and clearly dropped over the period 1995-2003 (Figure 2.13, Annex 2). This finding, apparently out of line with the increase in perceived accessibility or availability for most drugs, may have something to do with changes in selling techniques.

Perception of the importance of the illegal drug problem and drug addiction-related delinquency

In 2003, 39% of the Spanish population between 15 and 64 regarded illegal drugs to be an important problem and 24.6% thought that drug addiction-related delinquency was a serious problem in their place of residence. The perception of the severity of the illegal drug problem took a sharp downturn over the period 1995-2003 (from 56.3% to 39%), along with the perception of the importance of drug addiction-related delinquency (33.4% believed it to be very severe in 1995 compared to 24.6% in 2003).

Assessment of the importance of actions to attempt to solve illegal drug problems

In 2003 the population between 15 and 64 regarded drug education in schools to be the most important measure to solve the illegal drug problem. This was followed, in descending order of importance, by voluntary user treatment to abandon drugs, police and border control, publicity campaigns explaining the risks of drug use, strict anti-drug laws, medical administration of methadone for heroin users, mandatory treatment to abandon drugs, and the medical administration of heroin to users for whom other treatments have failed. The measures regarded to be least important were the legalization of cannabis or all illegal drugs (Figure 2.14, Annex 2). The importance attached to conventional measures or measures that had been in place for the longest time, such as drug education in schools, publicity campaigns, voluntary treatment to abandon drugs, police and border control and strict anti-drug laws declined in the period 1995-2003, while regard for other less conventional measures or measures that had been in place for less time grew. The latter included mandatory treatment to abandon drugs, medical administration of methadone, medical administration of heroin where other treatments have failed and legalization of cannabis or all illegal drugs (Figure 2.15, Annex 2).

- **Drug use in the school and youth population**

Biennial surveys were conducted in Spain between 1994 and 2004 to obtain a general overview of drug use among secondary school students between the ages of 14 and 18, as well as drug use trends and certain other related issues.

Several groups fall outside the sampling base established: 14-18-year-old students enrolled in primary school or university, those absent on the days the questionnaire was completed (absentees) and those enrolled in special programmes (social guarantee, distance education and so on). Another factor to bear in mind is that a fair number of teenagers drop out of school, particularly after the age of 17 or 18 and are therefore likewise excluded from the sample. In light of the foregoing, school absenteeism aside, the surveys were estimated to cover from 75 to 82% of the Spanish population between 14 and 18 years of age.

Two-stage cluster sampling was used, first randomly selecting schools as first stage units and then classrooms as secondary units. All the students in the classrooms selected were included in the sample. An attempt was initially made to select schools within each autonomous community stratum by means of with-replacement sampling in which probability was proportional to size (measured in number of students), to ensure that the probability of inclusion in the sample was the same for all students and thus obtain self-weighted final samples in each autonomous community. However, since it proved to be very difficult to obtain prior information on the number of 14-18-year-old students in each school, beginning in 2000 the probability of selection was the same for all the schools in each stratum, regardless of size. The second stage units were selected with identical probability from all the classrooms in the schools selected. For economic reasons, two or more classrooms were selected per school. In each of the five surveys, the samples covered around 20,000-25,000 students, 800-1000 classrooms and 400-600 schools. Sample allocation by autonomous community (19 strata) was disproportional, establishing a minimum number of valid surveys in each. Moreover, the final sample showed substantial deviations from strict proportionality in terms of school legal ownership status (public or private) and type of studies delivered (compulsory secondary education, baccalaureate, vocational training-training courses). Table 2.12 (Annex 1) shows the sample distribution in accordance with these variables.

The proportion of enrolled students absent when the survey was conducted varied from one survey to another (13.9% of enrolees in 1994, 13.7% in 2002 and 17.1% in 2004).

A standardized, anonymous questionnaire was used. Four different model questionnaires have been used over the years (1994,1996-1998, 2000 and 2002-2004), but the questions on which the essential indicators are based (prevalence of drug use, perceived risk in different types of use behaviour and so on) have not been changed. The questionnaire was completed on hard copy (paper-and-pencil) by all the students in the classrooms selected, during a normal class period (45-60 minutes), in the absence of the teacher in 1994 and with the teacher present (but staying preferably behind his/her desk) in 1996-2004. In 1994-2002 the survey was conducted in the autumn (usually in November and December) and in 2004 in spring (May and June). School co-operation was high. In the 1994 survey, for instance, only 8.6% of the schools had to be replaced due to refusal to co-operate, in 2000 and 2002 the figure dropped to below 5% and in 2004 (conducted in spring with final exams just around the corner), it rose to 12.6% The proportion of students refusing to complete the questionnaire was negligible. In 1994-1998 the sampling and field work were performed by CUANTER SA and in 2000-2004 by IPD, SA.

A joint database was built with the data from all six surveys, eliminating students under 14 and over 18, to analyze the results. The data were then jointly weighted to correct for proportionality deviations in the sample with respect to the universe, calculating weighting factors to cross the following variables: autonomous community, school legal (ownership)

status and type of studies. Calculations were performed excluding all replies with unknown variables for the variables tabled from both numerator and denominator.

In 2002 and 2004 qualitative studies were also carried out, based on the "group discussion" technique, in order to discover and analyse discourse on which the drug-use culture of 14 to 18-year-old students is based. These studies aim to clarify, strengthen or qualify – as the case may be – the quantitative perspective obtained from the **ESTUDES** results.

Results

Prevalence of drug use

In 2004 the drugs of abuse most widely used by 14 to 18-year-old secondary school students in Spain were alcohol and tobacco: 65.6% in this age group had consumed alcoholic beverages in the 30 days prior to the survey and 37.4% had smoked. Of the illegally marketed drugs, the most common one by far was cannabis with a prevalence in the last twelve months of 36.6%, followed by cocaine with 7.2%, over-the-counter sedative-hypnotic drugs (4.7%), amphetamines, hallucinogens, ecstasy and inhalants (with annual prevalence figures ranging from 2% to 4%) and finally heroin (0.4%) (Table 2.13, Annex 1).

Average age of initiation

In 2004, the substances used at the earliest age were legal drugs such as tobacco (average age 13.2), alcoholic beverages (13.7) and inhalants (14). The illegally marketed drugs with the earliest initiation were heroin (14.4) and cannabis (14.7), while the drugs with the latest initial use were cocaine and hallucinogens (15.8) (Table 2.14, Annex 1).

The average age of initiation into drug use declined among 17- and 18-year-old students between 1994 and 2004 for tobacco, cannabis, ecstasy and heroin; the age of first use of alcoholic beverages, cocaine, amphetamines and hallucinogens remained flat while the age for OTC sedative-hypnotic drugs and inhalants rose.

Differences in drug use by sex

With the exception of tobacco and OTC sedative-hypnotic drugs (clearly more common among girls) and alcohol (with a similar prevalence in the two sexes), use of all other drugs was substantially higher among 14-18-year-old boys than girls of the same age. In the case of illegal drugs, in 2004 the greatest differences by sex in terms of prevalence of use were observed for heroin and the narrowest for cannabis. Contrary to general opinion, the differences in drug use by sex in 14-18-year-old students changed very little in magnitude and relative position (boys-more-than-girls or vice-versa) in the period 1994-2004 (Table 2.15, Annex 1).

Differences in drug use by age

It will be noted that the prevalence of alcohol, tobacco and other psychoactive drugs grows dramatically between the ages of 14 and 18, with the steepest rises recorded for cocaine, ecstasy, amphetamines and hallucinogens, and the smallest differences for inhalants and heroin. In the period 1994-2004 the psychoactive drugs most widely used by 14-year-olds, after alcohol, tobacco and cannabis, were OTC sedative-hypnotic drugs and inhalants; among 18-year-olds, however, the use of cocaine, amphetamines, hallucinogens and ecstasy clearly exceeded the use of OTC sedative-hypnotic drugs and inhalants (Table 2.16, Annex 1).

Smoking

In 2004, 21.5% of students between the ages of 14 and 18 had smoked daily in the last 30 days (18.4% in boys and 24.1% in girls), while slightly higher rates were recorded for the indicators on smoking in the 30 days and 12 months prior to the survey (Table 2.17, Annex 1). Users who smoked every day smoked an average of 7.7 cigarettes daily (21.2% smoked more than 10 cigarettes/day) Students who lived with a smoker, usually their father (33.2%), mother (32.1%) or a sibling (16.3%) accounted for 57.6% of the total.

Smoking prevalence was not observed to decline in the period 1994-2004 (Figure 2.16, Annex 2). By age, there was a certain downward trend among 14-16-year-old students and an increase among 17- and 18-year-olds. The percentage of students living with a smoker also slid between 1996 and 2004, from 62.6% to 57.6%.

Alcoholic beverages

In 2004 the proportion of students who had consumed alcoholic beverages in the 12 months and 30 days prior to the survey amounted to 81% and 65.6%, respectively. As far as drinking on a regular basis is concerned, 51.8% in boys and 42.8% in girls had consumed alcohol on more than 8 days in the last 30. The indicators of more problematic use showed that 58% had been drunk at least once and 34.8% in the 30 days prior to the survey. A further 12.3% was found to be "drinkers at risk", defined to be boys consuming 50 cubic centimetres (cc) of pure alcohol/day or more and girls drinking 30 cc/day or more in the last 30 days. Regular drinking (more than 8 days in the last 30) was more common among boys (51.8%) than girls (42.8%), as was risky use (13.1% in boys and 11.5% in girls) and drunkenness in the last 30 days (37% in boys and 32.5% in girls) (Table 2.18, Annex 1).

Considering all the respondents as a whole, the proportion of weekend consumers in the population from 15 to 64 was higher than weekday drinkers. In the 30 days prior to the 2004 survey, 65.6% of secondary school students between the ages of 14 and 18 had consumed alcoholic beverages on the weekend (Friday, Saturday or Sunday), whereas only 20.3% had had a drink on weekdays (Monday through Thursday) (Table 2.19, Annex 1). This tendency to drink on weekends only, which is higher among girls and the younger teenagers, is in any event stronger than among the overall population between the ages of 15 and 64. The beverages by far most commonly consumed by respondents on weekends were mixed drinks (58.4% reported drinking such beverages at least one weekend in the last 30 days). These were followed by beer/ cider (34.1%) and hard liquor, wine/champagne and fruit-base liqueurs (all three with prevalence rates ranging between 26% and 28%). On weekdays, by contrast, beer/ cider were the types of drink most commonly consumed (14,1%), followed by mixed drinks and wine/champagne (Table 2.19, Annex 1). Mixed drinks and hard liquor accounted for the largest share of weekend drinking, and beer/cider for the smallest. On weekdays consumption of all types of beverages was much higher among boys than girls (often over twice), whereas on weekends the prevalence of mixed drink and fruit-base liqueur drinking was similar in the two sexes, while wine/champagne drinking was only slightly higher among boys (Figure 2.17, Annex 2). On weekends, respondents tended to drink in public establishments such as bars, cafeterias, discotheques, and pubs (81% generally drink in such places, 47.5% in open spaces such as sidewalks and parks and 28.6% at home with friends). With respect to parental drinking habits, in 2004 82.5% of the students' fathers and 62% of their mothers had consumed alcoholic beverages in the last 30 days.

Prevalence indicators on drinking ever, in the last 12 months and the last 30 days declined gradually in the period 1994-2002 but turned sharply upward in 2002-2004, although without reaching the 1994 levels. The prevalence of students, who had consumed alcohol on 8 of the last 30 days, in turn, increased from 1996 to 1998, slid between 1998 and 2002 and rose again between 2002 and 2004 (Figure 2.18, Annex 2). Finally, the indicators of problematic

drinking, such as the prevalence of drunkenness or drinkers at risk, remained essentially flat in the period 1994-2002 and rose steeply in 2002-2004 (Figure 2.19, Annex 2). Such a sharp upturn is neither common nor readily explained and its possible consolidation will have to be monitored in future surveys. The change in the season when the fieldwork was done (autumn in 1994-2002 and spring in 2004) may contribute to explaining these differences. By type of beverage, the prevalence of mixed drinks has clearly climbed at the expense of beer and fruit-base liqueurs, especially on weekends.

Cannabis

This is the illegal drug most widely used by secondary school students between the ages of 14 and 18 in Spain. In 2004 42.7% had used this drug at least once; 36.6% in the last 12 months, 25.1% in the last 30 days and 1.3% on 20 of the last 30 days. An average of 2.5 joints was smoked on the days the drug was used. Prevalence and intensity were both higher among boys than girls (Table 2.20, Annex 1). A high percentage of users reported adverse consequences attributed to cannabis use at some time in their lives, the most frequent being memory loss (24%), difficulties to work or study (15.8%), sadness, despondency, depression (14.3%) and absenteeism from school (10%).

Cannabis use rose steeply between 1994 and 2004, irrespective of the indicator observed; and the average age of initiation into use declined (Figure 2.20, Annex 2).

Cocaine

Like in the general population between the ages of 15 and 64, for secondary school students between 14 and 18 in Spain, cocaine is the second most commonly used illegal drug. In 2004, 9% had used it at some time in their lives, 7.2% in the 12 months prior to the survey and 3.8% in the 30 days prior. Consumption was normally found to be sporadic (2.4% had used it on one or two days in the last 20), with only a small percentage reporting regular use. Only 0.2% had used cocaine on 20 or more days in the last 30. In 2004 use was much more prevalent among boys than girls (Table 2.21, Annex 1). This was also the drug with perhaps the greatest differences in use by age among the students surveyed. Prevalence of use in the last 12 months was 0.9% among 14-year-olds and 18.5% among 18-year-olds. A significant percentage of students reported adverse consequences attributable to cocaine use at some time in their lives, the most common being insomnia (44.1%), memory loss (14%), sadness or depression (12.6%) and financial straits (11.8%).

The indicators also show a substantial rise in prevalence in the period 1994-2004, with 3.5- and 4-fold increases, depending on the indicator. The average age of initiation, however, remained practically constant (Figure 2.21, Annex 2).

Ecstasy

In 2004, 5.% of the secondary school students between the ages of 14 and 18 had used ecstasy at least once in their lives, 2.6% in the last 12 months and 1.5% in the last 30 days. Use was highly sporadic. Only 0.1% had used ecstasy on 20 or more days in the last 30. Prevalence was substantially higher among boys than girls (Table 2.22, Annex 1). Taking the lifetime of the respondents as a reference, the maximum number of pills taken by respondents at any one time was 3.3. The questionnaire defined any one time as an interval in which the subject was continually under the influence of ecstasy, i.e., not sober at any time in the interim. A significant percentage of students reported adverse consequences attributable to ecstasy use, the most common being insomnia (37%), fatigue or weariness (21.7%), irritability(12.2%), arguments without physical aggression (12.1%), fights or physical aggression (11.5%), sadness or depression (11.5%), problems with parents or partner (11.3%) and financial straits (11%).

Consumption patterns over time followed a spiked or wavy curve, with a substantial decline in the prevalence of present and recent consumption (last 12 months and last 30 days) from 2000. The average of initiation remained flat (Figure 2.22, Annex 2).

Amphetamines

In 2004, 4.8% of secondary school students between the ages of 14 and 18 had consumed amphetamines at least once in their lives, 3.3% in the last 12 months and 1.8% in the last 30 days. As in the case of ecstasy, consumption was very sporadic, with less than 0.1% reporting use on 20 of the last 30 days. Like in the pattern for ecstasy, the prevalence of use was a broken or wavy line from which trends cannot be readily inferred, although use does not appear to be rising.

Hallucinogens

In 2004, 4.7% of the secondary school students between the ages of 14 and 18 had use hallucinogens at least once in their lives, 3.1% in the last 12 months and 1.5% in the last 30 days. As in the case of ecstasy and amphetamines, consumption was very sporadic, with only 0.1% reporting use on 20 of the last 30 days. Prevalence of use declined beginning in 1996, while the average age of initiation tended upward.

Heroin

The surveys very likely underestimate actual heroin usage. In 2004, 0.7% of the secondary school students between the ages of 14 and 18 had used heroin at least once in their lives, 0.4% in the last 12 months and 0.4% in the last 30 days. Conclusions cannot be readily drawn about consumption trends, although the various use indicators appear to suggest some stability.

Sedative-hypnotic drugs

The survey first explored the use of these substances with and without a prescription at some time in students' lives, and subsequently use in other periods without a prescription. In 2004, 10.2% of students between the ages of 14 and 18 had used sedative-hypnotic drugs under prescription at some time in their lives, while 7% had used them at some time without a prescription, 4.7% in the last 12 months and 2.4% in the last 30 days, likewise without a prescription. Most students used sedative-hypnotic drugs without a prescription only sporadically or over a short period of time (1.5% on one or two days in the last 30; 0.5% over a 3-5-day period). A small percentage used them for longer periods, however (0.3% on over 10 of the last 30 days). The chief reasons for use were to be able to sleep (50.4%) or relax (42.2%). Use was higher among girls. In the 12 months prior to the survey, 5.5% of girls compared to 4% of the boys had used sedative-hypnotic drugs (Table 2.23, Annex 1).

Prevalence of use at least once and with a prescription grew between 1994 and 2004, as did use without a prescription at some time in the subject's life and in the last 12 months. Finally, use without a prescription in the last 30 days remained essentially unchanged over the period studied. The average age of initiation, in turn, crept upward (Figure 2.23, Annex 2).

Inhalants

In 2004, 4.1.% of students between the ages of 14 and 18 had consumed these substances at least once in their lives, 2.2% in the last 12 months and 1.1% in the last 30 days. While use was sporadic as a rule, 0.2% had inhaled these substances on 20 or more days in the last 30. A certain increase in experimentation with inhalants was observed, while recent use held fairly steady. The average age of initiation sloped upward.

Polydrug use

People using a given substance in a certain period of time fairly frequently also used other drugs in the same period (polydrug use). This phenomenon is illustrated in Figure 2.24 (Annex 2). Users of illegally marketed drugs were nearly universally drinkers and the use of tobacco and cannabis was likewise generalized among this community. Cocaine use was also highly prevalent (over 60%) among amphetamine, ecstasy and heroin users. Polydrug use tended downward between 1994 and 2004 among cannabis users (Figure 2.25, Annex 2) Cocaine, sedative-hypnotic drug and heroin use increased among the users of other illegal drugs (very steeply among ecstasy users), whereas the use of hallucinogens slid (very sharply, except among heroin users) as did ecstasy consumption (very intensely among cocaine users). Amphetamine use also dropped among cocaine users.

Perceived risk of drug use among the population

The data shown refer to the percentage of students who believed that a given use behaviour may occasion a fair or even a large number of problems. In 2004, the drug use behaviour that 14 to 18-year-old students associated with the lowest risk included sporadic cannabis smoking (once a month or less), sporadic use of sedative-hypnotic drugs, 5 or 6 drinks on weekends, and 1 or 2 drinks every day (Figure 2.26, Annex 2).

Risk was perceived to be greater for routine than sporadic use, but the differences were much more significant for cannabis or sedative-hypnotic drugs than for ecstasy, cocaine or heroin. Substantial differences were also observed in perceived risk depending on the drug. For instance, the use of legal drugs (alcohol, tobacco and sedative-hypnotic drugs) was associated with less risk than the use of all illegal drugs other than cannabis, which was observed to follow the same pattern in this regard as legal drugs (Figure 2.26, Annex 2). Declines were recorded between 1994 and 2004 in the perceived risk of sporadic or routine cannabis use (Figure 2.27, Annex 2), moderate drinking on a daily basis (Figure 2.28, Annex 2) and the sporadic use of cocaine and sedative-hypnotic drugs (Figure 2.29, Annex 2); the perceived risk of the sporadic use of ecstasy rose, on the contrary, while the risk associated with other use behaviours remained fairly stable.

In qualitative studies, notably different risk levels were attributed to different substances, clearly delineating two separate groups: one comprised of heroin, cocaine and synthetic drugs, to which numerous risks are attributed, and another, comprised of tobacco, alcohol and hashish, which are perceived as less dangerous and therefore not truly considered drugs, when not consumed in excess. Heroin is associated with numerous risks (“it’s really addictive”, “you get hooked quickly”, “it does you in”, “it destroys your life”, etc.). Other drugs identified as dangerous and high-risk are cocaine, “acid” (LSD) and “pills” (synthetic drugs). Synthetic drugs have a negative social image associated with numerous risks, although these are not well defined and there is little information on the effects they produce. Rejection and an increase of perceived risk associated with their use has increased substantially compared to the qualitative study done in 2002, which indicates that performance expectations and interest in experiencing their effects has decreased.

Generally, the risks and dangers of drugs are not seen to affect them and their group, but rather younger adolescents: They (who are between 15 and 18 years old) “are in control”, “are old enough to use”. “The others” are the ones with problems, the ones who use drugs prematurely and aren’t in control. The youngest students are the ones, who suffer abuse problems, and they should therefore be more closely monitored and controlled; additionally, they feel that this younger group should be the principal target of prevention campaigns and measures.

Perceived availability of illegal drugs

The availability indicator used was the proportion of students believing that a given type of drug could be relatively or very readily obtained. In 2004 students perceived legal drugs (alcohol, sedative-hypnotic drugs, inhalants) to be the most readily available or accessible drugs. Cannabis was believed to be the most accessible illegal drug, with a perceived availability even higher than for sedative-hypnotic drugs and inhalants; it was followed by cocaine, ecstasy, hallucinogens and amphetamines and heroin, in that order (Figure 2.30, Annex 2). The overall pattern of perceived availability showed that students believed cannabis (Figure 2.27, Annex 2) to become much more accessible between 1996 and 2004, cocaine fairly more so (Figure 2.29, Annex 2) and alcoholic beverages, heroin and ecstasy somewhat more. For other drugs, perceived availability remained stable.

The qualitative studies showed that students perceive drugs as being very readily obtainable. The general perception is that the drugs are there and that young people have to learn to coexist with them. All drugs are available, although it is always easier to obtain the most popular drugs. In this sense, the hashish is perceived as always available, whereas obtaining "pills" (ecstasy or synthetic drugs) is a bit more difficult, but can be done with little extra effort.

Social image of various drugs

In the qualitative studies (discussion groups), students associate the word "drug" with the illegal status of the substance; in other words, drugs are the prohibited substances, although use of the word "drug" is also conditioned by the ability to create addiction that they attribute to each substance and by their subjective perception of their ability to control it. Each drug has symbolic connotations and, generally speaking, students mention a maximum of two or three substances when referring to drugs. The word "drug" is spontaneously associated with pills and hashish above all, less frequently with cocaine, and heroin is only mentioned when they are pressed for more drug names. However, alcohol and tobacco are not spontaneously classified as drugs; only when specifically asked about these substances do students admit them as such, although their admissions sound more like a memorised speech than a deep-seated conviction. For them, alcohol and tobacco are not the same as other drugs – they are a part of their everyday activities and relationships, which is why they refuse to include them in a category with pejorative connotations. Heroin is found in a world apart – it is perceived as the most distant and dangerous of all drugs. Heroin use would indicate the borderline of a new area, of a territory and social venue characterised by social marginalisation and exclusion. Cocaine is also situated in a territory relatively far removed from their everyday environment, although not to the same degree, and this discourse is obviously and directly at odds with the reality of increasing cocaine consumption among 14 to 18-year-old students. Hashish is perceived as a normalised and accessible drug, present in the realms of everyday activities, friends, leisure time and adolescent rites of initiation and socialisation.

In the majority of discussion groups, especially in the older groups, the risk of escalating drug use is not admitted (escalation defined as the jump to harder drugs once any kind of illegal drug use, usually hashish, has begun).

On the other hand, the escalation phenomenon is a behavioural trend that students reject.

- **Drug Use among specific groups**

No new information available.

3. Prevention

For the National Plan on Drugs, prevention continues being a priority, as it has been for years. In Spain the approach to the development and structuring of prevention varies greatly from one autonomous region to another, although their activities all tend to focus on schools, families and the media. With the former two, the tendency to apply structured programmes in sessions with additional resources continues. With regard to the media, most actions are campaigns used by the media as an informative prevention technique, although the media is becoming more and more involved as a collaborator in the effort to spread awareness about drugs.

Actions in the labour ambit have increased over the years, as efforts to apply the various programmes intensify. The Provisional Project for the Law on the Prevention of Tobacco Addiction has joint the efforts of many Autonomous Communities during the year 2004.

The community ambit principally deals with two types of programmes: those aimed at minors at-risk groups and those offering alternative leisure that have quickly become popular and widespread throughout Spain.

Intermediate assessment of 2000-2008 National Drug Strategy. Main results.

In the year 2004, the intermediate assessment of the 2000-2008 National Drug Strategy was started, using a questionnaire filled out by every Autonomous Plan on Drugs assessed the fulfilment of those Plan's objectives.

The preliminary prevention assessment highlights the achievements and shortcomings in this work area, which can be summarised as follows:

- Positive aspects:
  .- Progress in measures for controlling advertising of legal drugs
  .- Good progress in school prevention programmes.
  .- Introduction of prevention measures in penitentiary centres.
  .- Involvement of Municipal Authorities in prevention efforts (approval of municipal drug plans, application of prevention programmes…)

- Gaps:
  .- Prevention programmes aimed at vulnerable population sectors.
  .- Criteria and quality filters for prevention programmes (varies widely from one Autonomous Community to the next)
  .- Collaboration with the media and communications professionals.
  .- Co-ordination with the Primary Care health sector.

- **Universal prevention**

(Data showed are provisional since some Autonomous Communities have not yet submitted their results).

Prevention in schools

As a general rule, universal prevention programmes applied in all regions of Spain assume a comprehensive approach that includes multiple components. Health Promotion is the working model in Pre-school and Primary School Education, whereas Bandura's social learning, social cognitive and self-efficacy theories usually guide Secondary and Post-Secondary Education programmes.

Two clearly defined tendencies are observed in the various Autonomous Communities' approach to Prevention in Schools. In most Spanish Autonomous Communities the School Prevention policy is perfectly structured at all levels:

- They have a clearly defined organisational structure for the application of prevention programmes and actions: Regional Department of Education as the central body that sign agreements with other institutions and create Follow-up Committees for said agreements, or Inter-institutional Technical Committees.
- They actively promote the quality of the programmes enacted in their territories by creating the necessary mechanisms for approving, accrediting, and authorising prevention programmes.
- They carry out researches to evaluate the results of their own programmes.
- They have Education Plans for teachers, which include specific accredited courses for training teachers in the practical application of prevention programmes in their respective Communities.
- Their objective is to work with drug-addiction prevention material in order to eventually include them in the Secondary School curricula.
- They reinforce these actions with specific legislation.

On the other hand, the following is still true in some Autonomous Communities:

- There is no specific organisational structure for the application of prevention programmes and actions.
- School prevention policies become visible in some individual activities, such as participative lectures, non-specific prevention workshops, and the application of short-term programmes without any kind of structure or accreditation.
- Programme evaluation is carried out on the basis of its coverage and presence, without scientifically analysing the results of their actions.
- Teachers are given general instruction on the topic of drug-addiction. Sometimes the courses offered in this area are simply general Health Education modules.

Although there are no specific rules or policies for treating drug-related episodes in educational centres (these are regulated in a general way by the legislation adopted by each Autonomous Communities' Department of Education), new programmes created by specific bodies have begun to appear, which regulate drug trafficking and drug use as well as other conflictive behaviour in schools (Provisional Decree in Castilla y León to create the Monitoring Centre for Coexistence in Educational Centres).

With regard to the scope of the programmes, the available data shows that 6,840 educational centres, 18,381 teachers and 965,682 students participated in 2004.

Family programmes

Within the scope of the family, most Autonomous Communities still have difficulties encouraging parents to attend, participate and get involved in drug-addiction prevention programmes. A significant fact is that the Communities whose family-oriented prevention activities are less structured and concentrated (periodic seminars or participative lectures) are also those that struggle most with keeping parents interested in the activities they offer.

According to data from the 10 Autonomous Communities that submitted information on the scope of family programmes, a total of 90,685 fathers and mothers have participated in these programmes. This is an amazing increase compared to previous years.

Community programmes

Each year, more Communities adopt global prevention policies that call for a co-ordination of the various sectors involved (education, health, social services, economy, law enforcement and justice). In every case, the community programmes are developed in close collaboration with Local Corporations, by means of agreements or economic support. Many also have local co-ordination boards for promoting community prevention, in which representatives of many sectors participate (education, health, drugs, law enforcement, social services, etc.).

The initiatives they develop usually are activities to raise public awareness (prevention weeks, workshops, lectures, radio programmes, etc.); education for prevention instructors; educational sessions for families; programmes for risky youth; and alternative recreation programmes. In most cases, there is no an structured model of community prevention.

Alternative Recreation Programmes

These programmes are consolidated in almost every Autonomous Community for which data are currently available (some have informed of important increases in the number of participants compared to previous years). These include recreation programmes in the afternoon (for younger ones) and in the evening (for older ones). In some cases, these programmes include specific activities for risky groups.

Media

Three kinds of actions are included in this category:

- Social Awareness Campaigns: these still focus mainly on legal drugs, although at times they address other substances such as cannabis or cocaine. Young people are usually the target audience. Only on certain occasions do these campaigns target other relevant groups such as parents. Every Autonomous Community that has submitted data carries out specific actions on World Anti-Alcohol, Anti-Tobacco and Anti-Drug Days.
- Information and awareness actions in the media (written press, local radio and TV programmes) that aim to inform the public and disagree with false perceptions that encourage society's tolerance of drugs. This is achieved by collaborating with media professionals when commenting news, writing articles, sending press releases, etc.
- Reporting on the actions carried out by Regional Drug Plans.

Workplace

The Provisional Project for the law on preventing tobacco addiction has focused many of its actions on this area, with campaigns for increasing awareness and promoting non-smoking spaces, starting up programmes for stopping smoking in workplaces, and in some cases granting accreditation to smoke-free workplaces.

In addition, some Autonomous Communities have observed progress in this particular field, where actions are increasingly ambitious and well-structured and go beyond increasing awareness and creating union delegations, which are the two actions that are usually carried out. In every case, union organisations play a core role in workplace prevention programmes.

- **Selective/specific prevention**

School Programmes

There are still relatively few selective programmes in schools, according to information submitted by the Communities. Of the 50 programmes developed, only 5 are selective prevention programmes and none of them are for specific prevention. A total of 26,099 students were reached through these programmes.

Family-oriented Programmes

With regard to **selective** family-oriented prevention, two actions carried out in Castilla y León are particularly worth mentioning. The first action was the introduction of the Dedalus programme in five of the nine provinces of this Community, which has reached 239 parents and 209 children. A high percentage of the fathers and mothers who began this programme followed it through to finish and were highly satisfied with the results.

The second action consisted of the creation of a Manual for instructors, which structured the interventions and made the professionals' interaction with families much easier. This manual came about as a consequence of the results obtained with the 2003 "Alfil" programme for the prevention of drug use in children whose parents were being treated for alcoholism.

Several Communities, thanks to the efforts of many professional in the area of prevention, are currently producing materials dedicated to selective family-oriented prevention.

Programmes for at-risk youth

Almost every Autonomous Community offers services and programmes for at-risk youth. The highest-priority groups vary from one region to the next, but are usually minors with risky use habits (or with administrative sanctions for drug use in the street), with penal justice problems, children of multi-dysfunctional families, and young people who use drugs in recreational venues. Programmes aimed at these groups usually consist on workshops for the prevention of risks associated with drug use, street interventions, orientation programmes and counselling for families with children who use drugs. These are usually carried out in collaboration with the Juvenile Courts and Social Services. Few Autonomous Communities have provided data on the scope and reach of these programmes.

4. Problem Drug Use

- **Prevalence and incidence estimates**

Nation-wide estimates are available for problematic heroin and cocaine use only, although work has recently been undertaken on incidence estimates. For two decades (primarily intravenous) heroin was the drug that 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 nineteen nineties local estimates of problematic use were made in Barcelona and Madrid using the data capture-recapture method; the yearly prevalence figures for the period 1990-1993 in people between the ages of 15 and 54 obtained for Barcelona were 7.2-11.0/1000 and for Madrid 14.1/1000.

In 1999, an estimation of problematic cocaine use was done in Barcelona. Capture-recapture with a single source of data was used to estimate prevalence. All the Emergency rooms episodes with mention of cocaine use were “captured” in the three consecutive 4-month periods of the year. After Log-linear regressions models with interaction terms were fitted. It was estimated that there was a total of 25988 problematic cocaine users (95% confidence interval 11782-58064), yielding a rate of 31,3 per 1000 inhabitants aged 15 to 54 years (95% confidence interval 14,2-69,9).

Estimations of problematic use of opiates and cocaine for the period from 1999 –2002 have been made. The demographic and processing multiplier methods were used to estimate use for the entire country for this 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, times 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).

The processing multiplier method estimate 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%).

The results of these calculations are given in Table 4.1., Annex 1, which clearly shows that the number of problematic opiate users is declining while the number of problematic cocaine users is growing rapidly.

It will be noted that the demographic method yields lower opiate use prevalence figures than the treatment multiplier method. The former may underestimate prevalence due to bias possibly introduced by an artefact. That is to say, any decline in the number of patients initiating their first treatment would contradict the stable population assumption inherent in the method. Nonetheless, the estimation of a high confidence interval for this method, taking the average number of years of use to be twice the average number of years of use of persons admitted for treatment for the first time in their lives, yields fairly credible figures that are higher than the results obtained with the multiplier method estimate. The demographic method is often criticized and is not, in fact, listed by the EMCDDA among the methods regarded to be valid. But no alternative method can be applied for cocaine use, because no appropriate treatment multiplier is presently available in Spain. Applying the heroin multiplier

yields very low and scarcely credible figures, particularly in light of the bias to which the multiplier is known to be subject.

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 offering for methadone treatments. And on the other, the percentage in question was computed from a sample of persons captured in centres when they were beginning treatment who were more liable to have initiated another treatment in the 12 months previous than users to be found outside such institutions. It is difficult to determine which of the two biases has the greater impact and therefore to ascertain how they affect the final prevalence estimate.

- **Profile of clients in treatment**

The period between 1998 and 2002 saw a decrease in the number of admissions for treating abuse or addiction to psychoactive substances (excluding alcohol and tobacco) registered in Spain. In fact, the number dropped from 54,338 in 1998 (year of the highest admission rate) to 46,744 in 2002. This decrease is principally due to the effect of long-term treatments (programmes offering opiate substitutes), which cut back on user rotation between different social services.

However, after 2002 it is very likely that the number of treatments in all of Spain has risen again, mainly due to the substantial increase in cocaine and, to a lesser degree, cannabis treatments. In fact, the number of admissions for treating abuse or addiction to psychoactive substances (excluding alcohol and tobacco) went from 5,901 in 2002 to 7,002 in 2004 in Catalonia; from 5,104 in 2002 to 1,728 in 2003 in the Region of Valencia; from 2,841 in 2002 to 3,103 in Galicia; and from 1,443 in 2002 to 1,728 in the Basque Country. In other regions such as Andalusia (9,712 in 2002 and 9,729 in 2004) the number has remained relatively stable.

The profile of treatment admissions is rapidly changing, with a continued decrease in admissions for treatment for heroin and a rapid increase in admissions for treatment for cocaine or cannabis. Between 2002 and 2004 the number of admissions for treating heroin dropped from 6,251 to 4,497 in Andalusia, from 2,596 to 2,148 in Catalonia and from 2,442 to 1,942 in the Region of Valencia. However, the number of admissions for cocaine treatments in the same time period rose from 1,728 to 3,565 in Andalusia, from 2,168 to 3,683 in Catalonia and from 1,996 to 3,918 in the Region of Valencia. With regard to patients admitted for cannabis treatment, between 2002 and 2004 this number went from 895 to 1,101 in Andalusia, from 487 to 577 in Catalonia and from 412 to 687 in the Region of Valencia.

The number of patients admitted to treatment for hypnosedatives has probably continued to rise. However, certain data indicates that the number of persons admitted for treatment for stimulants other than cocaine (amphetamines, ecstasy) has remained relatively stable and at a very low level.

Cocaine is now the drug behind the majority of treatment admissions in some autonomous communities such as Catalonia or the Region of Valencia, clearly outranking heroin. In fact, in 2004 the number of patients admitted for cocaine treatment in Catalonia was 3,683 and the number for heroin 2,148, whereas the numbers in the Region of Valencia were 3,918 and 1,942 respectively.

Cannabis ranks third in proportion of treatments provoked by drug abuse or addiction. The proportion of admissions to treatment due to cannabis in 2004 was placed around 8-10%

(8.2% in Catalonia, 10.2% in the Region of Valencia, 10.4% in Andalusia), although if only first-time treatments are considered the proportion increases considerably. The proportion of treatments for other illegal psychoactive substances was low. The proportion of treatments for other illegal substances (including hypnosedatives) oscillated between 2% and 5%. Nevertheless, the impact of the various drugs varies greatly depending on whether or not the cases in question are first-time treatments. In fact, if only first-time treatments are taken into account, the impact of drugs such as cocaine or cannabis increases dramatically, whereas the proportional importance of heroin descends.

In 2004, the vast majority of patients admitted to treatment for illegal drugs (more than 80%) are still male. The highest proportion of males is seen among those treated for cocaine or cannabis, and the lowest among those treated for hypnosedatives. The average age of persons treated for heroin is around 33-35, for cocaine around 29-30, and for cannabis around 23-26. Between 4 and 8 percent of patients admitted for treatment were born outside of Spain.

The level of education of admitted patients tends to improve slightly over time, but still presents significant variations according to the main drug for which they are being treated. In 2004, patients admitted for heroin treatment had a primary-school education or less, whereas the number of patients admitted for cocaine or cannabis with this level of education was a minority. With regard to professional status, the proportion of employed persons among patients treated for cocaine or cannabis is much greater than the proportion of employed persons among patients admitted for heroin.

In 2003, variables related to housing situations, cohabitation and the reason why the patients sought treatment were introduced. In Spain it is noted that the vast majority of patients admitted for treating illegal drugs live in family residences (houses, flats or apartments). The proportions of persons admitted for treatment who live in institutions is around 2-3%, and of those who live in precarious or unstable dwellings (homeless), around 4-5%. The most frequent cohabitation models among patients admitted to treatment for illegal drugs are the nuclear family unit (living with parents) or the independent family unit (living with spouse and/or children). Differences are patent in housing situations and cohabitation models according to the principal drug responsible for admission: living in an institution or in precarious/ unstable dwellings is much more frequent among patients admitted for heroin treatment (17-18%) than among those admitted for cocaine or cannabis (5-6%). The opposite is true of the proportion of patients who live with parental family units or with their own families. With regard to the principal reasons for seeking treatment, the most frequent motives are the patient's own initiative or the encouragement of relatives or friends, although the public health care system (especially primary care) also represents an important motivating factor for seeking cocaine or cannabis treatments.

Among patients admitted to treatment for heroin in 2004, the predominant intake method for this drug during the 30 days prior to admission is still inhaling or smoking ("chasing the dragon"), followed by the much less popular parenteral or injection methods, as well as intranasal methods and snorting. Recent years have seen a radical change in the predominant method of consuming heroin. In fact, the proportion of first-time patients treated for heroin that primarily consumed by injection fell from 50.3% in 1991 to 18.1% in 2002, whereas the percentage of patients who preferred to smoke heroin went from 43.4% to 71.8% over the same period. Despite the fact that the diminished popularity of intravenous injection is a generalised trend, there are still significant differences between the preferred consumption method among first-time patients in different autonomous communities. For example, the proportion of patients admitted to treatment for heroin who prefer to inject this drug is 6.5% in Andalusia (2004), 39.3% in the Basque Country (2003) and 42.3% in Catalonia (2004).

Among those admitted to treatment for cocaine, the predominant intake method is intranasal or snorting (over 70%), followed by smoking (11-18%, depending on the autonomous community); the proportion of those who prefer intravenous injection is very low (1-9%). Between 1991 and 2002, the snorting method has become much more popular, injections have decreased, while the evolution of smoking methods is more uncertain. In fact, the proportion of first-time patients treated for cocaine who primarily chose to snort or sniff this drug went from 55.4% in 1991 to 77% in 2002; that of patients who chose injections went from 19.2% to 2.1%; and that of those who smoked cocaine went from 24.4% to 19.2%.

The pattern of polydrug use among patients admitted for treatment is firmly established. The greater part of patients admitted to treatment in 2004 had consumed some other drug (secondary drugs) in addition to the drug motivating treatment (principal drug) in the 30 days prior to their admission. Among those admitted for heroin, the most frequently mentioned secondary drugs were cocaine and cannabis. Among those admitted for cocaine, the most frequently mentioned secondary drugs were alcohol and cannabis.

A significant proportion of all patients admitted to treatment for the consumption of psychoactive substances in the year 2004 admitted to having received prior treatment for the same principal drug. This proportion was much greater among those treated for heroin (around 80%) than among those treated for cocaine (around 30%) or cannabis (around 15%).

In the year 2002, 32% of patients admitted for treatment who had injected drugs tested positive for HIV (33.3% of previously-treated patients and 24.3% of first-time patients). In recent years the prevalence of HIV infection among current needle-users has dropped slightly, going from 37.1% in 1996 to 32.0% in 2002.

- **Main characteristics and patterns of use from non-treatment sources**

No new information available.

5. Drug-Related Treatment

- **Treatment system**

The Government Delegation for the National Plan on Drugs is responsible for the promotion, general co-ordination and supervision of those services in charge of updating and implementing the National Plan on Drugs, under the higher supervision of the State Secretary of Health (Royal Decree 1555/2004, of 25 June, which enacted the basic organisational structure of the Ministry of Health and Consumer Affairs). The Autonomous Communities and Cities, via their respective Regional Plan on Drugs, must provide the necessary programmes and resources for rehabilitating drug addicts, as well as others related to harm reduction as regards drug use.

- **Drug-free treatment**

Drug-free treatments are those that include among their main objectives the specific therapeutic correction of drug-addiction problems, and the achievement and maintenance of abstinence. These treatments are carried out in the following types of centres:

Inpatient treatments: In Spain there are two types of centres that offer drug-free treatments on an inpatient basis.

- Hospitalised detoxification units. This category includes hospital-style resources dedicated to detoxification on an inpatient basis. In Spain, 40 Units of these characteristics were functioning and treated a total of 2,575 patients during the year 2004. (Provisional data supplied by 13 autonomous communities.)

- Therapeutic communities. These residential centres, which also work on an inpatient basis, are located in both rural zones and urban centres. During 2004 there were 84 centres in Spain, which treated 4,427 patients. (Provisional data supplied by 13 autonomous communities.)

Outpatient treatments: In Spain, this type of treatment is offered at:

- Outpatient assistance centres. The efforts of these centres, which are carried out on an outpatient basis, are concentrated on the evaluation, detoxification and withdrawal of drug addicts, as well as their stabilisation and social reintegration. These resources may set abstinence goals or other intermediary benchmarks and can make use of various strategies and intervention methods, due to the generally multi-disciplinary composition of the professional teams involved. In Spain during 2004 there were 389 centres of this type, which treated 58,491 patients. (Provisional data supplied by 13 autonomous communities.)

- **Medically assisted treatment**

Withdrawal treatment: Withdrawal treatment is offered at hospitals within Hospital Detoxification Units, on a non-hospital inpatient basis within Therapeutic Communities, and on an outpatient basis in the Outpatient Assistance Centres.

Substitution treatment: Withdrawal treatment is offered at hospitals within Hospital Detoxification Units, on a non-hospital inpatient basis within Therapeutic Communities, and on an outpatient basis in the Outpatient Assistance Centres.

In Spain, most patients are treated with methadone maintenance programmes. Two clinical trials using heroin were also carried out and are described in the following paragraphs:

- Centres offering programmes for Maintenance with Methadone. The goal of these centres is to carry out treatments substituting withdrawal from addictions to opiates with the therapeutic use of methadone hydrochloride. This substance is used in accordance with prescriptions for each individual case, after completing a personalised, multi-disciplinary evaluation and diagnosis for each patient within a pre-established and regulated programme.

  Methadone maintenance programmes have undergone heavy development in recent years, having experimented an increasingly greater rate of admissions. This phenomenon has been accompanied by the parallel increase throughout the various autonomous communities in the number of centres that offer this type of treatment. In Spain during 2004, 67,006 patients have received treatment in these programmes. (Provisional data supplied by 13 autonomous communities.)

- Clinical trials with heroin. Clinical trials have recently been performed in Catalonia and Andalusia by prescribing diacetylmorphine (heroin).

  In the case of Catalonia, the Public Health and Social Security Department of the Generalitat (Regional Government) has begun two clinical trials to assess the efficacy of oral doses of heroin and morphine. The Spanish Agency of Medicine and Health Products of the Ministry of Health and Consumer Affairs authorised the Public Health and Social Security Department to begin two trials for heroin and morphine treatments administered to those patients who did not succeed in the methadone maintenance programmes. The studies, organised by the Drug Addiction Unit of the Public Health and Social Security Department, allowed for an analysis of the effectiveness of oral heroin and morphine use on heroin addicts who were not successfully treated in the oral Methadone Maintenance Programme (Spanish acronym – PMM).

  The Regional Government of Andalusia, with the authorisation of the Spanish Agency of Medicine and Health Products, has completed a clinical trial to compare the effects of administering opiate agonists, among which is included diacetylmorphine (DAM) administered intravenously, with the effects of administering methadone orally. The trial was carried out in two treatment centres in Granada and La Línea (Cadiz) and finalised in 2005. The evaluation reports of the trial have not yet been published.

6. Health Correlates and Consequences

- **Drug related deaths and mortality of drug users**

Direct overdoses

The National Plan on Drugs indicator, "death caused by severe reaction to psychoactive substances", includes information on deaths involving judicial action in which the direct and fundamental cause of death is a severely adverse reaction to the non-medical and intentional ingestion of psychoactive substances (except alcohol and tobacco) by persons aged 10 to 64. Forensic institutes and toxicological laboratories supply the data. *A case is selected and included in the register* if it meets one of the four following criteria:

1. Evidence of recent psychoactive drug use (history of drug use according to family members or friends or registered in clinical reports, external physical signs of drug use, the presence of drugs or instruments used for taking drugs at the place of death).

2. Positive testing for a detectable substance.

3. Anatomical pathology findings in the autopsy compatible with death due to recent administration of a psychoactive substance.

4. Existence of a forensic diagnosis establishing death to be due to an overdose of a psychoactive substance.

Pursuant to the above definition, *the following types of death are excluded:*

1. Death in which there is no written record of judicial involvement or forensic examination into the cause. Nonetheless, the failure to conduct toxicological analyses is not sufficient reason for exclusion, although the availability of such analyses is highly recommended.

2. Deaths unrelated to the administration of psychoactive substances. Deaths caused by pathologies that may have been aggravated or complicated by the recent administration of psychoactive substances will not be excluded, however, if the criteria for inclusion are met.

3. Deaths *indirectly* related to the administration of detectable psychoactive substances; i.e., deaths in which the administration of a psychoactive drug contributed to but was not the basic or fundamental cause of death. For this reason, deaths for the following reasons will be disregarded:

a) Pathological infection presumably acquired as a result of drug use (AIDS, endocarditis, hepatitis, septicaemia, tetanus and so on).

b) Homicide, even if the deceased was under the influence of psychoactive substances or death occurred during the course of activities related with drug traffic or use. Homicide by means of psychoactive substances is likewise excluded.

c) Any manner of accident (industrial, domestic, traffic, or similar) in persons under the influence of psychoactive substances, unless the death was directly caused by acute poisoning or intoxication due to such substances.

d) Any manner of suicide (hanging, jumping from heights, drowning, firearm, or similar) in persons under the influence of psychoactive substances, unless the death was directly caused by acute poisoning or intoxication due to such substances.

e) Death due to involuntary or unintentional exposure to psychoactive substances.

f) Death due to adverse reactions to medication or correctly prescribed and administered pharmaceutical psychoactive substances.

g) Death to a chronic illness related to the consumption of alcohol and death due exclusively to acute alcoholic intoxication (drunkenness).

Although the annual mortality rate may vary in small cities due to random variables, a closer examination of available data since 1990 reveals that, in the vast majority of monitored areas, the number of "overdose" deaths has decreased, although at a much slower rate than to be expected in recent years (Table 6.1. Annex 1). In fact, in the Autonomous Community of Madrid the number of deaths has gone from 117 in 2000 to 114 in 2001, 97 in 2002, 122 in 2003 and 136 in 2004 (provisional data for 2003 and 2004). In the city of Barcelona, the deaths went from 101 in 2000 to 87 in 2001, 74 in 2002, 85 in 2003 and 73 in 2004. In the city of Palma de Majorca the deaths evolved from 50 in 2000 to 41 in 2001, 50 in 2002, 42 in 2003 and 50 in 2004 (provisional data for 2004). In the Basque Country they went from 35 in 2000 to 39 in 2001, 34 in 2002 and 35 in 2003. In the Autonomous Community of Galicia they went from 61 in 2000 to 40 in 2001, 56 in 2002 and 38 in 2003. In the city of Valencia they went from 29 in 2000 to 23 in 2001, 26 in 2002, 19 in 2003 and 11 in 2004. In the city of Seville they went from 27 in 2001 to 28 to 2002 and 34 in 2003.

In 2002, 496 deaths in 119 judicial districts with a total population of 19.800.071 (48.5% of the Spanish population) were recorded to be due to an overdose of psychoactive substances. Table 6.1 (Annex 1) shows the geographic distribution of these deaths. Most were reported by forensic institutes (IAF, Spanish initials for Instituto Anatómico Forenses), although a few were recorded by forensic surgeons affiliated with other entities (forensic clinics) or privately practising forensic surgeons. The results of toxicological analyses were obtained primarily from the National Toxicology Institute (Seville, Madrid, Barcelona and La Laguna Departments), although a sizeable proportion was also gathered in other forensic or toxicological laboratories. The quality of this information has improved substantially in recent years: toxicological analyses were available in 65.9% of the cases in 1993, 88.1% in 1998 and 98.6% in 2002.

Males accounted for 88.3% of the deaths. Their average age was 34.7. A majority of those for whom marital status information was available were single (67.9%), although the marital status was unknown for 39.1% of the deceased. There was strong evidence of suicide in 2.5% of the cases and some indication or suspicion of self-inflicted death in 2.0%. Venipuncture was found in 47.2% of the cases for which the information was available, indicating that nearly half died after injecting drugs (although there was no information on this item in 36.3% of the cases). HIV was positive in 47.3% of the cases where this data item was available, although again, information on this variable was lacking in a very high (62.1%) proportion of deaths (Table 6.2, Annex 1).

As in preceding years, in 2002 several drugs were found in most of the deceased, with a predominance of opioids or their metabolites. Of the cases for which toxicological analyses were available, 83.6% tested positive for opioids, 53.8% for cocaine, 52.8% for benzodiazepines, 42.9% for alcohol and 20.2% for cannabis. The rest of the drugs were found in fewer than 5% of the deaths (Figure 6.1, Annex 2, Table 6.3, Annex 1). Very high rates of cocaine-positives were found in Valencia (92.3%), Murcia (76.5%) and Palma de Majorca (69.8%).

In a total of 53 deaths (11.3%) in 2002, toxicological testing detected cocaine but no opiates. Of these, only cocaine was detected in 13 (2.6%), only cocaine and alcohol in 18 and cocaine and other combinations of drugs in all others. By way of comparison, in the period

1983-1989 cocaine was the only substance detected in less than 1% of the deaths. The figures on cocaine deaths, however, may not be an accurate reflection of reality because a high (and unknown) proportion of such deaths may not be the subject of judicial or forensic examination.

Although cannabis was detected in a fairly high percentage of deaths, there is no indication that this drug contributed to mortality.

Not a single OD death in which cannabis was the only substance detected was recorded in 2002. Nor were any deaths recorded in which the only substance detected was MDMA or some other phenylethylamine derivative. By contrast, there was one case in which amphetamines were the only substance detected.

In 2003 and 2004 the situation seemed to remain somewhat the same. For example, in the city of Barcelona in 2003, the proportion in which opiates, cocaine or benzodiazepines were detected was respectively 75.3%, 62.3% and 39.4%. In 2004 the proportions were 84.7%, 65.3% and 50%.

Several important geographic differences are obvious with regard to deaths caused by a severe reaction to psychoactive substances. For example, the cities of Palma de Majorca (13.2 deaths/ 100,000 inhabitants in 2002, and similar in 2004) present an extraordinarily high RASUPSI (Spanish acronym for “severe reaction to psychoactive substances”) mortality rate in comparison with other monitored areas and within the European context. The underlying causes of this situation must be studied in detail, although it is probably related to the high incidence of intravenous injection of heroin in this city. The remaining areas exhibited levels under 5% in 2002; only Barcelona (4.9/100,000) and Galicia (4/100,000) presented levels between 4 and 5%.

The proportion of deaths due to severe reactions to drugs containing opioids or their metabolites (largely attributable to heroin use) has barely decreased in recent years (90.4% in 1996 and 83.6% in 2002 averaged in all monitored areas). What has experienced a sharp decline, probably due to the increased tendency towards polydrug use, is the proportion of deaths in which only opioids are detected (Table 6.3, Annex 1).

The isolated presence of methadone, in turn, continued to be scant, although it has increased substantially in recent years in deaths involving opioids or cocaine (Table 6.4, Annex 1).

Contrary to the findings for opioids, the proportion of overdoses involving cocaine or its metabolites increased considerably after 1983, particularly between 1995 and 1999 (Figure 6.4, Annex 2). Increases were recorded in both the proportion of cases with cocaine only (from 0.6% in the period 1983-1989 to 3.2% in 2001 and 2.6% in 2002) and those in which cocaine but no opiates were found (from 1.2% in 1983-1989 to 7.9% in 2001 and 11.3% in 2002) (Figure 6.4, Annex 2).

Recent years have likewise seen a rise in the proportion of deaths in which benzodiazepines or their metabolites (29.7% in 1987, 43.8% in 1996 and 52.7% in 2001) as well as cannabis (from 6.5% in 1996 to 18.7% in 2001) were detected. No clear pattern can be discerned for amphetamines or ecstasy, however (Figure 6.1, Annex 2).

The rate of overdose deaths in which the forensic surgeon observed signs of recent venipuncture dropped from 89.6% in 1996 to 75.3% in 1999, 55.2% in 2001 and 47.2% in 2002, although this indicator may not be overly valid.

Estimate of number of illegal drug use-related deaths in Spain

The use of illegal drugs increases the likelihood of dying for a number of reasons, but its impact on the mortality of the population at large is not appropriately reflected in the mortality statistics normally used, so estimates must be used to quantify this parameter.

Illegal drugs may contribute to mortality through direct and indirect mechanisms. Deaths directly related to illegal drug use (DRD), otherwise known as “overdose” deaths, or deaths due to acute reaction or intoxication, can be estimated, albeit with some difficulty. Deaths indirectly related to illegal drug use (IRD), by contrast, are impossible to estimate with the information presently available, inasmuch as they are recorded in the general register of deaths under death categories (hepatitis B or C, non-alcoholic cirrhosis of the liver, accidents and so on) in which the proportion attributable to illegal drugs is unknown, with the exception of HIV-related deaths, where this proportion may be estimated from the records on cases of AIDS.

Moreover, in Spain DRD records cannot be obtained directly from the general register of deaths, which, according to the findings of earlier studies, substantially underestimates DRDs. Such underestimation was detected thanks to the existence of a specific register that has been in place for a large area of the country since 1983. Based on forensic and toxicological records, it is deemed to furnish higher quality information. Specifically, a study covering the years 1984-1993 showed that the general register recorded only 1285 drug-related deaths in the population between the ages of 15 and 49 in six major Spanish cities, while the Spanish Monitoring Centre for Drugs and Drug Addiction (OED – Observatorio Español sobre Drogas – Spanish acronym) mortality indicator recorded 3491 (2.7-fold higher). A second assessment was conducted in 1999-2000 over a much larger area, consisting of four autonomous communities (Community of Madrid, Region of Murcia, Basque Country and Galicia) and 11 cities (Badajoz, Barcelona, Caceres, Las Palmas de Gran Canaria, Palma de Majorca, Pamplona, Ponferrada, Saragossa, Seville, Valencia and Valladolid). The situation was found to have improved considerably, although the general register continued to underestimate the number of deaths directly related to drugs. The OED’s specific register recorded 1.28 and 1.44 times more deaths than the general register in 1999 and 2000, respectively. These differences may be attributed to the fact that in the general register the deaths directly related to drugs and other “external causes” are not appropriately recorded or coded. In such cases, an investigation, a court judgement and a forensic surgeon’s report are required to establish the cause of death, but the final outcome of the legal-medical procedure is often omitted from the death statistics bulletin (BED) and is not used to correct the cause of death initially shown in that document. Consequently, if the information in the legal-medical report is not retrieved before the cause of mortality is ICD-coded, the respective deaths are classified inappropriately and their prevalence underestimated in the general register of deaths.

The estimates of illegal drug use-related mortality in all of Spain and its impact on overall mortality described below include only deaths directly related to drugs or AIDS deaths associated with drug injection. The results necessarily underestimate the actual figures. Moreover, the present estimate includes only deaths related to the use of illegally marketed drugs such as opiates, cocaine, amphetamines, cannabis and hallucinogens and excludes tobacco-, alcohol-, sedative-hypnotic drug- and inhalant-related deaths, except where caused by some illegal drug in combination with these substances.

In estimating DRD deaths, nation-wide data on several selected ICD-10 categories were taken from the Spanish National Statistics Institute’s general register of deaths (anonymous file on causes of death) and the figures obtained were corrected. The categories included were the Selection B items proposed by the European Monitoring Centre for Drugs and Drug Addiction (The DRD-Standard, version 3.0 EMCDDA Scientific Report. EMCDDA/P1/2002).

Selection B covers the following ICD-10 categories: F11-F12, F14-F16 and F19 (mental and behavioural disorders due to psychoactive substances, except alcohol, tobacco, sedatives or hypnotics and volatile solvents), X41 (accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified), X42 (accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens] not elsewhere classified), X61 (intentional self- poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified), X62 (intentional self- poisoning by and exposure to narcotics and other psychodysleptics [hallucinogens] not elsewhere classified), Y11 (poisoning by and exposure to antiepileptic, sedatives-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified, undetermined intent) and Y12 (poisoning by and exposure to narcotics and psychodysleptics [hallucinogens] not elsewhere classified, undetermined intent). The EMCDDA recommends the combined use of Codes X and Y with Codes T 40.0-.9 and 43.6, which specify the type of drug involved, but this is unfortunately not possible in Spain because deaths are not coded to the T codes. Moreover, code X44 (accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances) was likewise included to adapt Selection B to the Spanish context, since this code is commonly used in some areas to code "overdose" deaths.

The number of DRDs for Spain as a whole was estimated by multiplying the annual number of deaths found in the selection of general register categories by the underestimation factor for these deaths in each year considered. This factor was calculated by dividing the number of overdose deaths extracted from the OED's specific register by the number of deaths in the selection of general register categories in an area covering 44% of the Spanish population, for which data for both registers were available. The deaths in the specific register are deaths judicially attributed to the non-medical and intentional use of psychoactive drugs, in which the respective forensic and toxicological certificates report positive post-mortem testing for illegal psychoactive drugs or other evidence of the recent use of such drugs and the absence of evidence of any other cause of death. Homicide, accidental or infection-mediated deaths in which drugs are detected are excluded. In 2001 the general register's underestimation factor for all ages was 1.38, and higher for men (1.41) than women (1.22) and for the 40-49 age group (2.33) than younger cohorts.

HIV-ID deaths were estimated by multiplying the yearly number of deaths recorded in the general register in categories ICD-9 (279.5, 279.6 and 759.8) or ICD-10 (B20 and B24), times the proportion of cumulative cases of AIDS through June 2003 attributable to drug injection.

Finally, mortality for all causes according to the general register was used to calculate the mortality rate per one hundred thousand and the proportion of mortality attributable to illegal drugs, to evaluate the weight of such mortality in the overall figures. The population numbers used to calculate the various rates were taken from the 2001 population census (www.ine.es/inebase).

The results show that there were 1969 illegal drug use-related deaths in Spain in 2001, most (1769) of which in the 15-49 age group, where overall mortality was 8.2 per one hundred thousand (13.4/100000 in males and 2.9/100000 in females), 7.4% attributable to drug use (8.6% in men and 4.5% in women). The impact of illegal drug-use-related mortality was strongest in the 30-39 age group, where the overall mortality rate was 16.3/100000, 15.3% of which was drug use-related. Overall, the mortality rate due to HIV infection in drug injectors (2.6/100000) was slightly higher than the rate directly related to drugs (2.3/100000). DRD mortality was, however, much higher than HIV mortality in the youngest injectors, particularly among males (4.4/100000 compared to 0.9/100000) (Table 6.5, Annex 1). Taking the period 1994-2001 as a whole, HIV infection mortality among injectors was observed to decrease substantially in 1997 and 1998 as a result of the introduction of highly active antiretroviral

therapy and to continue to fall very slowly since. DRD mortality, in turn, has declined gradually since 1996, but with no sharp downturn such as in the case of HIV-ID mortality (Figure 6.5, Annex 2). The mortality indicator data described in the preceding paragraph, however, suggest that there was a very substantial drop between 1992 and 1994. Further to the data in Figures 6.2 and 6.5, in 1991-1992 when DRD mortality peaked, this was the cause of death of an estimated 2000 people annually in Spain.

Any evaluation of the results should bear in mind that the DRD figures in this paper may be underestimated because they do not include drug-related deaths that are neither acknowledged/recorded by surgeons in official death certificates nor the object of a judicial and forensic investigation. There may be a fair number of these deaths in the case of certain drugs such as cocaine, where there is reason to suspect that a certain proportion of deaths attributed to cardiovascular causes in persons under 50 might be found to be due to cocaine if the cause of death were to be exhaustively investigated and correctly certified. Such under-reporting of DRD mortality may be on the rise, since the problems caused by cocaine are known to have increased substantially in recent years.

Mortality of drug users

In Spain in recent years, only one cohort study has been completed in order to study the causes of death of drug users and the evolution of this data. Due to its importance, its methodology and results are described in the following text (Brugal MT. Addiction 2004; 100: 981-989). The study focused on a cohort of 5,049 heroin users in Barcelona admitted to this city's centres for treatment of heroin abuse or addiction between 1992 and 1997. The subjects were recruited at different times throughout this period – a dynamic cohort – and the study of these subjects was finalized at the end of 1999. In addition to the treatment admission database, other information sources included: the AIDS register, the Residency Register, the General Register of Deaths and the Anatomic-Forensic Institute Register. In order to keep tabs on the subjects and connect the various databases, an identifier was used which included the full name, the first three letters of each surname, date of birth and sex of each subject. Data gathering included a basal clinical-epidemiological survey and follow-up surveys every 9 months. Various analyses were also completed, including the Cox proportional hazards survival regression with time-dependent variables.

In total, the study involved 23,048, 2 persons/ observation year. At the beginning of the study, 91% of the subjects used heroin on a daily basis, 79% had injected drugs at some point (59% in the 30 days prior to completing the basal survey), and 51% were HIV-positive. During the observation period, 50% entered a Methadone Maintenance Programme (MMP) at least once. The rest entered drug-free programmes. The total number of person-years on methadone went from 114 in 1992 to 1,225 in 1999. Subjects involved in an MMP stayed an average of 805 days, receiving an average dose of 71 mg of methadone, and 97% of these enjoyed a minimum of one take-home day.

1,005 patients died during observation: 386 of AIDS (38.4%), 349 of overdoses (34.7%) and 270 (27%) of other causes, primarily violence (7%) and cirrhosis or digestive complications (6%). Of those who died of an overdose, 41% were HIV-positive, 86% tested positive for opiates or their metabolites in their corporal fluids, 34% tested positive for cocaine or its metabolites, and 59% for benzodiazepines. 76% tested positive for more than one psychoactive substance, and 4% were not subjected to post-mortem toxicological analyses. With regard to MMPs, 81% of patients who died of overdoses were never involved in an MMP, and only 11 died while participating in an MMP. Of those who died of AIDS, 75% were registered as having the disease, and 25% were HIV-positive without meeting the clinical criteria for AIDS diagnosis (pre-AIDS cases).

The overall mortality rate was 4.4 per 100 person-years for the entire period of 1992-1999. Overdose mortality declined progressively, going from 3.1/100 in 1992 to 0.6/100 in 1999. AIDS mortality increased from 1.3/100 in 1992 to a maximum of 3.4/100 in 1995, reaching as low as 0.4/100 in 1999. Mortality due to other causes experienced a lesser decline – going from 1.2/100 in 1992 to 0.7/100 in 1999 – and became the primary cause of death in 1999. Life expectancy of the cohort at birth was 39 years, 38 less than the general population of Barcelona. However, life expectancy increased from 32 years in 1993 to 53 in 1997, although the latter is still 25 years lower than that of Barcelona's general population.

Within the cohort group the factor most closely linked to the risk of death by overdose was not being involved in an MMP at the time of death (Relative Risk – RR: 7.1; CI 95%: 3.77-13.45). In addition, the risk of death among subjects using injections was double that of those not injecting, and was somewhat higher among HIV-positives than negatives (RR: 1.4; CI 95%:1.02-1.8).

Among heroin injectors the relative risk of dying from AIDS in 1996 versus 1999 was 4.6 (CI 95%: 2.8-7.4). Patients who has used for over 10 years exhibited a risk that was 2.7 (CI 95%: 1.7-4.3) times greater than that of patients who had used for less than 5 years. Additionally, those not enrolled in an MMP were at a 60% higher risk than those who were.

The most important conclusion of this study is that the AIDS and overdose mortality rate among heroin users in Barcelona has decreased substantially, and that this decline is directly related to the protective influence of MMPs. Another decisive factor in this trend is the implementation of highly efficient antiretroviral therapy (Spanish acronym – TARGA), which brought about a sharp decrease in the number of HIV-infected injectors; as well as substitution of injected heroin with smoked heroin. Currently, hepatitis C and its side effects constitute one of the most important factors of the morbimortality of Barcelona heroin users and, together with overdose and HIV infection, helps to explain the 25-year difference between the life expectancy of this group and that of the general population.

- **Drug-related infectious diseases**

AIDS cases related to drug injection (Registered AIDS cases)

Since the mid to late 1980's, AIDS and HIV infection have been one of the main problems associated with drug use in Spain. From 1981, the year the epidemic began, to 30 June 2005 there have been a total of 71,039 AIDS cases registered in Spain, of which 44,922 (63.2%) were related to drug injection. It is estimated that 2,071 new AIDS cases were diagnosed in Spain in 2004 (data adjusted due to notification delays), 46.3% of which (48.3% among men and 39.4% among women) were attributed to the injection of drugs. This proportion has decreased in recent years, following the peak reached in 1990 (69.6%), and the percentage attributable to heterosexual relations has risen proportionately. It is important to note that in 2004 the number of new AIDS cases diagnosed in women and linked to unprotected heterosexual relations was greater than the number of cases related to drug injection.

The annual number of new injection-related AIDS diagnoses (yearly incidence) has gone down significantly between 1994 and 2004. The decrease may be due to the various advances made in the fight against AIDS, but is most likely attributable to methadone maintenance treatments and to the abandonment of injection as the preferred method of administering heroin doses.

When interpreting data obtained from the National AIDS Register one must keep in mind that this register is cumulative and is affected by certain notification delays, which means that the

numbers may need to be adjusted at a later date. In addition, it is important to remember that this register only makes note of new AIDS cases diagnosed during each period and not of new human immunodeficiency virus (HIV) infections. AIDS is usually a subsequent consequence of HIV infection. Therefore, this register's data does not reflect the current incidence of new HIV infections.

Records of new HIV infections and incidence studies

To make up for the AIDS register's shortcomings, several autonomous communities have set up systems for registering new HIV infection cases. The data obtained by these registers indicates that in Navarra and La Rioja the incidence of new infections among drug injectors, after the peak reached in the second half of the 1980s (with more than 200 new cases each year) fell rapidly up until 1996, when signs of stabilisation or extremely slow decline began to appear. Currently, the number of newly infected patients who are also drug injectors is less than 20, clearly much lower than the number of patients infected by sexual relations (www.msc.es/Diseno/enfermedadesLesiones/enfermedades_transmisibles.htm). In the cohort of newly-infected patients at the Corona Metropolitana Suroeste in Madrid (COMESEM) a significant drop in the incidence of injection-related HIV infections is also evident, going from 465 cases per year in 1991 to 26 cases in 2002 (www.madrid.org/sanidad/salud/vigilancia/boletin). However, the percentage of total new HIV infections represented by drug injectors varies widely according to geographic location: 27% in Navarra (200-2001), 56% in La Rioja (2000-2001), 16% in the Canary Islands (2000-2001) and 28.7% in Madrid (2001). This proportion is also quite evidently falling; for example, in Madrid it has already fallen to 10.5% in 2003.

With regard to the rate of HIV seroconversion among persons who show signs of having recently tested negative for the virus, there are hardly any recent studies in Spain. According to Project EPI-VIH, in a network of 20 centres for the diagnosis of HIV and sexually transmitted diseases, the seroconversion rate per 100 follow-up person-years among HIV-negative drug injectors or ex-injectors who returned for a second HIV test in the period 2000-2003 was registered at 6.2% (n=1,494) (www.msc.es/Diseno/enfermedadesLesiones/enfermedades_transmisibles.htm). A recently presented cohort study of heroin users under 31 performed in Madrid and Barcelona between 2001 and 2004 indicates that the incidence of HIV infection among injectors was 3.2 per 100 person-years (PY) in observation (n=204, PY in observation=248). However, among non-injectors (n=135, PY of observation=160.4) no seroconversion was detected.

Simulation of the epidemic's behaviour using mathematical models allows the estimation that HIV transmission among drug injectors came about suddenly in the 1980s (reaching its peak incidence rate between 1985 and 1987, with between 12,000 and 15,000 new infections each year among injectors). Since that time, estimates indicate that a decline supported by incidence data took place, although at a slower rate in recent years, until reaching figures of less than 1,000 new infections per year at the end of the nineties.

Studies on the prevalence of HIV infection in injectors

There are few studies that clearly reflect the evolution of the prevalence of HIV infection in drug injectors. Most of them are very specific or limited to small samples or areas. This report only includes studies performed on relatively ample test groups or extensive geographic locations. Recently, data has been published on HIV infection in persons being tested for the first time in eleven centres for sexually transmitted diseases and/or HIV diagnosis, located in nine different cities (EPI-VIH Project). The number of drug injectors being tested has dropped tremendously, going from 1,547 in 1991 to 191 in 2004; the number of HIV-positives has dropped from 690 to 36 and the prevalence of HIV in this group went from 44.6% in 1991 to 20% in 2004. It is important to remember that the statistics of

infection in persons who voluntarily present themselves for testing do not reflect the real prevalence of the disease, since they do not usually include those persons who already know they are infected. Nevertheless, this data can detect temporal changes in HIV transmission (www.msc.es/Diseno/enfermedadesLesiones/enfermedades_transmisibles.htm).

Additionally, EMCDDA data on admissions to treatment for drug abuse or addiction shows that the prevalence of HIV infection among current injectors (those who had injected during the 12 days prior to admission to treatment) has gone down slightly in recent years, going from 37.1% in 1996 to 32.0% in 2002. This decrease affects both men and women and is somewhat less pronounced among injectors over age 34 (among whom prevalence has gone from 48.9% to 42.8%) than among those under age 25 (where has gone from 20.3% to 12.1%). What is more, 2002 data indicates that women who had recently injected had a higher HIV prevalence than men (38.9% and 30.9% respectively). However, when interpreting this data it is important to remember that serological status with regard to HIV was unknown in 29.2% of the injectors admitted to treatment.

Conclusions

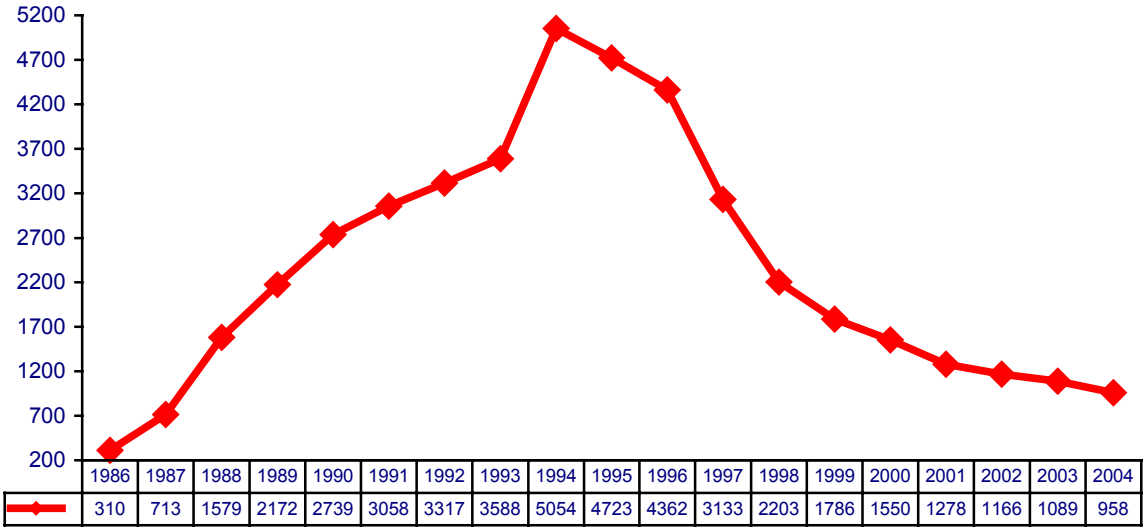
Although Spain has, in recent years, witnessed an important decrease of several data indicators of HIV infection related to drug injection, such as in the number of new HIV infections or in the number of AIDS cases diagnosed in drug injectors, the prevalence of HIV infection among injectors remains extraordinarily high in comparison with other European countries and has experienced a very slow decline in recent years, primarily due to the improved survival rate of infected persons who receive highly active antiretroviral treatments. This situation, together with the fact that, according to some specific studies, the prevalence of high-risk behaviour among injectors (using injection material previously used by others, vaginal or anal intercourse without condoms) remains quite elevated, suggests that the prevention and damage-control programmes that have been developed in recent years should be continued. This is necessary because a possible future increase in the number of injectors or in the prevalence of high-risk behaviour within this group could very well instigate a renewed spreading of the HIV epidemic linked to drug injection. In fact, the cohort study recently performed in Madrid and Barcelona shows that new HIV infections continue to appear among young drug injectors, at an annual rate of approximately 3%.

Viral hepatitis

Viral hepatitis infections have a significant effect on the health of drug users, especially injectors. However, in Spain over the past twenty years these effects have been eclipsed by the enormous magnitude of problems related to HIV infection. The decrease in HIV problems is allowing those related to viral hepatitis to come to the forefront and be more closely examined. In fact, there are signs that the number of deaths caused by hepatitis or related diseases among certain groups of heroin consumers in Spain may be equivalent to those caused by HIV. Infection with the hepatitis B virus (HBV) has always been widespread among drug injectors and other problematic drug users, despite the fact that selective hepatitis B vaccination has been recommended since 1982 for persons engaged in high-risk behaviours. Although there are very few recent studies on this subject, estimations indicate that infection is still relatively widespread (with a possible prevalence of infection between 20 to 40% for all heroin users, and between 40 to 60% for drug injectors). However, HVB vaccination programmes specifically aimed at adolescents, which began in 1991-1995 and reached about 80% of the target group, as well as the inclusion of this vaccine in children's vaccination calendars will undoubtedly help to control the problem in the medium term. For this reason, current concerns are more focused on infections of the hepatitis C virus (HCV), which, in addition to lacking an effective vaccine, is the most widespread disease among drug injectors. Although there is not much recent information in Spain on the prevalence of HCV infection among drug users, the latest published information estimated that the

prevalence of HCV infection is between 50 and 70% among all heroin users, and between 65 and 85% among drug injectors. In fact, in a study performed in 2002-2003 on 385 heroin users aged 30 or under (ITINERE Project), prevalence was shown to be 63.8% in Madrid and 59.7% in Barcelona. Moreover, in a study done on 158 new injectors (less than 2 years of experience with injecting drugs) who were admitted to 2 Barcelona hospitals between 1996 and 2002, an average prevalence of 55.6% was detected (quartile interval: 50-68%) (www.emcdda.eu.int). An additional problem is the high level of co-infection of HCV, HBV and HIV present in these population areas. Keeping in mind that the HCV infection rate among injectors is extremely high, without any important decreases having been observed, it is possible that this infection will generate significant public health care costs in future years in Spain, even if the number of injectors decreases.

Figure 6.6. Evolution of diagnosed AIDS cases associated to injecting drug use (number). Spain, 1986-2004*.



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
	310	713	1579	2172	2739	3058	3317	3588	5054	4723	4362	3133	2203	1786	1550	1278	1166	1089	958

(*) Updating date: 30 june 2005. Data corrected by delay of notification.
SOURCE: Ministry of Health and Consumer Affairs. National AIDS Register.

- **Psychiatric co-morbidity (dual diagnosis)**

No information available.

- **Other drug-related health correlates and consequences**

Non-fatal drug emergencies

Until 2002, information was gathered on all hospital emergencies whose medical records included doctor's notes that allowed data gatherers to relate them to the non-therapeutic consumption of psychoactive substances. This data was judged to have limited validity because data gatherers often had to make decisions based on scanty, ambiguous or inaccurate information. In fact, in a significant number of emergency cases, data gatherers did not find enough information in the medical records to decide whether or not the

emergency was directly related to the use of psychoactive substances. In addition, it is probable that doctors used different criteria when deciding whether or not to mention specific drugs in emergency cases, and that the data gatherers interpreted the various expressions used by doctors in different ways. What is more, the geographic range covered by these statistics has varied over time. Consequently, data on the number of emergency admissions cannot be compared with the data gathered in all monitored areas unless first subjected to detailed scrutiny, although the nature of the emergencies can be compared when certain precautions are taken. In this aspect, the period between 1996 and 2002 saw a significant decrease in the proportion of cases mentioning heroin (61.4% in 1996 and 26.8% in 2002) and an increase in the proportion of cases mentioning cocaine (27.3% in 1996 and 49.0% in 2002). Hypnosedatives were also mentioned more often, the proportion rising from 25.7% in 1996 to 34.1% in 2002, as well as cannabis (from 7.4% to 22.8%) and ecstasy (from 1.6% to 5.3%).

Due to the abovementioned problems, the definition and contents of the hospital emergency indicator was modified in 2003. The principal modifications introduced were the following:

1. Record all emergency cases in which the use of psychoactive substances or drugs is mentioned (except those in which only alcohol or tobacco use is mentioned) and not just those cases directly related to drug use. This involves recording infectious complications and any other emergency in which the non-medical consumption of registered drugs is mentioned.
2. Record emergency cases from a wider age group (15 to 54 years old) instead of from the previous age group (15-49 years old).
3. Record literally every emergency room diagnosis mentioned in the medical history records instead of classifying the emergency according to the 5 large diagnostic categories used previously, which are very unspecific and of little use.

Information on the new version of the indicator from some of the monitored areas is available. In Barcelona in 2004, 4,526 hospital emergency cases of illegal drug users were recorded, and 63.9% of medical records for these cases mentioned cocaine, 54.5% mentioned opiates, 18.9% alcohol and 25.9% other drugs. The most frequent diagnoses for these emergency cases were: mental disturbances (18.3%), overdoses (18.1%), external or violent causes (10.6%), physical complications, mainly infections (10.3%), withdrawal (1.9%) and other diagnoses, presumably unrelated to drugs (40.8%). If the diagnoses are examined according to the drugs mentioned, it becomes apparent that in cocaine cases the most frequent diagnoses were mental problems (principally anxiety attacks and psychosis), cardiovascular problems such as palpitations, hypertensive crises and heart pains, overdose and accidental injuries. In the case of heroin, the most frequent diagnoses were overdose, infections, liver complications and mental health problems. Between 1997 and 2004, the number and proportion of hospital emergencies mentioning opiates have diminished, going from 3,100 and 82.4% in 1997 to 2,212 and 54.5% in 2004. The same period has seen an increase in the number and proportion of episodes in which cocaine was mentioned, going from 1,090 and 29.0% in 1997 to 2,593 and 63.9% in 2004.

The data gathered in the Autonomous Community of the Basque Country was consistent with data gathered in Barcelona and indicate that in 2003 the most frequent diagnoses in emergency cases of drug users were mental and behavioural disorders. Cocaine was by far the most frequently mentioned illegal drug in medical history records.

7. Responses to Health Correlates and Consequences

- **Prevention of drug related deaths / Prevention and treatment of drug-related infectious diseases**

In Spain, these programmes are called Harm Reduction Programmes, and are those involving active drug addicts – in other words, persons who continue to use drugs and are not abstinent.

They are based on strategies aimed at contacting and caring for persons who are affected by social and health problems related to drug use and who do not normally turn to drug-addiction treatment centres for help.

The public health objective of these programmes is to minimise harm to the state of health (transmission of the human immunodeficiency virus, hepatitis B and C, etc.) related to drug use. They also perform social and psychological interventions and other activities aimed at diminishing the risk of drug-related death (overdose).

These programmes include:

- The "Social Emergency Centres", also called meeting and reception centres, are places of rest and meeting points linked to public health programmes. Aimed at the most marginalized sectors, they care for immediate needs: laundry services, showers, food and hot beverages, rest, etc. They offer health information, orientation on social resources, legal or work-related advice, cures for minor health problems or health care advice, and they occasionally provide condoms or injection materials. During 2004, there have been 25 centres of this kind active in Spain. (Provisional data provided by 13 autonomous communities).

- The "Mobile Units" (omnibuses, vans, cars) attempt to reach populations that cannot come to treatment centres and are highly marginalized. They are part of the so-called "outreach strategies" and include teams of professionals suited to this end. In Spain during 2004, 32 mobile units have been in active service. (Provisional data provided by 13 autonomous communities).

- The "Pharmacy Offices" are the principal locations for syringe distribution; they are the first health care centre that drug injectors turn to, are easily accessible and cover a wide range of territory. These facts, together with the health-care qualifications of their employees, allow pharmacists and their assistants the unique opportunity of contacting directly with drug injectors and of actively participating in disease prevention and health promotion, helping to reduce the spread of HIV and other pathogenic germs transmitted through the blood. In Spain during 2004, 803 pharmacy establishments participated in these programmes. (Provisional data provided by 13 autonomous communities).

- The "syringe exchange programmes (seps)". These programmes occupy a place of special importance among the strategies aimed at damage control for parenteral drug use. Some of its main characteristics are: *SEPs reduce the average useful life of syringes and are effective in preventing the spread of HIV, HBV and HBC*; and they have a positive effect on the prevention of harmful health consequences associated with injected drug use and *do not increase drug use*. In Spain during 2004, these programmes were implemented at 543 syringe exchange locations. (Provisional data provided by 13 autonomous communities).

- The "injection rooms". In Madrid, the Basque Country and Catalonia also have active "safe injection or venipuncture rooms." These locales offer adequate hygienic conditions, health care supervision, the possibility of qualitative and voluntary analysis of the substances' quality, and aim to reduce health risks by providing a safer method of consumption, thus preventing HIV infection or overdose, and equipped to provide emergency care. Health care professionals supervise all procedures.

  The three existing centres of this kind are called: in the Community of Madrid, the "Assisted Venipuncture Mechanism (Spanish Acronym – DAVE)", in Catalonia, the "Hygienic Consumption Mechanism" and in the Basque Country, the "Munduko Medikuak Supervised Consumption Room".

- **Interventions related to psychiatric co-morbidity**

In Spain, psychiatric co-morbidity is attended both at drug-addict care centres (see those mentioned under Drug-free treatment and Medically assisted treatment) and at mental health centres. Additionally, in the year 2004, 190 "Dual Pathology Care Programmes" were carried out and attended 4,612 drug-addict patients suffering from psychiatric co-morbidity. (Provisional data provided by 13 autonomous communities).

- **Interventions related to other health correlates and consequences**

No information available.

8. Social Correlates and Consequences

- **Social Exclusion**

No new information available.

- **Drug related Crime**

Over the past ten years, the number of arrests on drug trafficking has oscillated between 17,430 and 12,718, with a slight downward tendency. The drop observed in 2003 is largely attributed to the change in the methodology of reception and analysis treatment brought about by the enactment of the System for the Analysis, Evaluation and Exploitation of data on Drugs.

The standard profile of a person arrested in Spain for drug trafficking in 2004 is as follows:

- Male in 85% of cases
- Between 19 and 40 years old in 72% of cases
- Spanish national in 64% of cases
- If the detainee is a foreigner, nationality was Moroccan in 40% of cases, Colombian in 13%, French in 5%, Algerian in 3.4% and British in 3.2%.

The evolution of the number of accusations/ charges shows an almost linear tendency on a steep incline. This is an effect consistent with the fact that most drug operations are carried out under the aegis of Organic Law 1/1992, on the Protection of Citizen Safety (police carried out 156,595 confiscations in application of this law).

The standard profile in Spain of a person charged in application of Organic Law 1/1992, on the Protection of Citizen Safety, is as follows:

- Male in 95% of cases
- Between 19 and 40 years old in 80% of cases
- Spanish national in 91% of cases

Table 8.1.- Drug trafficking arrests

Spaniards	9.071
Foreigners	4.838
Nationality not specified	358
Total	**14.267**

Table 8.2.- Drug trafficking arrests by substance

Opiates	1.486
Cocaine	6.553
Cannabis	9.941
Others	1.895
Total	**19.775**

Table 8.3.- Charges for infringement of Law 1/1992*

Spaniards	136.174
Foreigners	14.013
Nationality not specified	6
Total	**150.193**

* illicit possession of drugs for own use, possession of instruments for drug use, use of illicit drugs in public settings

Table 8.4.- Charges for infringement of Law 1/1992, by substance

Opiates	5.591
Cocaine	27.493
Cannabis	124.268
Others	3.520
Total	**160.872**

- **Drug Use in Prison**

The number of inmates in penitentiary centres has followed an upward trend; this increase affects the number of sentenced inmates as well as of remand prisoners. As of 31 December 2004, there were 59,375 incarcerated persons, as opposed to 56,096 prisoners in 2003.

Figure 8.1 shows the characteristics of the prison population for the period 1999-2004:

- **The prison population is predominantly male** (92.3%) with an increasingly larger percentage of foreign nationals (29.4%). Additionally, in recent years this population has aged increasingly, a trend that only began to slow in 2003 when 37.5% of the prison population was between ages 31 and 40.
- **The foreign population** continues to expand as observed in recent years. The number of foreign nationals arrested and incarcerated in Spain has been on the rise since 1985. The increase in the number of incarcerated foreigners is consistent with a certain statistical reality, which must nevertheless be qualified due to the existence of a series of social, penal and judicial factors.

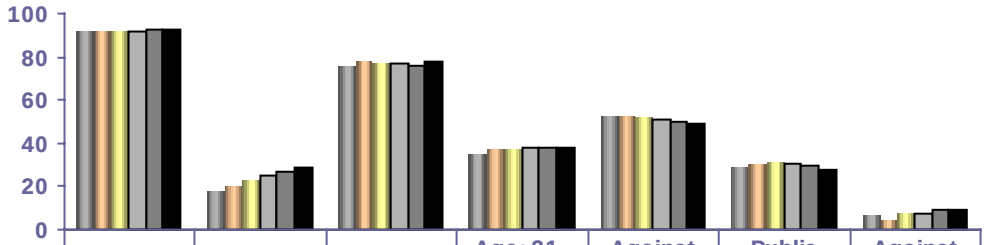
The difficulties that immigrants encounter in gaining access to social and public health services as well as to the job market partially explain their involvement in criminal activities. However, the significant level of foreign involvement in crimes committed against public health (drug traffic) is undeniable, as is the case of immigrants from the Maghreb region associated with the traffic of hashish, and of Latin Americans with cocaine. (Andalusian Ombudsman's Report. Special Report on the incidence of drugs in the immigrant population. July, 2004.)

- **According to the type of crime**, during 1999-2004 (as can be seen in Figure 8.1) the number of persons sentenced for breach of socio-economic order went down, whereas the number of persons sentenced for offences against human life rose. This fact may be influenced by age and repeat offence variables, given that studies indicate that as the offenders grow older, the kind of offence committed changes. It is true that other factors may also be involved.

The predominant types of offences are still, in first place, crimes against property (49.25% of prison population), followed by public order offences (28.12% of prison population). According to gender variable, 50.4% of the men were incarcerated for crimes against property, while 47.5% of the women were imprisoned for public order offences.

Up until now, in the Spanish penal system, the connection between heroin use and crimes against property had been observed, but the violent nature of the crimes among this group was not emphasized.

Figure 8.1. Evolution of the prison population profile. Spain, 1999-2004 (%)



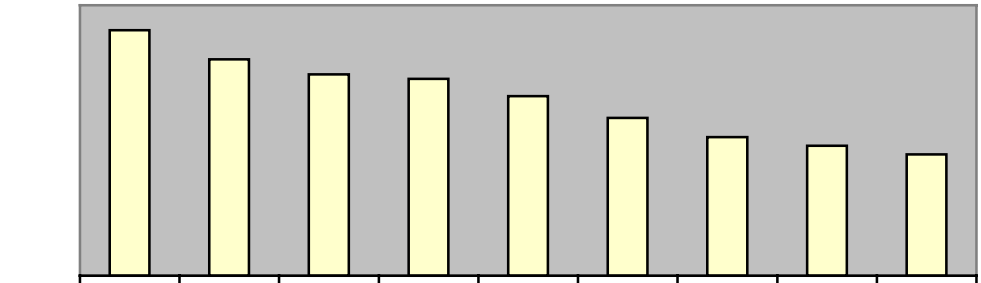
	Males	Foreigners	Convicts	Age: 31-40*	Against Property	Public Order	Against Persons*
1999	91,5	17,87	75,5	35,3	52,4	28,5	6,68
2000	91,9	19,93	77,8	36,9	52,56	30,2	4,19
2001	91,79	23,32	76,59	37,29	51,39	31,29	7,32
2002	91,9	25,4	76,8	38,1	50,87	30,5	7,86
2003	92,14	27,1	76,19	38,13	50,39	29,53	8,88
2004	92,3	29,14	77,58	37,57	49,25	28,12	9,26

(*) Percentages of convicted prison population.
Source: Government Delegation for the National Plan on Drugs. Based on penitentiary statistics from the Ministry of Interior.

Statistics: prevalence of diseases associated with drug use in 2004. Source: Health Records from Penitentiary Health Care.

- Prevalence of **HIV**: 11.2% of the total prison population commended to the General Directorate of Penitentiary Institutions. As Figure 8.2 would predict, the downward trend of HIV prevalence in prisons continues.

Figure 8.2. Evolution of the prevalence of HIV in the prison population. Spain, 2001-2004 * (%)

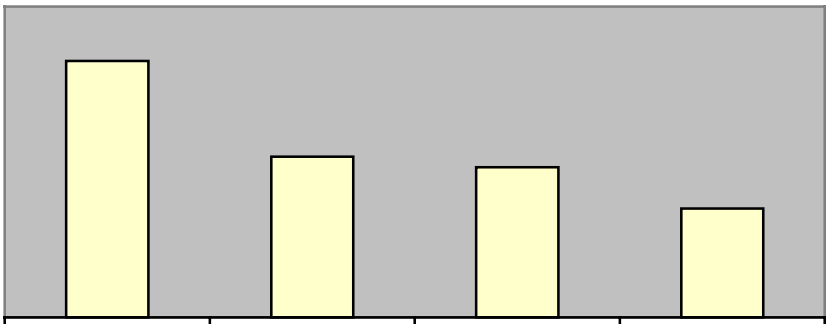


	1996	1997	1998	1999	2000	2001	2002	2003	2004
HIV	22,7	20	18,6	18,2	16,6	14,6	12,8	12	11,2

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

- Prevalence of **hepatitis C**: 36.3% of the total prison population under the General Directorate of Penitentiary Institutions. As Figure 8.3 would indicate, the downward trend of hepatitis C prevalence in prisons continues.

Figure 8.3. Evolution of the prevalence of hepatitis C in the prison population. Spain, 20001-2004 * (%)



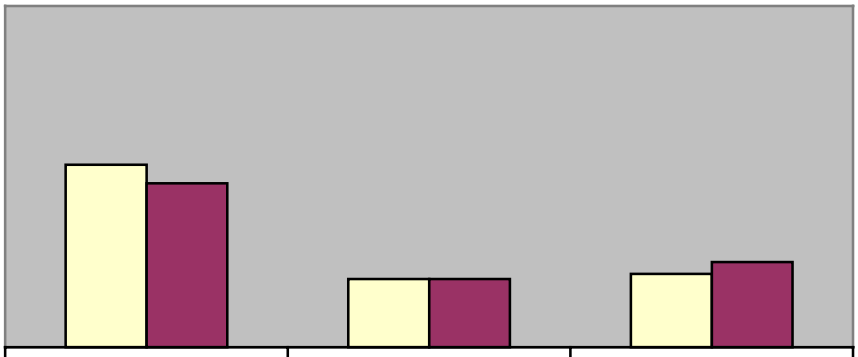
	2001	2002	2003	2004
Hepatitis C	41,9	38,2	37,8	36,2

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

- Prevalence of inmates receiving **antiretroviral** treatment under the General Directorate of Penitentiary Institutions: 6.2% of the prison population.

- Prevalence of **tuberculosis**: 0.23% of the prison population under the General Directorate of Penitentiary Institutions is being treated for this disease.
- Overdose deaths in penitentiary centres including the prison population of Catalonia. During the year 2004, 50 inmates have died of an overdose in penitentiary centres, 40 of HIV infection and 96 of non-HIV natural causes. See Figure 8.4.

Figure 8.4. Causes of death among the prison population. Spain, 2004



	Non-HIV Natural	HIV Infection	Overdose
2003	107	40	43
2004	96	40	50

Source: Government Delegation for the National Plan on Drugs. Data provided by the General Directorate of Penitentiary Institutions and by the Secretariat of Penitentiary Services, Rehabilitation and Juvenile Justice of Catalonia.

Statistics: Use of psychoactive substances by persons admitted to penitentiary centres. Source: Study on "Drug addicts admitted to prison: Use and High-Risk Practices", 2000. Deputy Direction of Prison Health and the National AIDS Plan.

The changes in the patterns of drug use in Spain in recent years are reflected in the criminal justice system. These changes demonstrate the importance of studying new variables and new use factors, especially those related to cocaine.

According to the latest study performed in the penitentiary sphere, entitled "Drug addicts admitted to prison: Use and High-Risk Practices" (a cross-section study carried out in November-December 2000 by the Deputy Directorate for Health in prisons and the National AIDS Plan):

- 77,2% of persons entering prison used psychoactive substances (including alcohol) in the month prior to incarceration. One of the characteristics that define these drug users at the time of admittance is polydrug use.
- 21,9% of persons entering prison had injected drugs in the month prior to incarceration. 54.3% of these employed or shared used syringes, and 17.9% did so frequently or always. The majority of drug injectors began administering drugs via injection over 10 years before incarceration.

Recent years have seen a significant decline in the use of injections for heroin and/or cocaine consumption. However, use of this administration method is still very common among drug addicts entering prison: 49.2% of heroin and cocaine users employed this method, 41.3% of only heroin users and 21.2% of only cocaine users.

In Catalonian penitentiary centres, it is estimated that 31% of the prison population are drug injectors and that 50% of these injectors are HIV-positive.

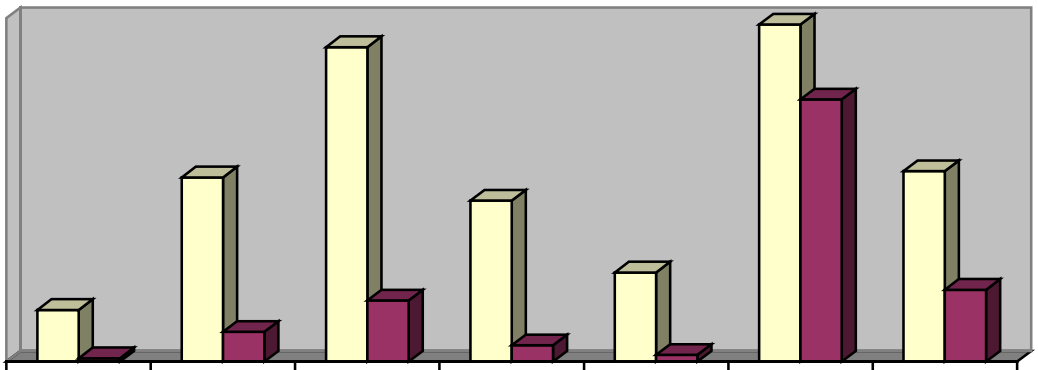
Statistics: Consumption of psychoactive substances in delinquent minors. Source: Study on "Analysis of the situation of protection and reform centres in the area of prevention" completed by Centre for Social Promotion Studies (Spanish acronym – CEPS), 2004.

The importance of the juvenile justice system as a detour towards treatment should not be underestimated; in fact, prevention and treatment are essential in order to control drug use and delinquency, especially among problematic youths. Drug use among young people is associated with most of the social and psychological problems that appear later on in their lives, with the consequent cost to society that these problems generate.

In the year 2004 the Government Delegation for the National Plan on Drugs (DGPNSD) financed the study *Analysis of the situation of protection and reform centres in the area of prevention*. The study was carried out in 23 reform centres in 4 different Autonomous Communities on a sample of 300 incarcerated juvenile delinquents. The results of this study with regard to drug use were as follows (Figure 8.5):

- Use of psychoactive substances is high, especially of tobacco, alcohol and cannabis
- over 90% of the sample group had taken these substances at some time in their lives. 68.7% have used tobacco on a weekly basis and approximately one-third have consumed cannabis with the same frequency. Almost 70% have admitted using cocaine at some point. The use of cannabis and inhalants is associated with Moroccans. The use of alcohol, pills and cocaine is associated with Spanish minors.
- Generally speaking, consumption is higher among boys, except in the cases of cocaine, solvents and tobacco, with similar intake levels.

Figure 8.5. Prevalence of psychoactive substance usage in reform centres. Spain, 2004.



	Heroin	Cocaine	Cannabis	Pills	Glue	Tobacco	Alcohol
At Any Time	15,08	53,62	91,55	46,89	25,98	98,1	55,46
Last 30 Days	1,01	8,7	17,84	4,78	1,96	76,3	20,95

Source: DGPNSD. "Analysis of the situation of protection and reform centres in the area of prevention", Centre for Social Promotion Studies (CEPS), 2004.

The results of this study reveal the same profile of the average delinquent minor in reform centres as that observed in the study on "Delinquent minors using drugs in reform centres" completed by DSIS and financed by the DGPNSD in 2002:

Profile of the average delinquent minor held in Spanish reform centres

Male
Spanish national (one-third of minors come from African countries, particularly Morocco)
Age: 17 years old
Failure in school

Use of psychoactive substances: The substances they most often admit to have consumed at some point are cannabis, cocaine and alcohol. They are generally polydrug users.
Current delinquency: Aggravated assault and robbery

To be sure, these minors are up against a constellation of risk factors, and the more they use drugs the more high-risk conduct they will exhibit. The relationship between tobacco, alcohol and other drugs begs consideration of the existence of a "risky behaviour syndrome".

The data describing the sample group indicates the basic intervention requirements: treatment of anti-social behaviour, drug use and education levels.

Social Costs

No new information available.

9. Responses to Social correlates and Consequences

- **Social Reintegration**

Table 9.1 provides the data from 2004 corresponding to 11 Autonomous Communities, which does not allow for comparisons with the previous year's data.

In the typology of resources for **residential care**, in Spain the model of supervised apartments with the presence of educators or social workers has been consolidated.

Among social reintegration programmes, the most notable are those whose objective is **obtaining remunerated employment**, for which there are a wide variety of temporary, subsidised, supervised, public or private alternatives, and which allowed almost 3,000 drug addicts to be reintegrated into the working world during the year covered by available data.

Table 9.1 also shows the number of centres offering social reintegration programmes, where follow-up is organised and the aforementioned education or work life integration programmes (which in some cases are actually given by these centres) are offered. The number of users at each centre is not shown, since the beneficiaries of the social reintegration programmes are included in the same table as beneficiaries of education, integration into working life or residential care resources.

Table 9.1. Social Reintegration Programmes. Type, number of programmes and number of users. Spain, 2004

	Number of programmes and/ or centres	Number of Users
Treatment centres with social reintegration activities and/ or programmes	243	
Social reintegration activity and/ or programme centres (without treatment)	53	
Residential Treatment Centres with social reintegration programmes (therapeutic communities)	74	
Residential care resources	119	2673
Educational programmes	386	10623
Programmes for integration into working life	225	2925

Source: DGPNSD. Data from the Plans on Drugs of 11 Autonomous Communities.

- **Prevention of drug related Crime**

Spain has a low crime rate and is considered fairly non-violent nation by virtue of, in first place, its homicide, rape and assault rates, which are well below European averages (www.coe.int, Council of Europe). And secondly, by reason of the low rates of escapes, deaths and suicides in prison as compared to the rest of Europe, despite having a high prison population rate (2002 SPACE data).

Basic criminality in Spain is linked to drug-related crimes: crimes against property (thefts) and offences against public order (drug traffic).

The link between problematic drug use and delinquent behaviour can be seen in the data obtained by surveys done on drug-addicted subjects in treatment (Table 9.2). As shown in Table 9.3, these percentages increase in the cases of subjects not being treated.

It truly seems that being a problematic drug consumer is a predictive factor for prison history – a significant percentage of subjects who consumed heroin and/ or cocaine have been in prison before and continue to be imprisoned. In the profile of the population treated for drug use in Spain, a common denominator is incarceration. Imprisonment is the most frequently recurring chapter in the life of a heroin addict, together with readmission to treatment programmes (Sánchez Carbonell, 2002). See Table 9.2.

Table 9.2. Criminal records for samples of drug users in treatment. Spain.

Study	Sample	History of prison time	Prior arrests
DGPNSD. Survey of heroin users in treatment. 1996	2.600 heroin users in treatment	40,3% had spent some time in prison	73,1 % had been arrested at some time
DGPNSD. Survey of heroin or cocaine users in treatment. 2003	1.831 heroin users in treatment 896 cocaine users in treatment	49,1% had spent some time in prison	59,7% had been arrested at some time.
Sánchez-Carbonell et al. Penitentiary evolution of a cohort of 135 heroin addicts between 1985 and 2000. Rev. Trastornos Adictivos 2004, 6 (1), 39-45	Longitudinal study of a cohort of 135 heroin addicts since they began treatment in 1985 up to 2000.	42,2% had spent some time in prison.	
Jiménez Treviño et al. 2000. Transversal evaluation after fifteen years in a sample of opiate addicts. Rev. Socidrogalcohol. 4(12)	215 opiate addicts in treatment: 64.2% had not died. Follow-up study.	29,3% had spent some time in prison.	41,9% of living subjects had been arrested at some time

Source: DGPNSD

Table 9.3. Criminal records for samples of users. Link between users not in treatment and criminal records. Spain.

Study	Sample	History of prison time	Prior arrests
March Cerdá JC. Research about lifestyles among socially excluded illegal drug users at risk for HIV/AIDS. 2000 Project financed by the EU. Based on a WHO questionnaire.	Socially excluded illegal drug users in 4 European cities, two of them Spanish: Seville 199 interviews Granada 193 interviews Global multi-focus descriptive study.	66% of the total sample had been in prison 70,8 of the Seville sample. 20,6 had injected drugs in prison. 53,1% of the Granada sample. 44,2% had injected drugs in prison.	
Iraurgi Castillo J. 2003 Psychosocial situation of heroin users not in treatment. Central Publications Service of the Basque Government. Report # 9	163 opiate consumers not entered in treatment or health care programmes	66,2% had been in prison at some time.	88,7% had been arrested at some time.

Source: DGPNSD

Assistance for drug users in prisons

a) Abstinence oriented treatments (detoxifications, drug free units, therapeutic communities in prisons). See Figure 9.1.

- Detoxification. Detoxification programmes are offered to everyone who is diagnosed as a drug addict upon entering prison and has not been entered in a methadone treatment programme. The number of inmates included in regulated detoxification during 2004 was 2,112 drug addicts incarcerated in 65 penitentiary centres managed by the Central State Administration (Ministry of Interior. General Directorate of Penitentiary Institutions). Prevalence as of 31 December 2004 was determined to be 0.17% of the prison population.

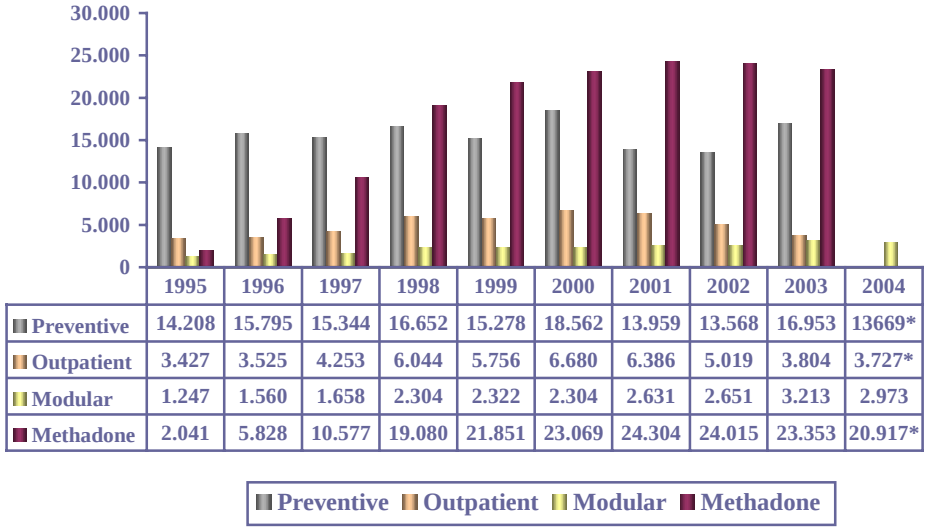
- Drug-free programmes. This type of treatment was given to 6,700 inmates during the year 2004.

- Outpatient detoxification programmes. Treated inmates live alongside the rest of the prison population and use the centre's general resources. During 2004, this treatment was give to 3,727 inmates in 64 penitentiary centres, with a prevalence as of 31 December 2004 of 3.20% of the prison population.

- Detoxification programmes in specific treatment spaces. These programmes take place in a specific space within the centre – they can either be day centres or treatment modules for staying overnight in the same space. During 2004, 2,683 inmates from 20 penitentiary centres participated in the treatment module

programme, with a prevalence as of 31 December 2004 of 2.12% of the prison population. 290 inmates participated in the day centre programme at 6 different penitentiary centres, with a prevalence of 0.20% of the prison population.

Figure 9.1. Evolution of the number of inmates in drug-addiction programmes. Spain, 1995–2004.



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

Does not include data on the prison population of Catalonia. Source: DGPNSD, from data provided by the General Directorate of Penitentiary Institutions.

b) Substitution treatment

These treatments have been offered in the prison system since 1992, acquired momentum and underwent notable developments in 1994, and in 1998 were extended to all penitentiary centres.

During 2004, a total of 20,917 inmates from 66 penitentiary centres have received methadone treatment, with a prevalence as of 31 December 2004 of 16.73%.

The rapid spread of these treatments can be explained by their high efficiency and especially by their proven effectiveness in the prevention of HIV infections.

c) Damage control measures

- Blood screening, vaccinations, provisions of disinfectants, provision of condoms. Every penitentiary centre now offers preventive and health education programmes, using their own resources as well as co-ordinating with communitarian mechanisms. These programmes are not only aimed at drug addicts but also at inmates who are at risk of beginning to use drugs in prison, mainly first-time and young inmates.

13,669 inmates from all penitentiary centres managed by Central Administration have passed through this kind of programme.

It is important to note that these programmes are especially relevant in the prison system, given the frequent and serious health problems many of these people have; for a significant percentage of the inmates, the only contact they ever have with the public health care system takes place upon entering prison.

Preventive activities that are carried out:

- Strategies for promoting health that range from health policies to intervention in the physical and social environment.

- Provision of bleach and condoms at every centre. In addition, some penitentiary centres provide aluminium foil and smoking filters.

- Health education for sick inmates.

- Hepatitis B vaccinations.

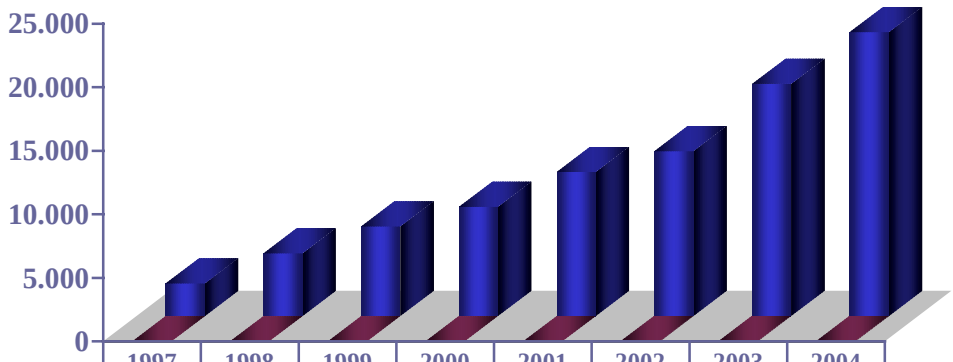
- Hepatitis treatments.

- Application of the tuberculosis prevention and control programme, whose basic objective is the early detection and treatment of both the infection and the disease in the prison population. Application of Directly Observed Treatment (DOT).

- Psychosocial and health support groups for the prison population infected with HIV or at risk of infection.

- Needles and syringe exchange. This offer is available at every centre managed by the General Directorate of Penitentiary Institutions and in two centres in Catalonia. During 2004, there were 37 penitentiary centres with registered users (Figure 9.2). During this same year, 22,356 syringes were distributed at centres belonging to central administration.

Figure 9.2. Evolution of syringe exchange programmes in penitentiary centres. Spain, 1997-2004.



	1997	1998	1999	2000	2001	2002	2003	2004
# Centres with users	1	2	4	9	11	27	39	37
# Syringes distributed	2.582	4.943	7.056	8.584	11.339	12.970	18.260	22.356

Source: Government Delegation for the National Plan on Drugs. Based on data provided by the General Directorate of Penitentiary Institutions and Penitentiary Services of Catalonia.* Some Catalonian data is missing.

This experience has demonstrated that these programmes can be applied in the penitentiary system, without causing distortions or direct problems in the area of regulations.

d) Community links (pre-release, units and release, working with families, throughcare, therapeutic communities for offenders outside the prisons, involvement of community health structures)

- Therapeutic communities for offenders outside the prisons. During 2004, 5,245 inmates have been brought from penitentiary centres to treatment:

. A total of 712 inmates to external outpatient centres.

. A total of 3,600 inmates to external methadone programmes.

. A total of 393 inmates to external therapeutic communities.

. A total of 540 inmates to other detoxification/ withdrawal resources.

e) Specific training

Educating professionals to work in the prison environment. Educational courses are given to all Government employees who enter the Penitentiary System. Following admission, they are given periodic courses to update them on the prevalent pathologies and new treatment alternatives.

During the year 2004, the General Directorate of Penitentiary Institutions has organised educational activities in a centralised fashion, dealing with aspects of prevention and health care, which were attended by a total of 1,230 prison system professionals.

Education for inmates. The ultimate goal of working with drug-addicted inmates in penitentiary centres is social reintegration; therefore, activities in this area must be aimed primarily at avoiding damages associated with drug use and subsequently at the normalisation and social reintegration of the drug addicts. This is why treatment alternatives should not remain isolated as simple treatment programmes, but rather integrated in the activities that comprise educational and cultural assistance.

During 2004, 7,371 inmates have begun Professional Occupational Education courses, 1,170 inmates have begun Work Life Insertion Orientation programmes, and 350 inmates have opted for work life insertion accompaniment actions. It is estimated that 50% of these students were drug addicts.

Alternatives to prison for drug users

Despite the methodological shortcomings of data gathering, this data provides an overview of a high percentage of measures aimed at drug addicts with regard to the total of alternative ways to serve prison sentences.

Various sources have attempted to describe a holistic view of the situation of these measures:

- Penitentiary Social Services of the Central Administration. During 2004, judges have communicated **a total of 838 alternative sentences** to the Penitentiary Social Services, **72.7% of which consisted of detoxification treatments**, most o which have been on an outpatient basis. 15.14% of these treatments were new cases.

- Basque Country Statistics: Report on Services for Assistance with Serving Sentences and Social Reintegration, 2004. A total of 761 alternative measures (in 2003: 649), of which 151 were new. The crimes that have most often led to these measures are, in first place, crimes against property (69.11% of measures), followed by offences against public order (15.37% of alternative measures). These sentences were applied to 446 subjects, 91.1 percent male. Of all measures enforced during 2004, only 7.09% were revoked due to non-compliance or leaving treatment (in 2003: 8.17%). 82.65% of all these sentences were applied to people with drug-addiction problems (in 2003: 82.74%).

Finally, the enactment of Organic Law 15/2003, of 25 November, modifying Organic Law 10/1995, of 23 November on the Penal Code, has increased the permitted margin of application of suspended sentences to drug addicts, which is now set at sentences of no more than five years.

10. Drug Markets

- **Trends in the manufacture and illegal trafficking of main narcotic and psychotropic substances**

Hashish

The available data shows a steady and rising evolution of hashish seizures in Spain over recent years, going from 474 tonnes in 2000 to 794 in the year 2004.

The evolution of confiscated quantities in Europe, however, shows a tendency to level out in the range of 650 to 795 tonnes, which indicates an increased relative importance of the quantities seized in Spain with regard to the total amount seized in Europe.

The wholesale hashish market in Spain, and in all Europe, corresponds to a regional model of production and use, originating primarily in Morocco and destined for Europe, whether sent directly, shipped through Spain or through other intermediary countries.

The information on confiscations and use in Europe suggests that the known level of production originating in Morocco is not enough to supply the market, which may mean that the known production level is lower than the actual production, or that there are other sources for the production and supply of hashish (in the form of resin, plants or oil) destined for Europe.

Product demand is constantly on the rise and is generally associated with recreational use. This evolution is consistent with the development of social movements that promote a generalised acceptance of this substance, and even its use for therapeutic reasons.

From this point of view, it can be stated that a large segment of the population, especially certain age groups, do not perceive hashish as a dangerous drug, and there are even certain social groups or socially influential persons who do not consider it as a drug.

According to the data on drug use in 2003, extracted from the latest population survey, this year saw an increase in both the number of occasional users as well as in the number of habitual users, and consequently an increase in quantities consumed. Use predictions for 2004 and 2005 establish the possibility that the prevalence curves may dip down in the categories of use during the final year and the final month, and may experience a slight increase in the category of daily use.

Nevertheless, it is crucial to remember that these tendencies could really indicate an increase in used quantities, and possibly in the total number of users, given the global population increase.

The data on prices, availability, demand, use and seizures seems to indicate that the hashish market is very stable, capable of handling habitual losses and even more important losses without suffering a supply shortage that would affect the market.

Heroin

The current situation of heroin use in Spain finds itself in a stable phase, with rate values that have not varied greatly since 1999, and the drug has an ever-lower acceptance among drug users due to the following:

- Heroin is one of the most toxic substances and creates an intense physical and psychological addiction as well as high tolerance levels; it is administered via the respiratory system or intravenously, exposing the user to diseases such as HIV;
- The sensibilization campaigns publicised by the institutions and the media.
- The increasing collaboration of different social sectors and the efforts made to improve education for young people and adolescents with regard to the effects of drugs.
- The efficiency of the law enforcement bodies in their efforts of prevention, analysis, detection and confiscation.

During the 2000-2004 period, the quantities confiscated and the number of seizures in our country went down about 45%. With regard to the number of arrested and charged persons in application of Organic Law 1/1992, the reduction is also near this same percentage.

In the same way, regarding quantities seized in Spain in comparison with the EU, a steady downward trend has been observed. Seizures have gone down almost 6 points in the 1998-2003 period, now situated at 3.81%.

Most of the heroin confiscated in Spain arrives from Turkey via the Balkan Route, and is smuggled in by Turkish organisations that take advantage of the infrastructure of Spanish retail organisations.

With regard to persons arrested for heroin trafficking , the majority (82%) were Spanish nationals last year.

These indicators inspire the expectation that, a stable process will be continued in the year 2005.

Although experimental use has temporarily picked up, all the reports and observations indicate a chronic use in the population with long-term addiction. Police arrests and are down slightly to moderately. Prices are generally stable for the variety of heroin that is most popular in Spain (brown sugar or Afghan heroin), a situation that correlates with the stability in cultivation regions and in resulting production levels.

The evolution of heroin variables is odd. As mentioned previously, indicators reflect the principal circumstance of a chronic use with a tendency to limit to marginal rates. However, world production continues to be relatively stable, and neither substance supply nor referential indicators (price, purity, etc.) were affected by the growing prohibition enacted in Afghanistan during 2001.

Taken individually, the variables have a certain internal coherency. On the other hand, as soon as they cross paths with other variables, the landscape changes. Generally, there are few variables that show a solid correlation between each other. The closest appears to be the relationship between purity and price, which maintains an inverse variation, so that over the years the purity of the dose has risen, although it has levelled off since 1999, while prices went down. Unsurprisingly, the stability of purity since the beginning of 2000 coincides with the stabilised low prevalence of use. The current feature indicates a continued production, a to the chronic use by lowering prices and improving the quality of the dose's active ingredient. What is more, this adaptation is made possible by the decline in heroin confiscations, which enables them to offer lower prices and higher purity than in the early nineties.

Cocaine

Cocaine is the second most problematic drug in the world and the main problematic drug in America. In Spain it is the most widely used, after cannabis.

It is the drug with the highest average initiation age (20.3 years old). The period 1995 to 1999 witnessed a stabilisation of the prevalence of both occasional and habitual use, but both indicators experienced an upward swing in the year 2001.

The comparative study on user habits covering the years 2001-2003 implies that, with regard to habitual use, the consumer population has increased from 2.5% to 2.7%. This data confirms an upward trend in cocaine users in Spain.

The continual increase of the average purity in kilograms of confiscated cocaine, 75% in 2004, is not consistent with the stabilisation of purity in grams, 51% over the two past years, which would indicate the tendency of an expanding market. However, purity in cocaine doses has gone up two points in the year 2004 (42% as compared to 40% in 2003) which could be interpreted as an indication of a certain stability of supply in the retail market as compared to the purity of large consignments.

With regard to trafficking, most of the cocaine used in Spain proceeds from Colombia, either directly or via third countries, and is smuggled directly into Spain by ships and boats, containers or airplanes.

The trend of cocaine arrests in Spain has fluctuated since 1999 in a clear "saw-tooth" pattern, with marked increases in 2001 and 2003. Cocaine arrests have gone down 32.76% between the year 2003 (49,279 kg confiscated) and the year 2004 (33,135 kg).

Confiscations carried out at the sea indicate the organisations' use of new routes that take advantage of the African continent as a previous platform from which to launch it into Europe. Consequently, Moroccan drug trafficking organisations specialised in smuggling hashish into Europe alternate their activities with cocaine trafficking.

The tendency to use African routes for large cocaine shipments headed for the European Union implies the establishment of Colombian organisations in countries around the Gulf of Guinea, in order to co-ordinate the transportation and routing of commercial exchange.

The data on prices, availability, demand, use and seizures seems to indicate that the cocaine market is clearly on the rise, with a great capacity to absorb habitual losses and even the loss of significant consignments, without suffering a supply shortage that would distort the market.

Synthetic drugs

We cannot limit ecstasy exclusively to MDMA. Such a restricted viewpoint would not include the entire dimension of the phenomenon: pills are being sold as ecstasy that contain amphetamines, metamphetamines, DOB, 4-MTA, 2C-B, MDEA, MBDB, 2C-T-2 and 2C7-7, and are all accepted as ecstasy.

The use of synthetic drugs in general and MDMA in particular has been consolidated among young people, more as a socio-cultural phenomenon with specific identifying characteristics, unprecedented in previous use methods, than as an individual and isolated act.

The expansion of drug use associated with juvenile recreation came about in the wake of the widespread rejection of heroin and everything related to that drug. Its use has spread more

like a cultural movement than like an awful habit and, rather than an individual phenomenon, it is a group activity, a public and routine practice that has become a statement of self-affirmation in the face of society.

Some indicators, such as confiscations, laboratories discovered, prices and recent survey incline us to believe that a stabilisation of synthetic drug use is taking place.

The confiscations of amphetamine derivatives in general has experienced a evident decrease over the past two years, and the same is true for ecstasy seizures, the number of which have gone down since 2002.

The control of the industrial chemical substances needed for manufacturing ecstasy has become one of the fundamental international strategies for avoiding the diversion of this material for illicit drug manufacture.

The United Nations Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances of 19 December 1988 proposed that its Member-states to control a series of chemical substances. In Spain, Law 3/1996 19 January on measures for controlling catalogued chemical substances liable of being diverted for the illicit manufacture of drugs, further developed by Royal Decree 865/1997 6 June, and the Agreement for voluntary collaboration between the Administration and the chemical and pharmaceutical industry, establish the obligated parties, the operators´ obligations, and register and the penalisation regime.

The manufacture of synthetic drugs requires the use of large quantities of chemical precursors, with markedly aggressive effects on the environment; in this sense, it should be considered a short-term ecological damage risk and a direct threat to public health brought about by the uncontrolled dumping of waste obtained during the illegal manufacturing process.

Part B: Selected Issues

Part B: SELECTED ISSUES

11. Gender Differences

The 2005-2008 Spanish Action Plan establishes the perspective on gender that will be adopted in all the axis and measures proposed by this Plan: the actions included in its six axis shall systematically consider the differences between the respective conditions, situations and needs of men and women in the planning, implementation and evaluation phases of said actions, integrating the gender perspective in accordance with the directives of the United Nations, the European Union and with the equity policy promoted by the Government of Spain.

At practical level, the available data that can be analysed from a gender perspective in Spain are as follows:

- **Evolution of cocaine and cannabis use according to gender in Spain**

The figures on the evolution of use can be seen in Tables 11.1 and 11.2 (Annex 1) and in Figures 11.1 and 11.2 (Annex 2).

a) Situation and tendency to use drugs according to gender

The prevalence of use of the main illegal drugs (cannabis, cocaine, ecstasy, amphetamines, hallucinogens, heroin) is several times higher among men than among women, both in the general population living in family residences (15-64 years old) and in secondary school students (14-18 years old) (Tables 11.1 and 11.2, Annex 1). The least differences in illegal drug use were observed in cannabis use, especially among 14 to 18-year-old students. Contrary to the opinion held by many citizens and professionals, the inter-gender differences in illegal drug use have not experienced important changes in amount or trend over the last decade (Tables 11.1 - 11.3, Annex 1) (Figures 11.1 and 11.2, Annex 2).

In the case of hypnosedatives (tranquillisers or sleeping pills) without medical prescription, the prevalence of use among women exceeds that of men both in the general 15 to 64-year old population and among secondary school students aged 14 to 18 (Tables 11.1 and 11.2, Annex 1).

With regard to tobacco use, it remains more prevalent among men than among women in the 15 to 64-year-old population (Table 11.1, Annex 1), although among young people aged 15 to 34, the difference is considerably reduced. In fact, in 2003 the prevalence of daily tobacco use in this age group was 40% among men and 36.8% among women. The intensity of use in the 15 to 64-year-old population was higher in men (17.7-cigarettes/ day on average) than in women (13.1 cigarettes per day. With regard to use trends, the prevalence of daily tobacco use has increased over recent years, above all in women, among whom it rose from 27.1% in 1997 to 31.3% in 2003. By age and gender groups and using 1997 as the base year, the increase is observed above all in women aged 35 to 64, whose prevalence of daily use went from 19.1% in 1997 to 27% in 2003. Among secondary school students aged 14 to 18, prevalence of tobacco use among women is much higher than prevalence among men (Table 11.2). In 2004 the proportion of 14 to 18-year-old students who had smoked every day over the last 30 days was 18.4% among men and 24.1% among women. That same year, the use intensity was higher among men (8.1 cigarettes/ day on average) than among women (7.5 cigarettes/ day) and the average age of initiation into tobacco use was very similar in men and women. The decade between 1994 and 2004 observed a slight decrease of differences in the prevalence of daily tobacco use in the 14 to 18-year-old population (Figure 11.3, Annex 2).

With regard to the prevalence of alcohol use, the situation is similar to tobacco use. In the 15 to 64-year-old population, use is far more prevalent in men than in women (Table 11.1, Annex 1), although the differences are less notable in young people ages 15 to 34. The gender differences are present among sporadic, habitual and high-risk smokers. For example, in 2003 the prevalence of weekly use over the last 12 months was 63.3% among men as opposed to 32.9% among women; prevalence of drunkenness over the same period was 29.6% and 12.7% respectively; and prevalence of high-risk use in the last 30 days was 7.4% and 3.1%. In addition, the greatest gender differences in the prevalence of use of various beverages are observed on weekdays, when the prevalence of men can be several times higher than that of women. Among secondary school students aged 14 to 18, the prevalence of sporadic or experimental alcohol use is fairly similar for both sexes (Table 11.2). However, habitual use (more than 8 out of the last 30 days) was more widespread among men (51.8%) than among women (42.8%), and the same was true of high-risk use (consuming more than 50 cubic centilitres (cc) of pure alcohol/ day in men or more than 30 cc/ day in women) (13.1% in men and 11.5% in women) as well as the prevalence of drunkenness in the last 30 days (37% in men and 32.5% in women).

b) Situation and tendencies of drug-use problems according to gender

The health and social consequences of drug use continue to principally affect males. In 2002 the proportion of affected women did not exceed 30% in any of the main indicators of drug problems analysed in Spain (admissions to treatment for drug abuse or addiction, deaths caused by adverse reactions to drugs (overdoses), hospital emergency cases involving drug users, AIDS cases linked to drug injection). Female involvement was more important in emergency cases, where in 2002 they accounted for 27.4% of cases. On the other hand, for the treatment, death and AIDS cases linked to drug injection indicators, the proportion of women in 2002 was around 12 to 18%; lower in the death indicator (12.1%) than in treatment 815.3%). In 2004, the proportion of women among AIDS cases linked to drug injection was 17.7%.

It is estimated that 958 new cases of drug injection-related AIDS cases were diagnosed in Spain in 2004, 788 in men and 170 in women (data adjusted due to delayed notification). It is interesting to note that in 2004, the number of new AIDS cases diagnosed in women and related to unprotected heterosexual relations was higher than the number of drug injection-related cases. The overwhelming predominance of men in cases of AIDS and HIV infections linked to drug injection can be explained by the fact that drug injection is much more common among men than among women. In fact, the opposite is true. In 2002, the prevalence of HIV infection among persons admitted to treatment who had injected drugs in the last 12 months was eight percent higher among women (40.4%) than among men (32.3%).

Over the past decade, the proportion of women with drug problems detected by the indicators of emergency cases and deaths caused by severe reactions to drugs has gone up, whereas the proportion detected by the treatment indicator has remained more or less the same.

- Among patients admitted to treatment, the proportion of women was 15.8% in 1991, 15.5% in 1996, 15.1% in 1999 and 15.3% in 2002 (Figure 11.4, Annex 2). An increase was not detected in the proportion of patients being treated for the first time, either (Figure 11.5, Annex 2).
- In emergency cases of severe reactions to drugs, the proportion of women went from 20.4% in 1991, to 19.5% in 1995, 21.4% in 1996 and 27.4% in 2002 (Figure 11.4, Annex 2).
- In deaths caused by severe reaction to drugs, the proportion of women went from 12.3% in 1991 to 14.8% in 1996, 14.7% in 1999, and 12.1% in 2002 (Figure 11.4, Annex 2).

- The comparative presence of men and women in drug injection-related AIDS cases has varied little over the past 20 years. In fact, the proportion of men has gone from 87.0% in 1985 to 81.9% in 1990, 81.1% in 1995 29.2% in 2000 and 82.3% in 2004. In recent years, the prevalence of HIV infection among drug injectors has developed in a similar trend among both men and women, going from 35.9% in 19996 to 32.3% in 2002 in men, and from 43.4% in 1996 to 40.4% in 2002 among women (Figure 11.6, Annex 2).

- **Treatment**

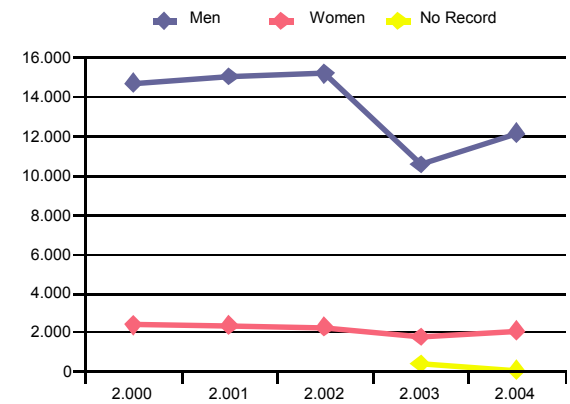
In Spain the treatment resources for drug addicts care for both men and women. This is true in drug-free programmes as well as methadone programmes and other damage control activities.

Nevertheless, it is necessary to point out that there are 30 “Specific Care Programmes for Women” which in 2004 have treated 1,240 women (provisional data provided by 13 Autonomous Communities).

- **Crimes and arrests**

Figure 11.7. Evolution by gender. Arrested persons on drug-related crimes.

	2.000	2.001	2.002	2.003	2.004	Variation % 2.000 - 2.004
Men	14.681	15.019	15.181	10.547	12.115	**-17,48 %**
Women	2.386	2.361	2.249	1.774	2.080	**-12,82 %**
No Record	0	0	0	397	72	
TOTAL	**17.067**	**17.380**	**17.430**	**12.718**	**14.267**	**-16,41 %**



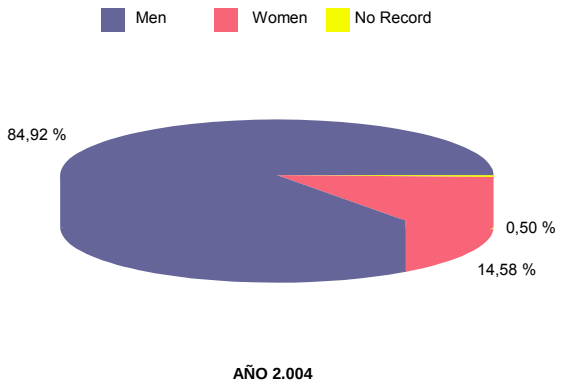
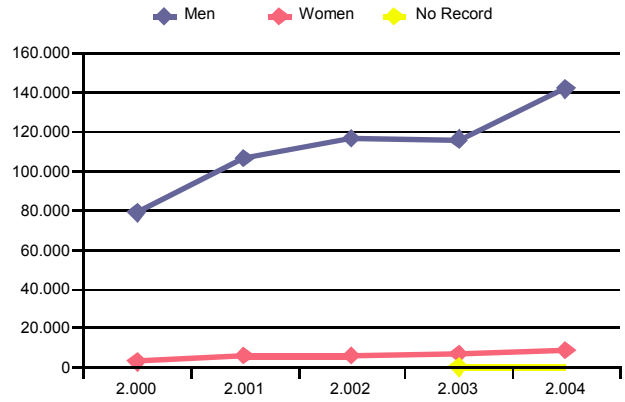
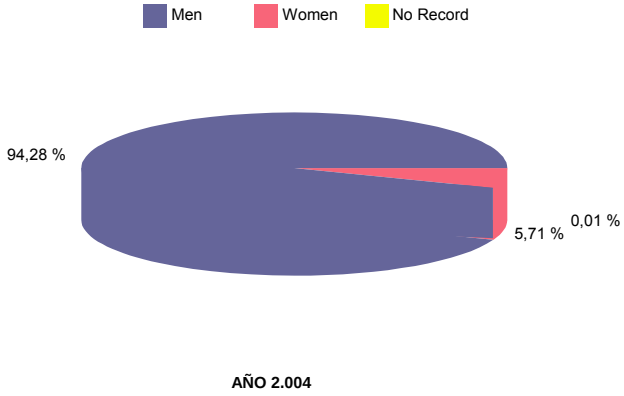


Figure 11.8 Criminal reports: evolution by gender. Charged persons on administrative sanctions for drug public use

	2.000	2.001	2.002	2.003	2.004	Variation % 2.000 - 2.004
Men	78.591	106.442	116.452	115.850	141.598	**80,17 %**
Women	2.711	5.828	5.833	6.660	8.582	**216,56 %**
No Record	0	0	0	124	13	
TOTAL	**81.302**	**112.270**	**122.285**	**122.634**	**150.193**	**84,73 %**





- **Gender-specific aspects in the criminal justice system**

  Gender-specific prison responses, differences in culture or practices in men's/ women's prison settings

All criminological knowledge, as well as Penal Laws, has been created by men, especially men in conflict with the penal system, without completing the analytical task of explaining female criminality (Howe, 1990). Consequently, gender-specific policies for women are missing from the criminal policy agendas of most nations.

The increase in the female population observed in the penal-penitentiary system worldwide over the past 25 years has had and still has its consequences for this system that was ill-prepared to deal with such a situation.

In Spain, from a historical perspective, two facts regarding the participation of women in crimes and their association with drug use must be underscored:

- Increase in the number of arrested and incarcerated women.
- Prominent role of women in committing crimes against the public order.

Arrests by gender

In recent years the number of arrested underage women has constantly risen; and despite the increasing number of women arrested, the percentage of women sentenced decreases every year, undoubtedly due to the possibilities of excessive resort to the courts.

Arrested women.- Female participation represented 9.9% of the total number of arrests performed in 2004. However, we see that although women still maintain a low criminal

participation rate, of the total arrests for drug traffic, 10.56% of female arrests corresponded to this type of crime, whereas only 7.6% of male arrests were related to this crime.

Arrested minors (14-18 years old).- In 2004, arrests of underage (14 to 18-year-old) women accounted for 11.10% of all arrests of minors. 30.27% of the total number of minor women arrested were foreign nationals. With regard to drug use, drug consumption is unknown in 85.18% of the arrest cases; of cases where it is know, the most frequently mentioned (illegal) substance they say they have consumed is cannabis (9.92%) followed by cocaine (3.82%). Sporadic alcohol consumption was declared in 64.81% of known cases, and is unknown in 83.06% of the cases.

If we analyse the arrested women between 18 and 20 years old, we see that the predominant crime was theft (93.21% of cases) followed by narcotics offences (4.59% of cases). Narcotics crimes become more pronounced among women as they grow older.

Incarcerated Women.- The increased number of women in penitentiary centres has been a constant in recent years that affects any approximation to an analysis of their situation within the Spanish penitentiary system. Additionally, their numbers have not only increased quantitatively; the number of women serving long-term sentences has also grown due to the increasing participation of women in more serious crimes. Prison population growth is primarily due to their increased level of participation in crimes against the public order (Table 11.1). The role played by offences against the public order is fairly recent. In the study conducted by Canteras Murillo in 1983 and 1987, the author observed that the most common crime among women was crime against property (over 60%). This evolution indicates the beginning of a new social comportment, in which the combination of spreading drugs and increasing law enforcement is bringing many more women into the prisons.

Table 11.5 Characteristics of the Spanish prison population, according to the gender variable. Spain, 2004 (%)

Characteristics of prison population		Man	Woman
Foreign nationals		29,13	29,17%
Convicts		77,8	74,6
Penitentiary Classification			
	1st degree	2,6	2
	2nd degree	75,6	67,7
	3rd degree	11.7	20,1
Age (convicts)			
	31-40	37,7	36,1
	> 30	60,1	62,97
Criminal typology (convicts)			
1. Against the Public Order		26,6	47,5
2. Against the Socio-economic Order		50	39,4
*Use of heroin and/ or cocaine in the month prior to imprisonment		46,9	39,8
*Use of injection for drug administration prior to imprisonment		22,4	21,4
Total Prison Population		54.805	4.570

Under-directorate of Penitentiary Health and the National AIDS Plan. Drug addicts admitted to prison: Use and High-Risk Practices (2000). Source: Government Delegation for the National Plan on Drugs based on data provided by the General Directorate of Penitentiary Institutions. Prison population as of 31.12.2004.

Modern research on delinquent/ incarcerate women is relatively recent. In Spain in recent years, two studies have been conducted on incarcerated women and one on drug-addicted female inmates (Table 11.2). These studies show the following differences between female and male prisoners:

- Female inmates are convicted of offences against the public order in greater proportion, except drug-addicted inmates who are largely incarcerated for crimes against property.
- The proportion of female inmates who are married and have children is greater than that of men. Premature motherhood is also common.
- Female convicts have incarcerated spouses in greater proportion than men.
- Female convicts are regularly employed to a lesser degree than men.
- Female convicts often present past histories of domestic violence and sexual abuse. 38.2% said they had been beaten at some point in their lives, in most cases by their partners, 59.6% of the women studied.

The study of the "Analysis of the effectiveness and adaptation of penitentiary policies to the needs and demands of female prisoners", highlights the increase of the female prison population since 1985, due to the expansion of drug traffic, of which most of the studied population was convicted. This research detected three primary groups of women, classified according to their needs and demands:

- Foreign nationals: 12% of the sample.
- Gypsies: 30% of Spanish nationals.
- Drug Addicts: 35% admitted to having consumed heroin several times per day. Only 37% had received treatment, partly due to the discrimination present in co-ed centres, where men had more access to resources like drug-free modules.

According to the exhibited data, among the factors that influenced women to enter the downward criminal spiral was their role of keeping their marriages and families together. Generally, these are not sophisticated criminals – they are often chronically unemployed, single mothers, and there is a disproportionate representation of ethnic minorities. In the case of drug-addicted female convicts**, the conditions of social exclusion and marginalisation that they suffer because of their gender are multiplied and exacerbated**. The modern female delinquent is more often a victim of the feminisation of poverty.

Table 11.6. Drug use in the female prison population, according to various studies, 1998 –2001.

SOURCE	SAMPLE	USED DRUGS AT SOME POINT	USED DRUGS IN THE LAST 30 DAYS
The drug-addicted female convict in penitentiary centres. DSIS. 2001	1,123 convicted prisoners in 7 penitentiary centres. 30.6% of prisoners in whom drug-addiction is detected are the object of this study.	575 prisoners (51.20%) are estimated to be drug addicts. 30.6% of these comprise the study sample.	- 19,3% of drug-addicted prisoners studied said they had used some kind of psychoactive substance in the last 30 days. - Type of substance used: Hashish: 38.23 Heroin: 26.47 Heroin + cocaine: 8.82 Heroin + hashish: 8.82 - Main administration method: Smoked: 76.47 Oral: 5.88 More than one method: 20.58
Barañí Project. Gypsy women and the penal system. La Kalle. 2000.	292 gypsy prisoners from 12 penitentiary centres.	49% consume or have consumed illegal drugs.	
Analysis of the effectiveness and adaptation of penitentiary policies to the needs and demands of female prisoners. Miranda MJ, Barberet R, Canteras A, Romero E. 1998	Administration of a questionnaire to 365 women selected at random from 18 centres.	- 70% said they had used drugs at some point: Alcohol 42%; heroin 41%; and cocaine 39%. - Previous frequency of consumption “several time per day” declared for these substances was: alcohol 6.2%; heroin 35.4%; and cocaine 27%	

Source: Government Delegation for the National Plan on Drugs.

The study on the "Analysis of the effectiveness and adaptation of penitentiary policies to the needs and demands of female prisoners" underscored the following intervention needs in the penitentiaries:

- Increase access to drug-addiction treatments.
- Design programmes aimed at victims of domestic violence. When the studied was conducted there were no such programmes.
- Include family planning programmes.
- Facilitate access to drug addiction treatments. According to the cited study, only 37% of female drug addicts had received treatment, partly due to the discrimination that existed in co-ed centres, where men had access to more resources such as drug-free modules.

The study on "The drug-addicted female convict in penitentiary centres" financed by the DGPNSD, emphasized the following intervention needs in the penitentiaries:

- Introduce programmes specifically for women. All the centres offered methadone treatment programmes that were available to women, buy not all offered them drug-free programmes. Absence of female-oriented programmes
- Increase women's participation in remunerated activities. Almost 100% of the women studied were involved in activities within the centre but a very small percentage had remunerated activities.
- Facilitate access to drug addiction treatments. When they entered the prison system, over 80% of the women were not in any kind of treatment. During their time in prison over 60% were in treatment, almost all of them with methadone.

The evolution of drug use among women, the needs that have been described, and the assistance model we currently have force us to consider a new approach to long-term intervention for this population. Faced with this situation, different administrations have introduced programmes that respond to the perceived needs of female convicts.

Among the **measures** contemplated to this end by **penitentiary policy**, the most important include:

- Promoting intervention strategies in those cases where both members of the nuclear family are incarcerated., and also for imprisoned mothers who live with their children under the age of 3:

  . Domestic tasks are considered an outside employment, which can facilitate access to a 3rd degree (open-ended scheme).
  . Flexible schedules for mothers classified as 3rd degree delinquents: possibility of spending only a certain time in the centre and of sleeping in their residences.
  . Incarceration in units for mothers.- These units are designed for children and their mothers. These Units offer a Child Education Specialist who will guide the educational and recreational programme of the children's activities. Visiting rights may be limited for security reasons only
  . Facilitating access of prisoners with children to the Dependents Units. The Dependents Units are spaces physically located outside the penitentiary centre walls, preferably in community dwellings whose visible exterior is for all extents and purposes like any other residence. The services offered are managed directly and preferably by non-prison associations or organisations. Some are dedicated to helping drug-addicted women.
  . Opening of a penitentiary centre (Madrid, 1998) with a co-ed sector, with the aim of encouraging the cohabitation of spouses in prison. One of its objectives is the

minimisation of the effects of imprisonment on children under age 3, whose parents are both incarcerated.

- Design and implementation of a programme specifically for prisoners accused of abusing their partners.

- Increasing participation in service programmes such as: family planning, pregnancy care, treatment of gynaecological infections, dealing with sexual abuse and domestic violence, preparation for the working world.

- Design of intervention programmes adjusted to the specific needs of women.

Drug policies have also taken into account the needs of the female prison population:

- **Objective 10 of the 2000-2008 National Drug Strategy** pursues "the development of penitentiary programmes aimed specifically at women." In addition, it establishes that in the year 2003, each Autonomous Community and City shall have penitentiary modules for women and at least one prison programme specifically geared toward and adapted to drug-addicted women – an objective that has undoubtedly been achieved.

- The **2005-2008 Action Plan** includes carrying out a study of prevalence and associated variables on the prison population. At the present moment, a survey on health and drug use in the prison population is being completed, in which women are represented in an exaggerated proportion in order to perform differential analyses on encouraging the full-time cohabitation of incarcerated spouses for this variable.

12. European drug policies: extended beyond illicit drugs?

- **Official endorsement by the National Drug Strategy**

The National Drug Strategy includes alcohol and tobacco use among the main drug use tendencies; these are the two substances most heavily consumed by Spaniards.

Section 4.1.1, which refers to demand reduction for drugs and specifically to prevention, establishes the following general objectives:

- Offer the public enough information about the risks of consuming tobacco, alcohol and other substances capable of creating addiction or whose use may put its consumers at risk.
- Activate control measures for the publicity and advertisement of alcoholic drinks and tobacco to protect minors.
- Develop programmes and protocol for early diagnosis of problems related to the use of tobacco, alcohol and illegal drugs, aimed at Primary Health Care professionals.

In Section 4.1.2 on harm reduction, another objective set is the activation of health education programmes to limit the damages to the general population brought about by alcohol, tobacco and other drug use. Special emphasis will be placed on programmes for controlling damages associated with the use of alcohol in connection with traffic accidents and violence.

With regard to social assistance and reintegration (4.1.3), a main objective is the incorporation of strategies for improving treatment approaches for persons who have problems with the abuse of alcohol and tobacco, new drugs and new consumer patterns.

Another objective in the area of legislation is the promotion of the drafting and enactment of national and regional laws on drugs and drug addiction with reference to limiting publicity, advertisement, sales and consumption of alcoholic beverages and tobacco.

As of this moment, 14 Autonomous Communities have enacted drug-addiction laws in which limitations of publicity, advertisement, sales and consumption of alcoholic beverages and tobacco are contemplated. Some Communities have specific laws on these substances instead of generic drug-addiction laws.

The Second Axis regarding Prevention and Social Awareness of the 2005-2008 Action Plan establishes the following actions:

- Creation and enactment of the Law that regulates tobacco sales, distribution and advertisements.
- Development of specific actions aimed at reducing alcohol consumption in the general population and especially among young people.

The Third Axis regarding Integral Attention established the reinforcement of programmes aimed at reducing damages caused by the use of alcohol and other drugs as an important action in the area of controlling and preventing consequential damages.

Thus, the conclusion may be drawn that both the 2000-2008 National Drug Strategy and the 2005-2008 Action Plan refer to alcohol and tobacco as substances regulated by legislation in all areas covered by drug-addiction legislation (prevention, treatment, assistance).

Law in Spain does not regulate compulsive gambling and pathological gambling is not considered an addiction; it is rather considered a behavioural or psychological addiction associated with a certain kind of behaviour similar to other addictions such as pyromania, kleptomania, addiction to Internet, etc… According to a study conducted by Enrique Echeburúa, professor of clinical psychology at the Basque Country University, on over 1,500 people, 82% of addicts in need of treatment are addicted to slot machines. Compulsive gambling mainly affects men who tend to seek therapeutic help more often than women, although there is often a long period of time between when they begin to gamble and when they decide to turn to a specialist for treatment of this addiction.

Finally, Spain has a specific regulation dealing with doping, although it is not considered addictive behaviour and is not included in the National Drug Strategy.

Said regulation is an extension of Law 10/1990 of 15 October on sports, which orders the creation of a National Anti-doping Committee and further develops legislation on the procedures for collecting samples, authorisation of specialised laboratories, penalties, etc… The list of prohibited substances and pharmacological groups and non-regulation doping methods in sports is periodically modified. At the moment, the legislation in force is the Resolution of 27 December 2004, which replaces that of 10 December 2003, of the Higher Sports Council Presidency.

Article 58 of Section VIII of the aforementioned Law 10/1990 on Sports states that "All sports professionals licensed to participate in official competitions in national territory shall be obligated to submit to the anti-doping tests contemplated in the preceding article, during, before or after competitions, when so required by the Higher Sports Council of Spanish Sporting Federations, Professional Leagues or by the National Anti-doping Committee." Age and competition level are not factors, the only prerequisite is that the event be an official competition held in Spanish territory.

At the present time, a Provisional Project for an Organic Law on Health Protection and the Fight against Doping in Sports is being presented. This Law's objective is to update control and suppression measures in the area of competitive sports, as well as to create a systematic and transversal system of general doping prevention, control and suppression. Doping is considered a social nuisance, a blight and a serious health risk to both professional sports competitors and habitual or sporadic participants in any kind of sporting event.

- **Genesis and rationale**

The reasons for including alcohol and tobacco in the 2000-2008 National Drug Strategy and in the 2005-2008 Action Plan are based on the fact that these substances create the greatest number of addictions in Spain. Epidemiological data has showed that these substances have traditionally caused the most serious public health problems, and in response to this social situation no distinction was made between illegal and legal drugs when drafting the Strategy.

Tobacco is the principal public health problem in Spain and the main cause of disease, disability and preventable death. For these reasons, in 2004 the Provisional Project for the Law on the Prevention of Tobacco Addiction was put into motion; as of today, this law has already been passed and will enter into effect on 1 January 2006 (see section 12.4).

Alcohol has also traditionally been considered a serious public health problem due to its elevated production levels and the high prevalence of use, and also because of the widespread social acceptance of alcohol consumption in our society.

Since the end of the 1960s, problems caused by alcohol use have been viewed from the Public Health perspective; a scientific understanding of the factors and/or risks associated with alcohol use has sparked a public debate regarding its consequences.

- **Responsibility and competences (co-ordination)**

The Ministry of Health and Consumer Affairs is the responsible for co-ordinating alcohol and tobacco policies in Spain.

Nevertheless, problems related to alcohol consumption imply a global, and multi-disciplinary approach, with the participation of different concerned areas : Health, Education, Social Welfare, Labour, Road Traffic, Agriculture, Commerce, Justice and Finance.

In 2004, the Government granted the Autonomous Communities the sum of 12 million euros for the prevention and control of tobacco addiction. These resources were assigned according to the number of health care professionals and educational institutions as registered in the official reports available at the Ministry of Health and Consumer Affairs, the Ministry of Education and Science and the National Statistics Institute (INE).

In 2004, the Ministry of Health launched a media campaign to intensify awareness among young people of the dangers of driving under the influence of alcohol, in which the Government Delegation for the National Plan on Drugs and the National Directorate of Road Traffic also participated.

This campaign was motivated by the situation in Spain, whereby the use and abuse of alcohol among young people have established new patterns. Young people who drink are now consuming ever-greater quantities, and large amounts of alcohol are being consumed over shorter periods of time. Moreover, alcohol is a factor in a significant proportion of traffic accidents and causes a large number of disabilities, most of them in very young people.

In Spain, all treatment centres address problems related to alcohol consumption; nevertheless, the following programmes that specifically deal with alcoholism also exist:

- 198 outpatient centres that have treated 22,377 patients
- 38 hospital units that have treated 1,538 patients.
- 41 residential centres that have treated 1,304 patients[1]

As far as doping is concerned, the responsible organisation is the National Anti-doping Committee, managed by the Higher Sports Council, a body of the Ministry of Education and Science; the Committee is composed by representatives of the State Administration, Autonomous Communities, Spanish Sporting Federations or Professional Leagues and of individuals of acknowledged competence in the technical, sporting and legal arenas, in the terms dictated by pertinent legislation (Section 1 of article 57 of Law 10/1990, of 15 October, on Sports.

The National Anti-doping Committee, under the supervision of the Higher Sports Council, has the following responsibilities:

1. Propose preventive educational and informative activities on doping and its control, and co-ordinate these activities carried out at the national level by the relevant authorities, when appropriate.

[1] Data provided by 13 Autonomous Communities.

2. Periodically modify the List of Doping Substances and Methods prohibited in sporting events, proposing the same for official publication by the Higher Sporting Council.
3. Report on national or international official texts on doping control.
4. Periodically establish the procedures for doping tests in and outside competition timeframes.
5. Evaluate, after studying all relevant reports, the decisions of the Spanish Sporting Federations in doping analysis cases; when appropriate, request the Sporting Federations to impose disciplinary action, and when in disagreement with Federation decision, appeal them before the Spanish Committee of Sports Discipline.
6. Establish each year, the list of official competitions in national territory in which doping tests will be mandatory, and determine which tests should be administered outside competition timelines.
7. Approve non-government doping control laboratories and oversee the conditions of approval and their enforcement.
8. Appoint the persons responsible for collecting samples for sports doping tests.
9. Approve the materials to be used when collecting samples and in the mobile doping control units.
10. Any other responsibilities that may be commended to the Committee by the Minister of Education and Culture by proposal from the President of the Higher Sports Council.

The President of the National Anti-doping Committee is the General Director of Sports of the Higher Sports Council.

- **New legislation on tobacco in Spain**

On 1 December 2004, a Law Project on health measures on tobacco was presented to the Parliament; the Draft establishes limitations on the sale and supply of tobacco products, on its consumption at the workplace and other settings and on tobacco publicity, advertising and sponsorship. It also contains a list of sanctions.

The Ministry of Health and Consumer Affairs not only intends to guarantee the rights of the non-smoking population to breath clean air but also to design informative and assistance strategies to prevent on the health risks associated with smoking and make quitting easier for those who wish to do so.

Among other measures, the Law Project establishes the following provisions:

1.- Limits on the sale and supply of tobacco.- The project stipulates that the retail sale and supply of tobacco products may only be effected by the Network of Tobacconist and Stamp Shops or by tobacco vending machines with the pertinent administrative authorisation, and therefore expressly prohibited at all other locations or by other methods. In addition, the following measures are established:

- Selling or supplying tobacco, or products that imitate tobacco or encourage smoking, to persons under 18 is prohibited.
- The sale of tobacco by persons under 18 is prohibited.
- Sale of tobacco is prohibited in places such as public buildings or branches, health or social service centres, educational, cultural or sporting centres, centres for the care and/ or recreation of minors, and any other place, centre or establishment where smoking is prohibited.
- Regarding to vending machines, the project stipulates that these must be placed in locations where they can be supervised directly by the owner or the employees of the

establishment, and the front of the machine must display in a clear and visible fashion a warning about the health risks of tobacco. To ensure a correct usage of these machines, mechanisms will be installed that allow the owner of the establishment to activate the machine when a purchase is requested.

2.- Limitations on tobacco consumption.- The project also defines those places where tobacco consumption will be restricted.

Smoking will be absolutely prohibited in inside workplaces and offices, both public and private; health care centres and establishments; educational centres; enclosed sports installations; spaces enabled for attending citizen concerns; social service centres for persons under 18 and recreation or leisure centres where minors are allowed; cultural centres, libraries, museums, etc.; discotheques or locales open to the general public where minors are allowed; areas where food is made, transformed, prepared or sold; elevators; telephone boxes, automated teller machine areas and small spaces of public use; public transport vehicles; omnibus stations (except when out-of-doors); all underground transportation spaces; railroad and maritime transports (except exterior spaces); and airplanes.

The project also establishes the places where smoking will be prohibited with the possibility of creating smoking sections. These places are: social service centres; discotheques or entertainment locales where minors are not admitted; private spaces where commercial activities are carried out; hotel and restaurant establishments with over 100 square metres of useful space; theatres, cinemas and other public shows performed indoors; and airports. Also, hotel and restaurant establishments where smoking is not legally prohibited must post a visible notice announcing whether or not smoking is permitted.

The requirements for smoking sections shall be: clearly indicated directions, physical separation from the rest of the areas and independent ventilation systems. In all cases in which these areas cannot be fitted with the necessary requirements, the smoking prohibition shall be applicable to the entire establishment.

Advertising and sponsorship

Under the legislation currently in effect, the prohibition of advertising and sponsorship of tobacco products affects television, both public and private channels (in accordance with the European Directive on “Television without Frontiers”) and public radio.

Once the new law is passed, and in compliance with European Directive 2003/33, of 26 May, on advertising and sponsorship of tobacco products, tobacco advertisements will be prohibited in the printed press, radio and television, on vending machines and on all advertising media of the Information Society. In addition, the free or promotional distribution of tobacco products and the sponsorship of activities and events that may be associated with the advertising and consumption of this type of products shall also be prohibited.

Violations and penalties

The draft project for the new law also includes a schedule of violations and penalties in which, in addition to classifying the corresponding violations and assigning their respective penalties, the responsible parties are identified and penalty jurisdictions clearly defined. In the case of violations committed by minors, their parents, custodians, foster parents or legal guardians shall be jointly and severally liable.

The amount of the penalty imposed, within the indicated limits, will be scaled according to the health risk produced, the social consequences of the violation, the profit obtained by the violator as a result of the violation, and prior violations of this law.

The examination and penalisation of violations of this law falls to the Autonomous Communities in their respective territories. When the violations are committed via radio or television, the Autonomous Communities will deal with local broadcast stations. The Government, through the Ministry of Interior, shall deal with broadcasts with national coverage.

13. Developments in drug use within recreational settings

- **New findings about trends in drug use, patterns of consumption and availability within recreational settings**

In general terms, it may be said that, throughout the 1980s in Spain, drug use was clearly characterized by its counter-cultural identity and by the fight for recognition of a certain social marginalisation instigated by drug users. In this context, although heroin was not the most consumed drug, it did occupy a position of importance in social concerns and was one of the most problematic drugs.

Since the mid or late 1990s we find ourselves faced with, on one hand, a constant decline in the number of new heroin users, and on the other hand, consumption habits focused on substances such as cannabis, cocaine, synthetic drugs (ecstasy, amphetamines) and alcohol. Use of these drugs, especially among a significant portion of the adolescent population, is seen as a form of group and social integration and of active participation in a culture of recreation and entertainment.

These users are very young in some cases (adolescents who have barely left childhood), which is one more reason to be concerned about the future.

In Spain, this situation, whose characteristics are similar to those of other European Union nations, presents a few elements that we could consider distinctive. For example, during the summer months, given the mild climate and the proliferation of local festivities, large groups of young people congregate in open spaces and take advantage of these circumstances to participate in musical, recreational and amusement activities, most of which include the use of alcoholic beverages as well as cannabis, cocaine or ecstasy.

Although these substances are used year-round in places such as discotheques or celebration halls, during the summer usage levels increase, supported by the belief that consumption is something occasional, “permissible” at this specific time of year, when many young people are on school or work holidays.

Although recreational activities are popular throughout all of Spain, the most numerous concentrations of young people take place on the Mediterranean coast, where there are also significant numbers of tourists and foreigners who join in this “party and fun” atmosphere, with the presence of drugs and alcohol.

In the specific case of alcohol, a popular expression has even been coined (“botellón”) for these congregations of young people, in greater or lesser numbers, who come together in plazas and public areas to drink alcohol (mostly various mixed drinks) and who see these situations as rites of socialisation and a way to make friends. This youth meetings have sometimes created tensions between citizens and episodes of verbal and physical violence between residents and “botellón” participants, which has required the intervention of police and health care professionals.

- **An overview of developments in responses, national policies and legal aspects**

In Spain, the mere use of drugs (legal or illegal) is not considered a criminal violation, and such conduct is therefore not assigned penalties in the Penal Code. However, in the case of illegal drugs the police confiscate these substances from anyone who may have them on their person.

In addition to this confiscation, Organic Law 1/1992 ,21 February, on the Protection of Citizen Safety, establishes the following:

1.- The toleration of consumption and traffic of illicit narcotics and psychotropic substances in public venues or establishments, or a lack of diligence in enforcing this prohibition by owners, managers or overseers of said establishments, is strictly prohibited.

2.- The following conducts are considered serious violations of citizen safety: a)consumption of narcotics and psychotropic substances in public places, thoroughfares, establishments or transportation vehicles; b) the illegal possession of such substances, as long as they are not destined for drug trafficking (if they were, this would be considered a serious crime); and c) Leaving tools or instruments used for the use of said toxic drugs in the aforementioned places.

In the abovementioned cases, the violations may be penalised by the pertinent administrative authorities with a fine of anywhere from 300 euros to 30,050 euros, in addition to the confiscation of the substances, as mentioned above, and other various administrative penalties. However, it is important to note that, with regard to the behaviours mentioned in point 2, these penalties – except confiscation of the substances – may first be suspended and later definitively declared ineffective if the violators agree to enter treatment programmes at certified centres.

The following table offers data from the past four years on police reports of possession or consumption of illegal drugs in the public settings in violation of Law 1/1992, on the Protection of Citizen Safety.

Table 13.1. Administrative sanctions for use or possession of drugs in public settings (Law 1/1992)

YEAR	2001	2002	2003
Sanctions imposed	52.843	62.446	64.488

Regarding these reports, and in accordance with what is established by Organic Law 1/1992, on the Protection of Citizen Safety, the following sanctions have been suspended, given that the sanctioned person agreed to be submitted to detoxification treatment in a properly certified centre or service.

Table 13.2. Administrative sanctions suspended following agreement of the sanctioned party to submit to detoxification treatment (Law 1/1992)

YEAR	2001	2002	2003
Sanctions suspended	3.692	3.446	3.949

Regarding alcohol , given the greater impact of its use on citizen safety, Organic Law 1/1992 determines that the admission of minors to public entertainment establishments when their admission is prohibited, and the sale or serving of alcohol to minors in such places constitute

minor violations. Violation of this regulation can be sanctioned with fines of up to 300 euros for the responsible parties and confiscation of the beverages.

Several Spanish Autonomous Communities have passed legislation that expressly prohibits the consumption of alcoholic beverage in the public settings (except in authorised areas), or have drafted the regulation of this prohibition in municipal ordinances that the various Municipal Authorities of their territory later approve and enforce. Consequently, there are already numerous Spanish municipalities that have passed and enacted such prohibitions under the aegis of their respective autonomous regulations.

Regarding preventive responses to drug use in recreational venues, the following is of special interest:

1.- The Spanish Drug Action Plan, approved by the Ministry of Health and Consumer Affairs in March 2005, dedicates the second of its six axis to prevention and social awareness. Among the specific actions included in this axis are:

- Creating extracurricular informative, educational and alternative recreation programmes, with well-organised activities, specifically aimed at young people, socially depressed individuals and at-risk groups.
- Starting up community programmes to prevent social exclusion, delinquency and marginalisation, especially among young people being initiated into drug use.
- Design innovative information campaigns to increase awareness about problems deriving from drug use (especially cannabis and cocaine) and about how to reduce risks.
- Design actions specifically aimed at cutting back on the general population's level of alcohol use, especially among young people.
- Encourage the use of projects for mediation between equals in recreational spaces as a basic tool for youth involvement.

2.- Since 1999, the Government Delegation for the National Plan on Drugs has assisted provincial capitals and capitals of Autonomous Communities, as well as other local corporation with special characteristics (basically, including island territories), in the financing of programmes for preventing drug addiction in these regions.

The goal of these programmes is to promote healthy activities as alternatives to the consumption of toxic substances during young people's free time, mainly weekends and vacation periods. The programmes are aimed at minors and at-risk adolescents, offering them the opportunity to participate in recreational, sports, cultural and social activities, in an attempt to avoid, reduce or replace the participation of these young people in activities related to drug use.

Table 13.3. Economic Grants from the Government Delegation for the National Plan on Drugs to Local Corporations for prevention programmes

	2001	2002	2003	2004	2005
Local corporations	26	27	27	38	37
Programmes financed	26	27	27	38	37
Amount granted (€)	1,021,720	1,500,000	1,500,000	1,650,000	1,700,000

For the year 2006, the Government Delegation for the National Plan on Drugs envisages increasing the number of local administrations that benefit from these economic grants, as well as increasing the total amount of funds dedicated to their programmes.

3.- Finally, the Autonomous Communities and Autonomous Cities (17 Communities and 2 Autonomous Cities) that comprise the Spanish nation, as well as numerous local administrations, are generating in their respective territories programmes for the prevention of drug addiction, aimed primarily at young people. These programmes, the total number and economic investment of which cannot be exactly estimated, include information activities in the places where young people usually go for recreation (music, dance and nightlife settings), as well as alternative activities of a cultural, sporting or recreational nature, where the use of tobacco, alcohol and drugs is not permitted.

Part C: Bibliography, Annexes, Standard for bibliographic references

Part C: BIBLIOGRAPHY, ANNEXES, STANDARD FOR BIBLIOGRAPHIC REFERENCES

14. Bibliography

ALPHABETIC LIST OF RELEVANT INTERNET ADDRESSES

www.madrid.org	Comunidad de Madrid
www.emcdda.eu.int	European Monitoring Centre for Drug and Drug Addiction
www.pnsd.msc.es	Government Delegation for the National Plan on Drugs
www.ine.es/inebase	Instituto Nacional de Estadística
www.msc.es	Ministry of Health and Consumer Affairs
www.coe.int	Pompidou Group

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DGPNSD	Government Delegation for the National Plan on Drugs
EMCDDA	European Monitoring Centre for Drug and Drug Addiction
PMM	Methadone Maintenance Programme

Table 2.1. PSYCHOACTIVE SUBSTANCE USE BY RESPONDENTS BETWEEN THE AGES OF 15 AND 64 (IN PER CENT) IN SPAIN, 1995–2003.

	1995	1997	1999	2001	2003
Prevalence of use at least once in lifetime					
Tobacco	–	69.7%	64.9%	68.4%	68.9%
Alcohol	–	90.6%	87.3%	89.0%	88.6%
Cannabis	14.5%	22.9%	19.6%	23.8%	29.0%
Ecstasy	2.0%	2.5%	2.4%	4.0%	4.6%
Hallucinogens	2.1%	2.9%	1.9%	2.8%	3.0%
Amphetamines/speed	2.3%	2.7%	2.2%	2.9%	3.2%
Powder cocaine	3.4%	3.4%	3.1%	4.8%	5.9%
Free base cocaine	.3%	.4%	.4%	.5%	.5%
Heroin	.8%	.6%	.5%	.6%	.9%
Other opiates	.2%	.5%	.3%	.6%	.4%
Inhalants	.7%	.8%	.6%	.8%	1.0%
Prevalence of use in the last 12 months					
Tobacco	–	46.8%	44.7%	46.0%	47.8%
Alcohol	68.5%	78.5%	75.2%	78.1%	76.6%
Over-the-counter sedative-hypnotic drugs	12.3%	2.3%	2.3%	2.8%	3.1%
Cannabis	7.5%	7.7%	7.0%	9.2%	11.3%
Ecstasy	1.3%	.9%	.8%	1.8%	1.4%
Hallucinogens	.8%	.9%	.6%	.7%	.6%
Amphetamines/speed	1.0%	.9%	.7%	1.1%	.8%
Powder cocaine	1.8%	1.6%	1.6%	2.5%	2.7%
Free base cocaine	.1%	.1%	.2%	.1%	.1%
Heroin	.5%	.2%	.1%	.1%	.1%
Other opiates	.1%	.1%	.1%	.2%	.1%
Inhalants	.1%	.2%	.1%	.1%	.1%
Prevalence of use in the last 30 days					
Tobacco	–	42.9%	40.1%	41.4%	42.9%
Alcohol	–	64.0%	61.8%	63.7%	64.1%
Cannabis	–	4.6%	4.5%	6.4%	7.6%
Ecstasy	–	.3%	.2%	.8%	.4%
Hallucinogens	–	.2%	.2%	.2%	.2%
Amphetamines/speed	–	.2%	.3%	.6%	.2%
Powder cocaine	–	.9%	.9%	1.3%	1.1%
Free base cocaine	–	.0%	.1%	.0%	.0%
Heroin	–	.1%	.0%	.0%	.0%
Other opiates	–	.1%	.1%	.1%	.1%
Inhalants	–	.1%	.0%	.1%	.0%
Prevalence of daily use in the last 30 days					
Tobacco	-	34.9	33.6	35.7	36.7
Alcohol	_	12.7	13.7	15.7	14.1
Cannabis	_	0.7	0.8	1.5	1.5

Note: Percentages based on number of responses containing information.

Source: Government's Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES,
Spanish initials for Encuesta domiciliaria sobre Abuso de Drogas en SPAIN)

Table 2.2. AVERAGE AGE OF INITIATION INTO PSYCHOACTIVE SUBSTANCE USE IN POPULATION BETWEEN THE AGES OF 15 AND 64. SPAIN 1995–2003.

AVERAGE AGE (years)	1995	1997	1999	2001	2003
NUMBER OF RESPONDENTS	8888	12304	12234	14113	12033
Tobacco	15.9	16.6	16.7	16.5	16.5
Tobacco (daily use)	18.5	18.5	18.6	18.4	18.3
Alcoholic beverages	-	16.8	16.9	16.9	16.7
Sedative-hypnotic drugs*	35.2	28.7	29.2	29.5	30.0
Cannabis	18.3	18.9	18.7	18.5	18.5
Powder cocaine	21.4	21.3	21.8	20.4	20.9
Heroin	20.3	20.1	19.0	20.7	22.0
Amphetamine	19.2	19.4	19.2	18.8	19.6
Hallucinogens	19.3	19.0	19.3	18.9	19.9
Inhalants	17.7	19.0	18.1	17.5	17.5
Free base cocaine	21.8	20.6	20.1	19.6	20.1
Ecstasy	21.1	20.0	20.7	20.2	20.3
Other opiates	21.1	21.1	19.6	22.6	20.4

Note: Percentages based on number of responses containing information.

(*) Tranquilizers or sleeping pills

Source: Government's Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES,
Spanish initials for Encuesta domiciliaria sobre Abuso de Drogas en SPAIN)

Table 2.3. PREVALENCE OF USE OF PSYCHOACTIVE SUBSTANCES BY RESPONDENTS BETWEEN THE AGES OF 15 AND 64, BY SEX (PER CENT). SPAIN 1995–2003.

	1995		1997		1999		2001		2003	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Prevalence of use at least once in lifetime										
Tobacco	–	–	79.0%	60.4%	72.6%	57.2%	76.0%	60.7%	76.0%	61.7%
Alcohol	–	–	95.3%	86.0%	92.1%	82.5%	93.6%	84.3%	93.8%	83.3%
Cannabis	19.9%	9.4%	31.1%	14.8%	25.9%	13.3%	31.0%	16.5%	38.2%	19.7%
Ecstasy	2.8%	1.2%	3.8%	1.2%	3.3%	1.5%	6.0%	2.0%	6.6%	2.5%
Hallucinogens	3.3%	1.0%	4.6%	1.2%	2.8%	1.0%	4.2%	1.3%	4.7%	1.3%
Amphetamines	3.1%	1.5%	4.0%	1.4%	3.1%	1.2%	4.1%	1.7%	4.6%	1.7%
Cocaine	4.8%	2.0%	5.4%	1.5%	4.5%	1.8%	7.0%	2.5%	9.2%	2.6%
Free base cocaine	.5%	.1%	.7%	.2%	.6%	.1%	.7%	.2%	.8%	.2%
Heroin	1.2%	.4%	.9%	.2%	.6%	.3%	1.0%	.2%	1.5%	.3%
Other opiates	.4%	.1%	.7%	.2%	.4%	.2%	.8%	.3%	.8%	.1%
Inhalants	1.1%	.3%	1.4%	.1%	.9%	.3%	1.2%	.4%	1.7%	.3%
Prevalence of use in the last 12 months										
Tobacco	–	–	55.0%	38.7%	50.3%	39.2%	51.5%	40.5%	53.0%	42.6%
Alcohol	79.3%	58.0%	86.4%	70.5%	83.2%	67.2%	85.2%	70.9%	84.5%	68.4%
Sedative-hypnotic d.	8.2%	16.4%	2.3%	2.4%	2.3%	2.4%	2.5%	3.1%	2.9%	3.3%
Cannabis	10.7%	4.4%	10.7%	4.7%	9.6%	4.3%	13.0%	5.5%	16.2%	6.3%
Ecstasy	1.9%	.7%	1.2%	.5%	1.2%	.5%	2.8%	.7%	2.0%	.8%
Hallucinogens	1.1%	.4%	1.4%	.4%	.8%	.4%	1.2%	.2%	.9%	.3%
Amphetamines	1.3%	.7%	1.4%	.4%	1.0%	.4%	1.6%	.6%	1.1%	.5%
Cocaine	2.7%	1.0%	2.6%	.6%	2.3%	.8%	3.8%	1.3%	4.1%	1.2%
Free base cocaine	.2%	.0%	.2%	.0%	.4%	.0%	.2%	.0%	.2%	.0%
Heroin	.8%	.3%	.4%	.1%	.2%	.0%	.2%	.0%	.2%	.1%
Other opiates	.1%	.0%	.2%	.0%	.2%	.0%	.3%	.1%	.1%	.0%
Inhalants	.2%	.1%	.3%	.0%	.1%	.1%	.2%	.1%	.1%	.1%
Prevalence of use in the last 30 days										
Tobacco	–	–	51.4%	34.4%	45.0%	35.2%	46.5%	36.3%	47.9%	37.9%
Alcohol	–	–	75.8%	52.1%	74.4%	49.1%	76.4%	50.9%	75.8%	52.1%
Cannabis	–	–	6.7%	2.5%	6.2%	2.8%	9.4%	3.4%	11.3%	3.9%
Ecstasy	–	–	.5%	.1%	.3%	.2%	1.3%	.3%	.5%	.2%
Hallucinogens	–	–	.3%	.1%	.3%	.1%	.4%	.1%	.3%	.1%
Amphetamines	–	–	.4%	.1%	.4%	.2%	.9%	.2%	.4%	.1%
Cocaine	–	–	1.5%	.2%	1.3%	.4%	2.2%	.5%	1.6%	.5%
Free base cocaine	–	–	.1%	.0%	.1%	.0%	.0%	.0%	.0%	.0%
Heroin	–	–	.2%	.1%	.1%	.0%	.1%	.0%	.0%	.1%
Other opiates	–	–	.1%	.0%	.1%	.0%	.1%	.1%	.1%	.0%
Inhalants	–	–	.1%	.0%	.0%	.0%	.1%	.0%	.0%	.0%

Note: Percentages based on number of responses containing information.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Household survey on drugs 1995–2003.

Table 2.4. PREVALENCE OF USE OF PSYCHOACTIVE SUBSTANCES BY RESPONDENTS BETWEEN THE AGES OF 15 AND 64 BY AGE (PER CENT). SPAIN 1995–2003.

	1995		1997		1999		2001		2003	
	15–34	35–64	15–34	35–64	15–34	35–64	15–34	35–64	15–34	35–64
Prevalence of use at least once in lifetime										
Tobacco	–	–	72.7%	66.9%	65.2%	64.7%	69.4%	67.6%	69.2%	68.7%
Alcohol	–	–	91.4%	89.9%	87.4%	87.2%	89.3%	88.8%	88.9%	88.3%
Cannabis	22.9%	6.1%	32.4%	14.4%	28.1%	12.3%	34.3%	15.3%	39.0%	21.0%
Ecstasy	3.5%	.5%	4.8%	.4%	4.4%	.7%	7.7%	1.0%	8.3%	1.6%
Hallucinogens	3.3%	.9%	4.7%	1.3%	2.9%	1.0%	4.6%	1.3%	4.7%	1.6%
Amphetamines	3.7%	1.0%	4.2%	1.3%	3.1%	1.3%	4.6%	1.5%	4.7%	1.9%
Cocaine	5.4%	1.4%	5.5%	1.6%	4.7%	1.8%	7.7%	2.4%	8.9%	3.6%
Free base cocaine	.5%	.1%	.7%	.2%	.6%	.2%	.7%	.3%	.7%	.3%
Heroin	1.4%	.2%	.9%	.3%	.6%	.3%	.7%	.5%	.8%	.9%
Other opiates	.3%	.1%	.7%	.2%	.4%	.2%	.7%	.5%	.6%	.3%
Inhalants	1.1%	.3%	1.3%	.3%	.9%	.4%	1.5%	.2%	1.7%	.5%
Prevalence of use in the last 12 months										
Tobacco	–	–	54.5%	39.9%	49.5%	40.6%	52.0%	41.2%	52.8%	43.8%
Alcohol	72.9%	64.1%	82.5%	74.9%	79.0%	71.8%	81.5%	75.2%	79.5%	74.2%
Sedative-hypnotic d.	7.6%	17.1%	2.3%	2.4%	1.9%	2.7%	2.8%	2.9%	2.5%	3.6%
Cannabis	12.7%	2.3%	14.2%	1.8%	12.6%	2.2%	16.7%	3.3%	20.1%	4.2%
Ecstasy	2.4%	.1%	1.8%	.0%	1.6%	.1%	3.7%	.2%	2.9%	.1%
Hallucinogens	1.3%	.2%	1.8%	.1%	1.2%	.2%	1.3%	.2%	1.1%	.2%
Amphetamines	1.8%	.2%	1.8%	.1%	1.3%	.2%	2.2%	.2%	1.6%	.2%
Cocaine	3.1%	.5%	2.9%	.5%	2.8%	.5%	4.5%	.9%	4.8%	.9%
Free base cocaine	.1%	.1%	.2%	.1%	.4%	.0%	.2%	.0%	.2%	.0%
Heroin	.9%	.1%	.4%	.1%	.2%	.0%	.1%	.1%	.2%	.1%
Other opiates	.1%	.1%	.2%	.0%	.2%	.0%	.2%	.2%	.1%	.1%
Inhalants	.2%	.1%	.4%	.0%	.1%	.1%	.3%	.0%	.2%	.0%
Prevalence of use at least in the last 30 days										
Tobacco	–	–	49.6%	36.9%	43.7%	36.9%	46.3%	37.5%	47.2%	39.5%
Alcohol	–	–	66.7%	61.6%	64.4%	59.4%	65.7%	62.1%	65.8%	62.7%
Cannabis	–	–	8.5%	1.1%	7.9%	1.5%	11.5%	2.3%	13.4%	2.9%
Ecstasy	–	–	.6%	.0%	.5%	.0%	1.5%	.2%	.7%	.0%
Hallucinogens	–	–	.4%	.0%	.3%	.1%	.4%	.1%	.4%	.0%
Amphetamines	–	–	.5%	.0%	.5%	.1%	1.1%	.1%	.4%	.1%
Cocaine	–	–	1.6%	.2%	1.5%	.3%	2.4%	.5%	1.9%	.4%
Free base cocaine	–	–	.1%	.0%	.1%	.0%	.0%	.0%	.0%	.0%
Heroin	–	–	.2%	.1%	.1%	.0%	.0%	.0%	.1%	.0%
Other opiates	–	–	.1%	.0%	.1%	.0%	.2%	.0%	.1%	.0%
Inhalants	–		.1%	.0%	.0%	.0%	.1%	.0%	.0%	.0%

Note: Percentages based on number of responses containing information.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Household survey on drugs 1995–2003.

Table 2.5. SMOKING HABITS IN POPULATION BETWEEN THE AGES OF 15 AND 64, BY SEX. SPAIN 1995–2003.

	1995		1997		1999		2001		2003	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
NUMBER OF RESPONDENTS	4140	4288	6086	6102	6075	6078	7062	6997	6508	6386
PREVALENCE OF DAILY USE (%)	–	–	42,8%	27,1%	38,0%	29,3%	40,9%	30,5%	42,0%	31,3%
No. OF CIGARETTES PER DAY(%)										
1–10	29.8%	55.7%	32.7%	49.9%	30.0%	49.8%	30.5%	49.0%	32.4%	49.0%
11–19	13.1%	13.6%	13.8%	13.7%	12.5%	13.6%	13.7%	14.9%	13.2%	15.3%
20–29	37.8%	24.9%	31.5%	22.5%	36.1%	22.8%	34.9%	26.6%	36.6%	27.5%
30–39	9.0%	3.6%	9.1%	4.2%	8.6%	4.8%	8.5%	3.1%	6.7%	3.5%
40 or over	10.3%	2.2%	12.8%	9.8%	12.8%	8.9%	12.4%	6.4%	11.1%	4.8%
AVERAGE No. OF CIGARETTES PER DAY	18.8	12.4	17.6	12.8	18.0	13.1	18.0	13.1	17.7	13.1

Note: Percentages based on number of responses containing information.

Source: Government's Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.6. DRINKING HABITS IN POPULATION BETWEEN THE AGES OF 15 AND 64, BY SEX. SPAIN 1997—2003.

	1997			1999			2001			2003		
	Men	Women	Total	Men	Women	Total	Men	Women	Total	Men	Women	Total
NUMBER OF RESPONDENTS	5888	6416	12304	5685	6549	12234	6809	7304	14113	5819	6214	12033
PREVALENCE OF WEEKLY DRINKING IN LAST 12 MONTHS	62.7%	32.3%	47.5%	61.8%	30.0%	45.9%	62.9%	32.4%	47.7%	63.3%	32.9%	48.2%
PREVALENCE OF DRINKING IN LAST 30 DAYS	75.7%	51.9%	63.8%	74.4%	49.1%	61.7%	76.4%	50.9%	63.7%	75.8%	52.1%	64.1%
PREVALENCE OF WEEKEND DRINKING IN LAST 30 DAYS	75.2%	50.9%	63.0%	74.0%	48.2%	61.2%	76.2%	50.4%	63.4%	75.5%	51.7%	63.8%
PREVALENCE OF WEEKDAY DRINKING IN LAST 30 DAYS	67.3%	31.6%	49.9%	66.1%	29.6%	48.3%	68.6%	32.0%	50.7%	68.3%	34.1%	51.8%
PREVALENCE OF DAILY DRINKING IN LAST 30 DAYS	20.2%	5.2%	12.7%	21.4%	6.1%	13.7%	24.5%	6.8%	15.7%	21.9%	6.2%	14.1%
PREVALENCE OF DRINKING ON MORE THAN 8 DAYS IN LAST 30	59.1%	30.1%	44.6%	60.7%	29.2%	45.0%	63.2%	31.3%	47.3%	63.0%	32.3%	47.8%
PREVALENCE OF DRINKERS AT RISK IN LAST 30 DAYS	8.0%	3.4%	5.7%	5.2%	2.5%	3.9%	7.6%	3.5%	5.6%	7.4%	3.1%	5.3%

Note: Percentages based on number of responses containing information. Drinker at risk: Consumer of 50 or more cc of pure alcohol/day (men) or 30 or more cc/day (women).

Source: Government’s Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.7. DRINKING HABITS AMONG RESPONDENTS BETWEEN THE AGES OF 15 AND 64, BY AGE GROUP (PER CENT), SPAIN 1997–2003.

	1997			1999			2001			2003		
	15–34	35–64	Total	15–34	35–64	Total	15–34	35–64	Total	15–34	35–64	Total
NUMBER OF RESPONDENTS	6898	5406	12304	6293	5941	12234	6915	7198	14113	6251	5782	12033
PREVALENCE OF WEEKLY DRINKING IN LAST 12 MONTHS	46.7%	48.3%	47.5%	45.0%	46.8%	45.9%	45.9%	49.2%	47.7%	46.4%	49.7%	48.2%
PREVALENCE OF DRINKING IN LAST 30 DAYS	66.5%	61.4%	63.8%	64.4%	59.4%	61.7%	65.7%	62.1%	63.7%	65.8%	62.7%	64.1%
PREVALENCE OF WEEKEND DRINKING IN LAST 30 DAYS	66.0%	60.4%	63.0%	64.0%	58.7%	61.2%	65.6%	61.5%	63.4%	65.5%	62.3%	63.8%
PREVALENCE OF WEEKDAY DRINKING IN LAST 30 DAYS	44.9%	53.3%	49.9%	43.4%	51.5%	48.3%	46.1%	53.6%	50.7%	47.3%	54.7%	51.8%
PREVALENCE OF DAILY DRINKING IN LAST A30 DAYS	5.2%	19.4%	12.7%	5.8%	20.7%	13.7%	7.1%	22.7%	15.7%	5.9%	20.8%	14.1%
PREVALENCE OF DRINKING ON MORE THAN 8 DAYS IN LAST 30	43.6%	45.6%	44.6%	43.7%	46.2%	45.0%	46.6%	47.9%	47.3%	46.7%	48.8%	47.8%
PREVALENCE OF DRINKERS AT RISK IN LAST 30 DAYS	4.7%	6.5%	5.7%	3.7%	4.0%	3.9%	5.0%	6.0%	5.6%	5.0%	5.6%	5.3%

Note: Percentages based on number of responses containing information. Drinker at risk: Consumer of 50 or more cc of pure alcohol/day (men) or 30 or more cc/day (women).

Source: Government’s Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.8. PREVALENCE OF USE OF DIFFERENT TYPES OF ALCOHOLIC BEVERAGES ON WEEKDAYS AND WEEKENDS IN THE 30 DAYS PRIOR TO THE INTERVIEW, AMONG RESPONDENTS BETWEEN THE AGES OF 15 AND 64, BY AGE (PER CENT). SPAIN 1995–2003.

	1997			1999			2001			2003		
	15–34	35–64	Total	15–34	35–64	Total	15–34	35–64	Total	15–34	35–64	Total
WEEKDAY DRINKING												
Some weekday (Monday-Thursday) in the last 30 days												
Wine/champagne	11.2%	31.0%	21.6%	11.5%	31.2%	22.1%	12.3%	30.5%	22.4%	12.3%	30.5%	22.3%
Beer/cider	20.5%	23.7%	22.2%	20.5%	23.8%	22.3%	24.0%	26.3%	25.3%	25.1%	29.2%	27.4%
Appetizers/vermouth	1.5%	2.3%	1.9%	2.0%	1.8%	1.9%	2.2%	2.6%	2.5%	2.6%	2.7%	2.7%
Mixed drinks	4.0%	3.7%	3.8%	4.6%	3.0%	3.7%	5.4%	3.5%	4.4%	7.1%	4.8%	5.8%
Hard liquor	1.5%	3.3%	2.4%	1.8%	2.8%	2.3%	1.7%	3.0%	2.4%	3.2%	3.4%	3.3%
Fruit-base liqueurs	1.6%	1.4%	1.5%	1.9%	1.3%	1.6%	1.7%	1.4%	1.5%	2.2%	1.8%	2.0%
All weekdays in the last 30 days												
Wine/champagne	3.0%	17.1%	10.5%	3.6%	18.7%	11.7%	3.6%	18.7%	12.0%	3.5%	16.8%	10.8%
Beer/cider	4.2%	8.1%	6.2%	4.7%	8.6%	6.8%	6.5%	10.9%	8.9%	6.0%	11.4%	9.0%
Appetizers/vermouth	.1%	.2%	.1%	.1%	.2%	.2%	.1%	.2%	.2%	.1%	.3%	.2%
Mixed drinks	.1%	.4%	.3%	.2%	.3%	.3%	.4%	.5%	.4%	.3%	.6%	.4%
Hard liquor	.4%	1.0%	.7%	.2%	.9%	.6%	.3%	1.1%	.8%	.3%	.8%	.6%
Fruit-base liqueurs	.1%	.2%	.2%	.1%	.1%	.1%	.1%	.1%	.1%	.0%	.3%	.2%
WEEKEND DRINKING												
Some weekend (Friday-Sunday) in the last 30 days												
Wine/champagne	20.2%	39.3%	30.3%	19.8%	38.3%	29.7%	21.1%	39.3%	31.1%	21.4%	39.6%	31.5%
Beer/cider	42.7%	32.9%	37.5%	39.3%	32.4%	35.6%	42.9%	37.8%	40.1%	43.8%	40.9%	42.2%
Appetizers/vermouth	6.5%	6.7%	6.6%	5.2%	5.3%	5.3%	6.1%	6.9%	6.6%	5.8%	6.1%	6.0%
Mixed drinks	34.2%	10.3%	21.6%	37.2%	11.3%	23.3%	40.1%	14.4%	25.9%	42.7%	16.1%	28.0%
Hard liquor	6.2%	6.2%	6.2%	6.8%	5.6%	6.2%	6.1%	5.6%	5.8%	7.7%	6.3%	6.9%
Fruit-base liqueurs	9.0%	3.3%	6.0%	7.6%	3.4%	5.3%	6.0%	2.9%	4.3%	6.7%	3.8%	5.1%
All weekends in the last 30 days												
Wine/champagne	7.4%	22.9%	15.6%	8.1%	24.6%	17.0%	9.2%	25.4%	18.1%	8.0%	23.6%	16.6%
Beer/cider	20.7%	15.8%	18.1%	19.6%	17.3%	18.4%	23.1%	22.1%	22.5%	22.6%	22.5%	22.5%
Appetizers/vermouth	1.7%	2.0%	1.9%	1.3%	2.0%	1.7%	1.8%	1.7%	1.7%	1.4%	1.9%	1.7%
Mixed drinks	13.4%	3.4%	8.1%	15.2%	4.0%	9.2%	19.4%	5.7%	11.8%	19.6%	6.4%	12.3%
Hard liquor	1.8%	2.2%	2.0%	2.0%	2.7%	2.4%	2.5%	2.6%	2.5%	2.9%	3.1%	3.0%
Fruit-base liqueurs	2.2%	.8%	1.4%	1.8%	.8%	1.2%	1.5%	.6%	1.0%	1.5%	.7%	1.1%

Note: Percentages based on number of responses containing information.

Source: Government's Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.9. GENERAL CHARACTERISTICS OF CANNABIS USE AMONG RESPONDENTS BETWEEN THE AGES OF 15 AND 64 BY SEX AND AGE GROUP (PER CENT). SPAIN 1995–2003.

	1995				1997				1999				2001				2003			
	15–34		35–64		15–34		35–64		15–34		35–64		15–34		35–64		15–34		35–64	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
NUMBER OF RESPONDENTS	2721	3092	1255	1820	3396	3502	2492	2914	3022	3271	2663	3278	3465	3450	3344	3854	3247	3004	2572	3210
PREVALENCE OF CANNABIS USE AT LEAST ONCE IN LIFETIME	29.9%	15.7%	9.2%	3.3%	42.2%	22.3%	20.8%	8.3%	34.9%	21.0%	17.9%	6.8%	42.4%	25.9%	21.5%	9.2%	47.4%	30.1%	30.5%	11.6%
AVERAGE AGE OF INITIATION INTO CANNABIS USE (YEARS)	17.4	17.9	20.3	21.9	17.4	17.8	21.2	23.0	17.6	17.6	20.7	21.5	17.3	17.9	19.9	21.1	17.3	17.8	19.9	20.1
PREVALENCE OF CANNABIS USE LAST 12 MONTHS	17.0%	8.3%	4.1%	.8%	19.2%	9.1%	2.8%	.9%	16.4%	8.6%	3.6%	.8%	22.3%	10.7%	5.2%	1.3%	27.0%	12.8%	7.2%	1.3%
PREVALENCE OF WEEKLY CANNABIS USE IN THE LAST 12 MONTHS	5.6%	1.7%	1.0%	.0%	7.4%	1.9%	1.8%	.1%	6.7%	2.9%	1.6%	.2%	11.7%	3.9%	2.6%	.5%	14.3%	4.7%	3.3%	.5%
PREVALENCE OF CANNABIS USE IN LAST 30 DAYS	–	–	–	–	12.1%	4.8%	1.8%	.5%	10.4%	5.3%	2.4%	.7%	16.2%	6.6%	3.8%	.9%	18.8%	7.7%	5.0%	.9%
PREVALENCE OF DAILY CANNABIS USE	–	–	–	–	1.9%	.2%	.5%	.0%	1.9%	.8%	.6%	.1%	3.8%	1.2%	1.2%	.2%	4.3%	1.1%	.9%	.1%

Note: Percentages based on number of responses containing information.

Source: Government's Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.10. RESPONDENTS BETWEEN THE AGES OF 15 AND 64 WHO BELIEVE THAT THE DRUG USE BEHAVIOUR DESCRIBED MAY OCCASION A FAIR OR EVEN A LARGE NUMBER OF PROBLEMS, BY SEX (PER CENT). SPAIN 1995–2003.

	1997		1999		2001		2003	
	Men	Women	Men	Women	Men	Women	Men	Women
NUMBER OF RESPONDENTS	6086	6102	6075	6078	7062	6997	6508	6386
Smoke one pack of cigarettes per day	75.4%	84.1%	78.5%	86.3%	80.1%	87.2%	81.6%	87.7%
Drink 5 or 6 beers/ drinks on weekend	38.0%	53.3%	41.8%	56.7%	37.7%	50.8%	34.4%	49.4%
Drink 5 or 6 beers/drinks per day	84.8%	93.5%	86.9%	94.6%	81.2%	91.0%	78.0%	88.7%
Smoke cannabis once a month or less	61.0%	76.7%	68.9%	80.6%	62.8%	73.1%	55.5%	68.7%
Smoke cannabis once a week or more	78.2%	89.7%	83.5%	91.7%	78.8%	87.4%	73.3%	85.3%
Take sedative-hypnotic drugs once a month or less	60.0%	60.8%	69.2%	71.1%	67.3%	66.0%	65.2%	65.4%
Take sedative-hypnotic drugs once a week or more	81.3%	81.5%	86.2%	87.5%	85.2%	84.4%	84.8%	86.0%
Use ecstasy once a month or less	91.1%	94.0%	93.3%	96.0%	91.7%	93.6%	90.6%	94.5%
Use ecstasy once a week or more	98.0%	99.2%	98.4%	99.4%	97.8%	97.9%	97.6%	99.1%
Use cocaine once a month or less	91.7%	95.3%	94.0%	96.8%	92.0%	94.7%	91.1%	95.1%
Use cocaine once a week or more	97.9%	99.1%	98.8%	99.6%	97.5%	98.3%	97.9%	99.2%
Use heroin once a month or less	97.1%	98.1%	98.1%	98.8%	96.8%	96.6%	96.5%	98.2%
Use heroin once a week or more	99.1%	99.7%	99.5%	99.8%	99.0%	98.6%	99.0%	99.6%
Use hallucinogens once a month or less	94.7%	97.4%	96.5%	98.3%	95.0%	96.1%	95.2%	97.4%
Use hallucinogens once a week or more	98.6%	99.5%	99.2%	99.7%	98.6%	98.3%	98.8%	99.4%

Note: Percentages based on number of responses containing information.

Source: Government’s Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.11. RESPONDENTS BETWEEN THE AGES OF 15 AND 64 WHO BELIEVE THAT DRUGS CAN BE RELATIVELY OR VERY READILY OBTAINED, BY AGE (PER CENT). SPAIN 1995–2003.

	1995		1997		1999		2001		2003	
	15–34	35–64	15–34	35–64	15–34	35–64	15–34	35–64	15–34	35–64
NUMBER OF RESPONDENTS	5813	3075	6898	5406	6293	5941	6915	7198	6251	5782
Hashish/Marihuana	61.6%	37.6%	64.8%	39.5%	60.9%	43.2%	71.5%	48.5%	70.8%	49.0%
Heroin	42.6%	30.7%	41.2%	31.3%	39.8%	34.6%	46.8%	36.1%	42.5%	36.3%
Cocaine	46.3%	32.0%	46.2%	32.4%	44.2%	35.8%	55.4%	38.8%	53.8%	40.1%
LSD. acid	44.9%	28.6%	44.9%	29.3%	41.6%	33.1%	51.1%	35.1%	46.1%	34.6%
Ecstasy or other designer drugs	50.0%	31.1%	50.0%	32.0%	45.3%	34.7%	58.8%	38.4%	55.0%	38.2%

Note: Percentages based on number of responses containing information.

Source: Government’s Delegation to the National Drug Plan. (DGPNSD). Spanish Drug Observatory (OED). Household survey on substance abuse in Spain (EDADES)

Table 2.12. Distribution of 14-18-year-old students included in the EESTUDES nation-wide secondary school survey on drugs by autonomous community of residence, legal status of school and type of studies. Spain, 1994-2004

	Numbers						Percent					
	1994	**1996**	**1998**	**2000**	**2002**	**2004**	**1994**	**1996**	**1998**	**2000**	**2002**	**2004**
AUTONOMOUS COMMUNITY												
Andalusia	2469	2075	1976	2372	2552	2464	11.8	10.9	10.9	11.6	9.6	9.7
Aragon	1014	941	775	671	2185	1757	4.8	5.0	4.3	3.3	8.2	6.9
Asturias	993	875	765	661	744	584	4.7	4.6	4.2	3.2	2.8	2.3
Balearic Isles	758	661	679	602	1762	1795	3.6	3.5	3.8	2.9	6.6	7.0
Canary Islands	880	859	966	739	960	835	4.2	4.5	5.3	3.6	3.6	3.3
Cantabria	746	575	722	1244	1169	1478	3.6	3.0	4.0	6.1	4.4	5.8
Castile and Leon	1356	1120	1093	919	1140	983	6.5	5.9	6.0	4.5	4.3	3.9
Castile- La Mancha	893	982	943	1749	2501	860	4.3	5.2	5.2	8.6	9.4	3.4
Catalonia	2304	1881	1681	1552	1885	2831	11.0	9.9	9.3	7.6	7.1	11.1
Valencian Community	1720	1466	1395	2287	1685	1362	8.2	7.7	7.7	11.2	6.3	5.3
Extremadura	928	659	718	443	796	1693	4.4	3.5	4.0	2.2	3.0	6.6
Galicia	1064	1436	1333	1170	2108	1245	5.1	7.6	7.4	5.7	7.9	4.9
Madrid	2123	1979	1853	2929	3308	3033	10.1	10.4	10.2	14.3	12.4	11.9
Murcia	907	818	813	727	1394	1468	4.3	4.3	4.5	3.6	5.2	5.8
Navarre	836	659	553	627	530	600	4.0	3.5	3.1	3.1	2.0	2.4
Basque Country	1293	1104	1021	852	806	990	6.2	5.8	5.6	4.2	3.0	3.9
Rioja	647	651	570	462	457	975	3.1	3.4	3.2	2.3	1.7	3.8
Ceuta	0	128	30	323	130	140	0.0	0.7	0.2	1.6	0.5	0.5
Melilla	0	97	199	121	464	428	0.0	0.5	1.1	0.6	1.7	1.7
SCHOOL OWNERSHIP												
Public	15204	13716	12766	10421	14445	14889	72.6	72.3	70.6	51.0	54.4	58.3
Private	5727	5250	5319	10029	12131	10632	27.4	27.7	29.4	49.0	45.6	41.7
TYPE OF STUDIES												
Compulsory secondary	2191	5129	9560	13664	14400	14415	10.5	27.0	52.9	66.8	54.2	56.5
Baccalaureate	13611	10495	7312	5869	10733	9468	65.0	55.3	40.4	28.7	40.4	37.1
Vocational/Training courses	5129	3342	1213	917	1443	1638	24.5	17.6	6.7	4.5	5.4	6.4
TOTAL	20931	18966	18085	20450	26576	25521	100.0	100.0	100.0	100.0	100.0	100.0

Table 2.13. PREVALENCE OF PSYCHOACTIVE SUBSTANCE USE BY SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18 (PER CENT), SPAIN 1994—2004.

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

Note: Percentages based on number of responses containing information. (*) Over-the-counter tranquilizers and sleeping pills.

SOURCE: Government's Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES) 1994—2004.

Table 2.14. AVERAGE AGE OF INITIATION INTO PSYCHOACTIVE SUBSTANCE USE AMONG SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18 (AGE IN YEARS), SPAIN 1994–2004.

	1994	1996	1998	2000	2002	2004
Tobacco	13.9	13.3	13.2	13.1	13.1	13.2
Tobacco(daily)	.	14.6	14.5	14.4	14.4	14.5
Alcohol	13.5	13.7	13.8	13.6	13.6	13.7
Alcohol (weekly)	.	15.0	15.0	14.9	15.0	15.1
Sedative-hypnotic drugs*	14.1	14.5	14.8	14.5	14.6	14.8
Cannabis	15.1	15.1	15.0	14.9	14.7	14.7
Cocaine	15.6	15.9	15.8	15.8	15.7	15.8
Heroin	14.3	14.7	14.4	15.4	14.9	14.4
Amphetamines	15.5	15.7	15.6	15.6	15.6	15.7
Hallucinogens	15.4	15.6	15.4	15.5	15.5	15.8
Inhalants	13.3	13.6	13.4	13.9	14.3	14.0
Ecstasy	15.6	15.7	15.5	15.7	15.4	15.6

Note: Percentages based on number of responses containing information.

(*) Over-the-counter tranquilizers and sleeping pills.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES), 1994—2004.

e 2.15. PREVALENCE OF PSYCHOACTIVE SUBSTANCE USE BY SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18, BY SEX, SPAIN 1994–2004.

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
USE AT LEAST ONCE IN LIFETIME												
Tobacco	56,0%	65,1%	58,9%	69,4%	57,4%	68,5%	57,1%	66,7%	54,6%	64,7%	56,6%	64,1%
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%
Sedative-hypnotic d.*	4,8%	7,4%	4,5%	7,6%	4,4%	8,2%	5,2%	8,6%	5,0%	7,9%	5,8%	8,1%
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%
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%
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%
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%
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%
Heroin	,7%	,3%	,8%	,3%	1,2%	,7%	,8%	,3%	,6%	,5%	1,1%	,3%
Inhalants	4,1%	2,1%	4,2%	2,5%	5,1%	3,4%	5,7%	3,0%	4,8%	2,7%	5,2%	2,9%
USE IN 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%
Sedative-hypnotic d.*	3,2%	5,6%	3,2%	5,8%	3,3%	5,9%	3,5%	6,6%	3,2%	5,7%	4,0%	5,5%
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%
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%
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%
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%
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%
Heroin	,5%	,2%	,6%	,2%	,8%	,5%	,7%	,1%	,4%	,2%	,8%	,1%
Inhalants	2,5%	1,3%	2,4%	1,7%	3,3%	2,0%	3,3%	1,8%	3,0%	1,5%	3,0%	1,4%
USE IN 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%
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%
Sedative-hypnotic d.*	1,9%	3,3%	1,5%	2,9%	1,5%	3,0%	1,7%	3,4%	1,7%	3,1%	1,8%	3,0%
Cannabis	15,1%	9,8%	18,4%	13,2%	20,3%	14,5%	24,5%	16,9%	25,8%	19,6%	28,3%	22,0%
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%
Hallucinogens	3,6%	1,7%	3,8%	1,9%	2,6%	1,5%	2,6%	1,3%	1,8%	,7%	2,3%	,7%
Amphetamines	2,9%	1,6%	3,2%	2,0%	2,7%	1,5%	2,5%	1,4%	2,5%	1,5%	2,7%	1,0%
Cocaine	1,4%	,7%	2,1%	1,2%	3,2%	1,8%	3,4%	1,5%	3,7%	2,8%	5,1%	2,6%
Heroin	,4%	,1%	,4%	,1%	,6%	,2%	,5%	,1%	,3%	,2%	,7%	,1%
Inhalants	1,5%	,8%	1,5%	1,0%	2,2%	1,5%	1,8%	1,1%	1,5%	,8%	1,6%	,7%

Note: Percentages based on number of responses containing information.

(*) Over-the-counter tranquilizers and sleeping pills.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES), 1994–2004.

e 2.16 PREVALENCE OF PSYCHOACTIVE SUBSTANCE USE BY SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18, BY AGE (PER CENT), SPAIN 2004.

AGE (years)	14	15	16	17	18
USE AT LEAST ONCE IN LIFETIME					
Tobacco	42.1%	54.7%	62.3%	70.0%	77.3%
Alcohol	59.2%	76.6%	86.9%	91.9%	93.8%
Sedative-hypnotic drugs*	4.1%	6.2%	7.1%	8.0%	10.8%
Cannabis	19.6%	33.7%	45.9%	56.7%	63.5%
Ecstasy	.5%	2.3%	4.3%	9.0%	13.7%
Hallucinogens	.7%	2.6%	4.0%	8.5%	12.1%
Amphetamines	.6%	2.3%	4.0%	9.3%	12.0%
Cocaine	1.2%	4.1%	7.6%	17.0%	23.6%
Heroin	.4%	.4%	.8%	1.0%	1.1%
Inhalants	2.3%	3.1%	4.0%	5.8%	6.2%
USE IN LAST 12 MONTHS					
Alcohol	57.9%	75.6%	85.9%	91.1%	93.0%
Sedative-hypnotic drugs*	2.7%	3.9%	5.1%	5.6%	7.1%
Cannabis	17.2%	29.3%	39.5%	48.4%	51.8%
Ecstasy	.3%	1.3%	2.3%	4.9%	6.5%
Hallucinogens	.5%	1.7%	2.7%	5.6%	7.8%
Amphetamines	.5%	1.7%	3.1%	5.8%	7.9%
Cocaine	.9%	3.2%	6.1%	14.0%	18.5%
Heroin	.3%	.3%	.5%	.6%	.8%
Inhalants	1.4%	2.1%	2.1%	2.7%	3.1%
USE IN LAST 30 DAYS					
Tobacco	15.5%	28.9%	38.6%	51.3%	60.1%
Alcohol	38.0%	57.7%	71.9%	78.2%	81.5%
Sedative-hypnotic drugs*	1.6%	2.1%	2.6%	2.7%	3.3%
Cannabis	10.0%	19.2%	27.8%	34.6%	35.7%
Ecstasy	.2%	.8%	1.2%	2.6%	4.0%
Hallucinogens	.3%	.9%	1.4%	2.3%	3.7%
Amphetamines	.2%	1.0%	1.9%	2.8%	4.5%
Cocaine	.5%	1.6%	3.1%	7.2%	11.1%
Heroin	.2%	.2%	.4%	.5%	.7%
Inhalants	.7%	1.1%	1.1%	1.3%	1.6%

Note: Percentages based on number of responses containing information.

(*) Over-the-counter tranquilizers and sleeping pills.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES), 1994–2004.

Table 2.17. SMOKING HABITS IN SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18 (MEANS AND PER CENT), BY SEX.
SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
NUMBER OF RESPONDENTS	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF TOBACCO USE AT LEAST ONCE 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%
AVERAGE AGE OF INITIATION INTO SMOKING FOR PRESENT AND EX-SMOKERS (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
PREVALENCE OF SMOKING IN LAST 30 DAYS	26.0%	36.3%	26.2%	38.1%	25.5%	37.6%	27.3%	37.1%	25.0%	33.4%	32.9%	41.9%
PREVALENCE OF DAILY SMOKING	17.8%	25.4%	19.0%	28.1%	17.9%	27.5%	19.3%	27.0%	17.7%	24.2%	18.9%	24.1%
AVERAGE AGE OF INITIATION INTO SMOKING FOR PRESENT AND EX-SMOKERS (years)	.	.	14.5	14.6	14.6	14.5	14.4	14.3	14.4	14.3	14.5	14.4
No. OF CIGARETTES SMOKED DAILY												
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%
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%
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%
over 21	2.5%	1.0%	1.6%	.9%	1.3%	.6%	.0%	.0%	1.7%	1.2%	1.8%	1.0%
AVERAGE No. OF CIGARETTES SMOKED	9.1	7.2	8.3	6.9	7.9	7.0	7.6	6.8	7.8	7.3	8.1	7.5

Note: Percentages based on number of responses containing information.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES), 1994–2004.

Table 2.18 DRINKING HABITS AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14 AND 18, BY SEX (PER CENT), SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
NUMBER OF RESPONDENTS	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF DRINKING ONCE 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%
AVERAGE AGE OF INITIATION (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
AVERAGE AGE OF INITIATION INTO WEEKLY DRINKING (years)	.	.	15.0	15.0	15.0	15.1	14.8	14.9	15.0	14.9	15.2	15.1
PREVALENCE OF DRINKING IN 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%
PREVALENCE OF DRINKING IN 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%
PREVALENCE OF WEEKEND DRINKING IN LAST 30 DAYS	-	-	66.0%	66.4%	67.0%	68.1%	60.1%	59.8%	56.3%	55.2%	65.1%	65.5%
PREVALENCE OF WEEKDAYS DRINKING IN LAST 30 DAYS	-	-	26.8%	14.9%	26.0%	16.1%	30.0%	16.8%	20.8%	10.6%	26.5%	14.1%
PREVALENCE OF DRINKING ON 8 OF LAST 30 DAYS	-	-	52.8%	45.2%	55.5%	49.1%	51.0%	41.6%	44.9%	36.8%	51.8%	42.8%
FREQUENCY OF DRINKING IN LAST 30 DAYS (days/month)												
1-4 days	44.4%	55.9%	17.9%	23.3%	15.7%	22.4%	14.8%	21.5%	18.5%	26.4%	16.9%	22.8%
5-8 days	36.7%	35.1%	15.4%	19.7%	14.8%	17.5%	15.2%	21.1%	16.7%	21.1%	15.6%	22.2%
over 8 days	18.9%	8.9%	66.8%	57.0%	69.5%	60.1%	70.1%	57.4%	64.8%	52.5%	67.5%	55.1%
DRINKERS AT RISK IN LAST 30 DAYS	-	-	9.5%	7.8%	10.0%	8.8%	10.5%	9.0%	9.3%	8.2%	13.1%	11.5%
PREVALENCE OF DRUNKENNESS IN LAST 30 DAYS	21.7%	19.8%	23.7%	20.7%	24.7%	23.4%	24.0%	19.9%	25.8%	23.1%	37.0%	32.5%

Note: Percentages based on number of responses containing information.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES), 1994–2004.

Table 2.19. PREVALENCE OF TYPES OF ALCOHOLIC BEVERAGES CONSUMED ON WEEKDAYS AND WEEKENDS DURING 30 DAYS PRIOR TO THE SURVEY BY SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14 AND 18 (PER CENT).SPAIN 1996-2004.

	1996	1998	2000	2002	2004
Weekdays					
(Any day from Monday through Thursday in the last 30 days)					
Wine	8.1%	8.9%	8.2%	4.9%	6.6%
Beer	15.3%	14.0%	16.2%	10.5%	14.1%
Appetizers	3.0%	3.2%	2.6%	1.7%	2.4%
Mixed drinks	5.4%	6.4%	6.8%	5.0%	6.8%
Hard liquor	3.2%	3.6%	3.5%	2.3%	3.2%
Fruit-b liqueurs	6.6%	7.5%	6.2%	3.8%	4.2%
All weekdays					
(Every day from Monday through Thursday in the last 30 days)					
Wine	.8%	1.0%	.9%	.3%	.7%
Beer	1.7%	1.5%	2.2%	.9%	1.7%
Appetizers	.2%	.3%	.3%	.1%	.3%
Mixed drinks	.2%	.3%	.6%	.2%	.6%
Hard liquor	.1%	.4%	.4%	.1%	.4%
Fruit-b liqueurs	.3%	.8%	.6%	.2%	.5%
Weekends					
(Any day from Friday through Sunday in the last 30 days)					
Wine	32.8%	32.8%	23.7%	21.0%	27.7%
Beer	46.9%	40.7%	30.8%	27.1%	34.1%
Appetizers	12.0%	13.6%	9.6%	8.0%	11.0%
Mixed drinks	48.8%	53.7%	49.2%	48.2%	58.4%
Hard liquor	24.5%	26.7%	22.4%	22.3%	27.8%
Fruit-b liqueurs	36.2%	37.1%	25.6%	22.6%	26.0%
All weekends					
(Every day from Friday through Sunday in the last 30 days))					
Wine	9.6%	10.6%	8.6%	5.9%	7.5%
Beer	19.9%	17.6%	14.4%	10.7%	13.8%
Appetizers	2.9%	4.2%	3.3%	2.1%	2.7%
Mixed drinks	19.6%	23.5%	22.2%	18.9%	22.5%
Hard liquor	8.2%	10.8%	10.1%	7.7%	9.4%
Fruit-b liqueurs	10.2%	12.0%	9.0%	6.0%	6.8%

Note: Percentages based on number of responses containing information.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES) 1994–2004.

Table 2.20. CANNABIS SMOKING HABITS IN THE SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18 (PER CENT, BY SEX. SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
NUMBER OF RESPONDENTS	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF CANNABIS USE AT LEAST ONCE IN LIFETIME	23.8%	18.0%	28.8%	24.2%	31.6%	27.6%	36.2%	30.1%	40.6%	34.6%	45.3%	40.2%
AVERAGE AGE OF INITIATION (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
PREVALENCE OF CANNABIS USE IN 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%
PREVALENCE OF CANNABIS USE IN 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%
FREQUENCY OF CANNABIS USE IN LAST 30 DAYS												
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%
1 or 2 times	6.9%	5.1%	7.3%	7.2%	8.4%	7.4%	8.6%	8.8%	8.6%	9.1%	9.4%	9.8%
3 to 5 times	3.0%	2.1%	4.1%	2.7%	3.8%	3.0%	4.7%	3.5%	4.8%	3.8%	4.4%	4.5%
6 to 9 times	2.1%	1.4%	2.9%	1.3%	3.2%	1.9%	3.1%	1.9%	3.9%	2.8%	3.5%	2.6%
10 to 19 times	1.5%	.6%	2.0%	1.0%	2.1%	1.3%	3.5%	1.3%	3.0%	1.8%	3.5%	2.3%
20 to 29 times	1.5%	.6%	2.2%	.9%	2.8%	1.0%	4.7%	1.4%	5.5%	2.1%	7.4%	2.8%
MEDIAN OF JOINTS SMOKED IN LAST 30 DAYS	-	-	-	-	-	-	2.0	2.0	2.0	2.0	2.0	1.0
AVERAGE JOINTS SMOKED IN LAST 30 DAYS	-	-	-	-	-	-	3.3	2.4	3.4	2.4	2.9	2.1
No. OF JOINTS SMOKED IN LASTA 30 DAYS												
None	-	-	-	-	-	-	76.6%	84.2%	75.2%	81.6%	72.0%	78.3%
One	-	-	-	-	-	-	5.5%	5.5%	5.2%	6.6%	7.9%	8.4%
2 – 3	-	-	-	-	-	-	9.4%	7.2%	10.8%	8.0%	10.9%	8.8%
4 – 5	-	-	-	-	-	-	4.7%	2.0%	4.5%	2.4%	4.6%	2.8%
6 or over	-	-	-	-	-	-	3.8%	1.1%	4.2%	1.3%	4.5%	1.7%

Note: Percentages based on number of responses containing information.
SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES), 1994—2004.

Table 2.21 COCAINE USE HABITS AMONG THE SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18 (PER CENT, BY SEX. SPAIN, 1994-2004

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
NUMBER OF RESPONDENTS	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF COCAINE USE AT LEAST ONCE IN LIFETIME	3.1%	1.9%	4.0%	2.8%	6.5%	4.4%	8.4%	4.5%	9.0%	6.4%	11.3%	6.8%
AVERAGE AGE OF INITIATION INTO COCAINE USE	15.7	15.5	15.9	15.9	15.9	15.7	16.0	15.6	15.8	15.6	15.9	15.7
PREVALENCE OF COCAINE USE IN 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%
PREVALENCE OF COCAINE USE IN LAST 30 DAYS	1.4%	.7%	2.1%	1.2%	3.2%	1.8%	3.4%	1.5%	3.7%	2.8%	5.1%	2.6%
FREQUENCY OF COCAINE USE IN 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%
1 to 2 days	.9%	.4%	1.5%	.8%	1.8%	1.0%	2.5%	1.1%	2.3%	2.1%	3.1%	1.7%
3 to 5 days	.2%	.2%	.3%	.2%	.6%	.5%	.5%	.2%	.9%	.5%	1.0%	.5%
6 to 9 days	.2%	.1%	.1%	.2%	.3%	.2%	.2%	.1%	.3%	.1%	.6%	.2%
10 to 19 days	.1%	.0%	.0%	.0%	.2%	.0%	.0%	.0%	.2%	.1%	.2%	.1%
20 TO 29 DAYS	.1%	.1%	.1%	.1%	.2%	.1%	.1%	.1%	.1%	.0%	.2%	.1%

Note: Percentages based on number of responses containing information.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Drug survey on school population (E.D.P.E) 1994-2004.

Table 2.22 ECSTASY* USE HABITS AMONG SECONDARY SCHOOL STUDENTS BETWEEN THE AGES OF 14 AND 18 (PER CENT)M BY SEX. SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
NUMBER OF RESPONDENTS	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF ECSTASY USE AT LEAST ONCE IN LIFETIME	4.7%	2.5%	6.1%	4.8%	4.0%	3.2%	7.6%	4.8%	7.0%	5.8%	6.0%	3.9%
AVERAGE AGE OF INITIATION INTO ECSTASY USE	15.7	15.5	15.6	15.7	15.5	15.5	15.9	15.4	15.4	15.3	15.7	15.4
MAXIMUM No OF PILLS AT ANY ONE TIME	.	.	2.6	2.0	2.1	1.7	2.2	2.1	3.2	3.1	3.7	2.7
PREVALENCE OF ECSTASY USE IN 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%
PREVALENCE OF ECSTASY USE IN 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%
FREQUENCY OF ECSTASY USE IN 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%
1 to 2 days	1.6%	1.0%	1.3%	1.2%	1.0%	.6%	2.2%	1.3%	1.6%	1.1%	1.0%	.7%
3 to 5 days	.6%	.2%	.7%	.4%	.3%	.3%	1.1%	.4%	.3%	.3%	.3%	.2%
6 to 9 days	.4%	.1%	.5%	.2%	.2%	.2%	.2%	.1%	.2%	.2%	.4%	.1%
10 to 19 days	.2%	.0%	.1%	.0%	.2%	.0%	.0%	.0%	.0%	.0%	.1%	.0%
20 to 29 days	.1%	.1%	.2%	.1%	.2%	.1%	.2%	.0%	.0%	.0%	.1%	.1%

Note: Percentages based on number of responses containing information.

(*) Ecstasy or other designer drugs.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES) 1994—2004.

Table 2.23. SEDATIVE-HYPNOTIC DRUG* USE HABITS AMONG SCHOOL POPULATION BETWEEN THE AGES OF 14 AND 18(PER CENT), BY SEX. SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls
NUMBER OF RESPONDENTS	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF S-H DRUG USE W/ PRESCRIPTION AT LEAST ONCE	5.8%	8.1%	6.6%	9.1%	6.4%	9.3%	7.3%	10.2%	6.8%	9.9%	8.1%	12.3%
PREVALENCE OF S-H DRUG USE W/O PRESCRIPTION AT LEAST ONCE	4.8%	7.4%	4.5%	7.6%	4.4%	8.2%	5.2%	8.6%	5.0%	7.9%	5.8%	8.1%
AVERAGE AGE OF INITIATION INTO S-H DRUG USE (years)	13.6	14.4	13.9	14.8	14.4	15.0	14.3	14.7	14.4	14.8	14.7	14.9
PREVALENCE OF OTC S-H DRUG USE IN 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%
PREVALENCE OF OTC S-H DRUG USE IN 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%
FREQUENCY OF S-H DRUG USE IN 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%
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%
3 to 5 days	.3%	.7%	.2%	.7%	.3%	.5%	.4%	.7%	.3%	.6%	.4%	.5%
6 to 9 days	.1%	.3%	.1%	.1%	.1%	.2%	.1%	.2%	.1%	.3%	.1%	.2%
10 to 19 days	.1%	.1%	.1%	.1%	.1%	.2%	.2%	.1%	.0%	.1%	.1%	.1%
20 to 29 days	.1%	.1%	.1%	.1%	.1%	.1%	.1%	.2%	.1%	.1%	.1%	.2%
REASONS FOR USING SEDATIVE-HYPNOTIC DRUGS												
To relax	-	-	-	-	-	-	29.4%	51.0%	36.5%	47.4%	29.4%	51.3%
To sleep	-	-	-	-	-	-	51.2%	58.0%	49.6%	60.0%	42.9%	55.8%
To try	-	-	-	-	-	-	6.6%	2.4%	9.9%	2.8%	9.2%	2.1%
To feel good. forget problems	-	-	-	-	-	-	9.4%	14.2%	8.5%	12.7%	10.2%	13.9%
To counter effects of other drugs	-	-	-	-	-	-	3.7%	2.9%	6.7%	2.3%	7.8%	1.4%

Note: Percentages based on number of responses containing information.
(*) Tranquilizers or sleeping pills.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Nation-wide survey on drug use in secondary schools (ESSTUDES) 1994–2004.

Table 4.1- Estimated prevalence of heroin and cocaine use in Spain, 1999-2002

		TM Opiates	DM Opiates	DM Cocaine	DM Opiates +Cocaine	Combined method Opiates+Cocaine
1999	**Number**	149244	116657-189927	41993-72302	158650-262229	187470-217779
	Rate per 1000 inhabitants (15-64)	5.34	4.17-6.8	1.5-2.59	5.68-9.38	6.71-7.79
	Rate per 1000 inhabitants (15-64)	3.65	2.86-4.65	1.03-1.77	3.88-6.42	4.59-5.33
2000	**Number**	144198	99585-156680	41639-73293	141224-229973	182498-214152
	Rate per 1000 inhabitants (15-64)	5.16	3.56-5.61	1.49-2.62	5.05-8.23	6.53-7.66
	Rate per 1000 inhabitants (15-64)	3.53	2.44-3.84	1.02-1.79	3.46-5.63	4.47-5.24
2001	**Number**	137107	95733-145970	49038-86250	144771-232220	182775-219987
	Rate per 1000 inhabitants (15-64)	4.91	3.43-5.22	1.75-3.09	5.18-8.31	6.54-7.87
	Rate per 1000 inhabitants (15-64)	3.36	2.34-3.57	1.2-2.11	3.54-5.69	4.47-5.39
2002	**Number**	112851	71964-102822	124964-166926	196928-269748	233827-275789
	Rate per 1000 inhabitants (15-64)	4.04	2.57-3.68	4.47-5.97	7.05-9.65	8.37-9.87
	Rate per 1000 inhabitants (15-64)	2.76	1.76-2.52	3.06-4.09	4.82-6.60	5.72-6.75

MT: Treatment multiplier method; MD: Demographic method

Table 6.1 PSYCHOACTIVE SUBSTANCE OVERDOSE MORTALITY IN SEVERAL SPANISH CITIES*, BY YEAR OF DEATH. Spain, 1990 – 2002.

	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Badajoz 1	3	2	3	2	1	4	4	2	2	3	1	0	
Barcelona	132	159	160	151	125	150	148	130	113	121	101	89	74
Barakaldo	-	15	8	11	10	9	7	10	11	10	6	7	6
Bilbao	23	25	40	26	32	39	43	21	20	17	13	20	9
Cartagena	5	4	8	3	8	10	14	6	0	7	4	3	-
Coruña (A)	-	-	-	7	6	10	14	11	9	13	21	9	5
Donostia-San Sebastian	-	12	6	15	13	12	12	10	18	11	10	5	10
Getafe	-	3	5	1	3	3	2	3	0	2	2	3	1
Granada	-	28	29	19	14	22	9	-	-	-	-	13	12
Leganes	-	7	0	5	8	4	2	2	1	1	1	6	1
Lugo	-	-	-	2	0	0	2	1	6	3	1	0	2
Madrid	227	285	255	179	146	132	140	122	98	90	106	93	83
Majadahonda	-	5	4	1	2	2	1	2	0	1	4	2	3
Malaga	-	20	20	15	9	7	12	-	-	-	-	19	11
Murcia	5	14	9	6	9	3	4	14	12	9	-	4	-
Ourense	-	-	-	2	6	3	5	5	1	2	2	7	6
Palma de Majorca	0	22	27	31	31	37	38	51	38	42	50	41	44
Palmas de Gran Canaria	-	1	14	13	7	4	7	-	-	7	4	5	4
Pamplona/Iruña	-	18	13	9	10	12	9	6	7	5	12	7	21
Ponferrada	-	1	5	6	3	4	1	2	4	3	1	0	4
Pontevedra	-	-	-	10	11	4	5	6	4	7	7	5	4
Ribeira	-	-	-	0	3	5	1	3	4	4	0	1	3
Santiago de Compostela	-	-	-	8	6	3	7	7	5	7	2	3	5
Saragossa	24	34	9	18	16	18	27	24	17	16	16	16	12
Seville	11	26	20	23	17	21	40	-	-	-	-	27	28
Valencia	38	50	74	47	52	35	32	25	23	14	19	23	26
Valladolid	-	9	14	8	20	11	15	15	12	13	13	6	7
Vigo	-	-	-	16	26	8	17	19	22	15	8	5	12

- From 1990 to 1995, includes only deaths due to opiate or cocaine overdose.
- For the major cities, the geographic scope concurs with the municipal districts. For cities with a smaller population, the municipal district includes the city and certain nearby towns.

SOURCE: GOVERNMENT'S DELEGATION TO THE NATIONAL DRUG PLAN (DGPNSD). Spanish Drug Observatory (OED).

Table 6.2. GENERAL CHARACTERISTICS OF DECEASED DUE TO OVERDOSE OF PSYCHOACTIVE SUBSTANCES (ABSOLUTE NUMBER, MEAN AND PER CENT). 2002.

	Six cities(*)	Other areas(+)	Total
NUMBER OF DEATHS	232	264	496
SEX			
Male	87.9%	88.6%	88.3%
Female	12.1%	11.4%	11.7%
AVERAGE AGE (years)	35.5	34.0	34.7
AGE GROUP (years)			
15-19	1.7%	.8%	1.2%
20-24	6.1%	9.5%	7.9%
25-29	11.4%	14.2%	12.9%
30-34	22.7%	28.1%	25.5%
35-39	28.8%	25.3%	27.0%
40-44	19.7%	14.6%	17.0%
>= 45	9.6%	7.5%	8.5%
MARITAL STATUS			
Single	70.1%	65.5%	67.9%
Married	11.5%	17.2%	14.2%
Separated/Divorced	16.6%	15.2%	15.9%
Widow/er	1.9%	2.1%	2.0%
CORPSE FOUND IN			
Home	52.9%	60.5%	56.8%
Hotel-boarding house	2.7%	4.2%	3.5%
Street	26.0%	17.2%	21.5%
Public premises	.9%	2.9%	2.0%
Hospital	9.9%	4.2%	6.9%
Prison	3.1%	2.1%	2.6%
Other	4.5%	8.8%	6.7%
EVIDENCE OF RECENT USE			
Yes	84.7%	86.7%	85.8%
No	15.3%	13.3%	14.2%
EVIDENCE OF SUICIDE			
Strong evidence	1.8%	3.1%	2.5%
Indication/suspected	.5%	3.6%	2.0%
No evidence	97.7%	93.3%	95.5%
SIGNS OF RECENT VENIPUNCTURE			
Yes	47.8%	46.7%	47.2%
No	52.2%	53.3%	52.8%
DEATH CAUSED BY PRIOR PATHOLOGY AGGRAVATED BY PSYCHOACTIVE SUBSTANCE USE			
Yes	64.8%	21.2%	42.2%
No	35.2%	78.8%	57.8%
ANTI-HIV ANTIBODIES			
Positive	51.0%	43.3%	47.3%
Negative	49.0%	56.7%	52.7%

(*) Data for Barcelona, Bilbao, Madrid, Saragossa, Seville and Valencia.

(+) Data for the areas listed in Table M20, excluding the five major cities specified above.

SOURCE: GOVERNMENT'S DELEGATION TO THE NATIONAL DRUG PLAN (DGPNSD). Spanish Drug Observatory (OED).

Table 6.3. DRUGS DETECTED IN TOXICOLOGICAL ANALYSES OF BIOLOGICAL SAMPLES OF OVERDOSE VICTIMS, BY GEOGRAPHIC AREA OF DEATH (ABSOLUTE NUMBERS AND PER CENT). 2002.

	Andalusia [A]	Saragossa [B]	P de Majorca	Canary I. [G]	Barcelona [D]	Valencian C [E]
Opiates	55	12	34	28	57	21
Cocaine	40	0	30	21	40	24
Barbiturates	2	0	4	0	0	0
Benzodiazepines	45	0	25	16	27	16
Amphetamines	0	0	4	1	0	2
MDMA & derivatives	3	0	1	1	3	0
Cannabis	11	0	18	4	29	7
Hallucinogens	0	0	1	0	0	0
Inhalants	0	0	1	1	0	0
Alcohol	20	0	32	4	32	5
Total	63	12	43	40	69	26

	Basque C. [G]	Galicia [G]	C. Madrid [F]	R. Murcia [G]	Other [H]	Total
Opiates	30	50	77	14	32	410
Cocaine	13	29	48	13	7	265
Barbiturates	0	0	0	0	0	6
Benzodiazepines	21	31	52	12	13	258
Amphetamines	2	1	3	1	0	14
MDMA & derivatives	3	0	1	0	0	12
Cannabis	8	18	2	1	2	100
Hallucinogens	0	0	0	0	1	2
Inhalants	0	0	1	0	0	3
Alcohol	7	28	61	6	13	208
Total	34	56	97	17	32	489

	Andalusia [A]	Saragossa [B]	Palma de Majorca [C]	Canary I. [G]	Barcelona [D]	Valencian C. [E]
Opiates	87.3%	100.0%	79.1%	70.0%	82.6%	80.8%
Cocaine	63.5%	.0%	69.8%	52.5%	58.0%	92.3%
Barbiturates	3.2%	.0%	9.3%	.0%	.0%	.0%
Benzodiazepines	71.4%	.0%	58.1%	40.0%	39.1%	61.5%
Amphetamines	.0%	.0%	9.3%	2.5%	.0%	7.7%
MDMA & derivatives	4.8%	.0%	2.3%	2.5%	4.3%	.0%
Cannabis	17.5%	.0%	41.9%	10.0%	42.0%	26.9%
Hallucinogens	.0%	.0%	2.3%	.0%	.0%	.0%
Inhalants	.0%	.0%	2.3%	2.5%	.0%	.0%
Alcohol	31.7%	.0%	74.4%	10.0%	46.4%	19.2%

	Basque C.	Galicia [G]	C. Madrid [F]	R. Murcia [G]	Other [H]	Total
Opiates	88.2%	89.3%	79.4%	82.4%	100.0%	83.6%
Cocaine	38.2%	51.8%	49.5%	76.5%	21.9%	53.8%
Barbiturates	.0%	.0%	.0%	.0%	.0%	1.4%
Benzodiazepines	61.8%	55.4%	53.6%	70.6%	40.6%	52.8%
Amphetamines	5.9%	1.8%	3.1%	5.9%	.0%	3.3%
MDMA & derivatives	8.8%	.0%	1.0%	.0%	.0%	2.5%
Cannabis	23.5%	32.1%	2.1%	5.9%	6.3%	20.2%
Hallucinogens	.0%	.0%	.0%	.0%	3.1%	.4%
Inhalants	.0%	.0%	1.0%	.0%	.0%	.6%
Alcohol	20.6%	50.0%	62.9%	35.3%	40.6%	42.9%

Note: Toxicological analyses are available for only 97% of the deceased. Each sample may test positive for several drugs. For this reason, the total samples analyzed (489) is always smaller than the sum of the positive results for all drugs.
The results of the toxicological analyses shown are for all the biological samples analyzed, not only blood samples.

(A) Includes municipal districts of Seville, Granada and Malaga
(B) Includes municipal district of Saragossa only.
(C) Includes municipal district of Palma de Majorca only.
(D) Includes municipal district of Barcelona only.
(E) Includes municipal district of Valencia only.
(F) Includes municipal district of Madrid or other municipal districts in the Community of Madrid. (See Table M20, Annex I, Coverage).
(G) Includes all municipal districts in the autonomous community.
(H) Includes the rest of the municipal districts monitored by the indicator and not included in other categories (See Table M20, Annex I, Coverage).

SOURCE: GOVERNMENT'S DELEGATION TO THE NATIONAL DRUG PLAN (DGPNSD). Spanish Drug Observatory (OED).

Table 6.4. Presence of methadone in psychoactive substance overdose deaths in Spain, 1996-2002

year	% of overdose deaths where only methadone is detected	% of overdose deaths where opiates including methadone are detected	% of cocaine overdose deaths 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

Table 6.5. Estimated illegal psychoactive drug-related deaths in . Spain, 2001

	Number			Rate per 100000[c]			Proportional mortality(%)[d]		
Men	DRD[a]	HIV[b]	Total	DRD	HIV	Total	DRD	HIV	Total
15-29	207	40	248	4,4	0,9	5,3	5,5	1,1	6,6
30-39	415	479	894	12,3	14,2	26,5	8,1	9,3	17,5
40-49	173	146	320	6,2	5,2	11,4	2,1	1,8	3,9
15-49	795	665	1461	7,3	6,1	13,4	4,7	3,9	8,6
All ages	802	841	1643	4,0	4,2	8,2	0,4	0,4	0,9
Women									
15-29	33	26	60	0,7	0,6	1,3	2,7	2,1	4,8
30-39	64	128	192	1,9	3,9	5,8	3,3	6,5	9,8
40-49	33	31	64	1,1	1,1	2,3	0,9	0,9	1,8
15-49	123	185	308	1,2	1,8	2,9	1,8	2,7	4,5
All ages	121	206	327	0,6	1,0	1,6	0,1	0,1	0,2
Total									
15-29	240	67	307	2,6	0,7	3,4	4,8	1,3	6,1
30-39	479	607	1086	7,2	9,1	16,3	6,8	8,6	15,3
40-49	206	177	383	3,7	3,1	6,8	1,8	1,5	3,3
15-49	918	851	1769	4,3	4,0	8,2	3,9	3,6	7,4
All ages	923	1047	1969	2,3	2,6	4,8	0,3	0,3	0,5

a :Deaths estimated by selecting data on the following ICD-10 codes from the National Statistics Institute's General Death Register: F11-F12, F14-F16, F19, X41, X42, X44, X61, X62, Y11 and Y12, and multiplying the figures obtained times the register's underestimation factor (calculated by crossing data with the Spanish Drug Observatory's specific register that covers an area with a population of over 18 million).

b: Deaths estimated by selecting data on ICD-10 codes B20-B24 from the National Statistics Institute's General Death Register and multiplying the figure obtained times the proportion of drug-injector cases of AIDS recorded in the National AIDS Register.

c: The population numbers for calculating the rates were taken from the 2001 population census (www.ine.es/censo2001/)

d: Proportional mortality=(drug-related deaths/all deaths)*100

Table 6.6 — GENERAL CHARACTERISTICS OF EMERGENCY EPISODES DIRECTLY RELATED TO THE USE OF PSYCHOACTIVE SUBSTANCES (ABSOLUTE NUMBER, MEAN AND PER CENT). 1996-2002.

	1996	1997	1998	1999	2000	2001	2002
NUMBER OF EPISODES	2.585	1.932	2.099	2.141	2.328	2.145	2.673
AVERAGE AGE (years)	27.8	28.1	29.1	29.4	30.3	29.8	29.8
SEX							
Men	78.6%	79.2%	76.9%	76.5%	72.6%	72.9%	72.6%
Women	21.4%	20.8%	23.1%	23.5%	27.4%	27.1%	27.4%
PSYCHOACTIVE SUBSTANCE*							
Heroin	61.4%	52.6%	43.8%	41.9%	40.5%	33.5%	26.8%
Other opiates	17.3%	26.2%	23.3%	23.4%	20.9%	21.9%	17.7%
Cocaine	27.3%	29.9%	37.2%	48.1%	45.3%	44.4%	49.0%
Amphetamines	3.1%	3.3%	3.4%	2.7%	2.6%	4.6%	3.8%
MDMA and derivatives	1.6%	2.7%	2.9%	3.1%	4.8%	5.2%	6.3%
Sedative-hypnotic drugs	25.7%	21.6%	26.1%	25.1%	30.6%	32.0%	34.1%
Cannabis	7.4%	7.3%	11.3%	12.2%	14.8%	19.1%	22.8%
Hallucinogens	2.7%	2.2%	2.9%	2.1%	2.9%	2.4%	1.4%
Inhalants	0.3%	0.1%	0.5%	0.1%	0.3%	0.9%	.3%
Alcohol	13.3%	15.8%	22.9%	22.0%	29.5%	33.8%	39.0%
Other substances	5.1%	3.6%	6.0%	2.0%	0.8%	2.8%	4.5%
RELATED PSYCHOACTIVE SUBSTANCES							
Heroin	56.1%	50.9%	38.7%	33.0%	35.3%	29.2%	21.4%
Other opiates	13.5%	17.4%	16.8%	18.9%	18.0%	17.4%	13.1%
Cocaine	19.9%	25.0%	31.6%	39.4%	40.9%	40.5%	44.7%
Amphetamines	2.2%	2.9%	3.0%	9.8%	2.2%	4.2%	3.4%
MDMA and derivatives	1.3%	2.2%	2.2%	2.4%	4.5%	4.4%	5.3%
Hypnotic and sedative drugs	23.6%	18.9%	24.3%	23.8%	28.9%	29.2%	30.1%
Cannabis	6.2%	6.6%	8.9%	9.3%	12.8%	16.9%	19.9%
Hallucinogens	2.1%	1.8%	2.4%	1.7%	2.7%	1.9%	1.3%
Inhalants	0.2%	0.1%	0.3%	0.1%	0.3%	0.9%	.2%
Alcohol	12.4%	15.2%	22.2%	20.0%	26.8%	29.0%	35.4%
Other substances	4.1%	3.2%	4.9%	1.3%	0.8%	1.6%	1.8%
DIAGNOSIS							
Overdose or acute intoxication	34.8%	33.0%	43.3%	44.0%	51.6%	52.6%	56.6%
Withdrawal symptoms	37.2%	41.7%	32.0%	28.1%	17.3%	16.2%	11.7%
Acute non-infectious organic r.	16.9%	16.3%	13.4%	14.8%	19.2%	9.6%	11.4%
Psychopathological problems	11.1%	9.0%	11.4%	13.1%	11.8%	21.6%	20.3%
LEGAL STATUS							
Arrested	14.4%	22.4%	11.7%	9.4%	6.4%	5.7%	5.2%
Not arrested	85.6%	77.6%	88.3%	90.6%	93.6%	94.3%	94.8%
OUTCOME OF EMERGENCY							

Discharge	80.5%	82.0%	81.2%	80.9%	78.7%	79.1%	82.1%
Voluntary discharge	7.0%	6.7%	8.8%	8.6%	8.5%	7.5%	7.4%
Admission to hospital	7.6%	7.2%	6.0%	6.5%	8.3%	7.8%	6.3%
Death in emergency room	0.1%	0.1%	0.0%	0.2%	0.7%	0.2%	.1%
Taken to another clinic	4.8%	4.1%	3.9%	3.9%	3.7%	5.4%	4.0%

(*) Includes substances used regularly and sporadically and substances related to the emergency.

SOURCE: Government’s Delegation to the National Drug Plan (DGPNSD). Spanish Drug Observatory (OED).

Table 11.1 EVOLUTION OF PREVALENCE OF PSYCHOACTIVE SUBSTANCE USE IN THE 15 – 64-YEAR OLD POPULATION, ACCORDING TO GENDER (PERCENTILES), SPAIN 1995—2003.

	1995		1997		1999		2001		2003	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Prevalence of use at sometime in life										
Tobacco	—	—	79,0%	60,4%	72,6%	57,2%	76,0%	60,7%	76,0%	61,7%
Alcohol	—	—	95,3%	86,0%	92,1%	82,5%	93,6%	84,3%	93,8%	83,3%
Cannabis	19,9%	9,4%	31,1%	14,8%	25,9%	13,3%	31,0%	16,5%	38,2%	19,7%
Ecstasy	2,8%	1,2%	3,8%	1,2%	3,3%	1,5%	6,0%	2,0%	6,6%	2,5%
Hallucinogens	3,3%	1,0%	4,6%	1,2%	2,8%	1,0%	4,2%	1,3%	4,7%	1,3%
Amphetamines	3,1%	1,5%	4,0%	1,4%	3,1%	1,2%	4,1%	1,7%	4,6%	1,7%
Cocaine	4,8%	2,0%	5,4%	1,5%	4,5%	1,8%	7,0%	2,5%	9,2%	2,6%
Crack cocaine	,5%	,1%	,7%	,2%	,6%	,1%	,7%	,2%	,8%	,2%
Heroin	1,2%	,4%	,9%	,2%	,6%	,3%	1,0%	,2%	1,5%	,3%
Other opiates	,4%	,1%	,7%	,2%	,4%	,2%	,8%	,3%	,8%	,1%
Volatile solvents	1,1%	,3%	1,4%	,1%	,9%	,3%	1,2%	,4%	1,7%	,3%
Prevalence of use in the last 12 months										
Tobacco	—	—	55,0%	38,7%	50,3%	39,2%	51,5%	40,5%	53,0%	42,6%
Alcohol	79,3%	58,0%	86,4%	70,5%	83,2%	67,2%	85,2%	70,9%	84,5%	68,4%
Hypnosedatives	8,2%	16,4%	2,3%	2,4%	2,3%	2,4%	2,5%	3,1%	2,9%	3,3%
Cannabis	10,7%	4,4%	10,7%	4,7%	9,6%	4,3%	13,0%	5,5%	16,2%	6,3%
Ecstasy	1,9%	,7%	1,2%	,5%	1,2%	,5%	2,8%	,7%	2,0%	,8%
Hallucinogens	1,1%	,4%	1,4%	,4%	,8%	,4%	1,2%	,2%	,9%	,3%
Amphetamines	1,3%	,7%	1,4%	,4%	1,0%	,4%	1,6%	,6%	1,1%	,5%
Cocaine	2,7%	1,0%	2,6%	,6%	2,3%	,8%	3,8%	1,3%	4,1%	1,2%
Crack cocaine	,2%	,0%	,2%	,0%	,4%	,0%	,2%	,0%	,2%	,0%
Heroin	,8%	,3%	,4%	,1%	,2%	,0%	,2%	,0%	,2%	,1%
Other opiates	,1%	,0%	,2%	,0%	,2%	,0%	,3%	,1%	,1%	,0%
Volatile solvents	,2%	,1%	,3%	,0%	,1%	,1%	,2%	,1%	,1%	,1%
Prevalence of use in the last 30 days										
Tobacco	—	—	51,4%	34,4%	45,0%	35,2%	46,5%	36,3%	47,9%	37,9%
Alcohol	—	—	75,8%	52,1%	74,4%	49,1%	76,4%	50,9%	75,8%	52,1%
Cannabis	—	—	6,7%	2,5%	6,2%	2,8%	9,4%	3,4%	11,3%	3,9%
Ecstasy	—	—	,5%	,1%	,3%	,2%	1,3%	,3%	,5%	,2%
Hallucinogens	—	—	,3%	,1%	,3%	,1%	,4%	,1%	,3%	,1%
Amphetamines	—	—	,4%	,1%	,4%	,2%	,9%	,2%	,4%	,1%
Cocaine	—	—	1,5%	,2%	1,3%	,4%	2,2%	,5%	1,6%	,5%
Crack cocaine	—	—	,1%	,0%	,1%	,0%	,0%	,0%	,0%	,0%
Heroin	—	—	,2%	,1%	,1%	,0%	,1%	,0%	,0%	,1%
Other opiates	—	—	,1%	,0%	,1%	,0%	,1%	,1%	,1%	,0%
Volatile solvents	—	—	,1%	,0%	,0%	,0%	,1%	,0%	,0%	,0%

Note: The percentiles are calculated with the number of cases with information.

Source: Government Delegation for the National Plan on Drugs. General Population Survey on Drugs and Alcohol in Spain (EDADES).

Table 11.2 EVOLUTION OF THE PREVALENCES OF PSYCHOACTIVE SUBSTANCE USE IN SECONDARY SCHOOL STUDENTS AGED 14-18 (PERCENTILES), ACCORDING TO GENDER, SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
USED AT SOMETIME IN LIFE												
Tobacco	56,0%	65,1%	58,9%	69,4%	57,4%	68,5%	57,1%	66,7%	54,6%	64,7%	56,6%	64,1%
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%
Hypnosedatives*	4,8%	7,4%	4,5%	7,6%	4,4%	8,2%	5,2%	8,6%	5,0%	7,9%	5,8%	8,1%
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%
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%
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%
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%
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%
Heroin	,7%	,3%	,8%	,3%	1,2%	,7%	,8%	,3%	,6%	,5%	1,1%	,3%
Volatile solvents	4,1%	2,1%	4,2%	2,5%	5,1%	3,4%	5,7%	3,0%	4,8%	2,7%	5,2%	2,9%
USED 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%
Hypnosedatives*	3,2%	5,6%	3,2%	5,8%	3,3%	5,9%	3,5%	6,6%	3,2%	5,7%	4,0%	5,5%
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%
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%
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%
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%
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%
Heroin	,5%	,2%	,6%	,2%	,8%	,5%	,7%	,1%	,4%	,2%	,8%	,1%
Volatile solvents	2,5%	1,3%	2,4%	1,7%	3,3%	2,0%	3,3%	1,8%	3,0%	1,5%	3,0%	1,4%
USED 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%
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%
Hypnosedatives*	1,9%	3,3%	1,5%	2,9%	1,5%	3,0%	1,7%	3,4%	1,7%	3,1%	1,8%	3,0%
Cannabis	15,1%	9,8%	18,4%	13,2%	20,3%	14,5%	24,5%	16,9%	25,8%	19,6%	28,3%	22,0%
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%
Hallucinogens	3,6%	1,7%	3,8%	1,9%	2,6%	1,5%	2,6%	1,3%	1,8%	,7%	2,3%	,7%
Amphetamines	2,9%	1,6%	3,2%	2,0%	2,7%	1,5%	2,5%	1,4%	2,5%	1,5%	2,7%	1,0%
Cocaine	1,4%	,7%	2,1%	1,2%	3,2%	1,8%	3,4%	1,5%	3,7%	2,8%	5,1%	2,6%
Heroin	,4%	,1%	,4%	,1%	,6%	,2%	,5%	,1%	,3%	,2%	,7%	,1%
Volatile solvents	1,5%	,8%	1,5%	1,0%	2,2%	1,5%	1,8%	1,1%	1,5%	,8%	1,6%	,7%

Note: The percentiles are calculated with the number of cases with information.

(*) Tranquillisers and sleeping pills without medical prescription.

Source: DGPNSD. National Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2004.

Table 11.3. GENERAL CHARCTERISTICS OF CANNABIS USE AMONG SECONDARY SCHOOL STUDENTS AGED 14-18 (PERCENTILES), ACCORDING TO GENDER. SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
NUMBER OF PEOPLE SURVEYED	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF CANNABIS USE AT SOMETIME IN LIFE	23,8%	18,0%	28,8%	24,2%	31,6%	27,6%	36,2%	30,1%	40,6%	34,6%	45,3%	40,2%
AVERAGE AGE OF INITIATION IN CANNABIS USE (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
PREVALENCE 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%
PREVALENCE 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%
FREQUENCY OF CANNABIS USE IN THE LAST 30 DAYS												
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%
1 to 2 times	6,9%	5,1%	7,3%	7,2%	8,4%	7,4%	8,6%	8,8%	8,6%	9,1%	9,4%	9,8%
3 to 5 times	3,0%	2,1%	4,1%	2,7%	3,8%	3,0%	4,7%	3,5%	4,8%	3,8%	4,4%	4,5%
6 to 9 times	2,1%	1,4%	2,9%	1,3%	3,2%	1,9%	3,1%	1,9%	3,9%	2,8%	3,5%	2,6%
10 to 19 times	1,5%	,6%	2,0%	1,0%	2,1%	1,3%	3,5%	1,3%	3,0%	1,8%	3,5%	2,3%
20 to 29 times	1,5%	,6%	2,2%	,9%	2,8%	1,0%	4,7%	1,4%	5,5%	2,1%	7,4%	2,8%
AVERAGE JOINTS PER DAY IN THE LAST 30 DAYS	-	-	-	-	-	-	2,0	2,0	2,0	2,0	2,0	1,0
AVERAGE NUMBER OF JOINTS PER DAY IN THE LAST 30 DAYS	-	-	-	-	-	-	3,3	2,4	3,4	2,4	2,9	2,1
NUMBER OF JOINTS PER DAY IN THE LAST 30 DAYS												
None	-	-	-	-	-	-	76,6%	84,2%	75,2%	81,6%	72,0%	78,3%
One	-	-	-	-	-	-	5,5%	5,5%	5,2%	6,6%	7,9%	8,4%
2 - 3	-	-	-	-	-	-	9,4%	7,2%	10,8%	8,0%	10,9%	8,8%
4 - 5	-	-	-	-	-	-	4,7%	2,0%	4,5%	2,4%	4,6%	2,8%
6 or more	-	-	-	-	-	-	3,8%	1,1%	4,2%	1,3%	4,5%	1,7%

Note: The percentiles are calculated with the number of cases with information.
Source: DGPNSD. National Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2004.

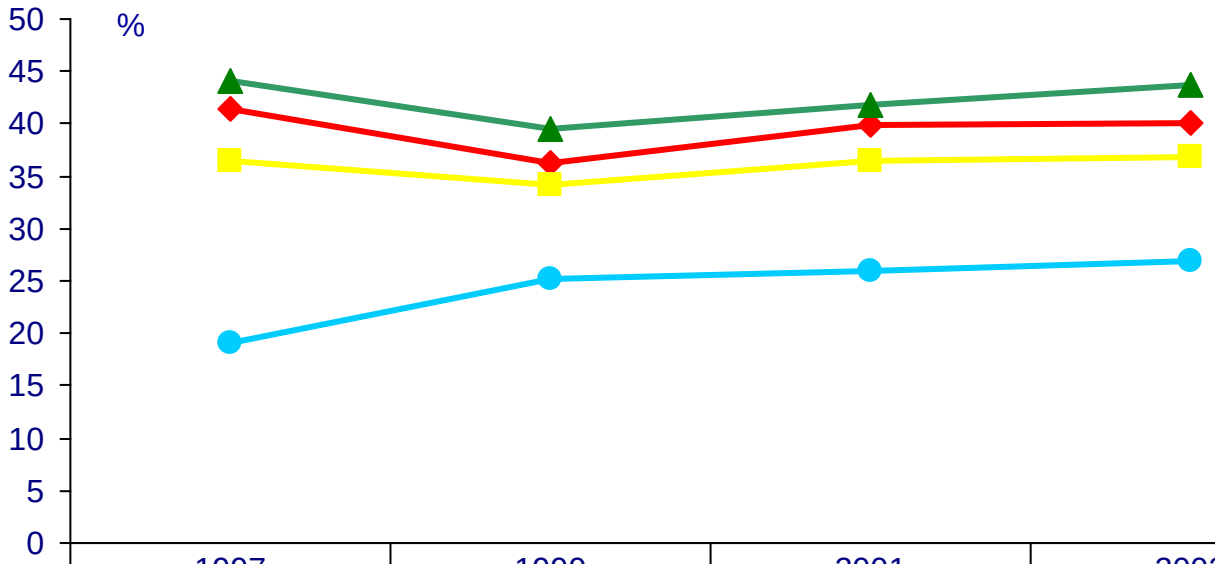
Table 11.4. GENERAL CHARACTERISTICS OF COCAINE USE IN SECONDARY SCHOOL STUDENTS AGED 14-18 (PERCENTILES), ACCORDING TO GENDER. SPAIN 1994-2004.

	1994		1996		1998		2000		2002		2004	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
NUMBER OF PEOPLE SURVEYED	10415	10374	8867	9668	8224	9341	10147	9777	12964	13946	12864	13076
PREVALENCE OF COCAINE USE AT SOMETIME IN LIFE	3,1%	1,9%	4,0%	2,8%	6,5%	4,4%	8,4%	4,5%	9,0%	6,4%	11,3%	6,8%
AVERAGE AGE OF INITIATION IN COCAINE USE (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
PREVALENCE 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%
PREVALENCE OF COCAINE USE IN THE LAST 30 DAYS	1,4%	,7%	2,1%	1,2%	3,2%	1,8%	3,4%	1,5%	3,7%	2,8%	5,1%	2,6%
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%
1 to 2 days	,9%	,4%	1,5%	,8%	1,8%	1,0%	2,5%	1,1%	2,3%	2,1%	3,1%	1,7%
3 to 5 days	,2%	,2%	,3%	,2%	,6%	,5%	,5%	,2%	,9%	,5%	1,0%	,5%
6 to 9 days	,2%	,1%	,1%	,2%	,3%	,2%	,2%	,1%	,3%	,1%	,6%	,2%
10 to 19 days	,1%	,0%	,0%	,0%	,2%	,0%	,0%	,0%	,2%	,1%	,2%	,1%
20 to 29 days	,1%	,1%	,1%	,1%	,2%	,1%	,1%	,1%	,1%	,0%	,2%	,1%

Note: The percentiles are calculated with the number of cases with information.

Source: DGPNSD. National Survey on Drug Use in Secondary Schools (ESTUDES), 1994-2004.

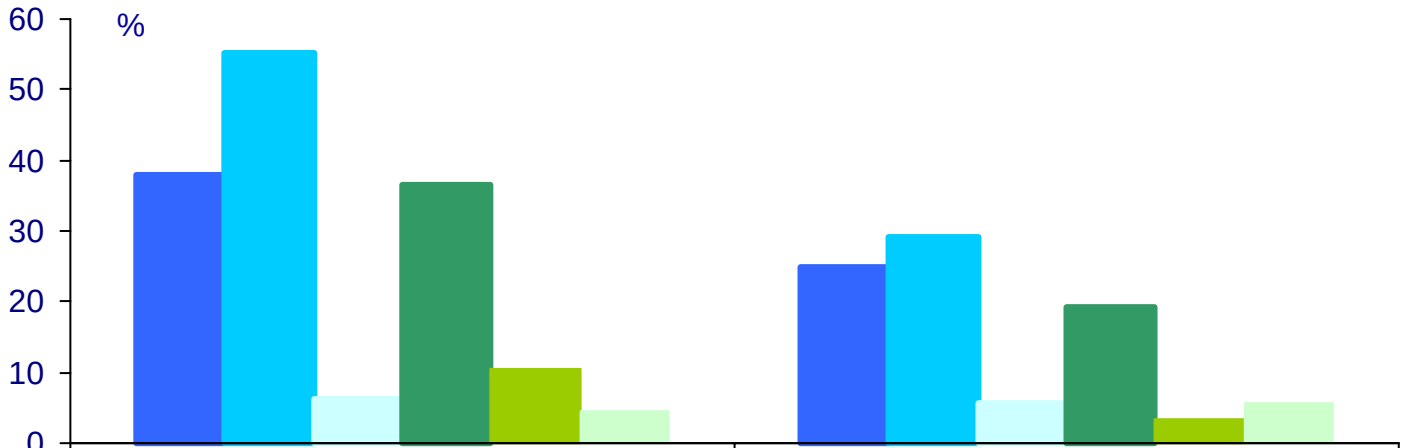
Figure 2.1. Prevalence of daily tobacco consumption in the population between the ages of 15 and 64, by age group (per cent). Spain, 1997-2003.



	1997	1999	2001	2003
Men 15-34	41,4	36,3	39,8	40
Women 15-34	36,5	34,2	36,4	36,8
Men 35-64	44	39,5	41,8	43,7
Women 35-64	19,1	25,1	25,9	27

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1997,1999, 2001, 2003.

Figure 2.2. Prevalence of weekend* consumption of different types of alcoholic beverages by the population between the ages of 15 and 64, by sex (per cent). Spain, 2003.

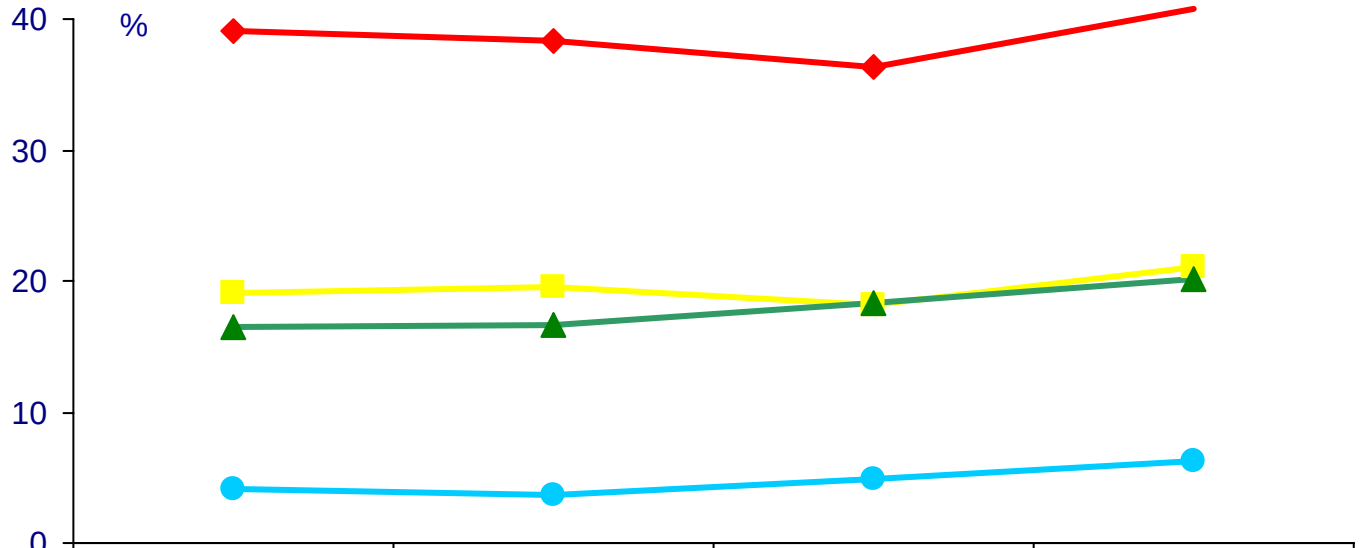


	Men	Women
Wne	38	24,8
Beer	55,1	29,1
Appetizers	6,3	5,7
Mixed drinks	36,5	19,3
Hard liquor	10,5	3,3
Fruit-base liq.	4,6	5,6

(*) Any Friday, Saturday or Sunday in the last 30 days.

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 2003.

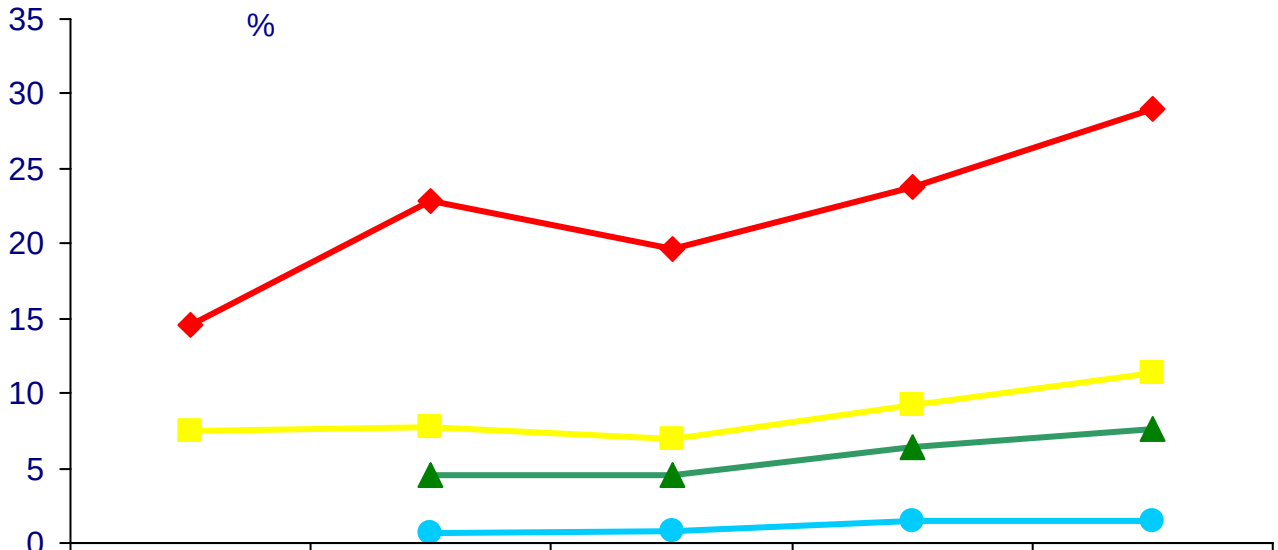
Figure 2.3. Proportion of episodes of drunkenness in the last 12 months in the population between the ages of 15 and 64, by age group and sex (per cent). Spain, 1997-2003.



	1997	1999	2001	2003
Men 15-34	39,1	38,3	36,3	40,7
Women 15-34	19,1	19,6	18,1	21
Men 35-64	16,5	16,6	18,3	20,2
Women 35-64	4,1	3,6	4,9	6,3

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1997,1999, 2001, 2003.

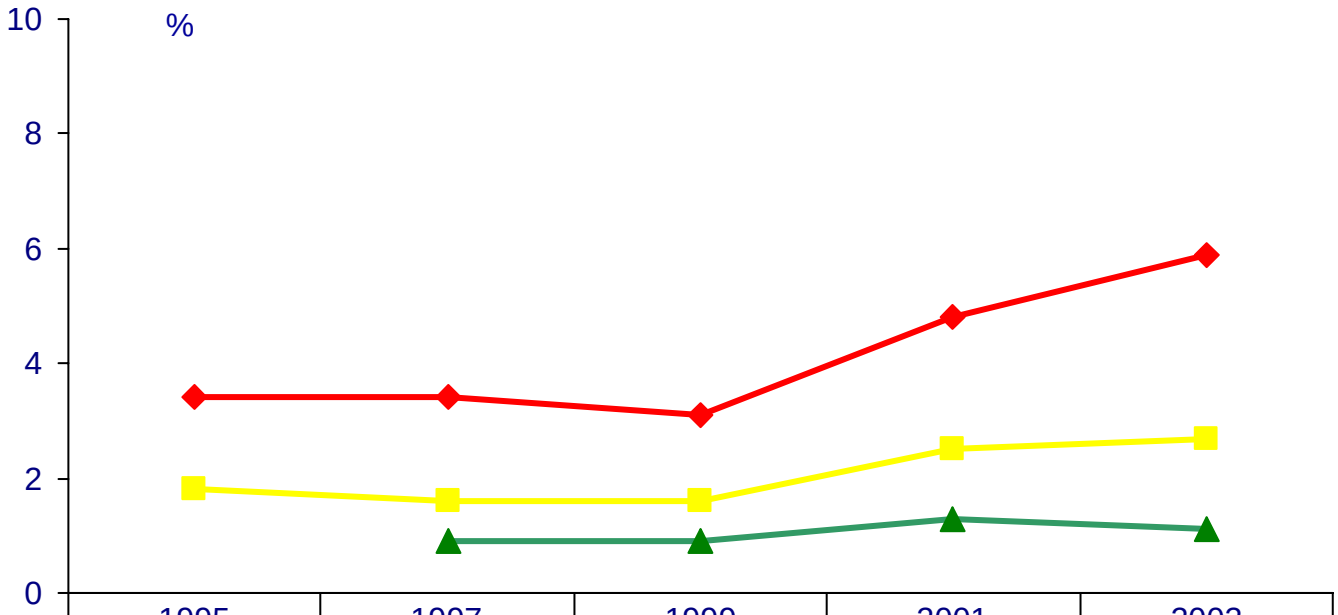
Figure 2.4. Prevalence of cannabis use in the population between the ages of 15 and 64. Spain, 1995-2003.



	1995	1997	1999	2001	2003
Once in lifetime	14,5	22,9	19,6	23,8	29
Last 12 months	7,5	7,7	7	9,2	11,3
Last 30 days		4,6	4,5	6,4	7,6
Daily in last 30 days		0,7	0,8	1,5	1,5

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1995, 1997,1999, 2001, 2003.

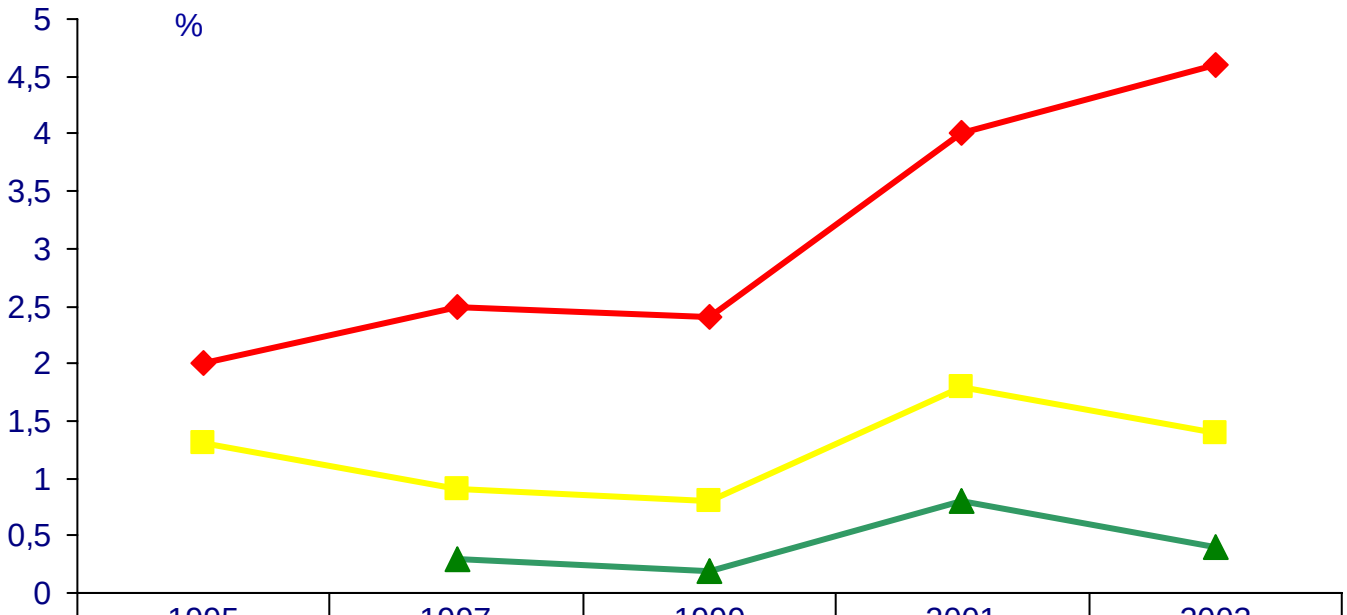
Figure 2.5. Prevalence of cocaine use in the population between the ages of 15 and 64. Spain, 1995-2003.



	1995	1997	1999	2001	2003
Once in lifetime	3,4	3,4	3,1	4,8	5,9
Last 12 months	1,8	1,6	1,6	2,5	2,7
Last 30 days		0,9	0,9	1,3	1,1

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1995, 1997,1999, 2001, 2003.

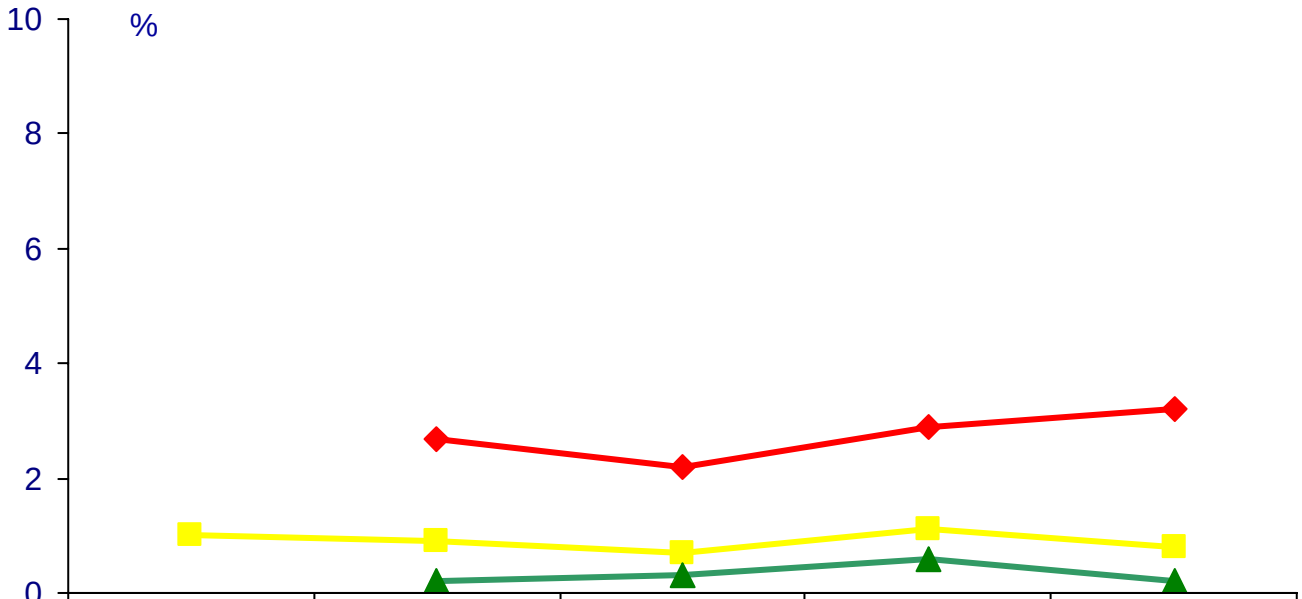
Figure 2.6. Prevalence of ecstasy use in the population between the ages of 15 and 64. Spain, 1995-2003.



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

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1995, 1997,1999, 2001, 2003.

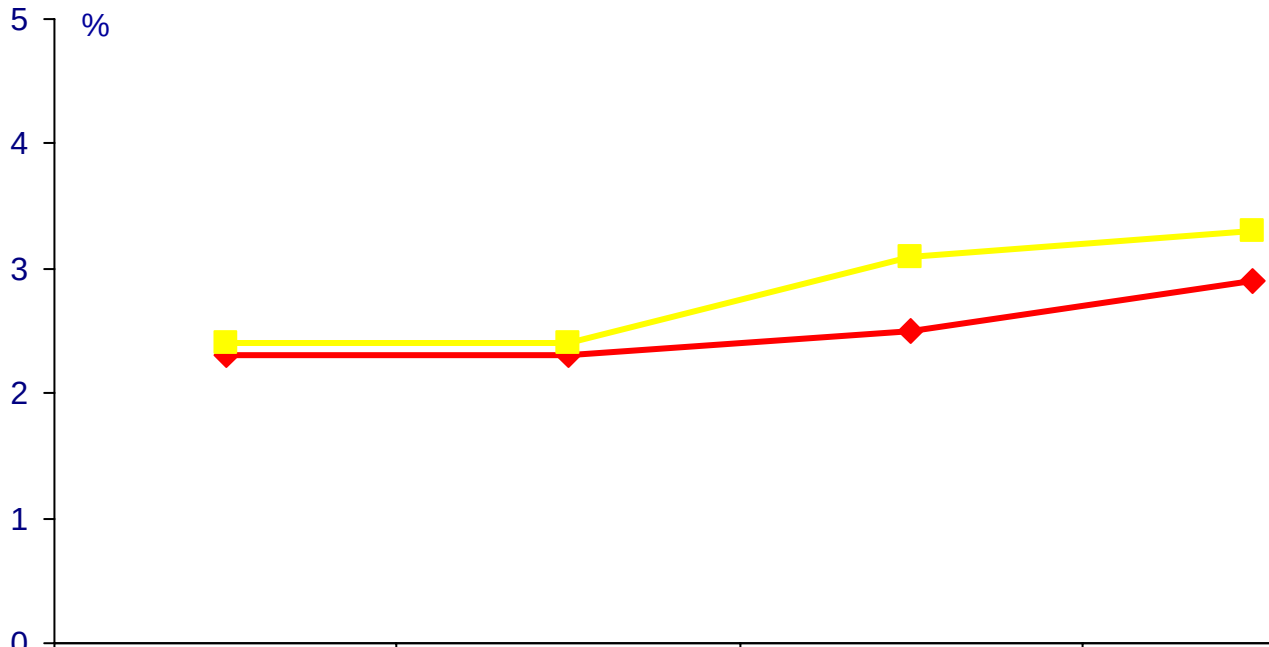
Figure 2.7. Prevalence of amphetamine use in the population between the ages of 15 and 64. Spain, 1995-2003.



		1995	1997	1999	2001	2003
Once in lifetime	Last 12 months		2,7	2,2	2,9	3,2
Últimos 12 meses	1		0,9	0,7	1,1	0,8
Last 30 days			0,2	0,3	0,6	0,2

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1995, 1997,1999, 2001, 2003.

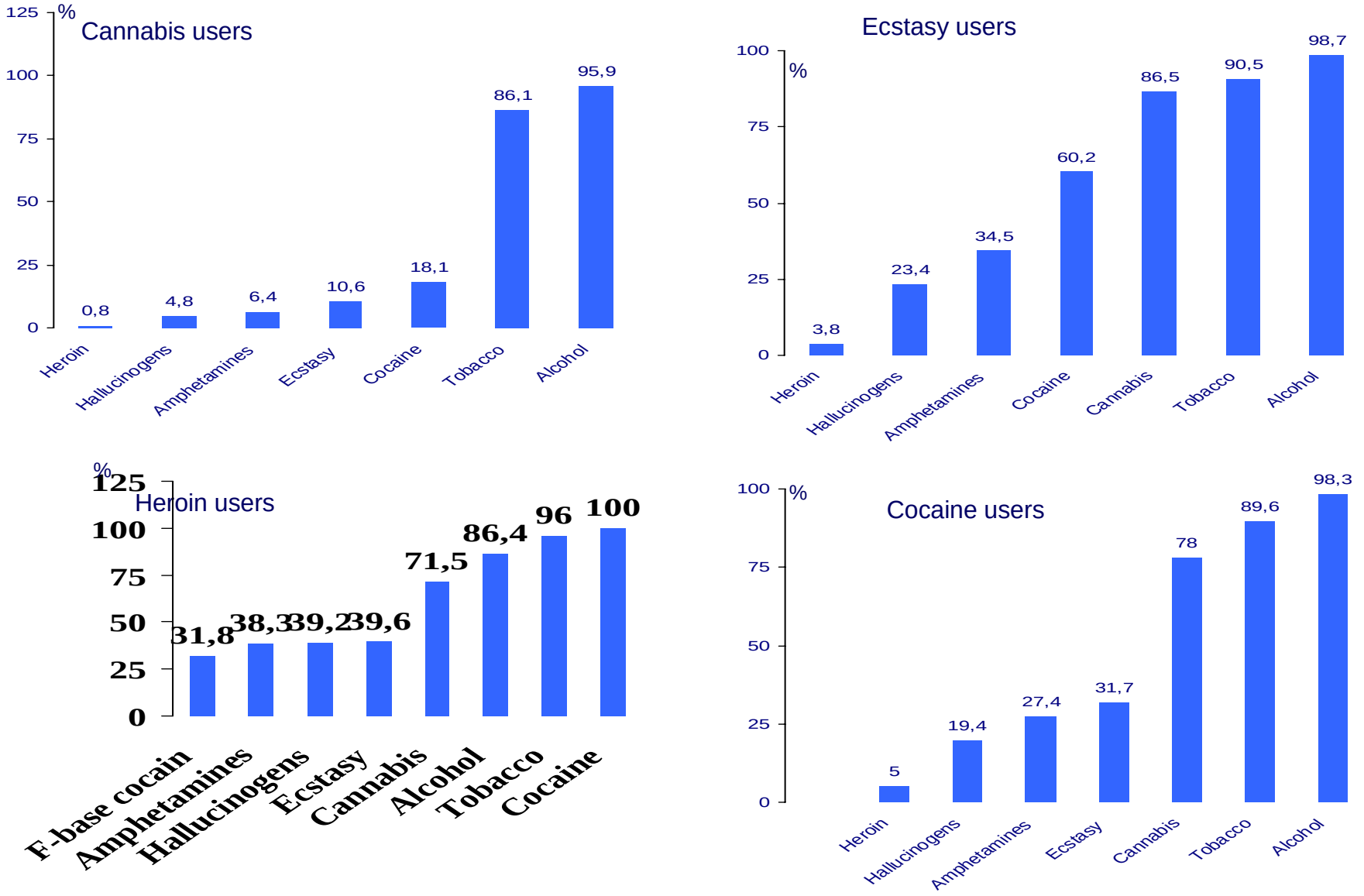
Figure 2.8. Prevalence of OTC sedative-hypnotic drug (tranquilizers and/or sleeping pills) use in the population between the ages of 15 and 64, by sex (per cent). Spain, 1997-2003.



	1997	1999	2001	2003
Men	2,3	2,3	2,5	2,9
Women	2,4	2,4	3,1	3,3

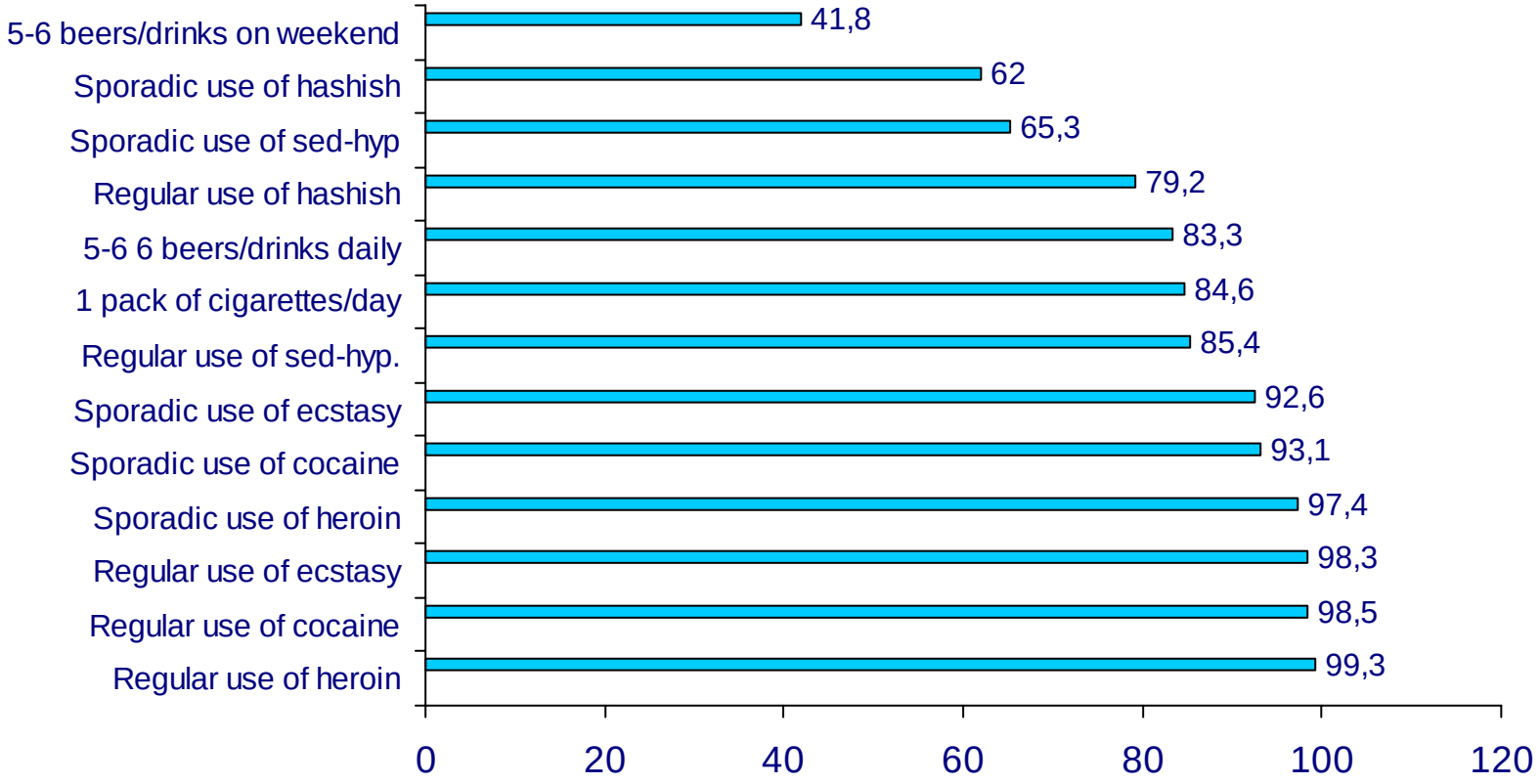
SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1997,1999, 2001, 2003.

Figure 2.9. Proportion of drug users consuming other drugs in last 12 months in the population between the ages of 15 and 64 (per cent). Spain, 2003.



SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 2003.

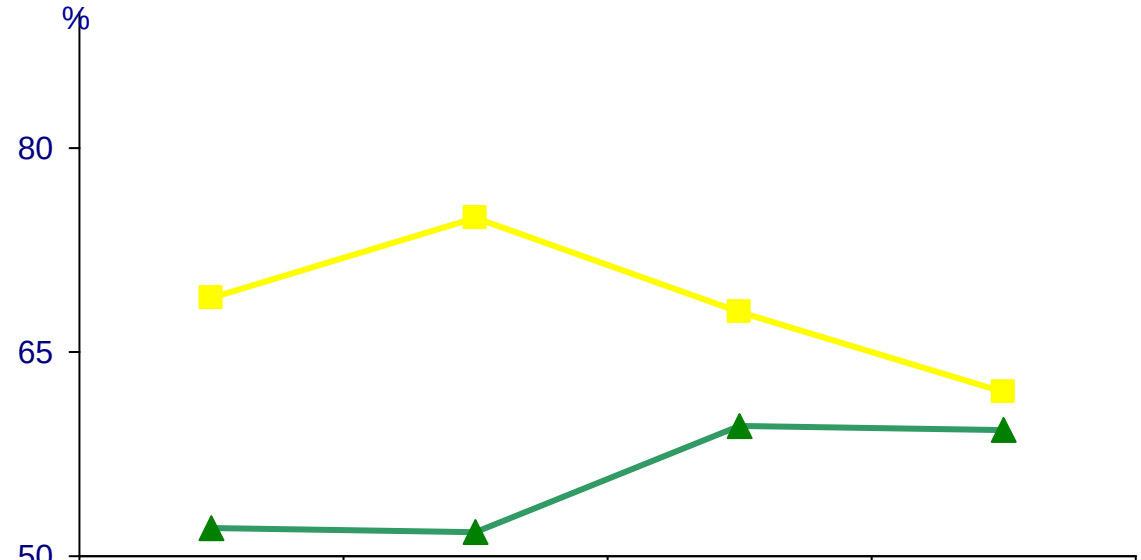
Figure 2.10. Spaniards between the ages of 15 and 64 who believe that the drug use behaviour described may occasion a fair or even a large number of problems (%). Spain 2003.



Sporadic use: once a month or less

Regular use: once a week or more

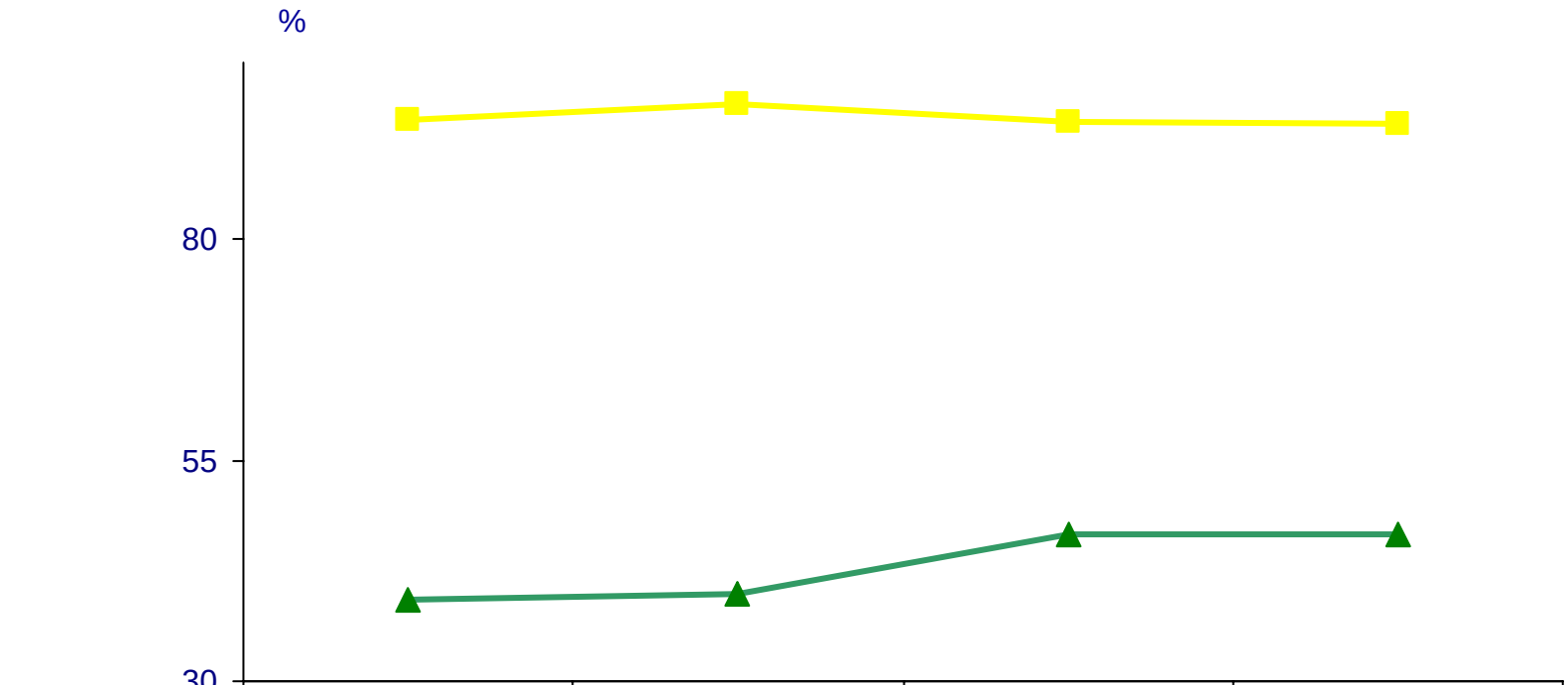
Figure 2.11. Prevalence of cannabis use, perceived risk of the sporadic use of this drug and perceived availability. Spain (%), 1997-2003.



	1997	1999	2001	2003
Perceived risk of sporadic use	68,9	74,8	67,9	62
Perceived availability (% believing it readily or very readily obtained)	52,1	51,8	59,5	59,2

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1997,1999, 2001, 2003.

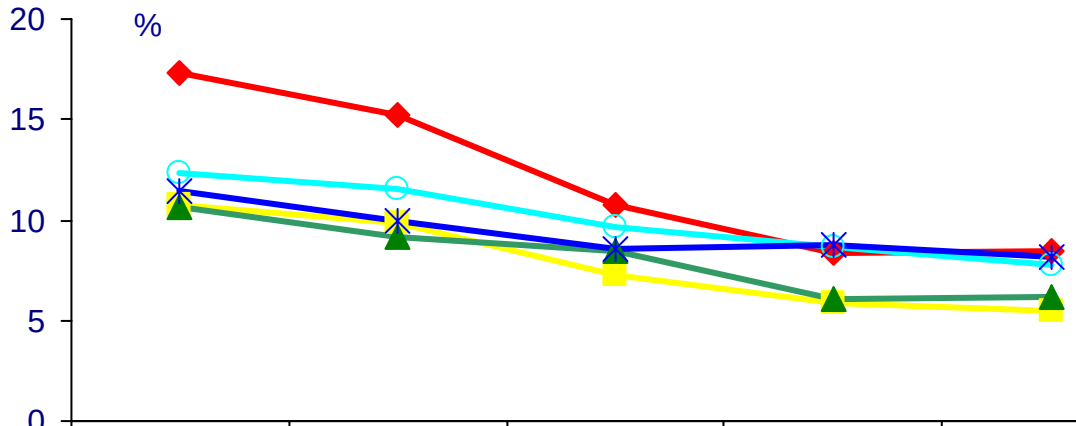
Figure 2.12. Prevalence of cocaine use (last 12 months), perceived risk (used once a month or less) and perceived availability (easy/very easy). Spain (%), 1997-2003.



	1997	1999	2001	2003
Risk	93,5	95,4	93,3	93,1
Availability	39,2	39,9	46,7	46,5

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1997,1999, 2001, 2003.

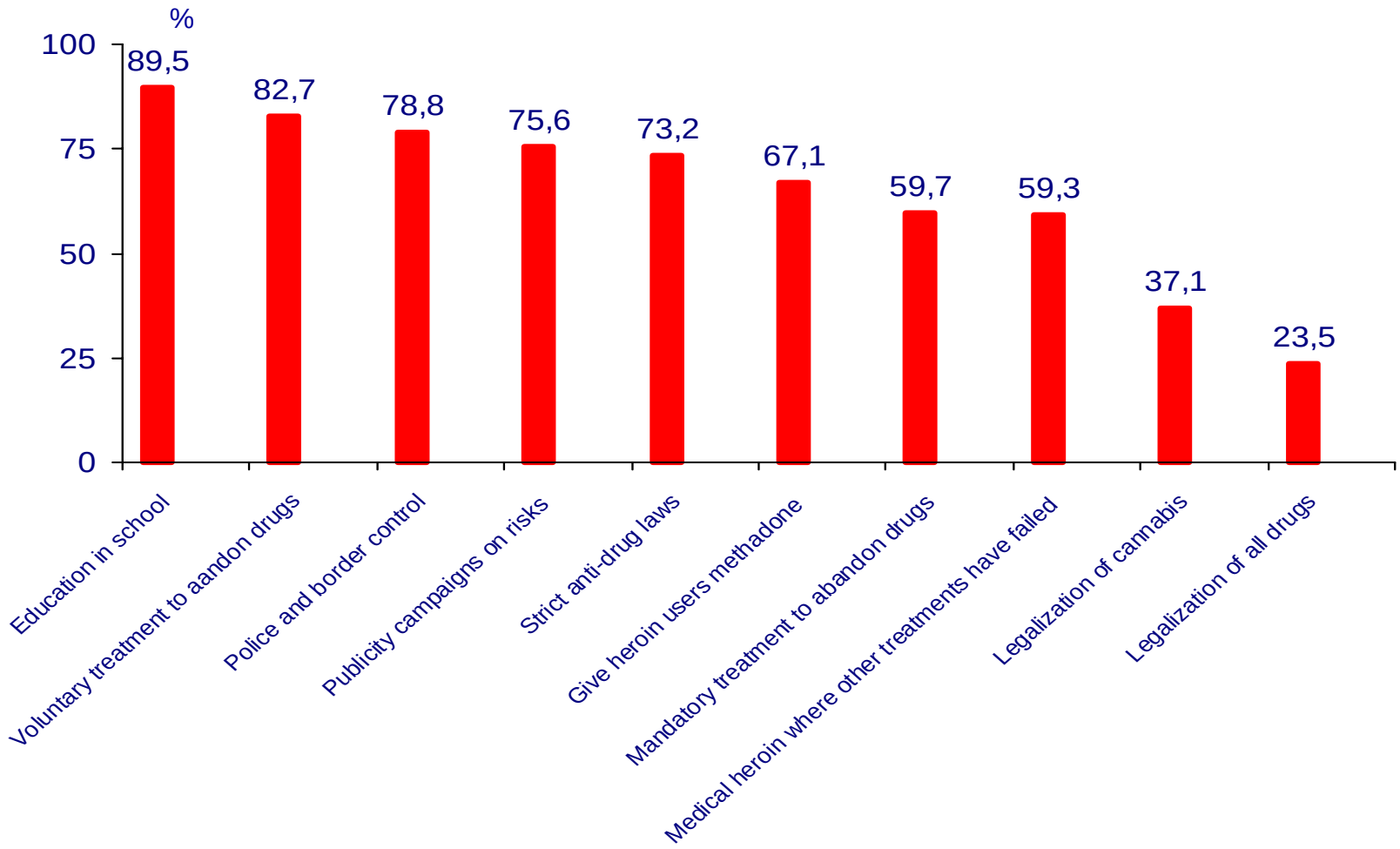
Figure 2.13. Visibility of illegal drugs in the immediate surroundings (percentage of population between the ages of 15 and 64 frequently or very frequently finding the situations described in neighbourhood or town where they live). Spain, 1997-2003.



	1995	1997	1999	2001	2003
Used syringes on ground	17,3	15,2	10,7	8,4	8,5
People injecting drugs	10,7	9,9	7,3	5,9	5,5
People sniffing drugs off aluminium foil	10,6	9,2	8,5	6,1	6,2
People passed outunder the influence	12,3	11,5	9,7	8,7	7,8
Dealers offering drugs	11,4	10	8,6	8,8	8,2

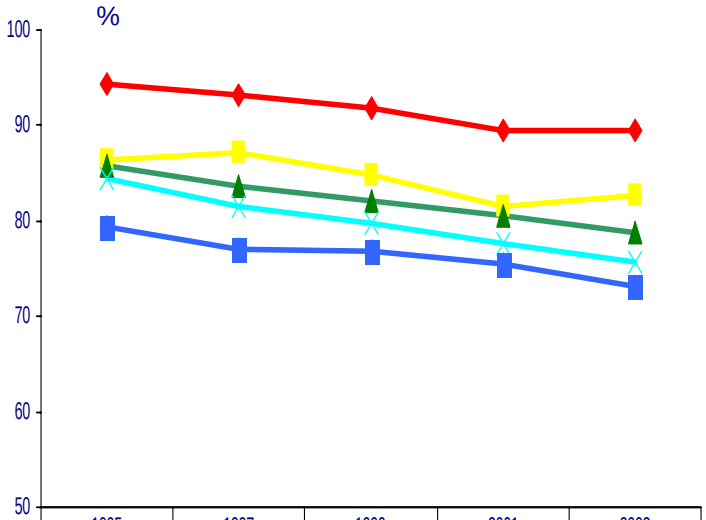
SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1997,1999, 2001, 2003.

Figure 2.14. Assessment by population between the ages of 15 and 64 of possible measures to attempt to solve the drug problem (per cent). Spain, 2003.

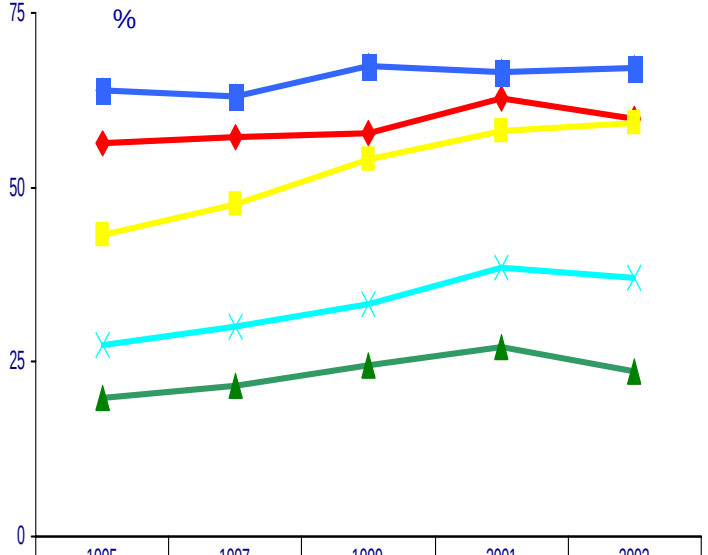


SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 2003.

Figure 2.15. Assessment by population between the ages of 15 and 64 of possible measures to attempt to solve the drug problem (per cent). Spain, 1995-2003.



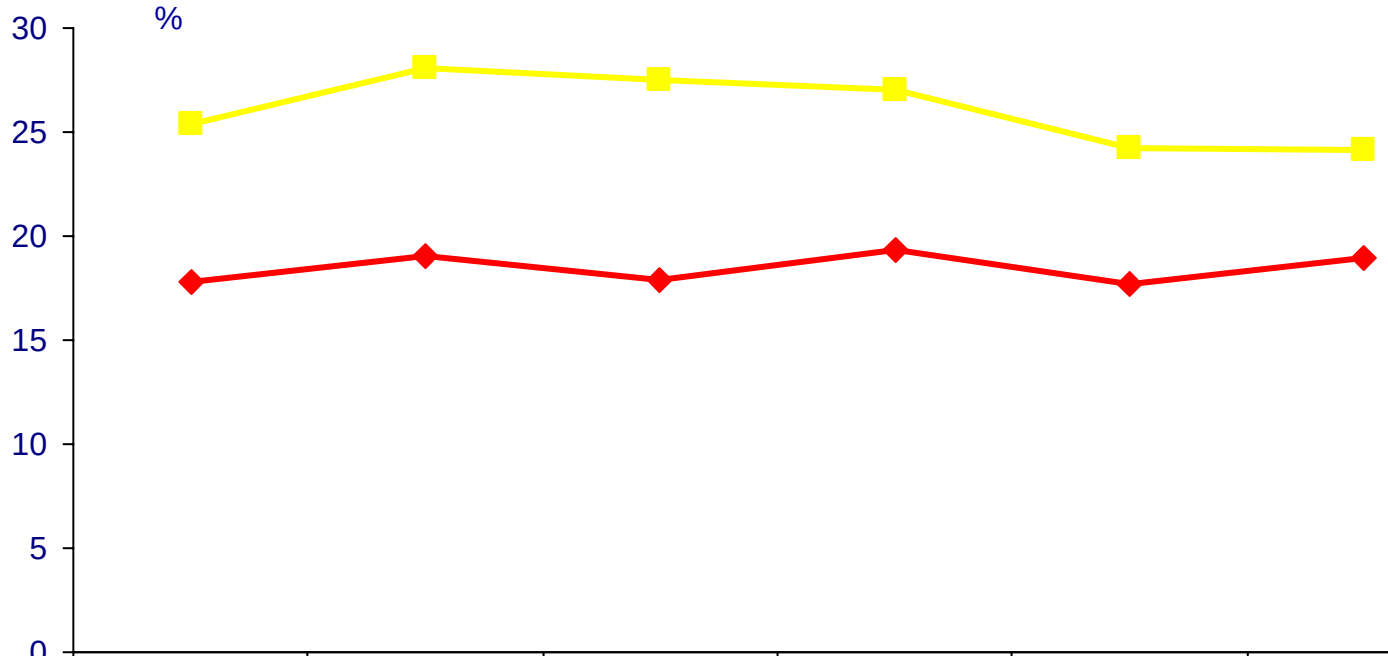
	1995	1997	1999	2001	2003
Education in school	94,3	93,1	91,8	89,4	89,5
Voluntary treatment	86,3	87,1	84,8	81,6	82,7
Police and border control	85,8	83,7	82,1	80,5	78,8
Publicity campaigns	84,5	81,5	79,8	77,6	75,6
Strict laws	79,3	77	76,9	75,5	73,2



	1995	1997	1999	2001	2003
Mandatory treatment	56,2	57,2	57,9	62,8	59,7
Heroin treatment	43,3	47,5	53,9	58,2	59,3
Legalization of drugs	19,8	21,5	24,6	27,1	23,5
Legalization of cannabis	27,3	30,2	33,3	38,5	37,1
Methadone treatment	63,8	62,9	67,5	66,6	67,1

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Household survey 1995, 1997,1999, 2001, 2003.

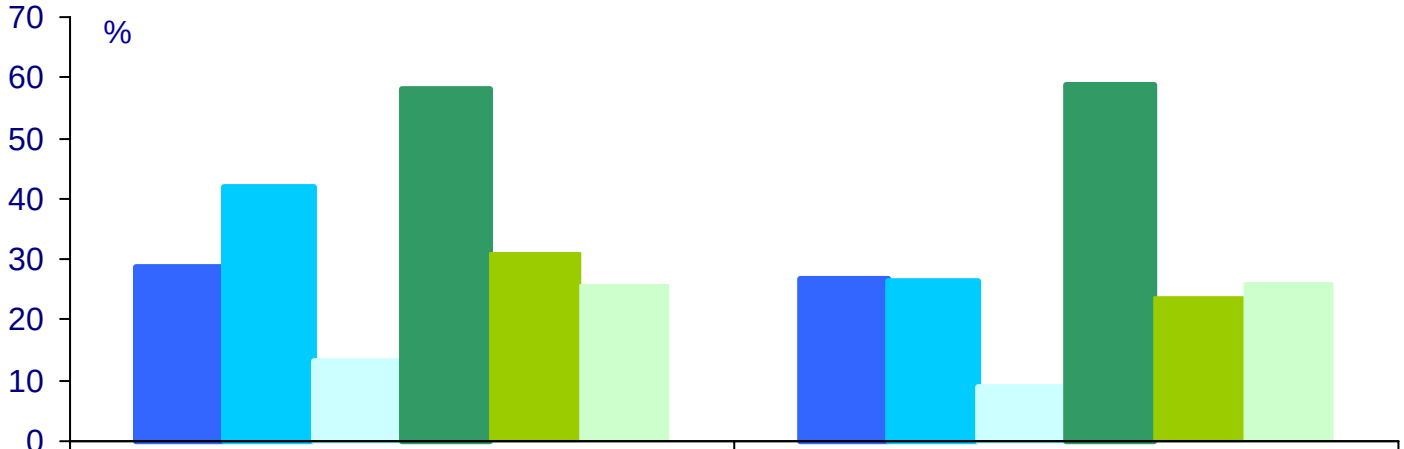
Figure 2.16. Prevalence of smoking among secondary school students between the ages of 14 and 18, by sex. Spain (%), 1994-2004.



	1994	1996	1998	2000	2002	2004
Boys	17,8	19	17,9	19,3	17,7	18,9
Girls	25,4	28,1	27,5	27	24,2	24,1

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

Figure 2.17. Prevalence of consumption of different types of alcoholic beverages on weekends* among secondary school students between the ages of 14 and 18, by sex (per cent). Spain, 2004.

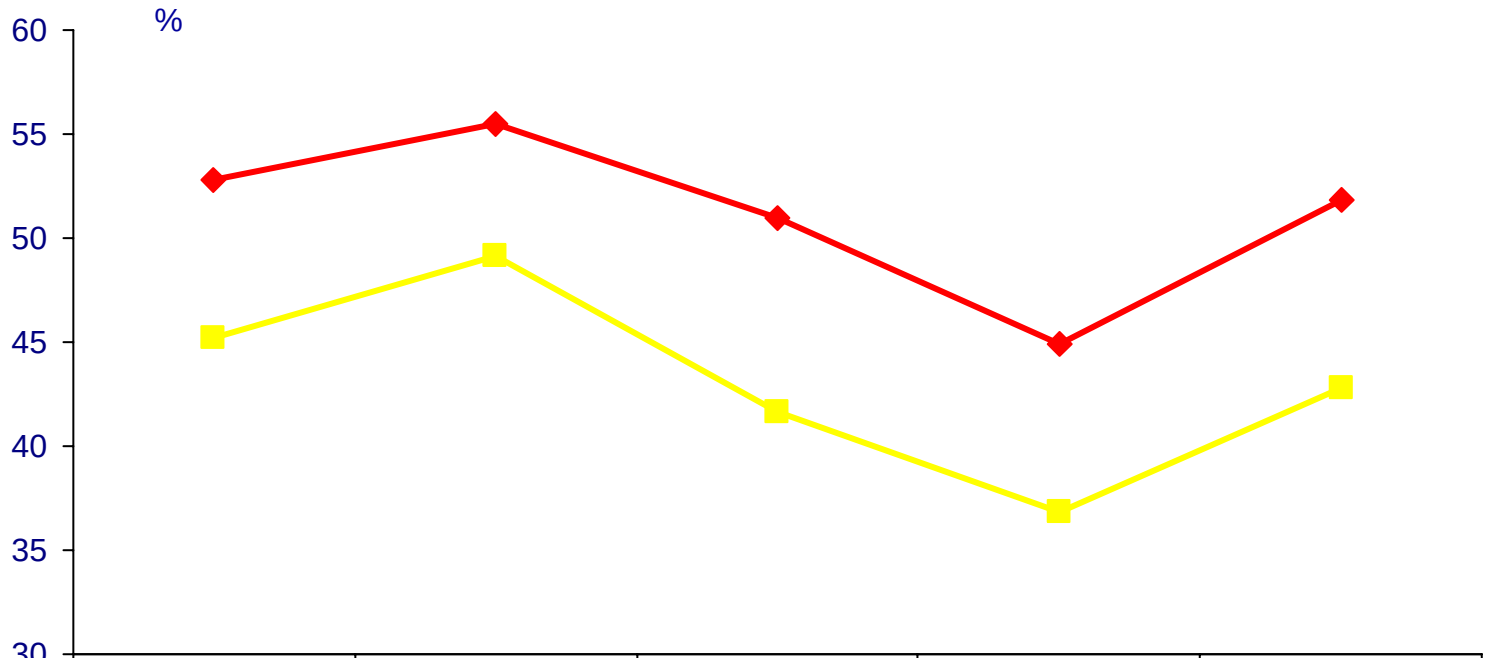


	Boys	Girls
Wine	28,8	26,6
Beer	41,9	26,5
Appetizers	13,2	8,8
Mixed drinks	58	58,7
Hard liquor	31,2	23,7
Fruit-b liqueur	25,8	26,2

(*) Any Friday, Saturday or Sunday in the last 30 days..

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

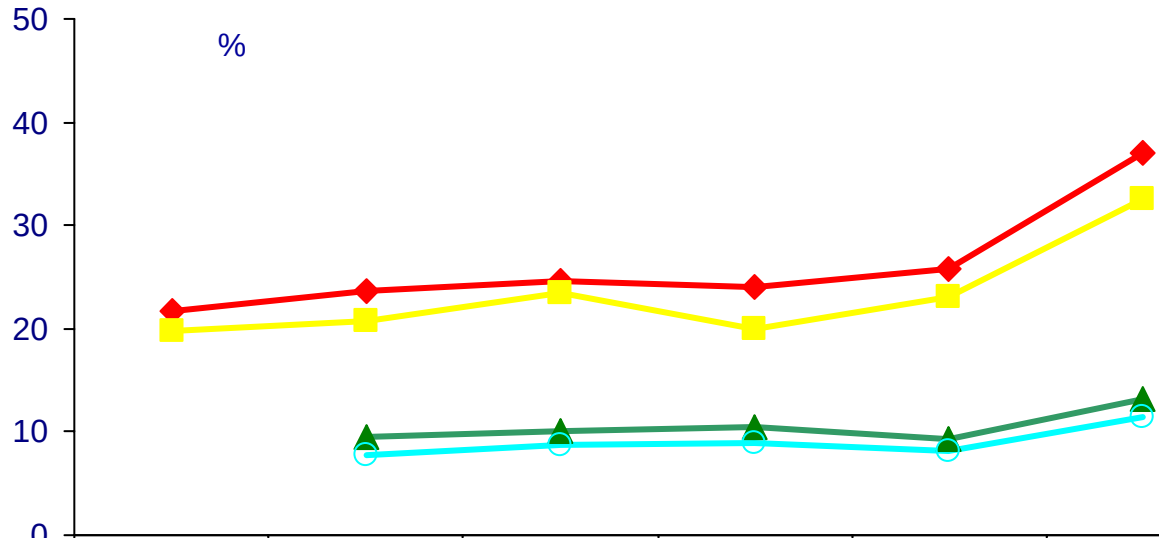
Figure 2.18. Percentage of secondary school students between the ages of 14 and 18 who drink more than 8 days a month, by sex. Spain (%), 1996-2004.



	1996	1998	2000	2002	2004
Boys	52,8	55,5	51	44,9	51,8
Girls	45,2	49,1	41,6	36,8	42,8

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

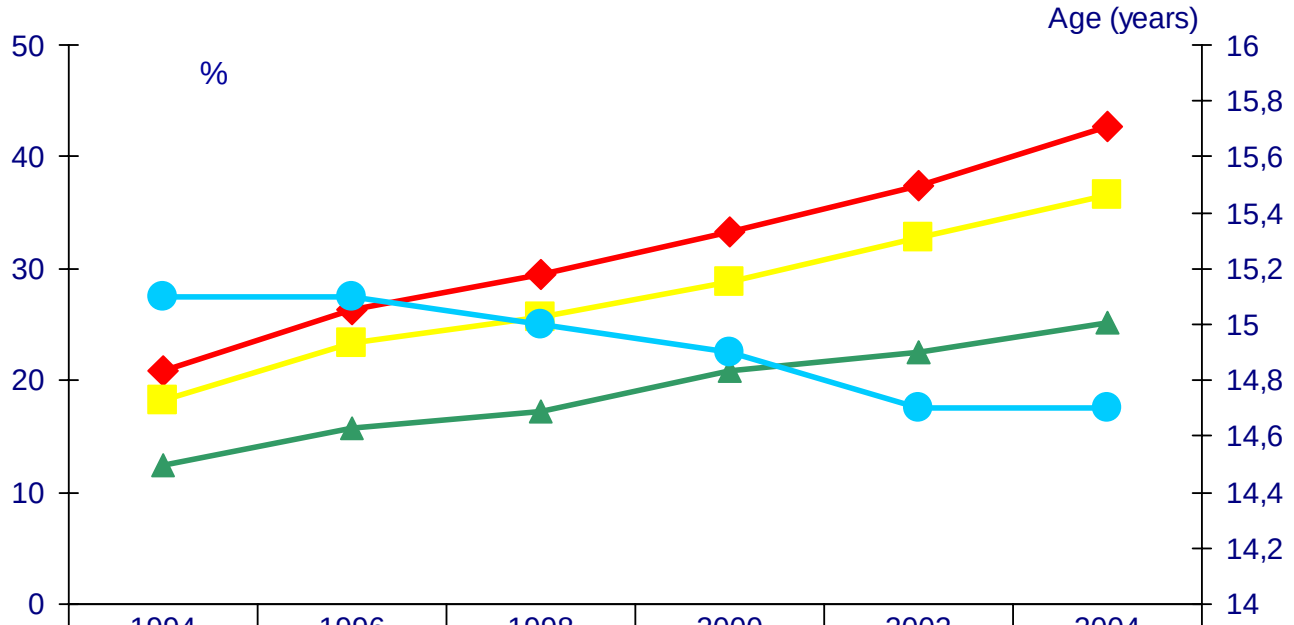
Figure 2.19. Prevalence of drunkenness and drinkers at risk in the last 30 days in secondary school students between the ages of 14 and 18, by sex (%). Spain, 1994-2004.



	1994	1996	1998	2000	2002	2004
Drunkenness (boys)	21,7	23,7	24,7	24	25,8	37
Drunkenness (girls)	19,8	20,7	23,4	19,9	23,1	32,5
Drinkers at risk (bosy)		9,5	10	10,5	9,3	13,1
Drinkers at risk (girls)		7,8	8,8	9	8,2	11,5

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

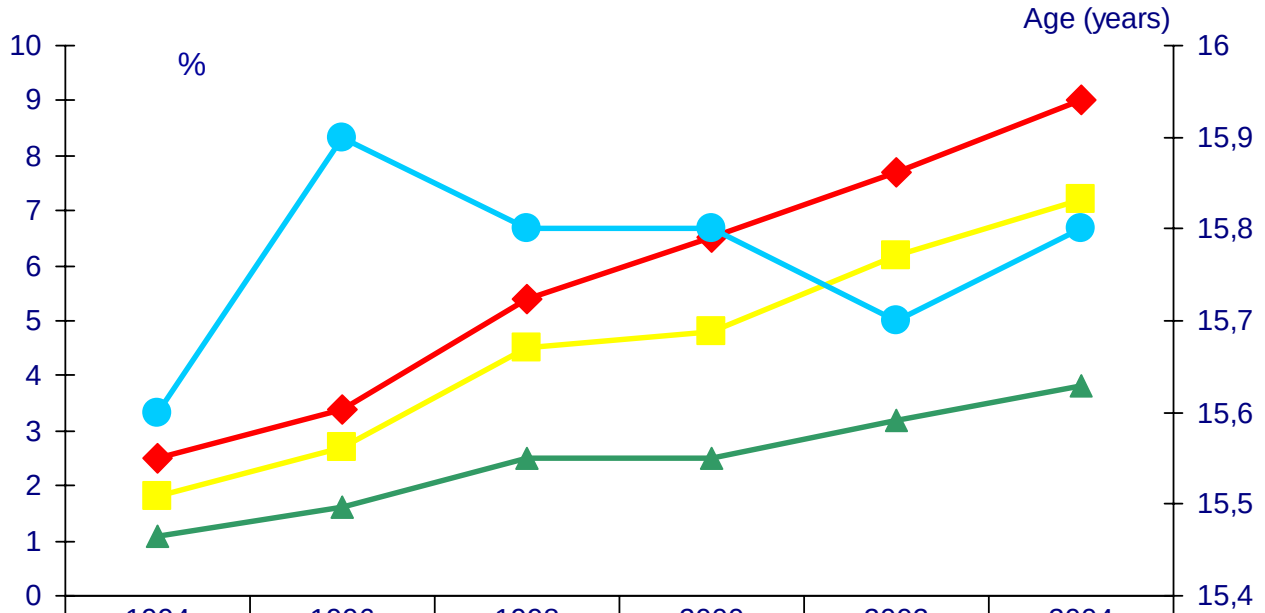
Figure.2.20. Prevalence of cannabis use and age of initiation in secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.



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

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

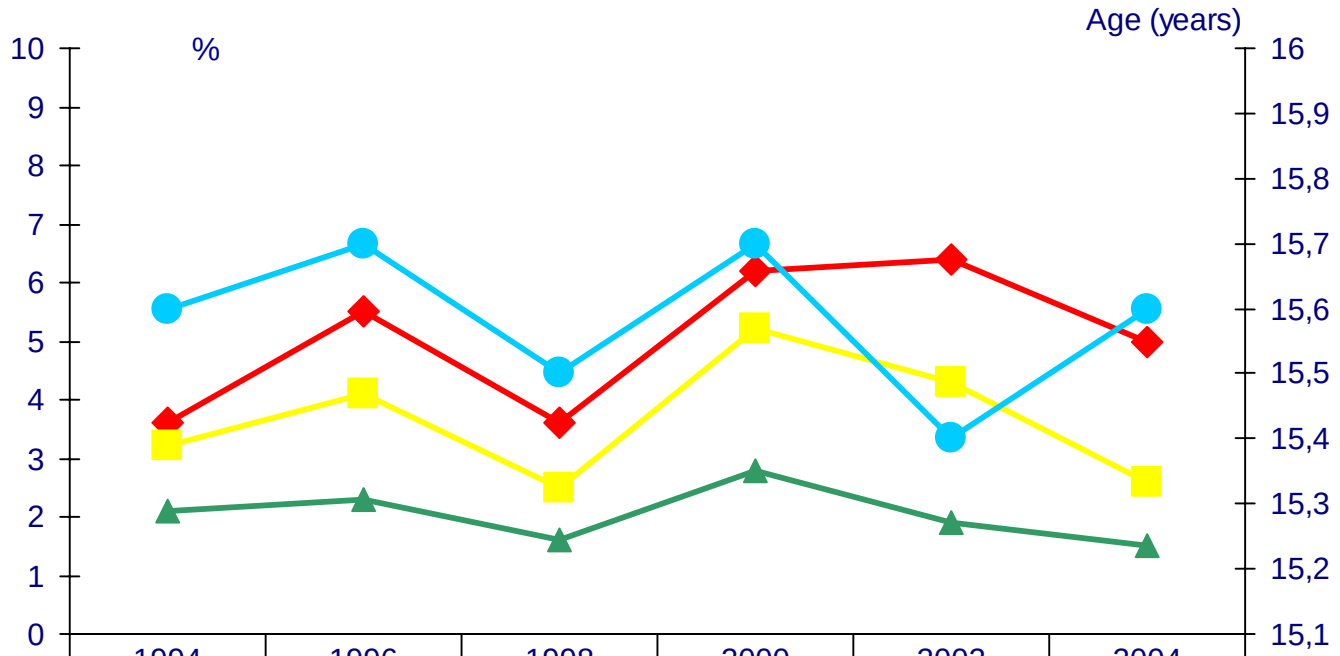
Figure 2.21. Prevalence of cocaine use and age of initiation in secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.



	1994	1996	1998	2000	2002	2004
Once in lifetime	2,5	3,4	5,4	6,5	7,7	9
Last 12 months	1,8	2,7	4,5	4,8	6,2	7,2
Last 30 days	1,1	1,6	2,5	2,5	3,2	3,8
Age of initiation	15,6	15,9	15,8	15,8	15,7	15,8

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

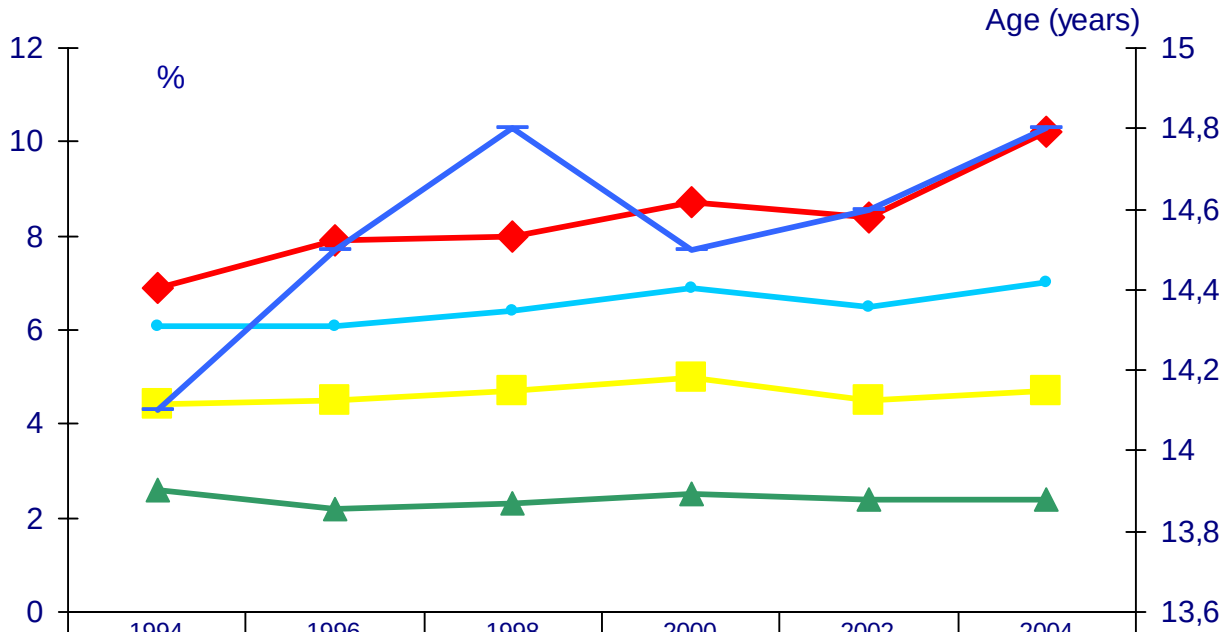
Figure 2.22. Prevalence of ecstasy use and age of initiation in secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.



	1994	1996	1998	2000	2002	2004
Once in lifetime	3,6	5,5	3,6	6,2	6,4	5
Last 12 months	3,2	4,1	2,5	5,2	4,3	2,6
Last 30 days	2,1	2,3	1,6	2,8	1,9	1,5
Age of initiation	15,6	15,7	15,5	15,7	15,4	15,6

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

Figure 2.23. Prevalence of sedative-hypnotic drug use and age of initiation in secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.

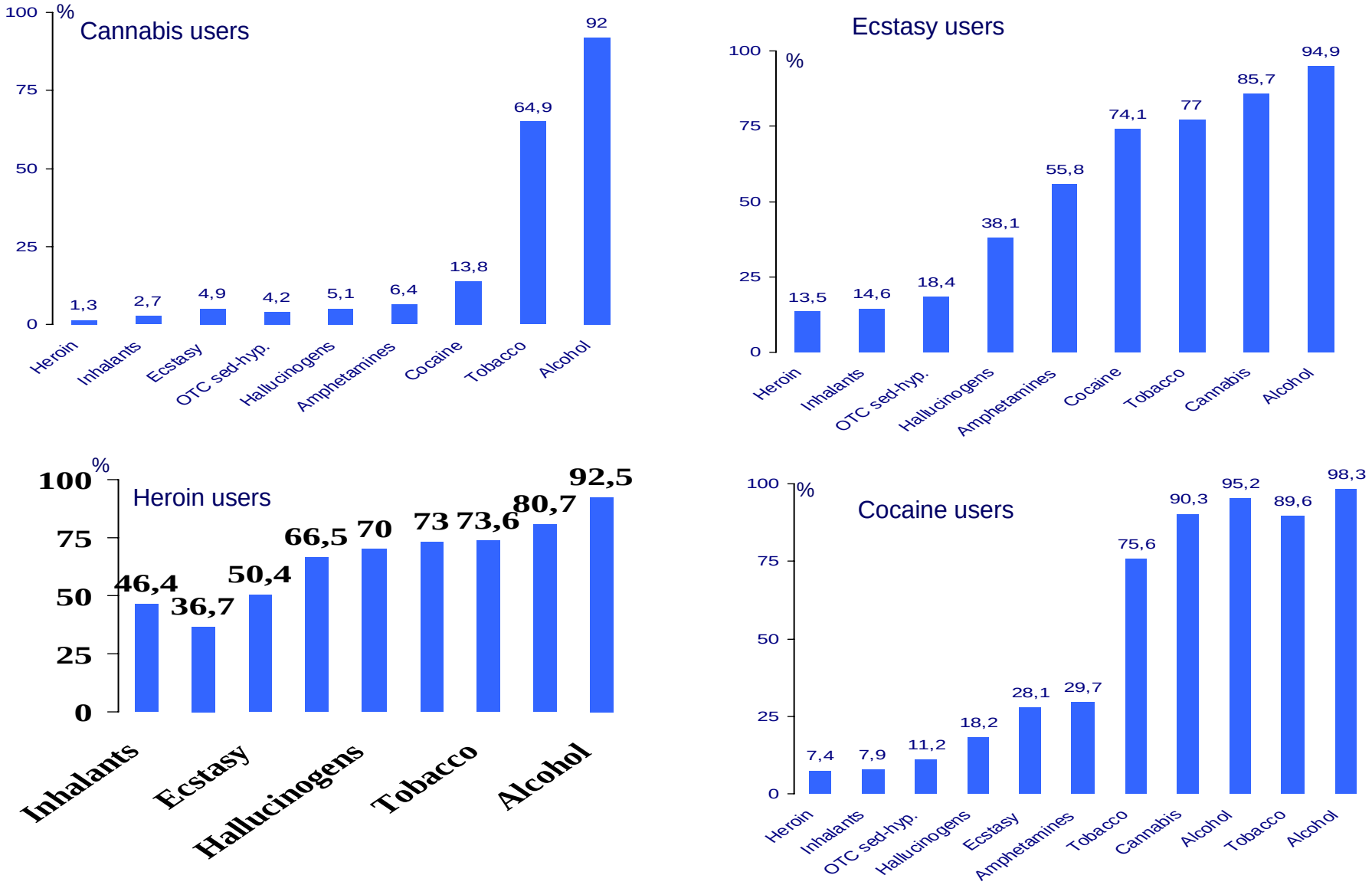


	1994	1996	1998	2000	2002	2004
With prescr. once in lifetime	6,9	7,9	8	8,7	8,4	10,2
OTC last 12 m onths	4,4	4,5	4,7	5	4,5	4,7
OTC last 30 days	2,6	2,2	2,3	2,5	2,4	2,4
OTC once in lifetime	6,1	6,1	6,4	6,9	6,5	7
Age of initation into OTC use	14,1	14,5	14,8	14,5	14,6	14,8

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

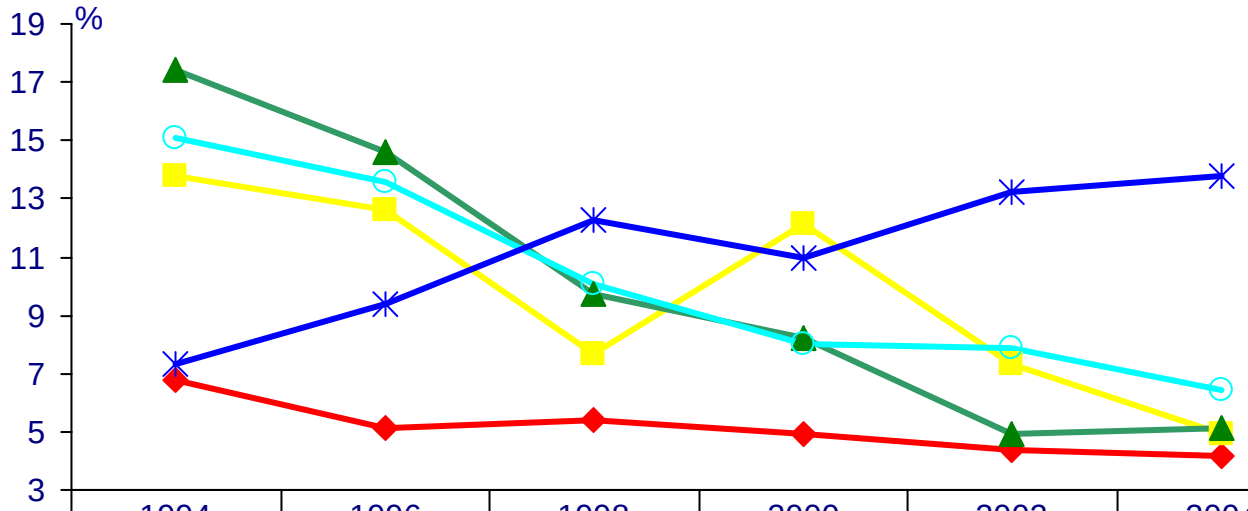
(*) Tranquilizantes y pastillas para dormir.

Figure 2.24. Drug-using secondary school students between the ages of 14 and 18 using other drugs in the last 30 days (per cent). Spain, 2004.



SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

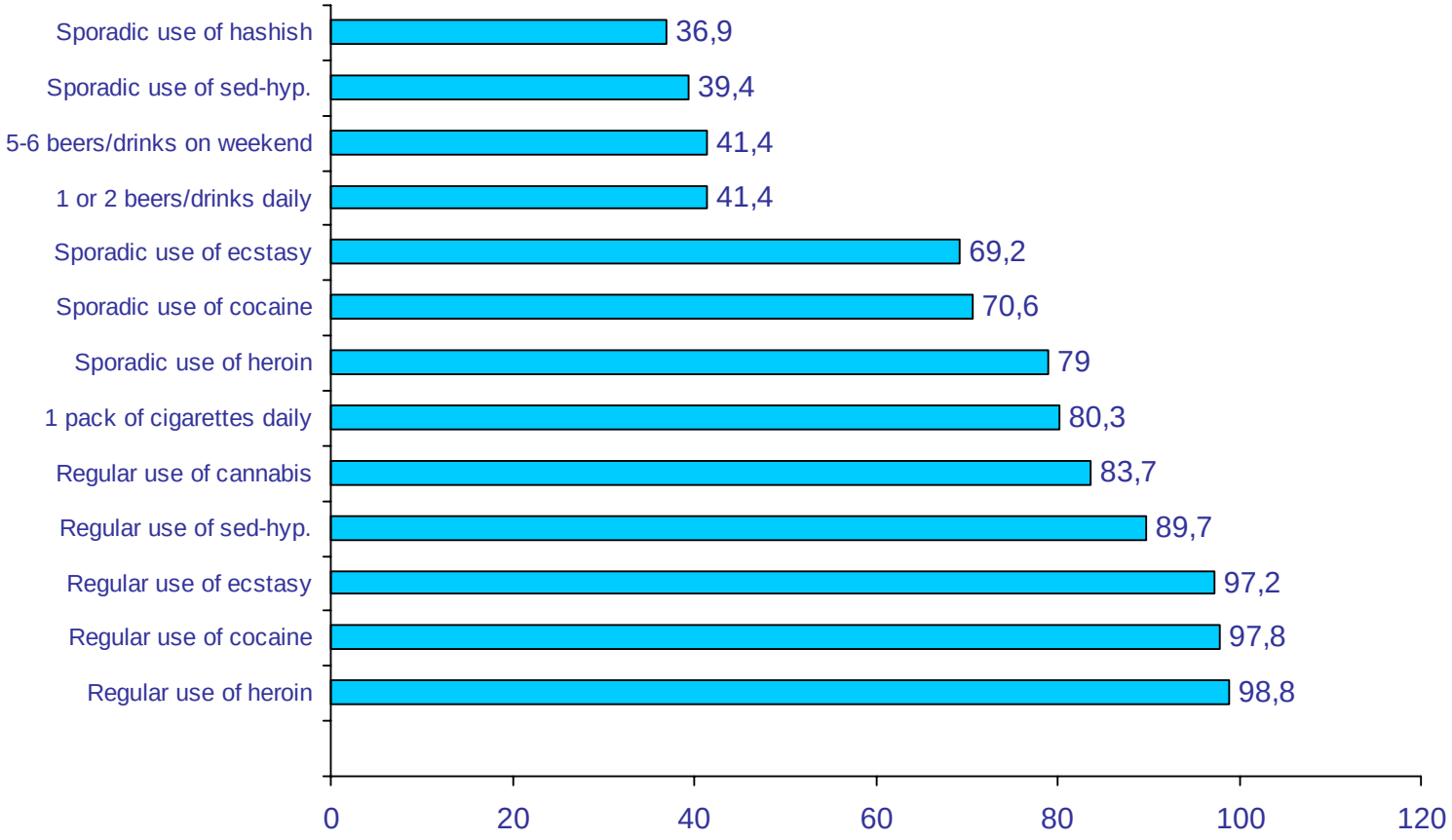
Figure 2.25. Prevalence of the use of different drugs in the last 30 days by secondary school students between the ages of 14 and 18 who smoked cannabis in the same period. Spain, 1994-2004.



	1994	1996	1998	2000	2002	2004
Sed-hyp. Drugs	6,8	5,1	5,4	4,9	4,4	4,2
Ecstasy	13,8	12,6	7,7	12,1	7,3	4,9
Hallucinogens	17,4	14,6	9,7	8,2	4,9	5,1
Amphetamines	15,1	13,6	10,1	8	7,9	6,4
Cocaine	7,3	9,4	12,3	11	13,2	13,8

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

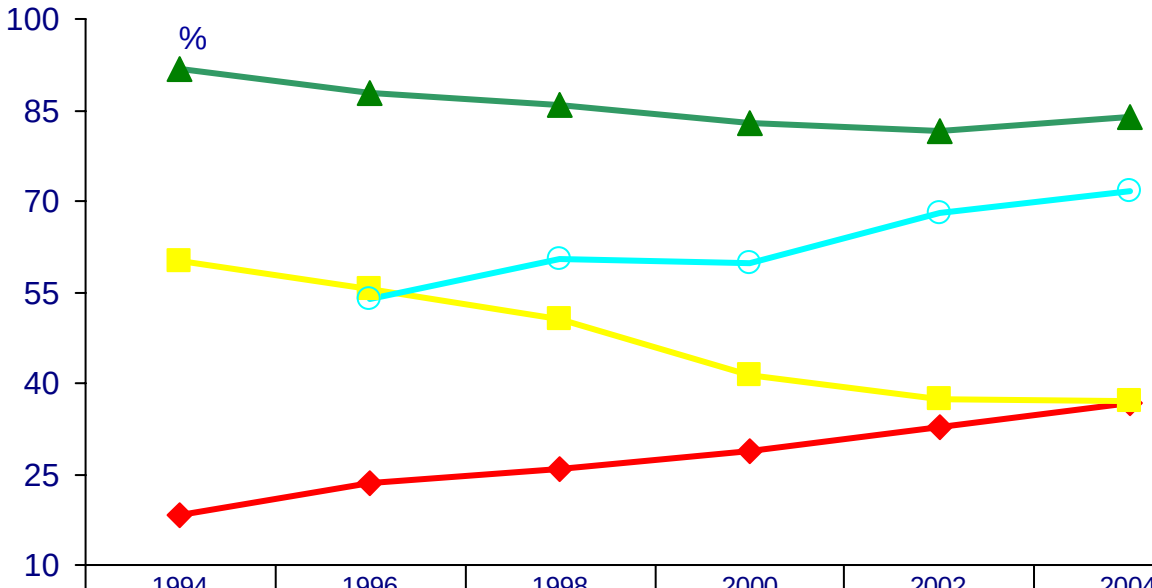
Figure 2.26. Secondary school students between the ages of 14 and 18 who believe that the drug use behaviour described may occasion a fair or even a large number of problems (%). Spain 2003.



Sporadic use: once a month or less Regular use: once a week or more

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004

Figure 2.27. Prevalence of cannabis use in the last 12 months, perceived risk of cannabis use and perceived availability of cannabis among secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.



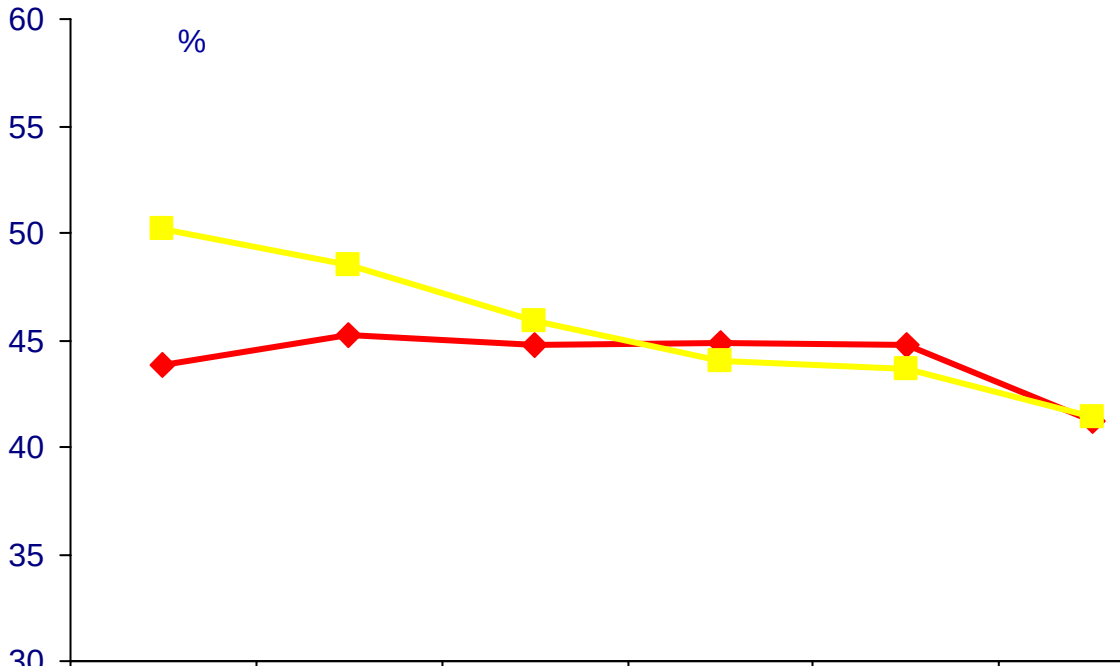
	1994	1996	1998	2000	2002	2004
Prevalence of use	18,2	23,4	25,7	28,8	32,8	36,6
Perceived risk of sporadic use	60	55,5	50,5	41,2	37,5	36,9
Perceived risk of regular use	91,9	87,7	85,9	82,8	81,7	83,7
Perceived availability		53,9	60,4	59,7	67,9	71,8

Perceived risk: Percentage of respondents who believe the sporadic or regular use of cannabis can cause a fair or even a large number of problems.

Perceived availability: Percentage of respondents who believe that cannabis can be readily or very readily obtained

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

Figure 2.28. Perceived risk of daily and weekend drinking among secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.

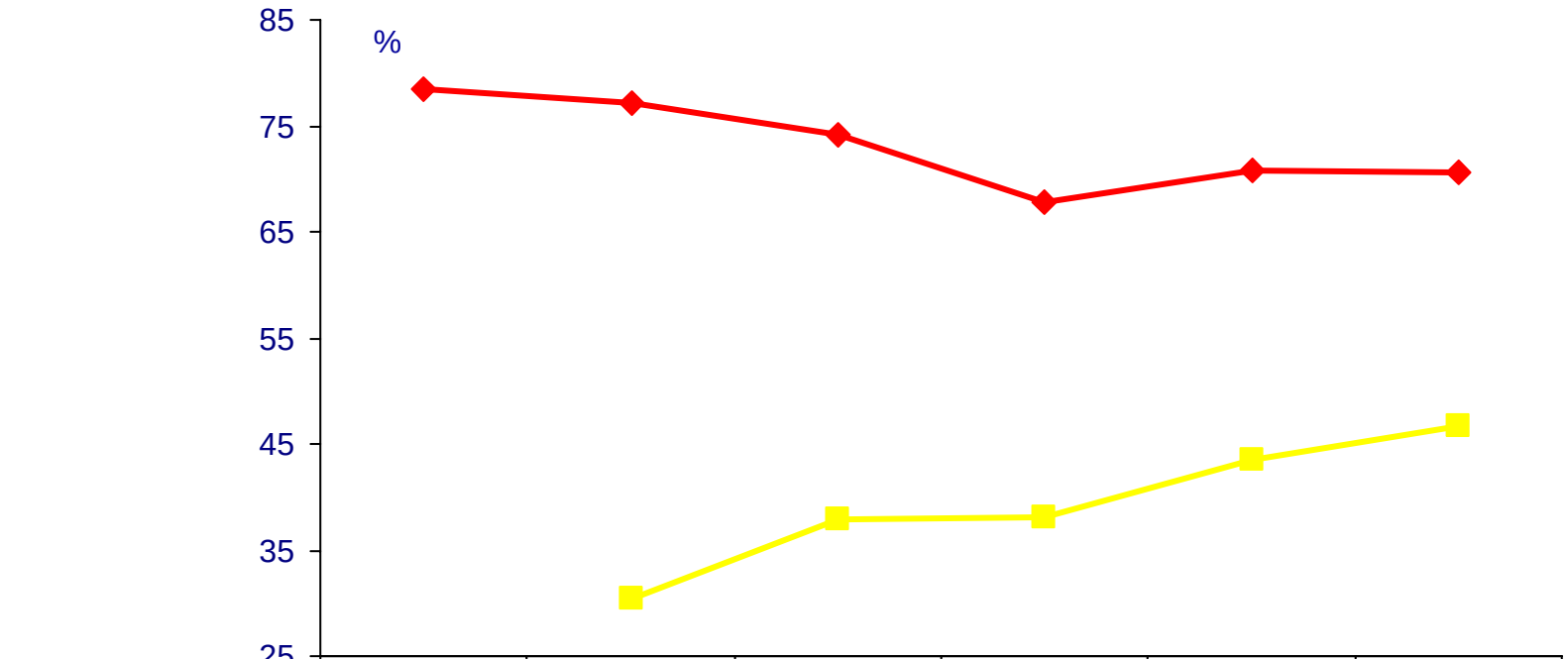


	1994	1996	1998	2000	2002	2004
5 or 6 beers/drinks on weekends	43,8	45,2	44,8	44,9	44,8	41,2
1 or 2 beers/drinks daily	50,2	48,5	45,9	44	43,6	41,4

Perceived risk: Percentage of respondents who believe drinking 5 or 6 beers/drinks on weekends or 1 or 2 beers/drinks daily can cause a fair or even a large number of problems.

SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

Figure 2.29. Perceived risk of cocaine use and perceived availability of cocaine among secondary school students between the ages of 14 and 18. Spain (%), 1994-2004.

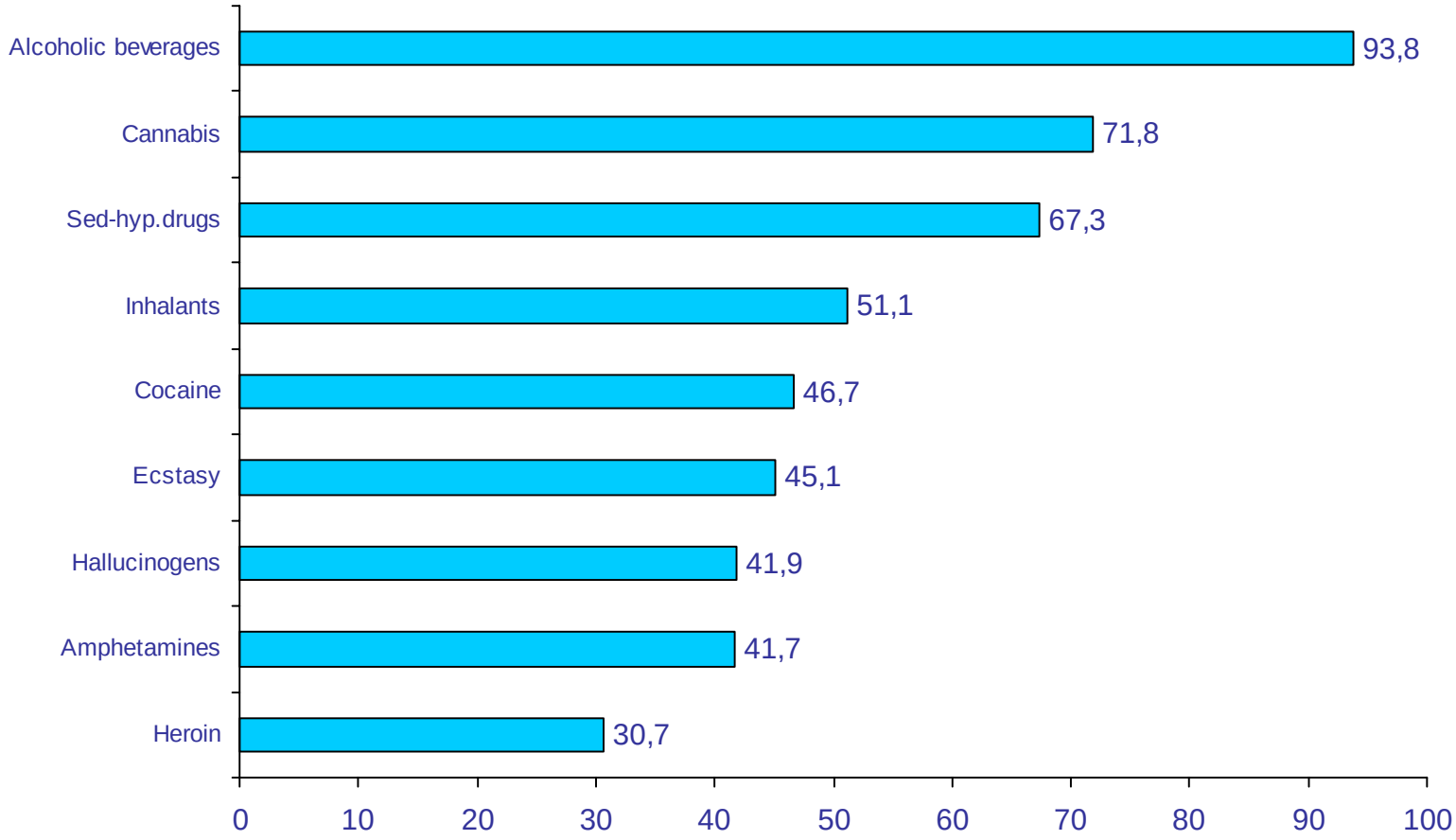


	1994	1996	1998	2000	2002	2004
Perceived risk	78,5	77,2	74,2	67,8	70,8	70,6
Perceived availability		30,4	37,9	38	43,5	46,7

Perceived risk: Percentage of respondents who believe the sporadic or regular use of cocaine can cause a fair or even a large number of problems.
Perceived availability: Percentage of respondents who believe that cocaine can be readily or very readily obtained

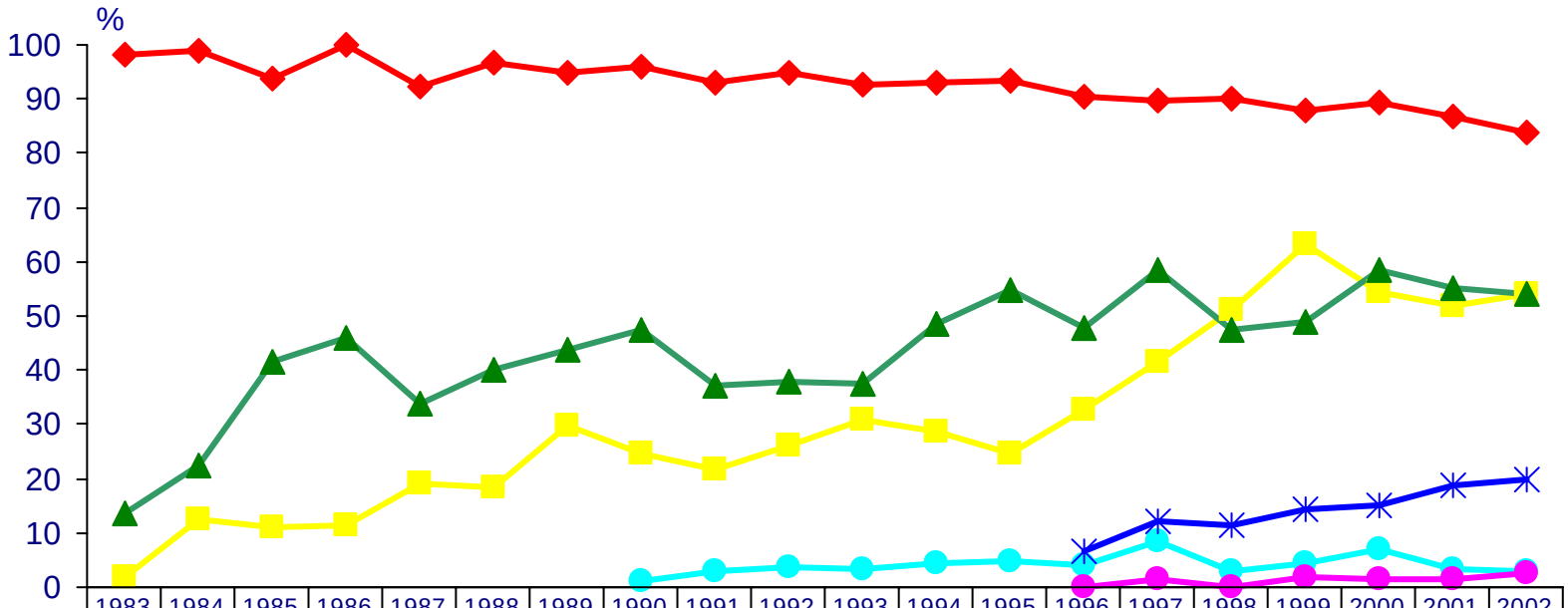
SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

Figure 2.30. Secondary school students between the ages of 14 and 18 who believe that the drugs listed can be readily or very readily obtained (%). Spain 2004.



SOURCE: DGPNSD. Nation-wide survey on use of drugs in secondary school (EESTUDES). 1994-2004.

Figure 6.1. Proportion of psychoactive substance overdose deaths in which toxicological analysis revealed the presence of the respective drugs. Spain* 1983-2001.

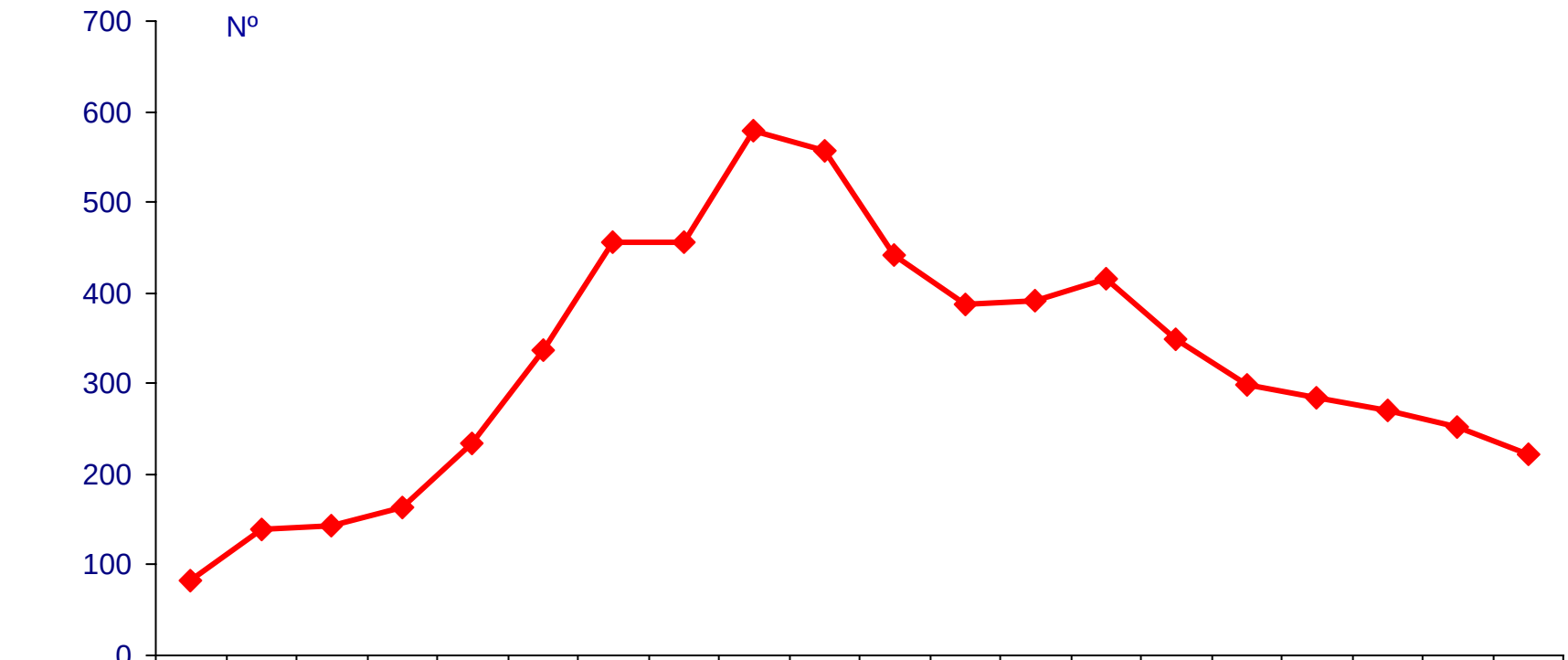


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Heroin	98	98,8	93,9	100	92,4	96,6	94,8	96	93,1	94,9	92,8	92,9	93,4	90,4	89,8	90,1	88	89,4	86,8	83,8
Cocaine	2	12,5	11	11,5	19,3	18,4	29,6	24,8	21,6	26	30,9	28,8	24,7	32,7	41,4	51,2	63,3	54,4	51,7	54,2
Sed-hyp. Drugs	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
Aphetamines								1	2,9	3,8	3,2	4,3	4,9	4	8,6	2,8	4,5	6,9	3,4	2,9
Cannabis														6,5	12,2	11,3	14,3	15,2	18,7	20
MDMA														0,1	1,5	0	1,8	1,6	1,5	2,5

(*) Includes data for all geographic areas monitored by the indicator.

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

Figure 6.2. Opiate or cocaine overdose deaths in six major Spanish cities. 1983-2002.

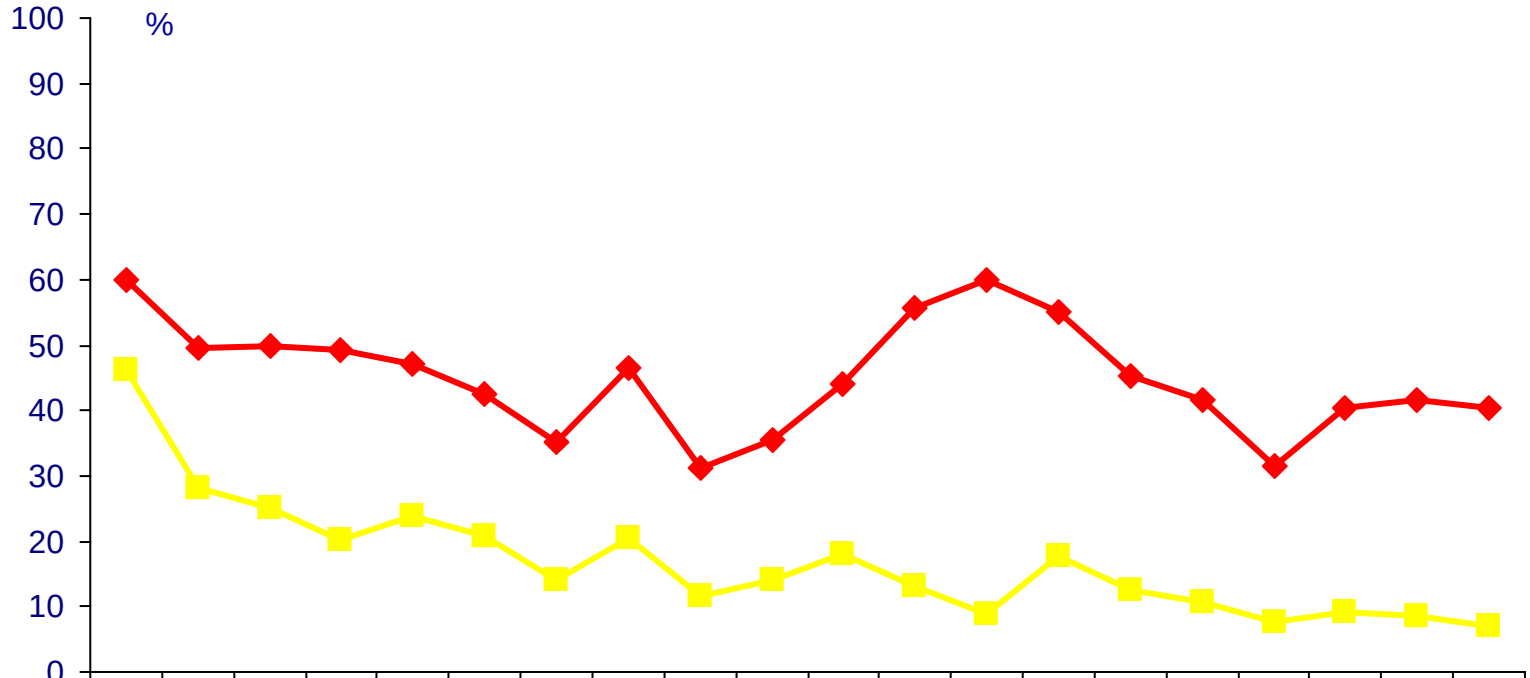


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Six cities	82	139	143	163	234	337	455	455	579	557	442	388	392	415	349	299	285	270	252	221

(*) Deaths occurring in the municipal districts of Barcelona, Bilbao, Madrid, Saragossa, Seville and Valencia. Data for Seville from 1997 to 2000 are estimates.

SOURCE: DGPNSD. Spanish Drug Observatory (OED). Indicador Mortalidad

Figure 6.3. Proportion of psychoactive substance overdose deaths in which toxicological analysis detected only opiates or opiates without cocaine. Spain*. 1983-2002.

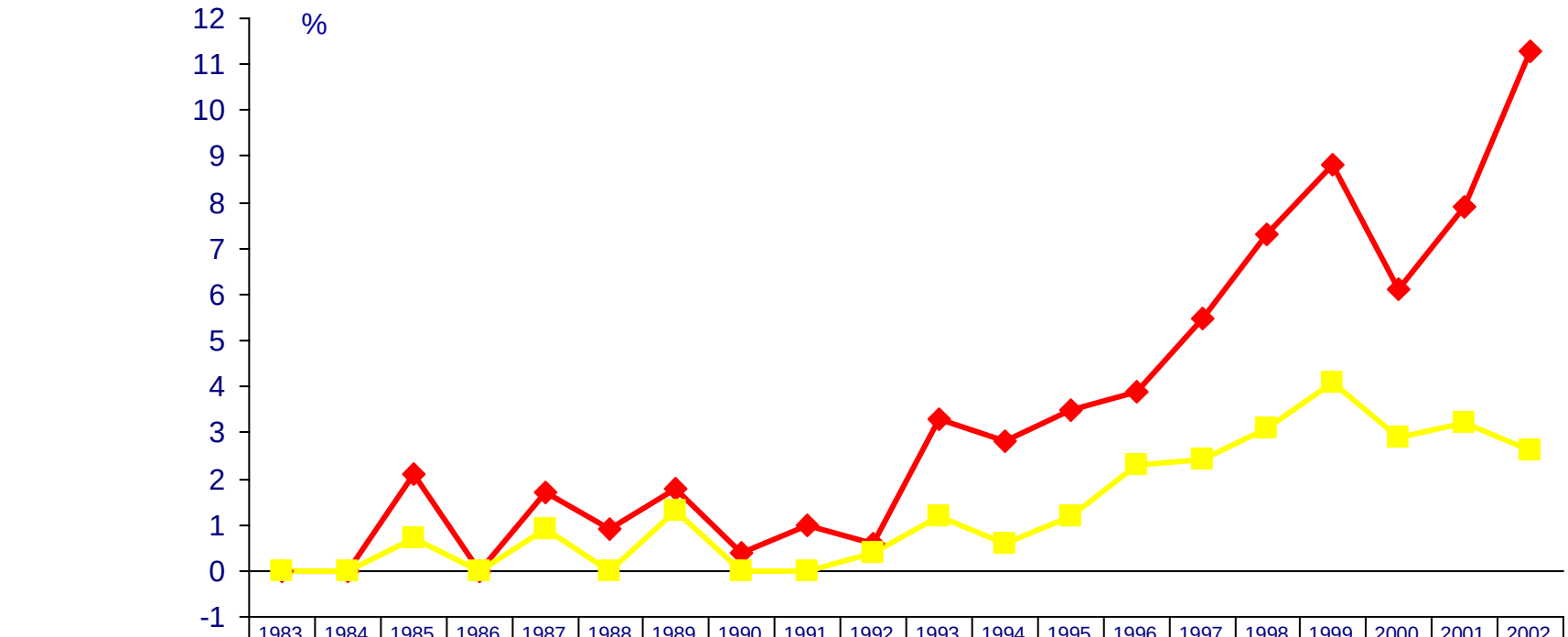


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Opiates, no cocaine	59,8	49,6	49,7	49,2	47	42,4	35,2	46,6	31,3	35,4	44	55,8	59,8	55,1	45,4	41,7	31,5	40,3	41,7	40,5
Opiates only	46,3	28,1	25,2	20,2	23,9	20,8	14,1	20,6	11,5	14,2	18,1	13,1	9	17,7	12,6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

(*) Includes data for all geographic areas monitored by the indicator.

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

Figure 6.4. Proportion of psychoactive substance overdose deaths in which toxicological analysis detected only cocaine or cocaine without opiates. Spain*. 1983-2002.

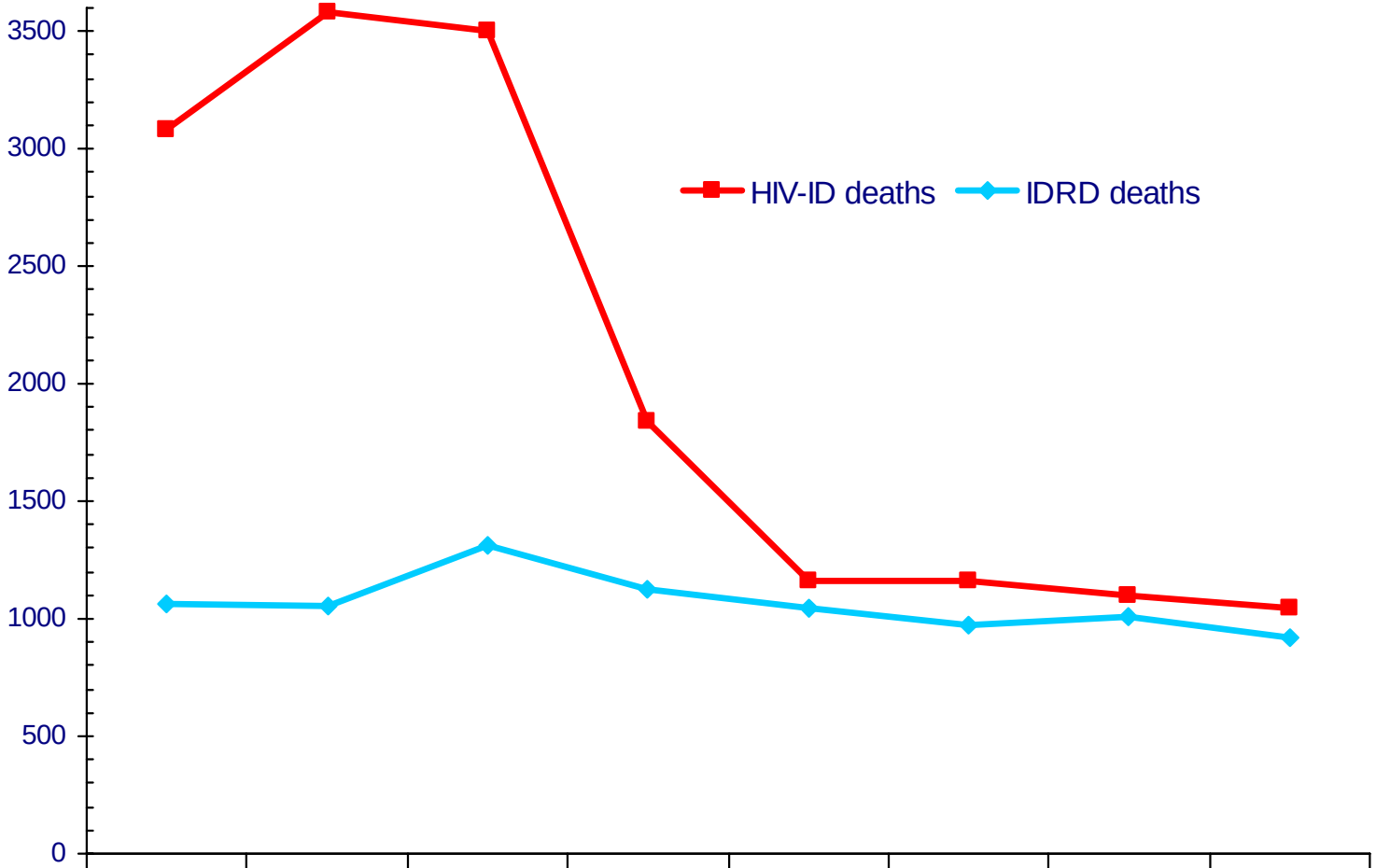


	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Cocaine, no opiates	0	0	2,1	0	1,7	0,9	1,8	0,4	1	0,6	3,3	2,8	3,5	3,9	5,5	7,3	8,8	6,1	7,9	11,3
Cocaine only	0	0	0,7	0	0,9	0	1,3	0	0	0,4	1,2	0,6	1,2	2,3	2,4	3,1	4,1	2,9	3,2	2,6

(*) Includes data for all geographic areas monitored by the indicator.

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

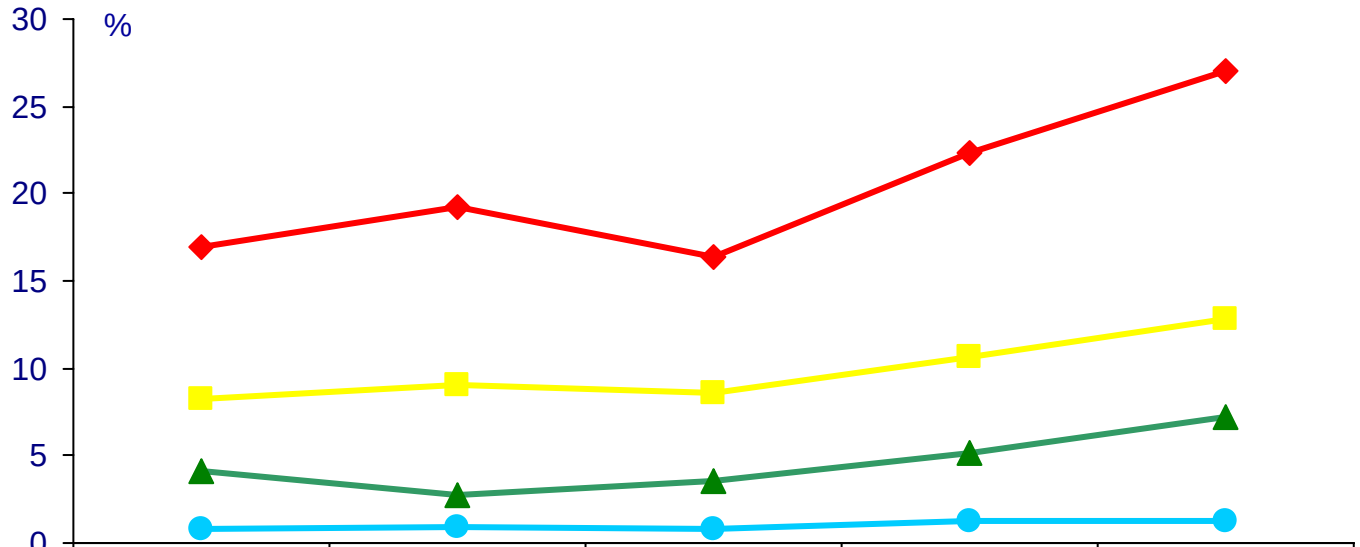
Figure 6.5. Illegal psychoactive drug use-related mortality in Spain, 1994-2001 (absolute numbers).



	1994	1995	1996	1997	1998	1999	2000	2001
HIV-ID deaths	3079	3583	3501	1839	1162	1158	1098	1047
IDRD deaths	1067	1051	1310	1127	1049	972	1012	923

IDRD deaths: illegal drug use-related deaths
HIV-ID deaths: Deaths due to illegal drug injection-related HIV infection

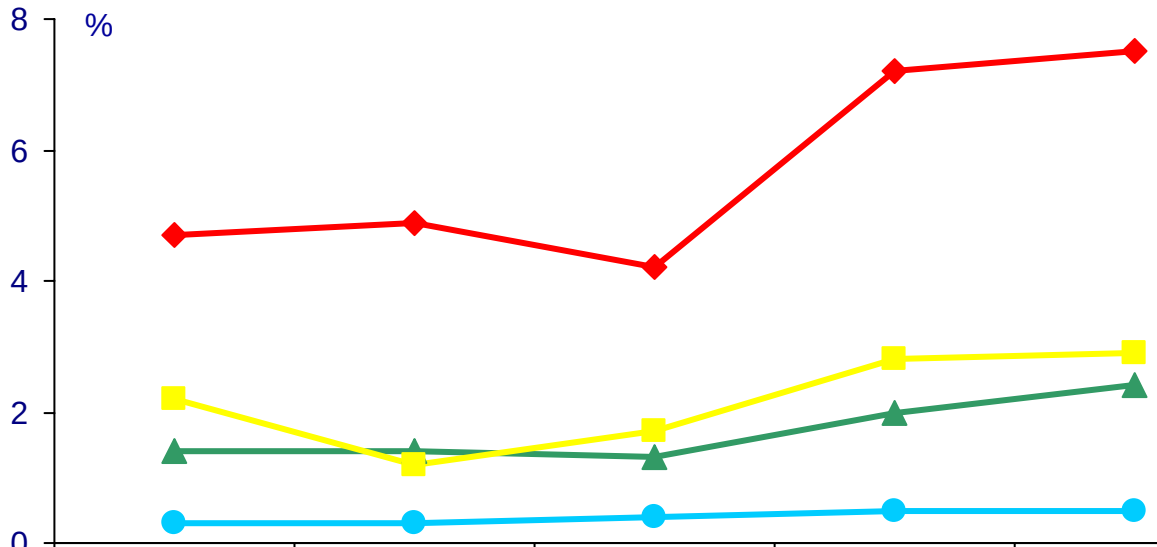
Figure 11.1. Prevalence of cannabis consumption in the last 12 months among the 15 to 64-year-old population, according to gender and age group (percentiles). Spain, 1995-2003.



	1995	1997	1999	2001	2003
Men 15-34	17	19,2	16,4	22,3	27
Women 15-34	8,3	9,1	8,6	10,7	12,8
Men 35-64	4,1	2,8	3,6	5,2	7,2
Women 35-64	0,8	0,9	0,8	1,3	1,3

SOURCE: DGPNSD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Door-to-Door Survey on Alcohol and Drugs in Spain (EDADES), 1995,1997, 1999, 2001, 2003.

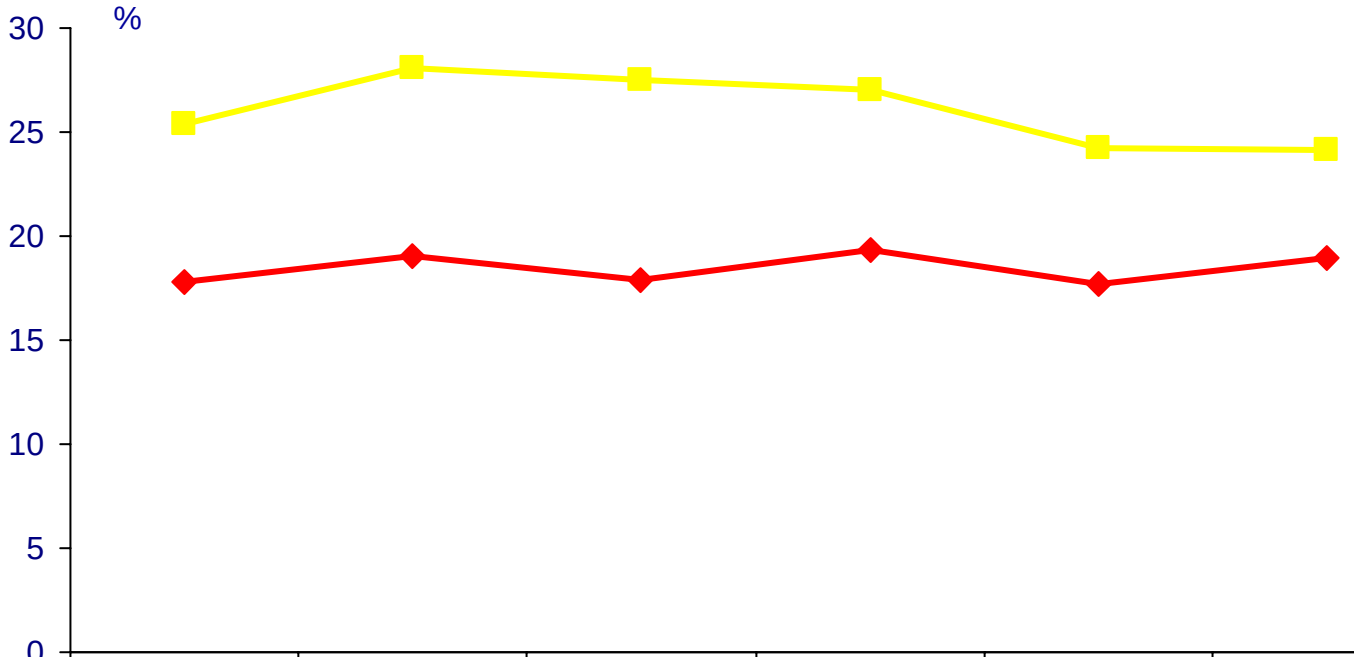
Figure 11.2. Prevalence of cocaine consumption in the past 12 months in the 15 to 64-year-old population, according to age and gender (percentiles). Spain, 1995-2003.



	1995	1997	1999	2001	2003
Men aged 15-34	4,7	4,9	4,2	7,2	7,5
Men aged 35-64	1,4	1,4	1,3	2	2,4
Women aged 35-64	0,3	0,3	0,4	0,5	0,5
Women aged 15-34	2,2	1,2	1,7	2,8	2,9

SOURCE: DGPNSD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA). Door-to-Door Survey on Alcohol and Drugs in Spain (EDADES), 1995,1997, 1999, 2001, 2003.

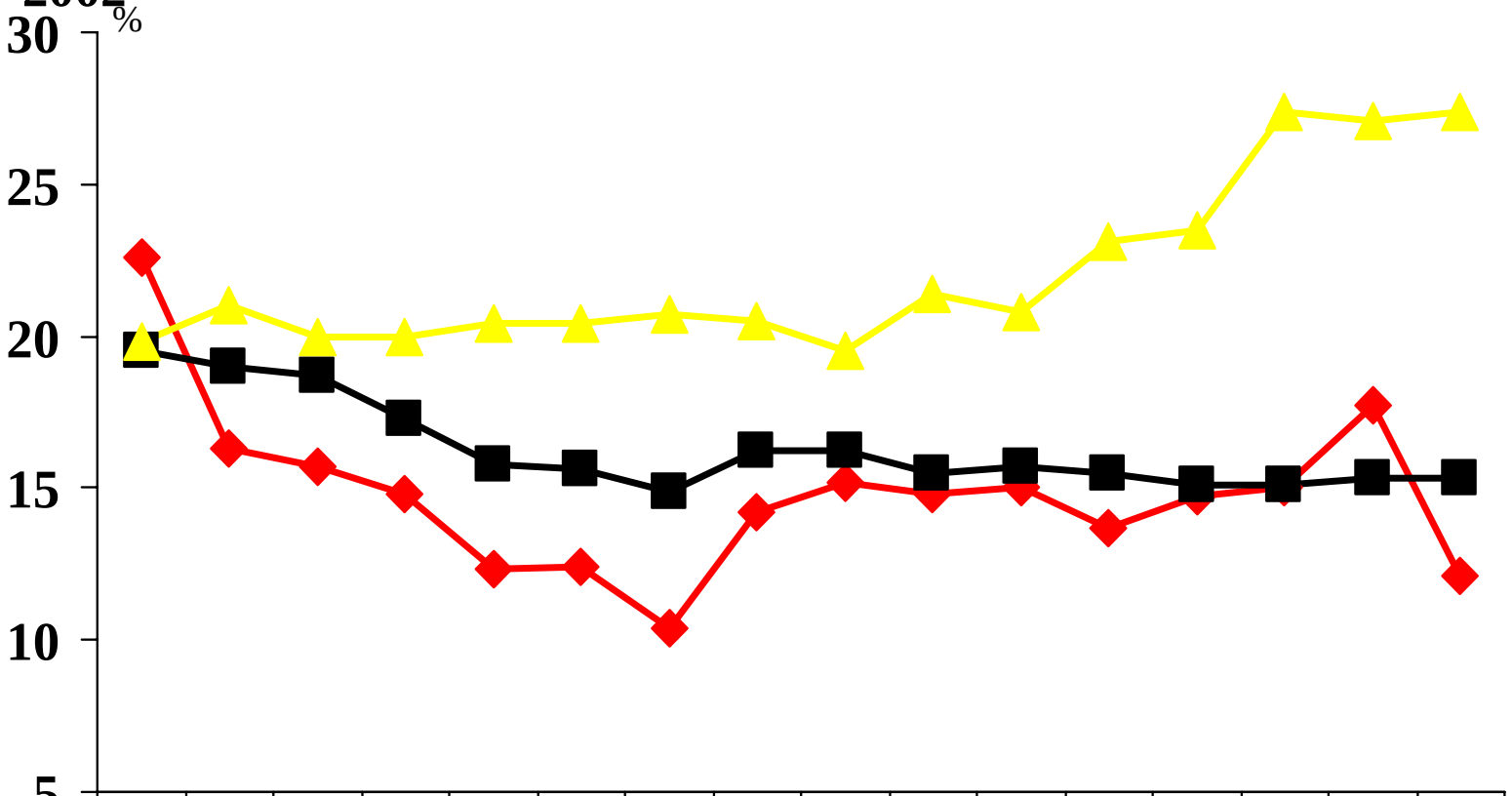
Figure 11.3. Evolution of the prevalence of daily tobacco consumption in Secondary Education students aged 14-18, according to gender. Spain (%), 1994-2004.



	1994	1996	1998	2000	2002	2004
Men	17,8	19	17,9	19,3	17,7	18,9
Women	25,4	28,1	27,5	27	24,2	24,1

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

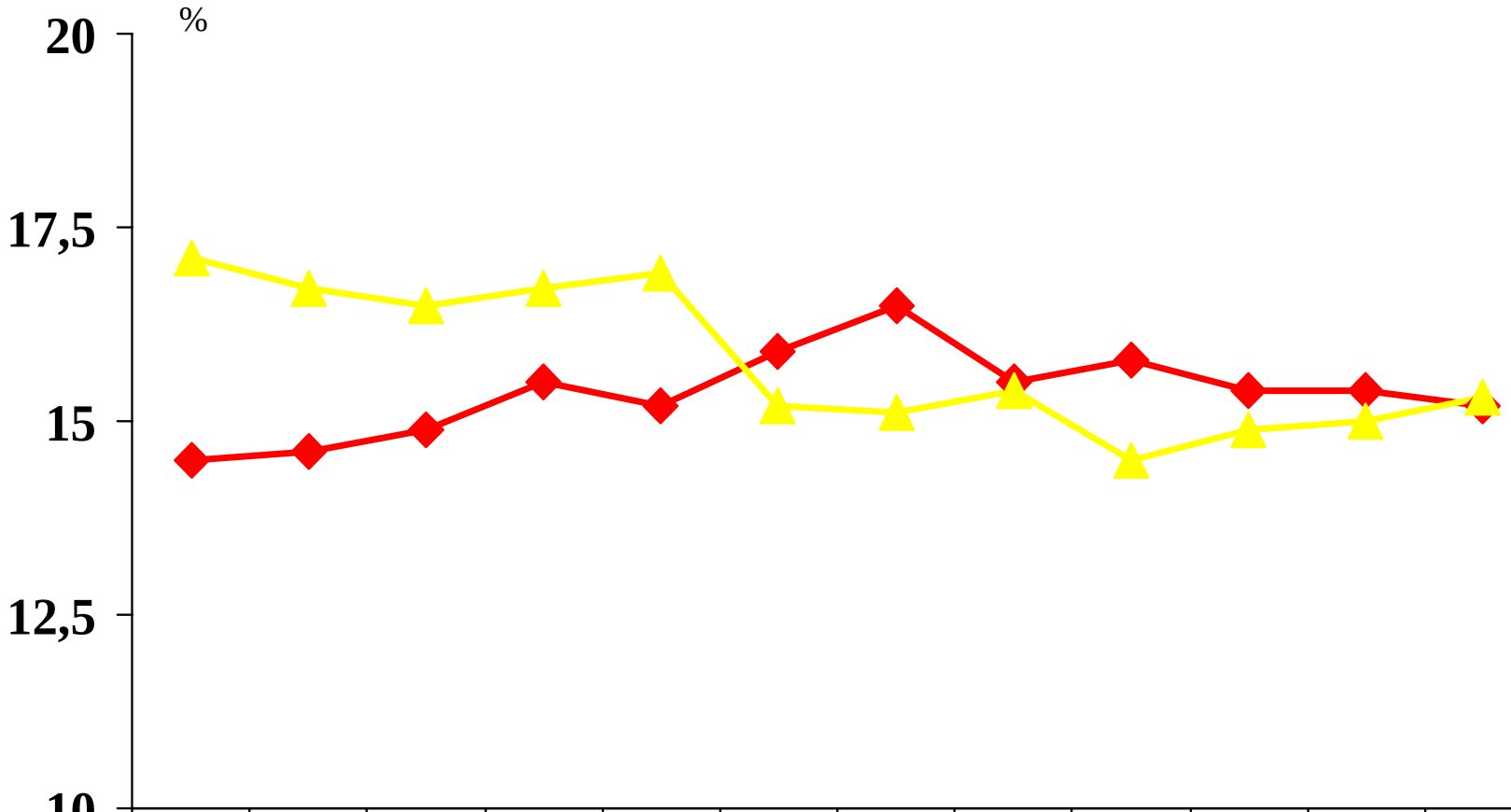
Figure 11.4. Evolution of the proportion of women among cases registered due to the National Drug Plan indicators of treatment, emergency and death. Spain, 1987-2002



	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
# Deaths*	22,6	16,3	15,7	14,8	12,3	12,4	10,4	14,2	15,2	14,8	15	13,7	14,7	15	17,7	12,1
# Admitted to treatment**	19,5	19	18,7	17,3	15,8	15,6	14,9	16,2	16,2	15,5	15,7	15,5	15,1	15,1	15,3	15,3
# Emergency cases ***	19,8	21	20	20	20,4	20,4	20,7	20,5	19,5	21,4	20,8	23,1	23,5	27,4	27,1	27,4

(*) Women who died from severe reactions to the consumption of psychoactive substances.
(**) Women admitted to treatment for psychoactive substance abuse or addiction.
(***) Women treated in hospitals for problems related to the consumption of psychoactive substances.
SOURCE: DGPNSD. Spanish Monitoring Centre for Drugs and Drug Abuse (OED or SMCDDA). Treatment, Emergencies and Death Indicators..

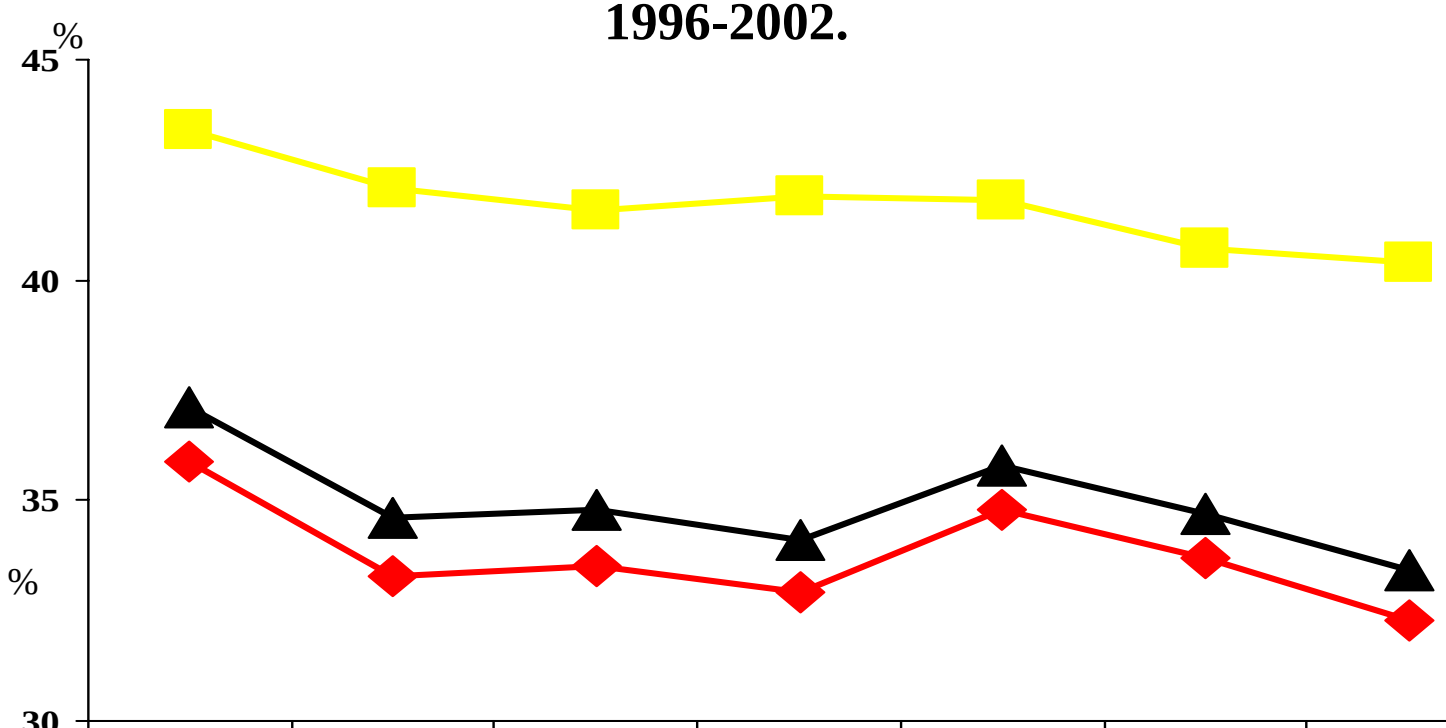
Figure 11.5. Evolution of the proportion of women among cases registered by the treatment indicator, according to records of previous treatment. Spain, 1991-2002



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
First-time treatment	14,5	14,6	14,9	15,5	15,2	15,9	16,5	15,5	15,8	15,4	15,4	15,2
Previously treated	17,1	16,7	16,5	16,7	16,9	15,2	15,1	15,4	14,5	14,9	15	15,3

SOURCE: DGPNSD. Spanish Monitoring Centre for Drugs and Drug Abuse (OED or SMCDDA). Treatment, Emergencies and Death Indicators..

Figure 11.6. Prevalence of HIV among patients admitted to treatment who had injected drugs in the 12 months prior to treatment, by gender. Spain, 1996-2002.



	1996	1997	1998	1999	2000	2001	2002
Men	35,9	33,3	33,5	32,9	34,8	33,7	32,3
Women	43,4	42,1	41,6	41,9	41,8	40,7	40,4
Total	37,1	34,6	34,8	34,1	35,8	34,7	33,4

Note: The percentiles are calculated based on the number of cases with information on serological HIV status and related variables. The proportion of injectors who were unaware of their HIV status was 34.6% in 1996, 29.5% in 1998, 26.9% in 2000, 25.5% in 2001, and 15.6% in 2002.
Data on this variable from the Communities of Galicia, la Rioja and Madrid is not included, since these were only included after the year 1996.

SOURCE: DGPNSD. Spanish Monitoring Centre for Drugs and Drug Addiction (SMCDDA or OED). Treatment indicator.