European Monitoring Centre
for Drugs and Drug Addiction

pnsd

plan nacional sobre drogas

2006 NATIONAL REPORT (2005 data) TO THE EMCDDA
by the Reitox National Focal Point

"SPAIN"

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

REITOX

SUMMARY

The present report on the drug situation in Spain in 2005 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.

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 2005.

As far as national regulations are concerned, the adoption of Law 28/2005, 26 December, *on* public health measures to counter tobacco addiction and regulate the sale, supply, consumption and advertising of tobacco products, is of particular importance*.*

The aim of the Law is to prevent tobacco consumption through the adoption of two different kinds of measures: on the one hand, new measures relating to the sale and consumption of tobacco are introduced in order to rectify the limitations and deficiencies of the current legislation, and on the other, measures which have an impact on the direct and indirect advertising and promotion of tobacco products, as well as sponsorship are established.

Royal Decree 515/2005, 6 May, should also be mentioned. It establishes the circumstances for the implementation of community service and curfew sentences, specific security measures, and for the suspension of the implementation of custodial sentences. Through this regulation, the actions of the custodial institutions are regulated in order to ensure compliance with the security measures and with the suspension of the implementation of the sentences. The assignment of the functions which correspond to the prison social services in this area is also regulated, so that they are the ones who are responsible for the coordination which must be established between the judicial bodies and the community services.

In 2005, Law 17/2005, 19 July, was also approved, which regulates the point-based driving licence and modifies the amended text of the Law on traffic, motor vehicle circulation and road safety.

With regard to regional legislation, the Parliament of the Autonomous Region of the Balearic Islands has passed ***Law 4/2005, 25 April, relating to drug dependency and other addictions*** in the Region.

In 2005, a new Household Survey on Alcohol and Drugs in Spain (EDADES) was carried out. The survey has been carried out every two years since 1995 as part of the National Plan on Drugs and is aimed at the population between the ages of 15 and 64 who live in family homes. The results of this survey are reflected in the report and show that in 2005 the most widespread psychoactive substances among the Spanish population between the ages of 15 and 64 were alcohol and tobacco. The most widespread illegal drugs were cannabis, cocaine and ecstasy.

Except for tranquilisers and sedatives, in 2005, consumers of psychoactive substances were predominantly young people between 15 and 34 years of age.

In general the Spanish population considers that it is quite easy to access illegal drugs.

However, the frequency with which the Spanish population between the ages of 15 and 64 find themselves in situations related to the most problematic uses of heroin and/or cocaine in the place where they live gradually decreased in the period from 1995 to 2005.

In 2005, the population between the ages of 15 and 64 considered education in schools to be the most suitable measure to resolve the drug problem.

In the prevention area, is particularly important the creation of the **"Society faced with Drugs**" **Forum**, in which more than 50 non-governmental organisations participate. In 2005, three work groups were established, "Youth", "Family" and "Media", which produced proposals relating to these issues throughout the year.

On its side, the Government Delegation for the National Plan on Drugs set up the "*Drugs; are you going to risk it?*" campaign in 2005. This campaign, in line with other previous campaigns run by the Delegation, is fundamentally addressed to the young population, with the aim of increasing the perception of the risk of drug consumption, with a positive tone which appeals to adolescents' sense of responsibility.

In the section devoted to controlling supply, the information available shows a noticeable upward trend in the number of arrests for trafficking in all the different drug groups, except for opiates. With regard to the number of drug seizures, in 2005 there was an increase of 50% in the number of confiscations compared to the previous year. As far as price is concerned, in the case of hashish and cocaine it has been stable, ecstasy prices have shown a continued tendency to go down, whilst the information on heroin shows a tendency towards price restraint, with a very slight decrease in the price per kilo over the last two years.

PART A: NEW DEVELOPMENTS AND TRENDS

1. NATIONAL POLICIES AND CONTEXT

- ### LEGAL FRAMEWORK

Various relevant provisions with national, regional and international scope were approved and/ or published in the year 2005.

A. Within the sphere of **national regulations**, the following is of particular interest:

1. *Law 28/2005, 26 December, on public health measures to counter tobacco addiction and regulate the sale, supply, consumption and advertising of tobacco products,* *in accordance* with the plans of the European Strategy for Tobacco Control 2002 in the European Region and with the WHO Framework Convention on Tobacco Control.

The purpose of this law is the prevention of tobacco consumption by adopting methods with two different approaches:

- methods that directly affect the consumption and sale of this product, the proliferation of smoke-free spaces, the limitation of the availability and accessibility of tobacco products (especially among the very young) and the assurance that the rights of the non-smoking population to breathe smoke-free air takes priority over the rights of smokers. To this end, new methods regarding the sale and consumption of tobacco have been introduced in order to rectify the limitations and defects of the current legislation.

- methods that affect the advertising and promotion of tobacco products, whether direct or indirect, as well as sponsorship, given the influence that sponsored activities have on personal behaviour and social conduct (especially on the youngest population). The innovation in this respect is that the law now prohibits the aforementioned advertising and promotional activities and sponsorship, with very few exceptions.

2. Law 15/2005, 8 July, which modifies the Civil Code and Law of Civil Procedure with regard to legal separation and divorce. In accordance with this reform, Article 82 of the Civil Code which regulated the causes of marital separation was revoked. Consequently, both alcoholism and drug addiction, which had previously been mentioned expressly in the aforementioned article, are no longer considered legal causes for divorce.

3. Royal Decree 515/2005, 6 May, which establishes the circumstances for the enforcement of community service sentences and parole, for certain security measures and for the suspension of prison sentences.

This decree regulates the actions of the penitentiary administration to enforce compliance with security measures and the suspension of relevant sentences. It also dictates the assignment of corresponding responsibilities in matters of prison social services, in such a way that said services now handle the necessary coordination between justice authorities and community services.

4. *Law 17/2005, 19 July, which regulates the points-based driving permit and license and modifies the legal provisions in matters of traffic, motor vehicle transit and road safety.*

This law classifies driving under the influence of alcoholic beverages or narcotics, psychotropic substances, stimulants or other substances with similar effects as a very serious traffic infraction.

5. With regard to preventing the laundering of assets obtained from illegal drug trafficking, the most important new legislation is ***Royal Decree 54/2005, 21 January, which modifies the Regulation of Law 19/1993, 28 December, on certain measures for preventing money laundering, passed by Royal Decree 925/1995, 9 June, and other regulations that apply to the banking, financial and insurance sectors.***

The purpose of this reform is to continue developing new legislation on this matter, which began to take shape after Law 19/2003, 4 July, was passed. It also introduces certain modifications deriving from the experience gained since 1995, required due to organisational and institutional changes that the Spanish administration has undergone, or inspired by standards issued by institutions such as the Financial Action Task Force, the Basel Committee on Banking Supervision, and other international financial institutions and organisations.

Also of interest in this area is ***Order EHA/2963/2005, 20 September, which regulates the General Notary Council's Centralised Organisation for the Prevention of Money Laundering.***

6. Finally, Order SCO/1932/2005, 20 June, which establishes the regulatory bases of calls for financial aid applications open to national private non-profit entities for the implementation of drug-addiction programmes.

This order establishes the conditions which in the future shall govern all notifications of financial aid offered to private non-profit entities operating throughout the national territory for the development of interregional programmes related to drug addiction, which are published by the Government Delegation for the National Plan on Drugs.

B. Within the sphere of **regional legislation**, an important development has been the approval of ***Law 4/2005, 25 April, on drug and other addictions*** by the Parliament of the Balearic Islands Autonomous Community.

By passing this Law, the Balearic Islands have adopted legislative actions which have already been enacted by the vast majority of Spain's Autonomous Communities.

- **INSTITUTIONAL FRAMEWORK, STRATEGIES AND POLICIES**

This section is contained in the Structured Questionnaire 32.

- **BUDGET AND PUBLIC EXPENDITURE**

Although definitive data is not yet available, currently available statistics and the pattern of expenses in previous years provide a basis for estimating that the Spanish government and the governments of the Autonomous Communities have invested a total of between 347 and 350 million euros in drug policies during 2005.

- **SOCIAL AND CULTURAL CONTEXT**

The information for this section is contained in the 2005 Spanish National Report.

2. DRUG USE IN THE POPULATION

- ### DRUG USE IN THE GENERAL POPULATION (*)

In 2005, a new Household Survey on Alcohol and Drugs in Spain (EDADES) was completed, which has been performed biennially since 1995 as part of the National Plan on Drugs and is aimed at the 15 to 64-year-old population residing in family homes. As a result, the population residing in institutions (quarters, convents, prisons, student residences or old people's homes, etc.), group establishments (hotels, boarding houses, etc.) and the homeless population are excluded from the sampling frame. The size of the sample in 2005 was 27,869 (in previous surveys the sample varied between 9,000 and 14,000), with an overrepresentation of the 15 to 39-year-old group and the smallest autonomous communities. Convenience sampling was performed at various stages (census sections, homes or individuals within the home). The employed questionnaire had two sections: one to be completed in a face-to-face interview (this included all questions except those on alcohol and drug use) and the other self-administered using pen and paper (questions on drug use). The field work was done between November 2005 and April 2006. No surveys were done in January, to avoid any special influence that the holiday season might have had on answers to questions about consumption in the past 30 days. The response rate for the initially selected sampling was 49.9%. Non-responses were distributed as follows: refusals in homes, including refusal to open doors and unwillingness of any occupant to be interviewed (22.6%), absence of all home residents (15.9%), refusal of the selected person (6.5%), absence of the selected person (5.1%). For analysis, data was weighted by autonomous community, age and gender to re-establish the sampling's proportionality. All calculations were done by excluding the numerator and denominator of subjects with unknown values for the variables that factor into each cross tabulation.

Prevalence of drug use

In 2005, the psychoactive substances most widely used by the Spanish population between the ages of 15 and 64 were alcohol and tobacco. Among illegally marketed drugs, the most widely used were cannabis, cocaine and ecstasy, all with prevalence rates of over 1% in the past twelve months (11.2% for cannabis, 3.0% for cocaine and 1.2% for ecstasy). Use of other illegally marketed drugs was less common. A particularly interesting discovery was made regarding the use of tranquilizers or sedatives, the prevalence of which in the past twelve months (3.9%) was only exceeded by that of alcohol, tobacco and cannabis (Table 2.1).

(*) **DATA ON DRUG USE IN THE GENERAL POPULATION CANNOT BE RELEASED UP TO 1 JANUARY 2007**

Table 2.1. Prevalence of psychoactive substance use by respondents between the ages of 15 and 64 (per cent). Spain, 1995-2005.

	1995	1997	1999	2001	2003	2005
Prevalence of use at least once in lifetime						
Tobacco	--	69.7	64.9	68.4	68.9	69.5
Alcohol	--	90.6	87.3	89.0	88.6	93.7
Tranquilizers or sedatives (with or without prescription)	_	_	_	_	_	7,7
Tranquilizers or sedatives (without prescription)	_	_	_	_	_	1,5
Cannabis	14.5	22.9	19.6	23.8	29.0	28.6
Ecstasy	2.0	2.5	2.4	4.0	4.6	4.4
Hallucinogens	2.1	2.9	1.9	2.8	3.0	3.4
Amphetamines/ speed	2.3	2.7	2.2	2.9	3.2	3.4
Powder cocaine	3.4	3.4	3.1	4.8	5.9	7.0
Free base cocaine	0.3	0.4	0.4	0.5	0.5	0.6
Heroin	0.8	0.6	0.5	0.6	0.9	0.7
Other opiates	0.2	0.5	0.3	0.6	0.4	0.5
Volatile inhalants	0.7	0.8	0.6	0.8	1.0	0.8
Prevalence of use in the last 12 months						
Tobacco	--	46.8	44.7	46.0	47.8	42.4
Alcohol	68.5	78.5	75.2	78.1	76.6	76.7
Tranquilizers or sedatives (with or without prescription)	_	_	_	_	_	3,9
Tranquilizers or sedatives (without prescription)	_	_	_	_	_	0,9
Cannabis	7.5	7.7	7.0	9.2	11.3	11.2
Ecstasy	1.3	0.9	0.8	1.8	1.4	1.2
Hallucinogens	0.8	0.9	0.6	0.7	0.6	0.7
Amphetamines/ speed	1.0	0.9	0.7	1.1	0.8	1.0
Powder cocaine	1.8	1.6	1.6	2.5	2.7	3.0
Free base cocaine	0.1	0.1	0.2	0.1	0.1	0.2
Heroin	0.5	0.2	0.1	0.1	0.1	0.1
Other opiates	0.1	0.1	0.1	0.2	0.1	0.1
Volatile inhalants	0.1	0.2	0.1	0.1	0.1	0.1
Prevalence of use in the last 30 days						
Tobacco	--	42.9	40.1	41.4	42.9	38.4
Alcohol	--	64.0	61.8	63.7	64.1	64.6
Tranquilizers or sedatives (with or without prescription)	_	_	_	_	_	2,8
Cannabis	--	4.6	4.5	6.4	7.6	8.7
Ecstasy	--	0.3	0.2	0.8	0.4	0.6
Hallucinogens	--	0.2	0.2	0.2	0.2	0.2
Amphetamines/ speed	--	0.2	0.3	0.6	0.2	0.4
Powder cocaine	--	0.9	0.9	1.3	1.1	1.6
Free base cocaine	--	0.0	0.1	0.0	0.0	0.1
Heroin	--	0.1	0.0	0.0	0.0	0.1
Other opiates	--	0.1	0.1	0.1	0.1	0.1
Volatile inhalants	--	0.1	0.0	0.1	0.0	0.1
Prevalence of daily use in the last 30 days						
Tobacco	--	34.9	33.6	35.7	36.7	32.8
Alcohol	--	12.7	13.7	15.7	14.1	14.9
Cannabis	--	0.7	0.8	1.5	1.5	2.0

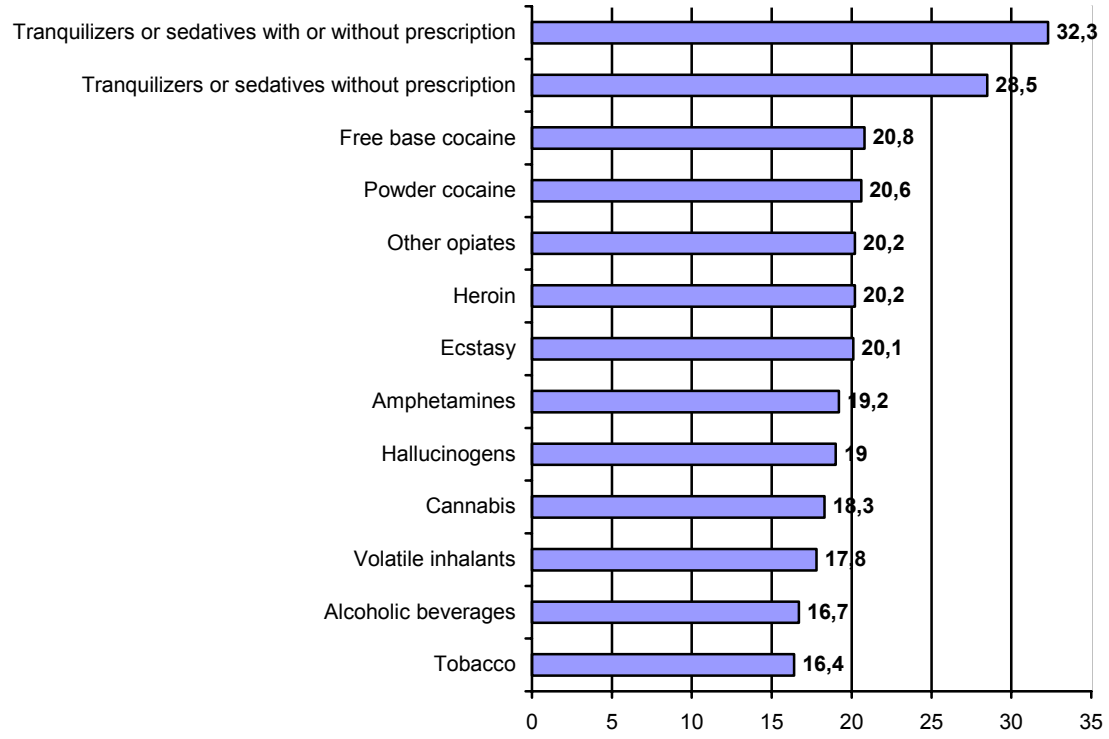
Average age of initiation

In 2005, the age of initiation into drug use varied substantially according to the type of drug. The substances used at the earliest age were legal drugs such as tobacco (average age 16.4), alcoholic beverages (16.7) and inhalants (17.8). Cannabis was the illegally marketed drug used at the earliest age (18.3). Sedative-hypnotic drugs, in turn, were the substances with first use occurring latest in life (age 28.5 without prescription and 32.3 with or without prescription). All other drug use began, on average, between the ages of 18 and 22 (Table 2.2).

Table 2.2. Average age of initiation into psychoactive substances use in the population between the ages of 15 and 64 (per cent). Spain, 1995-2005.

	1995	1997	1999	2001	2003	2005
Tobacco	15.9	16.6	16.7	16.5	16.5	16.4
Tobacco (daily use)	18.5	18.5	18.6	18.4	18.3	18.3
Alcoholic beverages	--	16.8	16.9	16.9	16.7	16.7
Tranquilizers or sedatives (with or without prescription)	_	_	_	_	_	28,5
Tranquilizers or sedatives (without prescription)	_	_	_	_	_	32,3
Cannabis	18.3	18.9	18.7	18.5	18.5	18.3
Powder cocaine	21.4	21.3	21.8	20.4	20.9	20.6
Heroin	20.3	20.1	19.0	20.7	22.0	20.2
Amphetamines	19.2	19.4	19.2	18.8	19.6	19.2
Hallucinogens	19.3	19.0	19.3	18.9	19.9	19.0
Volatile inhalants	17.7	19.0	18.1	17.5	17.5	17.8
Free base cocaine	21.8	20.6	20.1	19.6	20.1	20.8
Ecstasy	21.1	20.0	20.7	20.2	20.3	20.1
Other opiates	21.1	21.1	19.6	22.6	20.4	20.2

Figure 2.1. Average ages of initiation into use of different psychoactive drugs among Spaniards between ages 15 and 64 in 2005.



Differences in drug use by gender

Except in the case of sedative-hypnotic drugs, substance use was visibly higher among men than women, particularly in the case of illegal substances, where male prevalence is often several-fold greater. In the population from ages 15 to 64, notable differences can be observed in the use of cannabis (12.5% in men and 4.7% in women) and cocaine (2.5% in men and 0.7% in women) over the last 30 days.

Prevalence of use is also higher among men for legally marketed drugs. For example, the prevalence of alcohol consumption over the last 30 days was 76.0% for men and 52.9% for women, and the prevalence of tobacco use was 43.1% and 33.6% respectively, in the 15 to 64-year-old population (Table 2.3 and Figure 2.2).

The trend of differences in the 15 to 34-year-old population is equally apparent in the 35 to 54-year-old population (Figure 2.3).

Table 2.3. Prevalence of psychoactive substances use by respondents between the ages of 15 and 64, by sex (per cent) Spain, 1995-2005.

	1995		1997		1999		2001		2003		2005	
	Men	Women	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	75.5	63.3
Alcohol											5,6	9,7
Tranquilizers or sedatives (with or without prescription)											1,4	1,5
Tranquilizers or sedatives (without prescription)	--	--	95.3	86.0	92.1	82.5	93.6	84.3	93.8	83.3	95.7	91.6
Cannabis	19.9	9.4	31.1	14.8	25.9	13.3	31.0	16.5	38.2	19.7	36.8	20.1
Ecstasy	2.8	1.2	3.8	1.2	3.3	1.5	6.0	2.0	6.6	2.5	6.2	2.4
Hallucinogens	3.3	1.0	4.6	1.2	2.8	1.0	4.2	1.3	4.7	1.3	5.2	1.5
Amphetamines/ speed	3.1	1.5	4.0	1.4	3.1	1.2	4.1	1.7	4.6	1.7	5.0	1.8
Powder cocaine	4.8	2.0	5.4	1.5	4.5	1.8	7.0	2.5	9.2	2.6	10.5	3.4
Free base cocaine	0.5	0.1	0.7	0.2	0.6	0.1	0.7	0.2	0.8	0.2	1.1	0.2
Heroin	1.2	0.4	0.9	0.2	0.6	0.3	1.0	0.2	1.5	0.3	1.1	0.2
Other opiates	0.4	0.1	0.7	0.2	0.4	0.2	0.8	0.3	0.8	0.1	0.8	0.3
Volatile inhalants	1.1	0.3	1.4	0.1	0.9	0.3	1.2	0.4	1.7	0.3	1.2	0.4
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	47.2	37.5
Alcohol	79.3	58.0	86.4	70.5	83.2	67.2	85.2	70.9	84.5	68.4	84.0	69.2
Tranquilizers or sedatives (with or without prescription)											2,7	5,3
Tranquilizers or sedatives (without prescription)											0,8	1,0
Cannabis	10.7	4.4	10.7	4.7	9.6	4.3	13.0	5.5	16.2	6.3	15.7	6.6
Ecstasy	1.9	0.7	1.2	0.5	1.2	0.5	2.8	0.7	2.0	0.8	1.8	0.6
Hallucinogens	1.1	0.4	1.4	0.4	0.8	0.4	1.2	0.2	0.9	0.3	1.1	0.4
Amphetamines/ speed	1.3	0.7	1.4	0.4	1.0	0.4	1.6	0.6	1.1	0.5	1.4	0.5
Powder cocaine	2.7	1.0	2.6	0.6	2.3	0.8	3.8	1.3	4.1	1.2	4.6	1.3
Free base cocaine	0.2	0.0	0.2	0.0	0.4	0.0	0.2	0.0	0.2	0.0	0.3	0.0
Heroin	0.8	0.3	0.4	0.1	0.2	0.0	0.2	0.0	0.2	0.1	0.2	0.1
Other opiates	0.1	0.0	0.2	0.0	0.2	0.0	0.3	0.1	0.1	0.0	0.2	0.0
Volatile inhalants	0.2	0.1	0.3	0.0	0.1	0.1	0.2	0.1	0.1	0.1	0.2	0.1
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	43.1	33.6
Alcohol	--	--	75.8	52.1	74.4	49.1	76.4	50.9	75.8	52.1	76.0	52.9
Tranquilizers or sedatives with or without prescription											1,8	3,8
Cannabis	--	--	6.7	2.5	6.2	2.8	9.4	3.4	11.3	3.9	12.5	4.7
Ecstasy	--	--	0.5	0.1	0.3	0.2	1.3	0.3	0.5	0.2	0.9	0.3
Hallucinogens	--	--	0.3	0.1	0.3	0.1	0.4	0.1	0.3	0.1	0.4	0.1
Amphetamines	--	--	0.4	0.1	0.4	0.2	0.9	0.2	0.4	0.1	0.6	0.2
Cocaine	--	--	1.5	0.2	1.3	0.4	2.2	0.5	1.6	0.5	2.5	0.7
Free base cocaine	--	--	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Heroin	--	--	0.2	0.1	0.1	0.0	0.1	0.0	0.0	0.1	0.1	0.0
Other opiates	--	--	0.1	0.0	0.1	0.0	0.1	0.1	0.1	0.0	0.1	0.0
Volatile inhalants	--	--	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.0

Figure 2.2. Population rate ages 15 and 64 that have used drugs in the last 12 months (per cent).

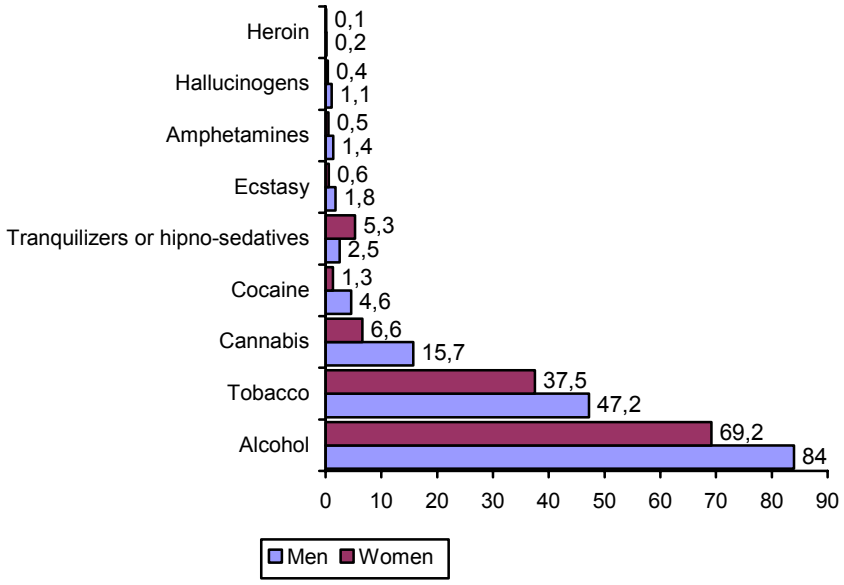
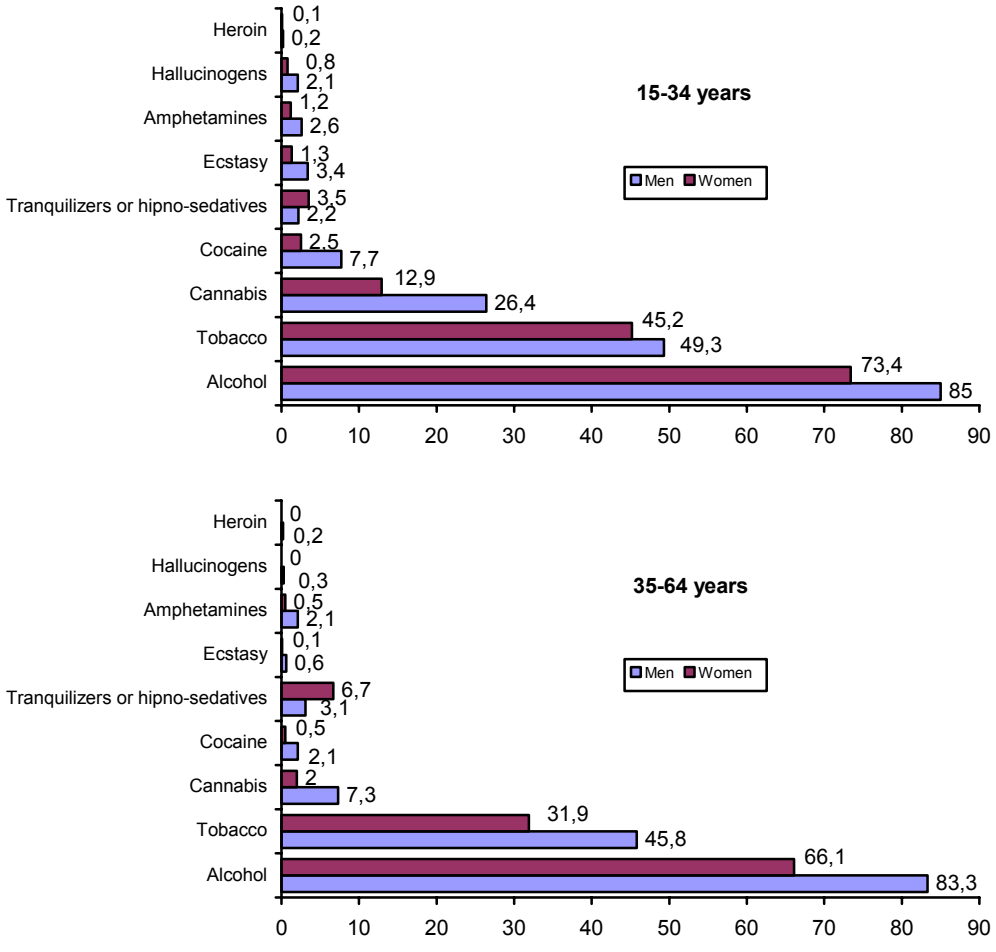


Figure 2.3. Population rate aged 15-34 and 35-64 that have used drugs in the last 12 months (per cent).



Differences in drug use by age

Except for tranquilizers or sedatives, in 2003 psychoactive substance users were predominantly young people between the ages of 15 and 34 (Figure 2.2, Table 2.4). This is especially true for illegal drugs; their prevalence of use in the last 12 months in the 15 to 34-year-old group is consistently higher than in the 35 to 64-year-old group. For example, the prevalence of use in the last 12 months for cannabis, cocaine and ecstasy was 19.8%, 5.2% and 2.4% respectively in the 15-34 age group, as compared to 4.7%, 1.3% and 0.4% in the 35-64 age group. The prevalence of alcohol or tobacco use over the last 12 months is somewhat higher in the 15-34 age group (79.4% and 47.3%) than in the 35-64 group (74.7% and 38.4%). Finally, the 35-64 age group consumes tranquilizers or sedatives in greater proportion (4.9%) than the 15-34 group (2.8%).

Table 2.4. Prevalence of psychoactive substances use by respondents between the ages of 15 and 64, by age (per cent). Spain, 1995-2005.

	1995		1997		1999		2001		2003		2005	
	15-34	35-64	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	67.9	70.7
Alcohol	--	--	91.4	89.9	87.4	87.2	89.3	88.8	88.9	88.3	93.2	94.1
Tranquilizers or sedatives (with or without prescription)											5,6	9,3
Tranquilizers or sedatives (without prescription)											1,3	1,6
Cannabis	22.9	6.1	32.4	14.4	28.1	12.3	34.3	15.3	39.0	21.0	9.4	20.4
Ecstasy	3.5	0.5	4.8	0.4	4.4	0.7	7.7	1.0	8.3	1.6	7.6	1.9
Hallucinogens	3.3	0.9	4.7	1.3	2.9	1.0	4.6	1.3	4.7	1.6	5.4	1.9
Amphetamines/ speed	3.7	1.0	4.2	1.3	3.1	1.3	4.6	1.5	4.7	1.9	5.2	2.0
Powder cocaine	5.4	1.4	5.5	1.6	4.7	1.8	7.7	2.4	8.9	3.6	10.4	4.4
Free base cocaine	0.5	0.1	0.7	0.2	0.6	0.2	0.7	0.3	0.7	0.3	0.7	0.6
Heroin	1.4	0.2	0.9	0.3	0.6	0.3	0.7	0.5	0.8	0.9	0.6	0.7
Other opiates	0.3	0.1	0.7	0.2	0.4	0.2	0.7	0.5	0.6	0.3	0.6	0.5
Volatile inhalants	1.1	0.3	1.3	0.3	0.9	0.4	1.5	0.2	1.7	0.5	1.2	0.5
Prevalence of use in the last 12 months												
Tobacco	72.9	64.1	54.5	39.9	49.5	40.6	52.0	41.2	52.8	43.8	47.3	38.8
Alcohol	7.6	17.1	82.5	74.9	79.0	71.8	81.5	75.2	79.5	74.2	79.4	74.7
Tranquilizers or sedatives (with or without prescription)											2,8	4,9
Tranquilizers or sedatives (without prescription)											0,7	0,9
Cannabis	12.7	2.3	14.2	1.8	12.6	2.2	16.7	3.3	20.1	4.2	19.8	4.7
Ecstasy	2.4	0.1	1.8	0.0	1.6	0.1	3.7	0.2	2.9	0.1	2.4	0.4
Hallucinogens	1.3	0.2	1.8	0.1	1.2	0.2	1.3	0.2	1.1	0.2	1.5	0.1
Amphetamines/ speed	1.8	0.2	1.8	0.1	1.3	0.2	2.2	0.2	1.6	0.2	1.9	0.3
Powder cocaine	3.1	0.5	2.9	0.5	2.8	0.5	4.5	0.9	4.8	0.9	5.2	1.3
Free base cocaine	0.1	0.1	0.2	0.1	0.4	0.0	0.2	0.0	0.2	0.0	0.2	0.1
Heroin	0.9	0.1	0.4	0.1	0.2	0.0	0.1	0.1	0.2	0.1	0.2	0.1
Other opiates	0.1	0.1	0.2	0.0	0.2	0.0	0.2	0.2	0.1	0.1	0.2	0.1
Volatile inhalants	0.2	0.1	0.4	0.0	0.1	0.1	0.3	0.0	0.2	0.0	0.2	0.1
Prevalence of use in the last 30 days												
Tobacco	--	--	49.6	36.9	43.7	36.9	46.3	37.5	47.2	39.5	42.3	35.5
Alcohol	--	--	66.7	61.6	64.4	59.4	65.7	62.1	65.8	62.7	66.3	63.4
Tranquilizers or sedatives with or without prescription											1,7	3,7
Cannabis	--	--	8.5	1.1	7.9	1.5	11.5	2.3	13.4	2.9	15.4	3.6
Ecstasy	--	--	0.6	0.0	0.5	0.0	1.5	0.2	0.7	0.0	1.1	0.2
Hallucinogens	--	--	0.4	0.0	0.3	0.1	0.4	0.1	0.4	0.0	0.5	0.1
Amphetamines	--	--	0.5	0.0	0.5	0.1	1.1	0.1	0.4	0.1	0.8	0.1
Cocaine	--	--	1.6	0.2	1.5	0.3	2.4	0.5	1.9	0.4	2.8	0.7
Free base cocaine	--	--	0.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Heroin	--	--	0.2	0.1	0.1	0.0	0.0	0.0	0.1	0.0	0.1	0.1
Other opiates	--	--	0.1	0.0	0.1	0.0	0.2	0.0	0.1	0.0	0.1	0.1
Volatile inhalants	--	--	0.1	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.1	0.0

Tobacco

42.4% of the population residing in Spain between the ages of 15 and 64 has smoked during the past year, whereas 38.4% has smoked in the last month and 32.8% has smoked daily during that period. These numbers continue to be quite high, especially considering the negative health effects of tobacco.

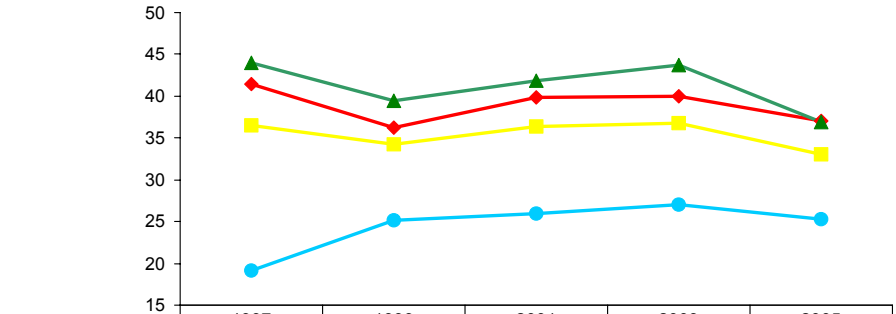
By age groups, the highest prevalence was found in people between ages 35 and 44 (38.4%), and the lowest between ages 55 and 64 (19.4%). The prevalence of daily consumption is markedly higher among men (37.0%) than among women (28.6%). Nevertheless, the relative differences between men and women are greater in the older age groups. In the 55-64 age group, 10.7% of women smoke daily, as opposed to 28.7% of men, whereas in the 25-34 age group, 34.2% of women and 40.1% of men smoke on a daily basis.

The average number of cigarettes smoked in the last month is 14.5 (12.9 in women and 15.7 in men). This number continues to increase until reaching the 35-44 age group, when it begins to diminish.

The average age of initiation into smoking was 16.4, with the men starting slightly earlier (15.9 year old) than women (17.1 years old).

With regard to time trends, until 2003 tobacco use had remained relatively stable. Between 2003 and the date of the present survey (November 2005 – April 2006), the prevalence of daily consumption has descended in every age group and both sexes, particularly in the 35-64 age group (with a greater decrease among men) (Figure 2.4).

Figure 2.4. Prevalence of daily tobacco use in the population between ages 15 and 64, by age group and sex (per cent). Spain, 1997-2005.



	1997	1999	2001	2003	2005
Hombres 15-34	41,4	36,3	39,8	40	37,1
Mujeres 15-34	36,5	34,2	36,4	36,8	33
Hombres 35-64	44	39,5	41,8	43,7	36,9
Mujeres 35-64	19,1	25,1	25,9	27	25,3

Alcoholic Use

Alcohol consumption is almost universal in Spanish society (93.7% of the population between ages 15 and 64 have consumed alcohol “at least once”). In addition, the majority of the population consumes alcohol sporadically or regularly (76.7% have drunk alcohol “in the past year”; 64.6% “in the past month”; and 14.9% “daily” during the last month).

Prevalence of use in the past month is very similar until the age of 44 (65%-67%), at which point prevalence begins to descend (Table 2.5).

Drinking is more common among men than women, especially regular or heavy drinking. 76.0% of men had consumed alcohol in the past month, as opposed to 52.9% of women, and 22.5% of men drank on a daily basis during that period as opposed to 7.0% of women. The relative differences in sporadic consumption between men and women increases with age (male prevalence is only 1.2 times higher than that of women in the 15-24 age group, whereas it is 1.7 times higher in the 55-64 group); however, the opposite is true when speaking of daily consumption (in the 15-24 group,

male prevalence is 5.4 times higher than female prevalence, while it is only 3.3 times higher in the 55-64 age group) (Table 2.5).

The average age of initiation into alcohol consumption is 16.7, with the men starting earlier (15.9 years old) than women (17.7 years old).

All alcoholic beverages are consumed in greater proportions on the weekends (Friday, Saturday and Sunday) than on weekdays. The differences are especially significant in the mixed drinks category; they were consumed by 0.5% of the population between the ages of 15 and 64 on every weekday during the past 30 days as compared to 10.8% who consumed such drinks every weekend. Drinks in the beer/cider category were consumed by 7.7% on every weekday and 20.8% on every weekend.

The most widely consumed beverages on the weekends were beer/ cider (20.8% drink them every weekend), followed by wine/ champagne (15.9%) and mixed drinks (10.8%). The prevalence of beer/ cider consumption every weekend is higher among men (30.3%) than among women (11.1%). By age groups, beer/cider consumption every weekend is more frequent in the population between ages 35 and 44 (24.4%).

The most widely consumed alcoholic beverages on weekdays among the Spanish population between the ages of 15 and 64 are wine/ champagne. In fact, 10.4% had consumed such beverages on every weekday for the last 30 days, with a much higher prevalence among men (15.5%) than women (5.3%). In addition, consumption is clearly concentrated in the more senior population (23.1% of the 55-64 group consume such drinks every weekday). Beer is the second most widely consumed drink on weekdays, with 4.7% of the population having drunk beer every day (12.6% of men and 2.7% of women).

With regard to alcoholic intoxication, in the past year 19.7% of the population between ages 15 and 64 had gotten drunk at least once (14.8% once a month or less and 5.0% more than once a month). The prevalence of drunkenness was greater among men (27.2%) than among women (12.0%), and among young people between the ages of 15 and 34 (30.9%) than among people over 34 (11.3%).

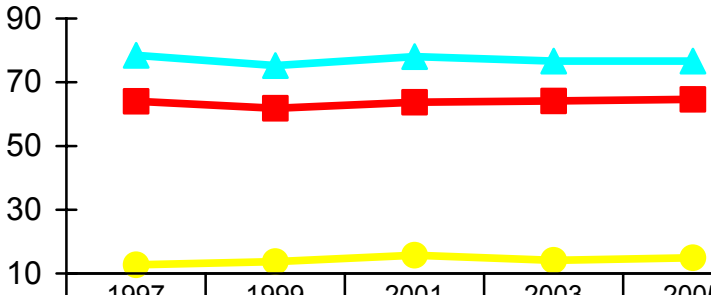
Finally, “at-risk drinkers” – i.e., men consuming 50 cubic centimetres (cc) of pure alcohol per day or more and women consuming 30 cc/day or more – were analysed. 5.5% of people between the ages of 15 and 64 were at-risk drinkers, with a greater percentage of men (6.5%) than women (4.1%). There are no great differences with regard to age, although the proportion is slightly higher among those between ages 15 and 34 (5.8%) than in the 35-64 age group (5.3%).

With regard to time trends, the prevalence of sporadic or regular alcoholic consumption can be considered stable, as can the prevalence of alcoholic intoxications (Figures 2.5 and 2.6).

Table 2.5. Population rate of consumers of alcoholic drinks by age groups and sex (per cent).

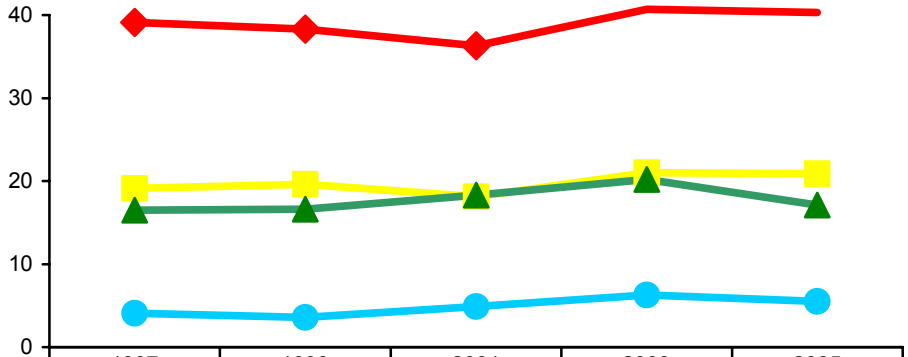
	15-24		25-34		35-44		45-54		55-64	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Last year	83.8	75.9	85.8	71.6	85.1	71.0	83.8	67.0	79.6	58.1
Last month	71.8	59.6	77.6	54.6	78.2	54.9	77.2	50.6	73.0	42.5
Daily in the last year	5.9	1.1	13.0	3.5	25.5	7.9	33.7	11.7	39.9	12.1

Figure 2.5. Population rate of consumers of alcoholic beverages. Spain (per cent), 1997-2005.



	1997	1999	2001	2003	2005
Last 12 months	78,5	75,2	78,1	76,6	76,7
Last 30 days	64	61,8	63,7	64,1	64,6
Daily during the last 30 days	12,7	13,7	15,7	14,1	14,9

Figure 2.6. 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, 1997-2005.



	1997	1999	2001	2003	2005
Men 15-34	39,1	38,3	36,3	40,7	40,3
Women 15-34	19,1	19,6	18,1	21	20,9
Men 35-64	16,5	16,6	18,3	20,2	17,1
Women 35-64	4,1	3,6	4,9	6,3	5,5

Cannabis

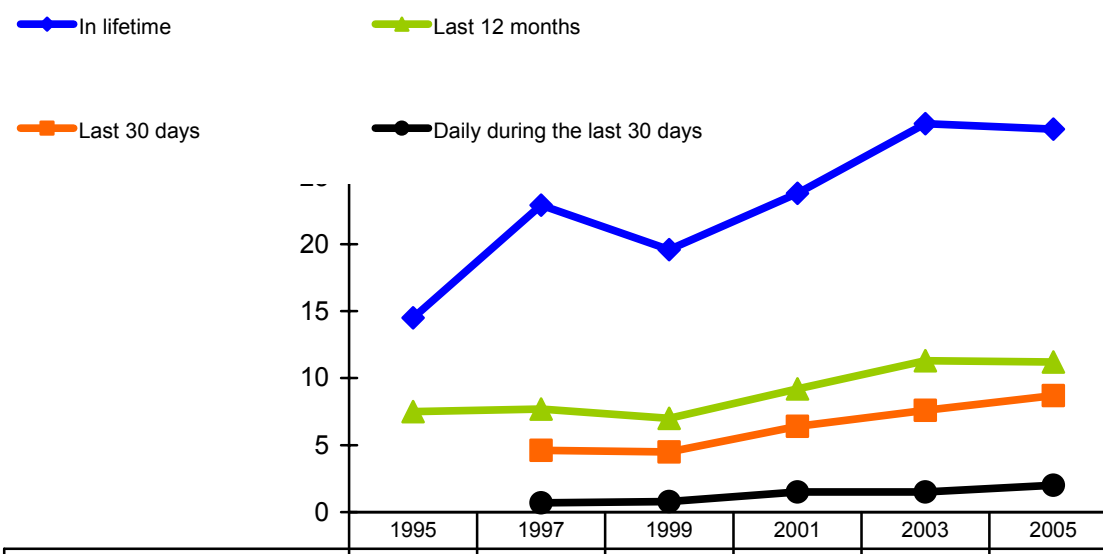
Cannabis continues to be the most widely used illegal drug in Spain. Specifically, 28.6% of the Spanish population claims to have tried it at least once, 11.2% used cannabis during the last year, 8.7% in the last month and 2.0% on a daily basis during the last month.

Consumption is significantly more prevalent among men (15.7% had used it in the last year) than among women (6.6%), and more widespread among young people between the ages of 15 and 34 (19.8%) than among individuals over 34 (4.7%). Relative gender differences in cannabis consumption are greater for monthly consumption (12.5% men and 4.7% women) and particularly for daily use (3.2% men and 0.8% women).

The average age of initiation into cannabis use was 18.3, with women starting slightly later (18.5) than men (18.2).

With regard to the evolution of consumption, experimentation (use at least once) and very sporadic use (at some point in the last year) of cannabis have stabilised, but monthly use continues to rise (7.6% in 2003 and 8.7% in 2005) as has daily consumption (1.5% in 2003 and 2.0% in 2005). The average age of initiation into cannabis use has dropped slightly from 18.5 years old in 2003 to 18.3 in 2005 (Figure 2.7).

Figure 2.7. Prevalence of cannabis use in the population between ages 15 and 64. Spain (per cent), 1995-2005.



	1995	1997	1999	2001	2003	2005
In lifetime	14,5	22,9	19,6	23,8	29	28,6
Last 12 months	7,5	7,7	7	9,2	11,3	11,2
Last 30 days		4,6	4,5	6,4	7,6	8,7
Daily during the last 30 days		0,7	0,8	1,5	1,5	2

Cocaine use

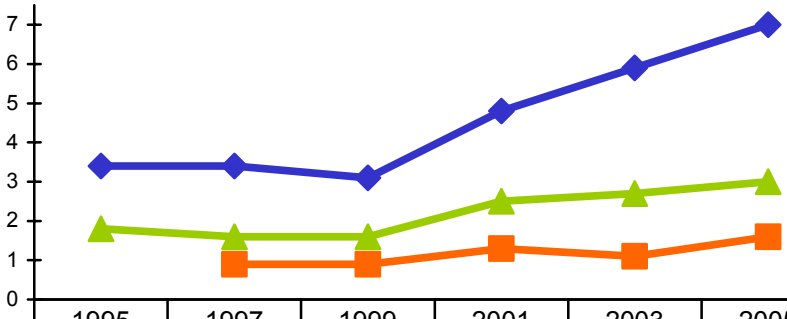
Cocaine in salt form (hydrochloride) or "powder cocaine" is clearly the second most widely consumed psychoactive drug in Spain: 7.00% of the population between the ages of 15 and 64 has tried it at least once on lifetime, 3.0% have done so in the last year, and 1.6% in the last month.

The prevalence of powder cocaine use in the last 12 months was significantly higher in men (4.6%) than in women (1.3%). It was also higher in the 15 to 34-year-old group (5.2%) than in the 34-64 group (1.3%). The average age of initiation into cocaine use was 20.6, with hardly any difference between men and women.

The use of free base or "crack" cocaine is much less prevalent: 0.6% of the population between the ages of 15 and 64 has used this substance at least once in their lives, 0.2% in the last year and 0.1% in the last month. Experimentation with this substance is much more widespread among men than among women; 1.1% of men have tried this drug as opposed to 0.2% of women. The average age of initiation is 20.8.

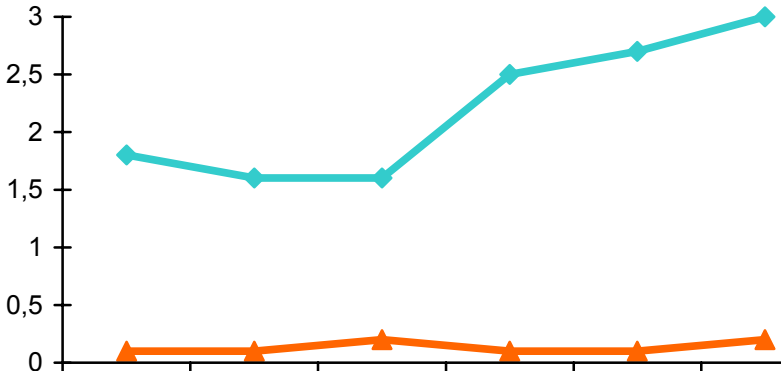
With regard to time trends, the prevalence of powder cocaine has increased spectacularly in recent years. The proportion of users in the last 12 months has gone from 1.8% in 1995 to 2.7% in 2003 and 3.0% in 2005. However, the prevalence of free base cocaine (crack) has remained stable at very low levels. The increased consumption of powder cocaine has not affected both sexes equally. In recent years, cocaine use has risen dramatically among men, going from 3.8% in 2001 to 4.6% in 2005, whereas the rate of use among women has remained stable (1.3%) (Figures 2.8-2.11).

Figure 2.8. Prevalence of cocaine use in the population between ages 15 and 64. Spain, 1995-2005.



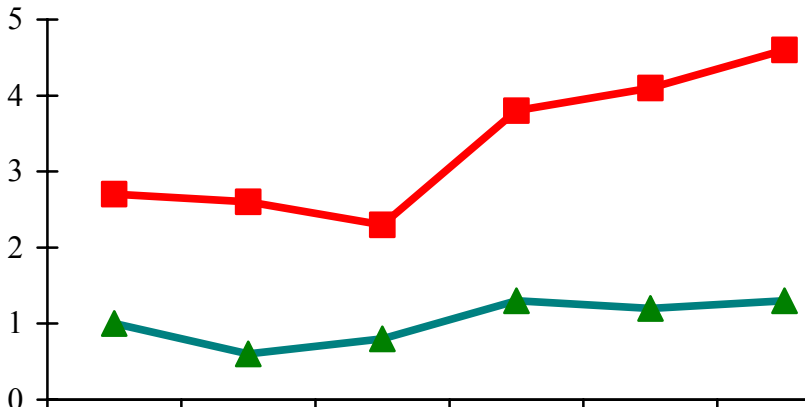
	1995	1997	1999	2001	2003	2005
In lifetime	3,4	3,4	3,1	4,8	5,9	7
Last 12 months	1,8	1,6	1,6	2,5	2,7	3
Last 30 days		0,9	0,9	1,3	1,1	1,6

Figure 2.9. Prevalence of powder cocaine and free base (crack) cocaine use in the last 12 months in the population between ages 15 and 64. Spain, 1995-2005.



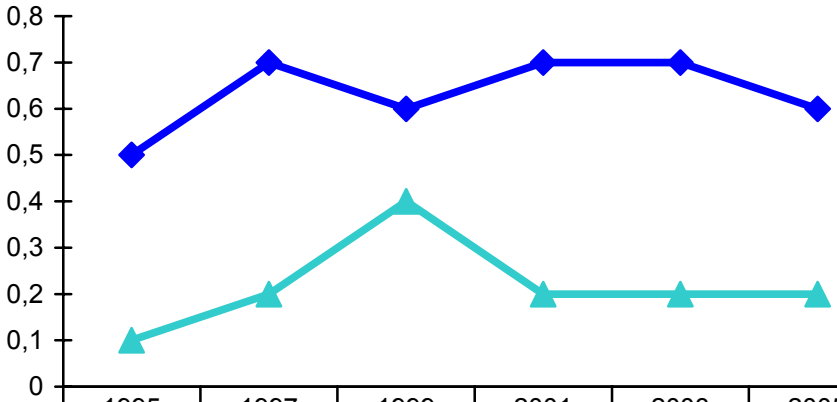
	1995	1997	1999	2001	2003	2005
Powder cocaine	1,8	1,6	1,6	2,5	2,7	3
Free base cocaine	0,1	0,1	0,2	0,1	0,1	0,2

Figure 2.10. Prevalence of powder cocaine use in the population between ages 15 and 64, by sex. Spain, 1995-2005.



	1995	1997	1999	2001	2003	2005
Men	2,7	2,6	2,3	3,8	4,1	4,6
Women	1	0,6	0,8	1,3	1,2	1,3

Figure 2.11. Prevalence of free base (crack) cocaine use in the population between ages 15 and 64. Spain, 1995-2005.



	1995	1997	1999	2001	2003	2005
In lifetime	0,5	0,7	0,6	0,7	0,7	0,6
Last 12 months	0,1	0,2	0,4	0,2	0,2	0,2

Ecstasy use

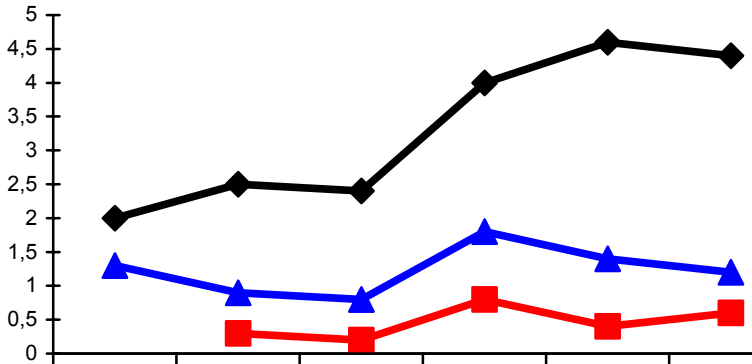
4.4% of the population between ages 15 and 64 have tried ecstasy at least once in their lives, 1.2% have used it in the last year and 0.6% in the last month.

The prevalence of use during the past year was greater among men (1.8%) than among women (0.6%), and greater among the 15-34 age group (2.4%) than among those over age 34 (0.4%). This drug is used very sporadically. In fact, there were no daily users in the sampling, and the prevalence of weekly use was minimal (0.1%).

The age of initiation into ecstasy use was 20.1 (20.2 in men and 19.7 in women), which is higher than the average initiation age for substances such as tobacco, alcohol, volatile inhalants, cannabis, hallucinogens or amphetamines.

The evolution of ecstasy use began to stabilise in 2001 (Figure 2.12).

Figure 2.12. Prevalence of ecstasy use in the population between ages 15 and 64. Spain, 1995-2005.



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

Use of other psychoactive drugs

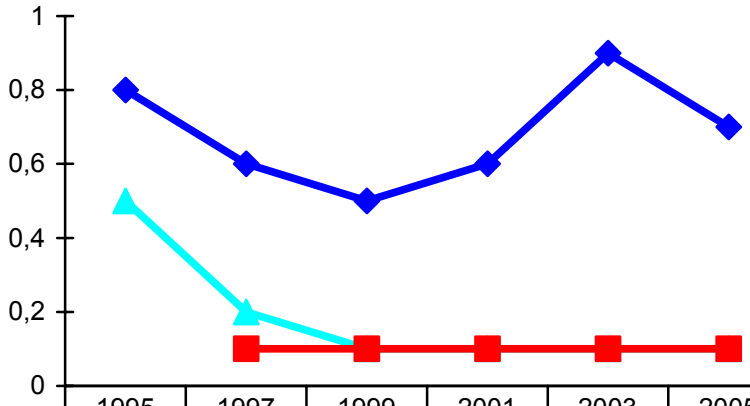
The other psychoactive substances, including amphetamines, hallucinogens, heroin, other opiates and volatile inhalants, are used far less frequently than the drugs mentioned above, especially heroin, other opiates and volatile inhalants. The prevalence of experimenters (tried at least once in lifetime) of the latter is under 1%.

As in the preceding cases, use is more widespread among men than among women, and more common in the 15-34 age group than in the 35-64 group.

The average age of initiation into these drugs was very young for volatile inhalants (17.8), hallucinogens (19.0) and amphetamines (19.2).

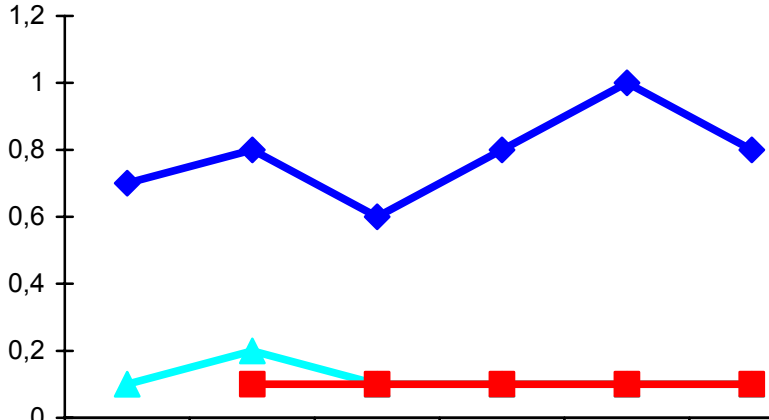
It is difficult to estimate time trends for substances with low rates of consumption because the values can be easily affected by random factors and the difficulty of convincing the most problematic users to participate in surveys. However, it is clear that heroin use has decreased (prevalence of use in the last 12 months went from 0.5% in 1995 to 0.1% in 2005) and hallucinogen use may also be diminishing (0.8% in 1995 and 0.7% in 2005). The prevalence of amphetamine use seems stable (1% in 1995 and 1% in 2005), as does prevalence of use of volatile inhalants and other opiates. (Figures 2.13-2.14)

Figure 2.13. Prevalence of heroin use. Spain (per cent), 1995-2005.



	1995	1997	1999	2001	2003	2005
In lifetime	0,8	0,6	0,5	0,6	0,9	0,7
Last 12 months	0,5	0,2	0,1	0,1	0,1	0,1
Last 30 days		0,1	0,1	0,1	0,1	0,1

Figure 2.14. Prevalence of volatile inhalant use. Spain (per cent), 1995-2005.



	1995	1997	1999	2001	2003	2005
In lifetime	0,7	0,8	0,6	0,8	1	0,8
Last 12 months	0,1	0,2	0,1	0,1	0,1	0,1
Last 30 days		0,1	0,1	0,1	0,1	0,1

Drug injection

Once again, it is important to note that surveys are not the best tool for estimating the scope of the drug-injection phenomenon. Nevertheless, other indicators suggest that this practice is rapidly disappearing. This survey's results indicate that 0.4% of the Spanish population has injected heroin or cocaine at least once in lifetime (1.1% of men and 0.3% of women), with the highest prevalence in the 35-44 age group (0.7%). Prevalence of injection in the last year was 0.1%.

Polydrug use

Actually, use of illegal psychoactive drugs is primarily limited to a sub-group of people who often use various drugs over a certain period of time. For example, a large proportion of those who have used cannabis in the last 12 months as well as tobacco and alcohol (consumed by almost everyone), have also used cocaine (21.7%), ecstasy (9.1%), amphetamines (7.8%) or hallucinogens (5.8%) during the same period.

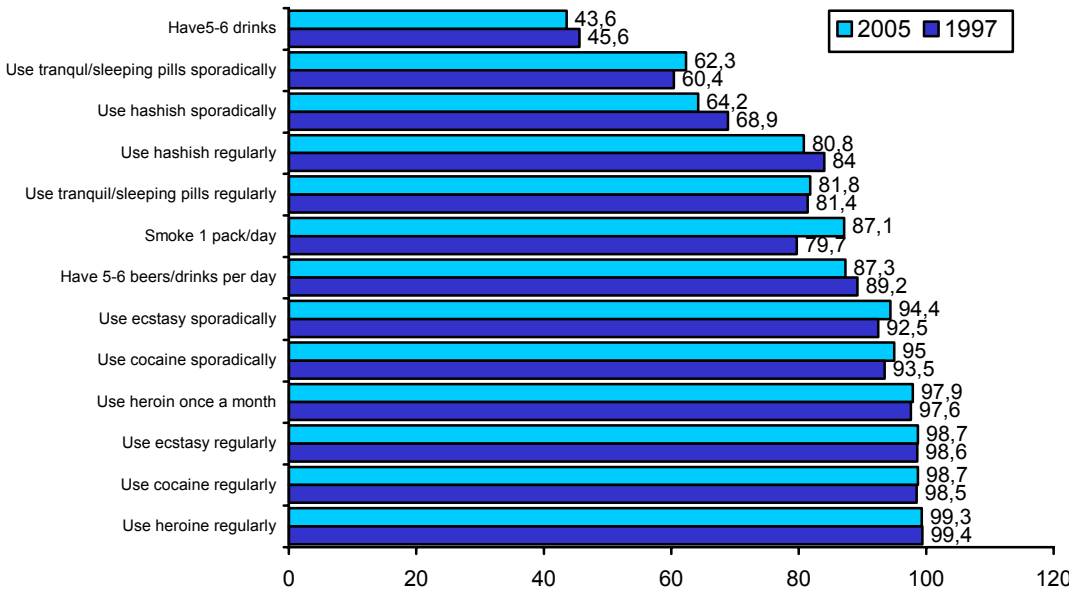
In addition, people who have used cocaine in the last 12 months, in addition to tobacco and alcoholic beverages (consumed by almost everyone), have also used cannabis (81.6%), ecstasy (27.5%), amphetamines (29.6%), hallucinogens (20.8%) or tranquilizers (10.6%) during the same period. The cases of amphetamine and hallucinogen users are similar, and polydrug use among heroin users is even more pronounced.

Perceived risk of drug use behaviour

The perceived risk of different drug use behaviours is probably related to the population's reluctance to acquire those habits in the present or the future. The greater the perceived risk, the less likely they are to engage in the behaviour in question, and vice versa.

Out of all the different manners of drug use, those considered most dangerous are regular use (weekly or more frequently) of heroin (99.3% believe that it can cause serious or significant problems), LSD or hallucinogens (99.2%), cocaine (98.7%) and ecstasy (98.7%). On the opposite end of the scale, the behaviours considered least dangerous are the consumption of five or six beers or alcoholic drinks on the weekend (43.6%), sporadic use (once per month or less) of tranquilizers or sleeping pills (62.3%) and sporadic cannabis use (64.2%). There is also a relatively low perceived risk associated with regular cannabis use (80.8%) or tranquilizers/ sleeping pills (81.8%), as well as the daily consumption of a pack of cigarettes (87.1%) or 5 o 6 beers/ alcoholic drinks (87.3%) (Figure 2.15).

Figure 2.15. Evolution of the proportion of the population between ages 15 and 64 that believe the drug use behaviour described may occasion a fair or even a large number of problems (per cent). Spain, 1997 and 2005.



There are important differences in perceived risk between genders. For all drug use behaviour except the regular use of tranquilizers or sleeping pills, women perceive the risk to be greater. The most significant differences can be seen in the cases of having 5 or 6 beers/ drinks on the weekend (36.7% of men as opposed to 50.7% of women), sporadic cannabis use (57.6% as opposed to 70.9%), regular cannabis use (75.5% and 86.3%), having 5 or 6 beers/ drinks every day (83.4% and 91.2%) and smoking one pack per day (84% and 90.2%) (Table 2.6).

Table 2.6. 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, by sex (per cent). Spain, 2005.

Fair/ large number of problems may be occasioned by:	TOTAL	MEN	WOMEN
Regular heroin use	99.3	99.2	99.4
Sporadic heroin use (in lifetime)	97.9	97.3	98.4
Regular cocaine use	98.7	98.4	99.2
Sporadic cocaine use (in lifetime)	95.0	93.3	96.8
Regular ecstasy use	98.7	98.4	99.0
Sporadic ecstasy use (in lifetime)	94.4	93.0	95.7
Regular hallucinogen use	99.2	99.0	99.4
Sporadic hallucinogen use (in lifetime)	97.1	96.2	98.0
Regular tranquil/ sleeping pill use	81.8	81.5	82.0
Sporadic tranquil/ sleeping pill use (in lifetime)	62.3	61.8	62.7
Regular hashish use	80.8	75.5	86.3
Sporadic hashish use (in lifetime)	64.2	57.6	70.9
Having 5-6 beers/ drinks per day	87.3	83.4	91.2
Having 5-6 beers/ drinks on weekends	43.6	36.7	50.7
Smoking one pack of cigarettes per day	80.1	84.0	90.2

An analysis of risk perception time trends, using 1999 as the base year, shows that:

- Perceived risk of smoking one pack of cigarettes per day has risen (from 82.4% to 87.1%).
- Perceived risk has dropped regarding the use of:
  .- Tranquilizers or sleeping pills (from 70.1% a 62.3% for sporadic use)
  .- Cannabis (from 74.8% to 64.2% for sporadic use)
  .- Alcoholic drinks (from 49.2% to 43.6% for having 5-6 beers/ drinks on weekends, and from 90.7% to 87.3% for daily consumption of 5-6 beers/ drinks).
- The perceived risks of other drug use behaviours (heroin, cocaine, ecstasy and hallucinogen use) have remained relatively stable at high levels.

The perceived risk of using tranquilizers or sleeping pills was the only category to experience a drop since 2003. The perceived risk for all other substances has risen slightly, except for regular consumption of heroin, which has remained stable at an extremely high level (Figure 2.15 and Table 2.7).

Table 2.7. Population between ages 15 and 64 who believe that the drug use behaviour described may occasion a fair or even a large number of problems (per cent). Spain, 1997-2005.

Fair/ large number of problems may be occasioned by:	1997	1999	2001	2003	2005	Difference 2005-2003
Regular heroin use	99.4	99.6	98.8	99.3	99.3	0
Sporadic heroin use (in lifetime)	97.6	98.5	96.7	97.4	97.9	0.5
Regular cocaine use	98.5	99.2	97.9	98.5	98.7	0.2
Sporadic cocaine use (in lifetime)	93.5	95.4	93.3	93.1	95.0	1.9
Regular ecstasy use	98.6	98.9	97.8	98.3	98.7	0.4
Sporadic ecstasy use (in lifetime)	98.5	94.6	92.6	92.6	94.4	1.8
Regular hallucinogen use	99.1	99.4	98.5	99.1	99.2	0.1
Sporadic hallucinogen use (in lifetime)	96.0	97.4	95.5	96.3	97.1	0.8
Regular tranquil/ sleeping pill use	81.4	86.8	84.8	85.4	81.8	-3.6
Sporadic tranquil/ sleeping pill use (in lifetime)	60.4	70.1	66.7	65.3	62.3	-3.0
Regular hashish use	84.0	87.6	83.1	79.2	80.8	1.6
Sporadic hashish use (in lifetime)	68.9	74.8	67.9	62.0	64.2	2.2
Having 5-6 beers/ drinks per day	89.2	90.7	86.1	83.3	87.3	4.0
Having 5-6 beers/ drinks on weekends	45.6	49.2	44.2	41.8	43.6	1.8
Smoking one pack of cigarettes per day	79.7	82.4	83.6	84.6	87.1	2.5

Perceived availability of drugs

In general, the Spanish population perceives illegally marketed drugs to be fairly easy to obtain. Over 43% of the Spanish population between the ages of 15 and 64 believes that it is easy or relatively easy to obtain any of the primary illegal drugs (heroin, cocaine, ecstasy, hallucinogens or cannabis) within a 24-hour period.

Although the perceived availabilities of different drugs do not vary noticeably, the most available drugs are cannabis (66.4% feel it is easy or relatively easy to obtain) and cocaine (53.3%). It is curious to note how the perceived availability of cocaine has surpassed that of ecstasy from 1995 to 2005.

The perceived difficulty of obtaining drugs increases with age; the oldest individuals believe that they would have more problems to obtain them.

With regard to time trends, between 1995 and 2005 the perceived availability of the five main illegally marketed drugs has risen considerably (heroin, cocaine, ecstasy, hallucinogens and cannabis), with the most substantial increases corresponding to cannabis (50.3% believed it was easy or relatively easy to obtain in 1995 and 66.4% in 2005) and cocaine (from 39.5% to 53.3%). If the time period is examined more closely,

the sharpest rises in perceived availability can be seen to have taken place from 1999 to 2001 and from 2003 to 2005 (Table 2.8).

Table 2.8. Perceived availability of psychoactive drugs (easy/ very easy to obtain within 24 hours) in the population between ages 15 and 64 (per cent). Spain, 1997-2005.

Easy/ very easy to obtain this drug within 24 hours:	1995	1997	1999	2001	2003	2005
Hashish/ Marijuana	50.3	52.1	51.8	59.5	59.2	66.4
Ecstasy	41.1	40.9	39.9	48.2	46.1	49.7
Cocaine	39.5	39.2	39.9	46.7	46.5	53.3
Heroin	37.0	36.2	37.2	41.2	39.2	43.4
LSD	37.1	37.0	37.2	42.7	40.0	44.8

Visibility of factors related to problematic drug use and supply

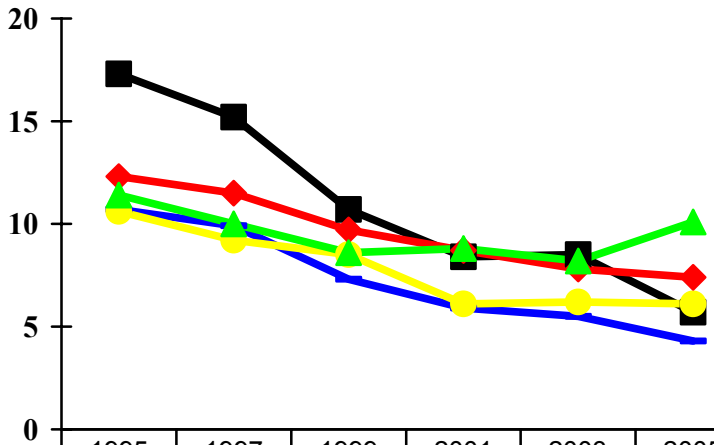
The frequency with which the Spanish population between the ages of 15 and 64 are faced with situations related to problem use of drugs in their neighbourhoods has dropped progressively throughout the 1995-2005 period. This is also true of the proportion of respondents who frequently or very frequently observe syringes lying on the ground (which has gone from 17.3% in 1995 to 5.7% in 2005) or people injecting drugs (from 10.7% to 4.3%) or people snorting or sniffing drugs off aluminium foil (from 10.6% to 6.1%) or intoxicated people passed out on the ground (from 12.3% to 7.4%).

However, the proportion of respondents who are frequently or very frequently approached by dealers who offer them drugs, which had fallen progressively from 1995 to 2003 (from 11.4% to 8.2%) has risen sharply in 2005 (10.1%), which is consistent with the rise in the population's perceived availability of drugs. This clearly demonstrates the important role played by supply and easy availability in the unvarying and increasing use of certain drugs (Table 2.9 and Figure 2.16).

Table 2.9. Visibility of certain situations related to illegal drug use in the immediate surroundings (percentage of population between the ages of 15 and 64 frequently or very frequently finding the situations described in the neighbourhood or town where they live). Spain, 1997-2005.

Percentage of the population who frequently or very frequently find:	1995	1997	1999	2001	2003	2005	Difference 2005-2003
Syringes on the ground	17.3	15.2	10.7	8.4	8.5	5.7	-2.8
People injecting drugs	10.7	9.9	7.3	5.9	5.5	4.3	-1.2
People smoking drugs off aluminium foil	10.6	9.2	8.5	6.1	6.2	6.1	-0.1
Intoxicated people passed out on the ground	12.3	11.5	9.7	8.7	7.8	7.4	-0.4
Dealers offering them drugs	11.4	10.0	8.6	8.8	8.2	10.1	1.9

Figure 2.16. Visibility of certain situations related to illegal drug use in the immediate surroundings (percentage of population between the ages of 15 and 64 frequently or very frequently finding the situations described in the neighbourhood or town where they live). Spain, 1997-2005.



	1995	1997	1999	2001	2003	2005
Syringes on the ground	17,3	15,2	10,7	8,4	8,5	5,7
People injecting drugs	10,7	9,9	7,3	5,9	5,5	4,3
People smoking heroin	10,6	9,2	8,5	6,1	6,2	6,1
Passed-out drug addicts	12,3	11,5	9,7	8,7	7,8	7,4
Drug dealers	11,4	10	8,6	8,8	8,2	10,1

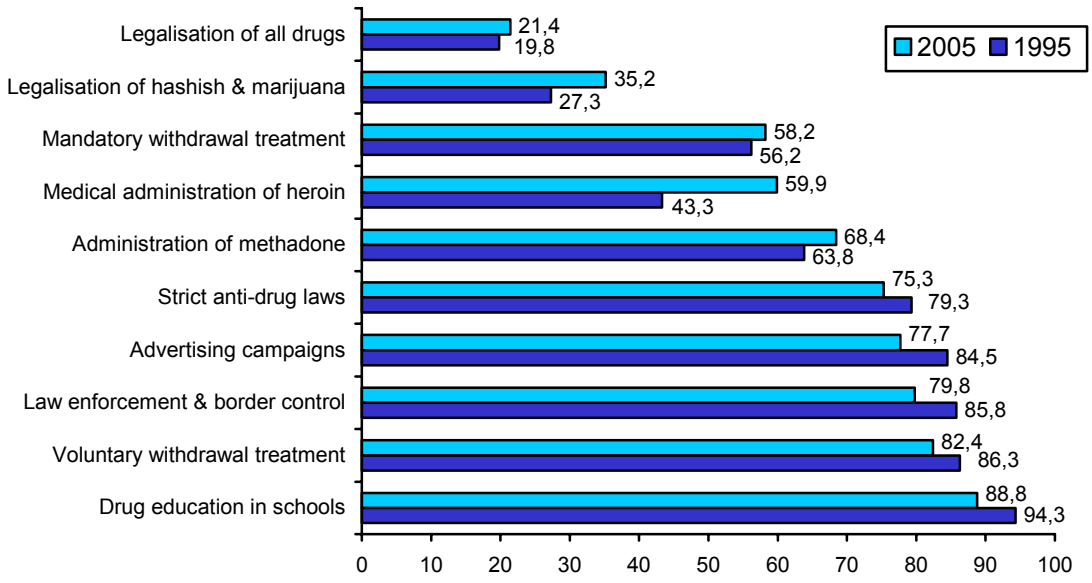
Assessment of importance of actions to attempt to solve the illegal drug problem

In 2005, the population between the ages of 15 and 64 perceived drug education in schools as the most important tool for solving the problem of illegal drugs. This measure was followed, in descending order of importance, by voluntary withdrawal treatment of drug users, law enforcement and border control, advertising campaigns explaining the risks of drug use, strict anti-drug laws, medical administration of methadone for heroin users, medical administration of heroin for users who fail to respond to other treatments, and mandatory withdrawal treatment. The measures considered least important were the legalisation of cannabis or all illegal drugs (Table 2.10, Figure 2.17). The importance attached to conventional measures or measures that have been in place for a long time, such as drug education in schools, advertising campaigns, voluntary withdrawal treatment, law enforcement and border control and strict anti-drug laws, decreased from 1995 to 2005, while the importance attached to less conventional or newer measures increased. The latter measures include obligatory withdrawal treatment, medical administration of methadone, medical administration of heroin when all other treatments fail, and the legalisation of cannabis or all illegal drugs (Table 2.10 and Figure 2.17).

Table 2.10. Assessment by the population between ages 15 and 64 of different measures to attempt to solve the drug problem (per cent). Spain, 1997-2005.

Considered very important for solving the drug problem:	1995	1997	1999	2001	2003	2005
Drug education in schools	94.3	93.1	91.8	89.4	89.5	88.8
Voluntary withdrawal treatment	86.3	87.1	84.8	81.6	82.7	82.4
Law enforcement & border control	85.8	83.7	82.1	80.5	78.8	79.8
Advertising campaigns	84.5	81.5	79.8	77.6	75.6	77.7
Strict anti-drug laws	79.3	77.0	76.9	75.5	73.2	75.3
Mandatory withdrawal treatment	56.2	57.2	57.9	62.8	59.7	58.2
Administration of heroin	43.3	47.5	53.9	58.2	59.3	59.9
Legalisation of all drugs	19.8	21.5	24.6	27.1	23.5	21.4
Legalisation of cannabis	27.3	30.2	33.3	38.5	37.1	35.2
Administration of methadone	63.8	62.9	67.5	66.6	61.7	68.4

Figure 2.17. Assessment by the population between ages 15 and 64 of different measures to attempt to solve the drug problem (per cent of those who feel the measure is very important). Spain, 1995-2005.



Conclusions

The most relevant conclusions that can be drawn from the 2005 EDADES survey and from the analysis of the past series of household surveys are: the decrease in tobacco consumption and the increase in perceived risk of tobacco use, the steadily increasing trend of cocaine use, and the increase in perceived availability of most illegal drugs. Fortunately, free base (crack) cocaine use has barely increased outside of the sphere of heroin users, but it is an ever-present threat that could manifest itself at any time. Ready-to-use crack cocaine is already being sold in several Spanish cities.

The positive trend of tobacco use is undoubtedly related to the recent measures enacted with regard to its consumption, because this is the first time that EDADES has discovered a net decrease in the prevalence of daily smokers (from 36.7% in 2003 to 32.8% in 2005). In addition, the drop in tobacco use was accompanied by an increase in the perceived risk of smoking. These measures must be continued and reinforced. They were introduced by Law 28/2005, 26 December, on public health measures to counter tobacco addiction and regulate the sale, supply, consumption and advertising of tobacco products (BOE 27/12/2005).

Alcohol consumption appears to have stabilised at very high levels. On a positive note, the continued descent in the perceived risk of daily use and weekend consumption observed between 1997 and 2003 has levelled off. However, the perceived risk of such use continues to be very low for a significant proportion of the population.

Although the proportion of people who experiment with cannabis or use it very sporadically (at least once a year) seems to have stabilised, the proportion of monthly or daily users continues to rise. Following the continual decline in perceived risk between 1997 and 2003, this indicator appears to have stabilised.

Use of amphetamines, ecstasy and hallucinogens currently appears to be stable or decreasing. Use of heroin and injected drugs continues to descend as well, although household surveys are not the best method of recording very problematic and marginalised problematic uses. However, the decrease in visibility of certain factors related to problematic drug use (seeing discarded syringes, people injecting drugs or people smoking drugs off aluminium foil, etc.) only serve to indirectly prove the decrease in drug injection and heroin use.

The increase in the perceived availability of illegal drugs is very strong. The increase in visibility of dealers offering drugs to people on the street reflects the same phenomenon.

- **DRUG USE IN THE SCHOOL AND YOUTH POPULATION**

The information for this section is contained in the 2005 Spanish National Report.

- **DRUG USE AMONG SPECIFIC GROUPS**

No new information available.

3. PREVENTION

The prevention objectives and guidelines of the National Plan on Drugs (PNSD) are laid out in the 2005-2008 Drug Action Plan, drafted by the Ministry of Health and Consumer Affairs as part of the 2000-2008 National Drug Strategy adopted by the Spanish government in December 1999. Prevention is one of the 6 axes established in said Action Plan. This particular axis proposes 13 actions that are directly related to the area of prevention, which refer to the promotion of family prevention, training for education professionals and including health care professionals in prevention activities in schools, spreading information to the general public and working with the media, promoting prevention in the workplace, working with at-risk populations, peer assesment, preventive intervention in underage alcohol use and associated problems, and finally preventive intervention with women.

The Government Delegation for the National Plan on Drugs (GDNPD) has financed prevention projects that will be managed by NGOs and autonomous regions and cities to implement the Action Plan. During this period, the following areas have been given priority status:

- School and family prevention
- Work with at-risk groups.
- Design of prevention materials.
- Prevention in the population at risk for social exclusion.
- Peer assesment.
- Spreading information to the general public.
- Prevention with families.
- Programmes aimed at women.

Joint efforts with **Non-Profit Entities** are also a top priority. For that reason the **"Society faced with Drugs" Forum** was created. in which more than 50 non-governmental organisations participate. In 2005, 3 work groups were created – "Youth", "Family" and "Media" – which drafted proposals on these themes throughout the year, that were presented in a Forum meeting on 29 November 2005 (http://www.pnsd.msc.es/Categoria3/prevenci/ForoSociedad.htm).

- **UNIVERSAL PREVENTION**

Prevention in Schools

Prevention in schools is well-established throughout the Spanish territory and works with more students every year. Although data from all Autonomous Communities is not yet in, prevention programmes are currently estimated to reach over 1 million students each year. In some Autonomous Communities, coverage in educational centres is complete. There are more than 40 programmes accredited by the Autonomous Communities, which are included in a catalogue published by the Government Delegation for the National Plan on Drugs. Some programmes are applied in various Autonomous Communities and reach a significant number of students. This is true of programmes such as *Prevent to Live (Prevenir para Vivir), Extraordinary (Órdago)* or *The Adventure of Life (Aventura de la Vida)*. The programmes used vary greatly as to the number of classroom session (between 3 and 40) and the intensity and difficulty of teacher training. Recently, new initiatives have been added that include a community factor, based on coordination between educational and health-care centres. This step is a direct result of one of the weaknesses detected in the National Drug Strategy's

evaluation, which showed that health care professionals needed to become involved in drug addiction prevention measures.

Outside of schools, but within the educational sector, prevention programmes are in place at universities which employ an informative strategy to raise awareness and are based on mediation between young people.

Family programmes

No great changes have been observed in this area. All Autonomous Communities and Cities promote family prevention, although this is often a complicated task given the difficulty of getting parents to enrol and participate consistently in the programmes. Even so, the number of families reached has grown over the years. Many of the difficulties inherent in working with families are detailed in the study completed by the "Society faced with Drugs" Forum's workgroup.

Community programmes

Alternative recreation programmes

Every Autonomous Community finances or co-finances local prevention projects with either public grants or collaboration agreements. Many such projects are designed for prevention in recreation areas and limitation of harm/ damages associated with recreational drug use.

Numerous Municipal Authorities carry out activities related to the prevention of alcohol and other drug use and care for people affected by said use, according to the authority granted them by virtue of the legislation in effect. Many such municipal governments, especially in more populated towns (more than 50,000 inhabitants), have a Local Drug Plan that clearly defines the objectives and measures to be taken in this area. In addition, these Local Drug Plans establish an organisational structure and earmark financial resources for implementing said measures.

The Ministry of Health and Consumer affairs, via the Government Delegation for the National Plan on Drugs, contributes to the funding of prevention activities carried out by local institutions. In the year 2005, the Delegation has granted 1.7 million euros in funding to 36 local institutions for the same number of drug addiction prevention programmes.

The objective of these programmes is to provide or encourage healthy activities as an alternative to drug use in young people's leisure time and are primarily aimed at youth between the ages of 14 and 30.

Programmes at conventional drug/ alcohol use settlings

Practically all Autonomous Communities are active in night clubs and settlings where alcohol or drugs are often consumed. These programmes usually focus on damage control by using informative strategies via youth mediators and on the prevention of traffic accidents by offering alternative transport measures (night buses and designated-driver programmes).

Media

All Autonomous Communities and Cities have media campaigns and promote programmes about drugs in the media, particularly on local radio stations.

In 2005, the Government Delegation for the National Plan on Drugs started the campaign entitled *Drugs: Are you going to risk it?* This campaign, along the lines of previous Delegation campaigns, is primarily aimed at young people and attempts to increase the perceived risk of drug use in a positive tone that appeals to adolescent's responsibility. It includes advertisements in the press, radio, television and internet, billboards, marquees and city buses, as well as illuminated advertisements in recreational venues (bars, cafés, discotheques).

The campaign budget is 640,000 euros (140,000 for design and 500,000 for outdoor advertising). Over 200 public and private entities, including municipal and regional authorities, NGOs and media networks throughout Spain, provide free services to disseminate the campaign message.

In addition, one of the workgroups of the "**Society faced with Drugs" Forum** is focused specifically on the media. One of this group's contributions is the publication of a guide of good practices for the media and communications professionals (http://www.pnsd.msc.es/prensa/BuenasPracticas.htm).

- **SELECTIVE/ INDICATED PREVENTION**

In Spain, 0.52% of personal income taxes are earmarked for financial aid granted to non-profit social organisations. A part of this quantity helps to fund drug programmes, and many of the projects benefiting from these funds are selective prevention programmes. In 2005, 619,874 € were set aside for programmes that work primarily with children and young people and, to a lesser degree, with families.

The Autonomous Communities also offer this kind of programme, although some information had not yet been submitted as of the closing of this report and therefore no specific data can be provided.

There are specific programmes for at-risk children that operate within the community and less frequently in schools. However, some clinical assistance programmes have long included selective and indicated prevention measures for underage users who are not considered addicts. Work with such users takes place on the streets, in community centres or in venues other than clinics to minimise contact with drug addicts. Most of these programmes include activities for personal growth, academic support and recreation.

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, the results are not available yet. 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.

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 results were presented on the 2005 Annual Report.

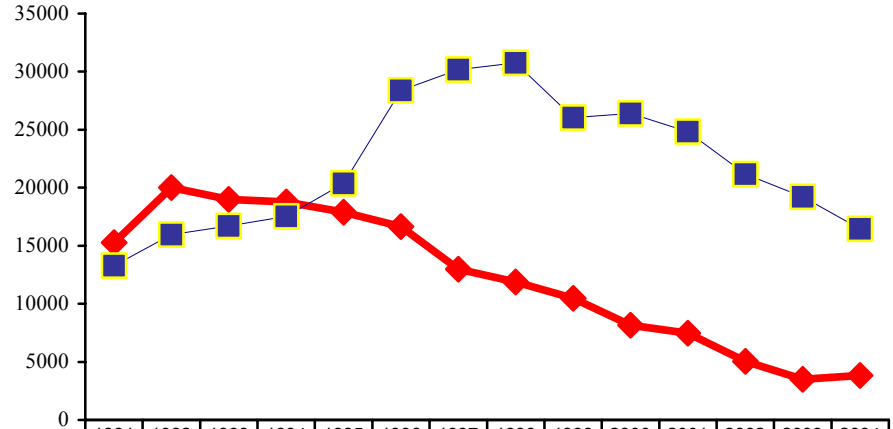
A recent study provided an estimate of the incidence of heroin and cocaine use in Barcelona between 1991 and 2003, based on admissions for treatment for drug abuse or addiction. The Reporting Delay Adjustment (RDA) statistical technique was used, which provides a prediction of future cases based on those cases observed by using the latency period (years between first consumption and first treatment) for each drug. The results show that the estimated incidence in Barcelona fell progressively after 1991; whereas that of cocaine rose rapidly until 1998 and later followed an irregular pattern (Sánchez Niubó A et al. 2005).

- ### 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. However, after 2002 the number of treatments rose again to 52,922 in 2004. The 1998-2002 decrease was probably due to the effect of long-term methadone treatment programmes, which cut back on user rotation between different treatment services. The subsequent rise in 2002 is in all probability due to the substantial increase in treatments for cocaine and cannabis use.

The profile of treatment admissions is rapidly changing, with a continued decrease in admissions for treatment for heroin and an increase in admissions for treatment for cocaine (above all) or cannabis. The number of first-time admissions for treatment for heroin (first time ever admitted) went down between 1992 (year with the highest number) and 2003, going from 20,017 to 3,496. However, in 2004 the number rose slightly to 3,821 admissions. Yet the number of patients admitted for treatment for heroin who had been treated before for this drug has followed a downward trend since 1998 (when it peaked), falling from 30,756 in that year to 16,448 in 2004 (Figure 4.1).

Figure 4.1. Number of patients treated for heroin abuse or addiction in Spain, 1991-2004.

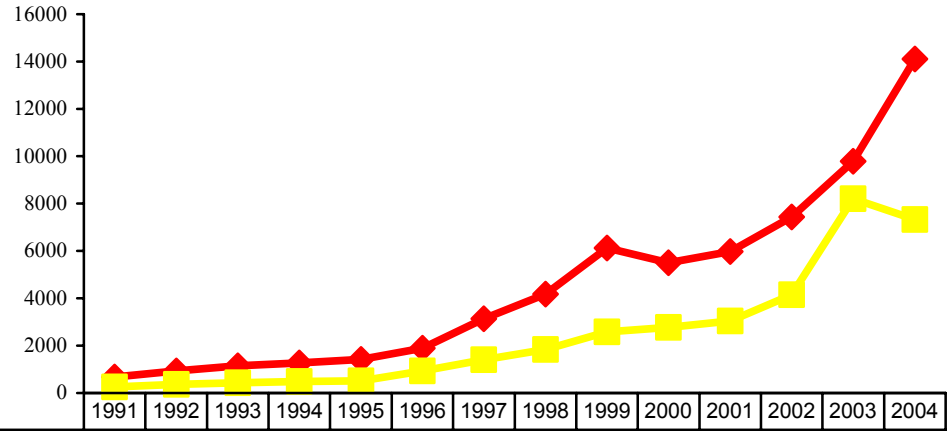


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
1st Time Treated	15277	20017	18977	18770	17878	16647	12993	11867	10473	8151	7461	5051	3496	3821
Treated in the Past	13296	15956	16703	17526	20369	28382	30173	30756	26031	26412	24844	21162	19197	16448

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

In recent years, the number of admissions for treatment for cocaine has experienced a very rapid growth. The number of first-time admissions for cocaine went from 681 in 1991 to 14,105 in 2004 (practically following an exponential growth rate after the year 2000). The number of admissions for cocaine abuse or addiction with a history of prior treatment increased between 1991 and 2003, but this number has dropped slightly in 2004 (Figure 4.2).

Figure 4.2. Number of patients treated for cocaine abuse or addiction in Spain, 1991-2004.

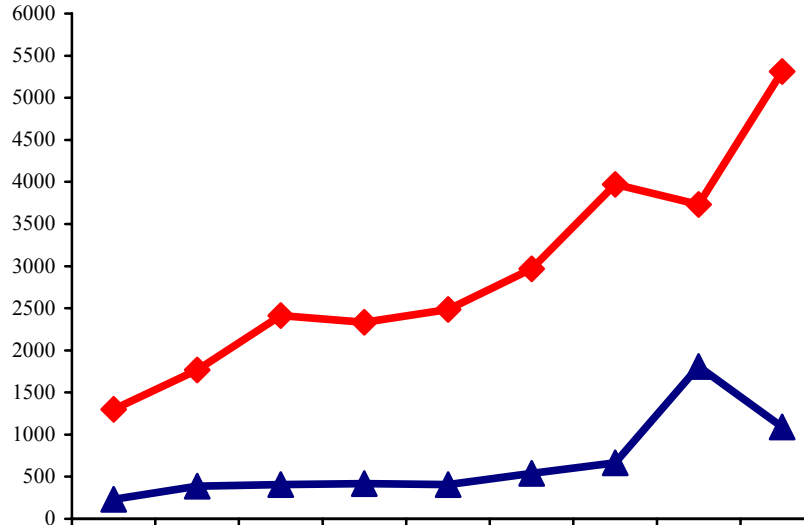


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
1st Time Treated	681	932	1146	1265	1415	1892	3129	4174	6126	5499	5977	7438	9782	14105
Treated in the Past	262	367	431	491	516	932	1402	1838	2576	2773	3046	4155	8206	7328

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

The number of admissions for treatment for cannabis abuse or addiction has highly increased in the last years. The number of first-time admissions rose from 1,300 in 1996 to 5,312 in 2004, and the number of admissions with a history of past treatment for this drug, went from 230 in 1996 to 1,807 in 2003, later falling to 1,091 in 2004 (Figure 4.3).

Figure 4.3. Admissions for treatment for cannabis abuse or addiction (absolute numbers). Spain, 1996-2004.

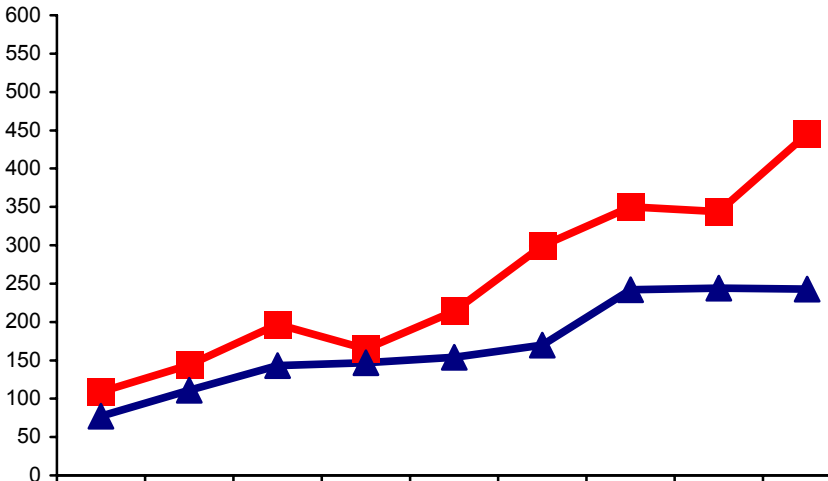


	1996	1997	1998	1999	2000	2001	2002	2003	2004
1st Time Treated	1300	1768	2412	2335	2487	2966	3972	3731	5312
Treated in the Past	230	387	407	418	408	540	665	1807	1091

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

Other drugs exhibiting an upward trend in treatment admissions are sedative-hypnotic drugs (tranquilizers, sedatives or sleeping pills). In fact, the number of first-time admissions rose from 109 in 1996 to 445 in 2004, and the number of admissions with a history of past treatment for these drugs went from 77 in 1996 to 243 in 2004 (Figure 4.4).

Figure 4.4. Admissions for treatment for sedative-hypnotic drug abuse or addiction (absolute numbers). Spain, 1996-2004.

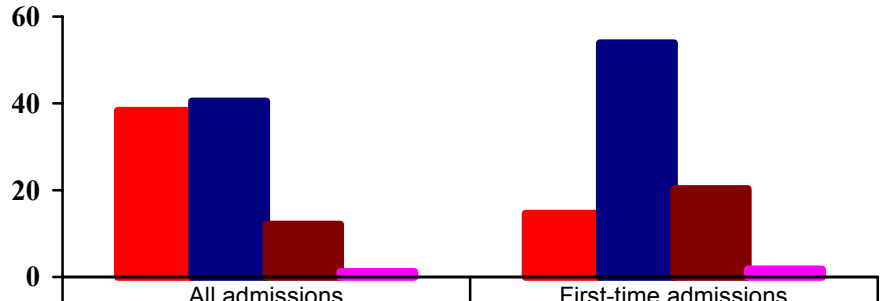


	1996	1997	1998	1999	2000	2001	2002	2003	2004
1st Time Treated	109	144	197	165	214	299	350	344	445
Treated in the Past	77	111	143	147	154	170	242	244	243

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

The other drugs played a very minor role with regard to treatment services. In fact, stimulants other than cocaine (amphetamines, ecstasy and others) in 2004 only represented 1.8% of first-time admissions and 1.2% of all admissions, and these numbers do not show signs of rising. If this is compared with cocaine, heroin and cannabis, it is clear that the impact of these drugs on special drug addiction treatment services in Spain is minimal (Figure 4.5).

Figure 4.5. Proportion of patients treated for abuse or addiction to heroin, cannabis, cocaine, and other stimulants in Spain, 2004.



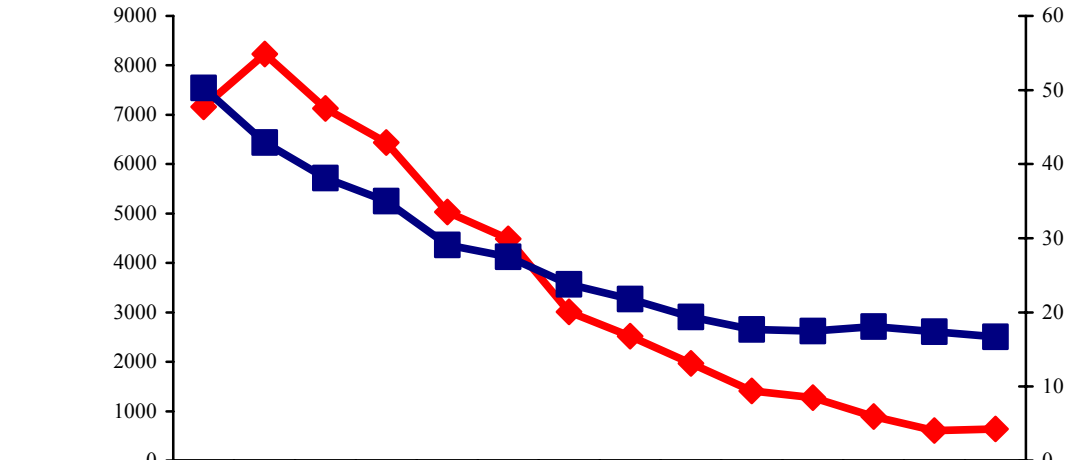
	All admissions	First-time admissions
Heroin	38,3	14,6
Cocaine	40,5	53,9
Cannabis	12,1	20,3
Other stimulants	1,2	1,8

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

As Figure 4.5 shows, in 2004 in Spain cocaine was the illegal drug responsible for the greatest number of admissions for treatment for psychoactive substance abuse or addiction with 40.5% of admissions, followed by heroin (38.3%) and cannabis (12.1%). The difference in favour of cocaine is even greater in first-time admissions. In fact, in this case, cocaine is the drug that provoked the most first-time admissions (53.9%), followed by cannabis (20.3%) and heroin (14.6%).

Among patients admitted to treatment for heroin in 2004, the predominant intake method for this drug during the 30 days prior to admission was inhaling or smoking ("chasing the dragon"), followed by injection and intranasal methods and snorting. Since the early 1980s, when the use of the injection method was almost universal among heroin users, a radical change in the predominant method of consuming heroin has come about and the preferred intake method is now pulmonary. In fact, the number of patients treated for heroin abuse or addiction that most frequently (or primarily or preferably) consumed by injection fell from 8,232 in 1992 (when the trend peaked) to 608 in 2003 and 638 in 2004. The proportion of these persons to the total number of patients admitted for heroin treatment went from 50.3% in 1991 to 16.7% in 2004 (Figure 4.6). However, it is important to note that, after many years of steady decrease, in 2003 the data showed signs of a levelling off or an increase in the number of first-time patients admitted for treatment for heroin who administered this drug by intravenous injection.

Figure 4.6. Number and percentage of first-time patients treated for heroin abuse or addiction that preferably used the intake method of injection. Spain, 1991-2004.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Absolute number	7164	8232	7129	6435	5033	4488	3011	2518	1969	1414	1276	894	608	638
Percentage	50,3	42,9	38,1	35	29,1	27,5	23,8	21,8	19,4	17,7	17,5	18,1	17,4	16,7

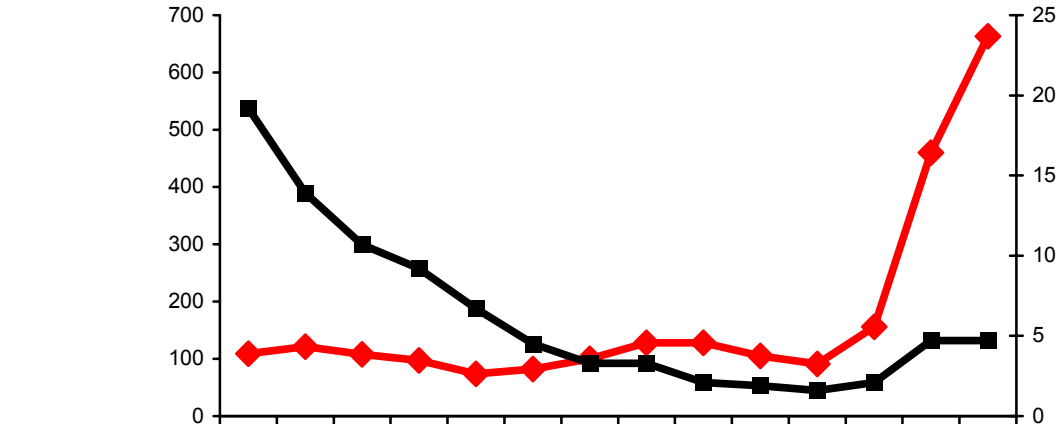
The percentages are out of the total number of first-time patients admitted for heroin

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

Despite the fact that intravenous heroin use has decreased across the board in every autonomous community, there are significant differences between communities in the proportion of patients treated for heroin who prefer to inject this drug. For example, in 2004 this proportion was 6.5% in Andalusia and 42.3% in Catalonia.

Among patients admitted for treatment for cocaine, the predominant intake method is intranasal or snorting (over 70%), followed by pulmonary intake or smoking (11-18%, depending on the autonomous community) and injection (6%). The proportion of patients admitted for cocaine that use injection as the primary method of intake for this drug went down between 1991 and 2001, with the proportion among first-time admissions going from 19.2% in 1991 to 1.6% in 2001, although it later rose to 4.7% in 2004. Nevertheless, the evolution of the absolute number of patients admitted for first-time treatment for cocaine with this pattern of use has followed a different trend, remaining more or less stable between 1991 (109 patients) and 2001 (91 patients) and later spiking up to a total of 663 patients in 1994 (Figure 4.8). It is possible that this phenomenon may reflect the impact of former injectors in opiate maintenance programmes who have only now begun receiving treatment for cocaine. In any case, this phenomenon must be closely monitored.

Figure 4.7. Number and percentage of first-time treated patients for cocaine abuse or addiction, that preferably are intravenous users. Spain, 1991-2004.

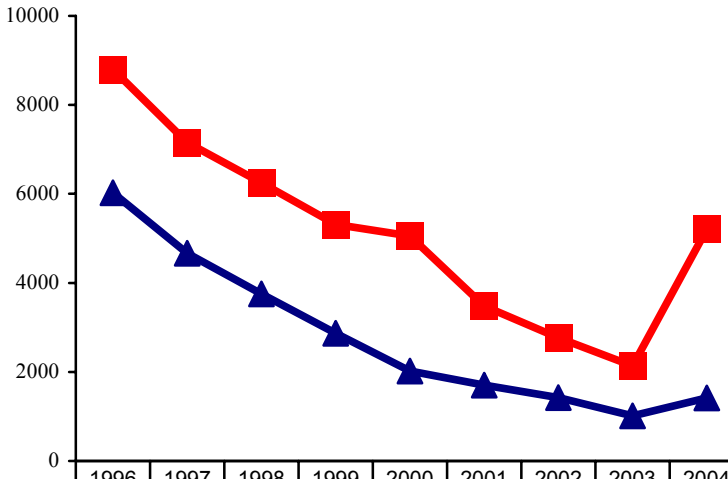


	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Absolute number	109	121	108	97	74	82	100	128	128	105	91	156	460	663
Percentage	19,2	13,9	10,7	9,2	6,7	4,5	3,3	3,3	2,1	1,9	1,6	2,1	4,7	4,7

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

Overall, use of intravenous injection among those admitted to treatment became less prevalent over the course of the 1990s up until 2003, but it appears to have gained new strength in 2004. In fact, the number of patients admitted for any psychoactive drug who had injected drugs at some point went from 8,801 in 1996 to 2,137 in 2003 and 5,208 in 2004, and the number of those who had injected in the last 30 days went from 6,027 in 1996 to 1,014 in 2003 and 1,413 in 2004 (Figure 4.8). The fact that the number of patients who had injected at least once in their lives was much greater than the number of those who had injected in the last 30 days suggests that the phenomenon may be due to former injectors or long-time injectors in opiate maintenance programmes who now inject cocaine and are receiving treatment.

Figure 4.8. Number of injectors admitted for treatment for drug abuse or addiction in Spain, 1996-2004.



	1996	1997	1998	1999	2000	2001	2002	2003	2004
Injected at least once	8801	7154	6247	5315	5055	3483	2765	2137	5208
Injected in the last 30 days	6027	4664	3752	2865	2022	1706	1427	1014	1413

SOURCE: GDNPD. Spanish Monitoring Centre for Drugs (OED). Treatment indicator.

In 2004, the vast majority of patients admitted for treatment for illegal drug abuse or addiction (83.4% of all admitted and 82.5% of first-time patients) continue to be male. The highest proportion of men is found among those admitted for cocaine or cannabis, and the lowest among patients admitted for sedative-hypnotic substances. The average age of patients admitted for treated was 32 for all admissions and 29.5 for first-time admissions. 7.4% of all admissions and 13% of first-time admissions were under the age of 20.

Table 4.1 Average age and distribution of patients admitted to treatment for drug abuse or addiction in spain, by age (per cent). Spain, 2004.

		All admissions to treatment			First-time admissions		
		Men	**Women**	**Total**	**Men**	**Women**	**Total**
Number of treatments		44,146	8,776	52,922	21,606	4,563	26,169
Average age (years)		31.9	32.5	32	29.2	30.8	29.5
Distribution by age (%)	**<15**	0.3	0.5	0.3	0.5	0.8	0.6
	15-19	6.9	8.1	7.1	12.2	13.6	12.4
	20-24	14.9	13.6	14.7	22.5	18.8	21.8
	25-29	19.2	17.1	18.9	22.4	18.0	21.7
	30-34	20.9	20.0	20.8	17.0	15.6	16.7
	35-39	18.9	18.7	18.8	12.1	13.2	14.3
	40-44	11.7	12.6	11.8	7.3	9.4	5.7
	45-49	4.6	5.2	4.7	3.2	5.0	3,5
	50-54	1.6	2.2	1.7	1.4	2.7	1.6
	55-59	0.6	1,0	0.6	0.7	1.2	0.8
	60-64	0.3	0.7	0.3	0.4	1.0	0.5
	>= 65	0.3	0.5	0.3	0.4	0.7	0.5

The average age of people admitted for heroin was 33-35, for cocaine 29-30 and for cannabis 23-26. Between 4 and 8% were born outside of Spain.

The level of education of admitted patients has tended to improve slightly over time, but it 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 proportion 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 was 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 that 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 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.

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.

Approximately half (51.6%) 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 (81.2%) than among those treated for cocaine (34.2%), cannabis (17%), amphetamines (25.8%) or ecstasy (30.8%).

- **MAIN CHARACTERISTICS AND PATTERNS OF USE FROM NON-TREATMENT SOURCES**

Heroin users recruited in community

In 2001-2003, the basal interview of a study of cohorts of young heroin users (Itínere Project) was carried out in Madrid, Barcelona and Seville (de la Fuente L et al. 2005b). The study was funded by various public agencies and institutions under the aegis of the Ministry of Health and Consumer Affairs (FIPSE, FIS, GDNPD and others) and was directed by researchers from different public administrations (Luis de la Fuente, Rosario Ballesta and Teresa Brugal). Current heroin users age 30 or under were selected from the community using chain sampling techniques. The data was gathered through a questionnaire administered via a computer assisted survey instrument (CASI), with an audio-CASI version to explore sexual behaviour. Blood samples were obtained with blotting paper and anthropometric measures. The participants and data gatherers were remunerated for their collaboration. The number of participants was 991 (364 in Barcelona, 427 in Madrid and 200 in Seville), most of whom were recruited by users or former users not participating in the study (44.7%) or nominated by other participants (39.7%). The target sampling was very difficult to obtain, presumably due to the scarcity of young heroin users. The socio-demographic characteristics of participants and their implication in situations of social conflict are reflected in Table 4.2.

Most of the users from the three cities (67-77.5%) began using heroin before or at age 18 and they generally began by smoking in Seville (88.9%) and Madrid (65.6%) and snorting (46.6%) or smoking (39.7%) in Barcelona. Starting out with injection was rare (4-13.8%). For the majority, the time lapsed between the first use and the beginning of weekly consumption was less than 6 months (61.3-80.7%). After beginning weekly use, smoking remained the predominant intake method in Seville (92.8%) and Madrid (77.7%), whereas in Barcelona the three methods mentioned had a similar prevalence. However, snorting has become less popular, with injections becoming more favoured in Barcelona and smoking more popular in Madrid. Between 19.1% (Seville) and 54.4% (Barcelona) had switched their preferred heroin intake method at least once in their lives (only changes lasting longer than one month were taken into account). In Barcelona, the switch from non-injected to injected methods was predominant (87.7%); in Seville, the predominant change was the exact opposite (82.2%) and in Madrid both kinds of changes were similarly reported (Table 4.2).

With regard to recent patterns of use (last 12 months), between 46.9% (Barcelona) and 69% (Seville) of participants used heroin daily or almost daily (5-6 days/ week). However, between 18.5 and 26.9% used it much less frequently (1-2 days/ week). As happened in the first stages of use, the most recent primary intake method differed

drastically according to the city: in Madrid (82.9%) and particularly in Seville (99%), smoking was the most predominant by far, and in Barcelona injection was preferred (59.3%), although there are many smokers (28.3%) and snorters (12.4%). The use of heroin mixed with cocaine in the same dose also varied unequally from city to city: in Seville, 86.1% had used this mix every or almost every time they used heroin, as opposed to 34.8% in Madrid and 27.5% in Barcelona. With regard to the type of heroin, almost all participants in Madrid (96.9%) and Seville (97.5%) always use brown heroin, whereas many in Barcelona (75.5%) always or almost always use white heroin (Table 4.2).

In Madrid and Barcelona, the preferred heroin use sites were popular areas for drug dealing and consumption, although many also cited their own residences and open-air spaces (streets, squares, parks, etc.). On the other hand, users in Seville hardly consumed in popular areas for dealing and consumption, preferring venues such as their houses, open-air public spaces and other locations (especially abandoned buildings or houses belonging to dealers, friends or partners). The majority of participants (52.5-70%) usually consumed heroin in the company of others, especially close friends, acquaintances or long-term sexual partners. The proportion of those who usually consumed alone was greater in Seville than in Barcelona or Madrid (Table 4.2).

Table 4.2. Patterns of heroin use among young users in Barcelona, Madrid and Seville. 2001-2003.

	Barcelona	Madrid	Seville	Total	p$
	(n=364)	(n=427)	(n=200)	(n=991)	
Initiation age					***
<15	11.5	23.7	27.0	19.9	
15-16	26.1	25.1	22.0	24.8	
17-18	29.4	24.4	28.5	27.0	
19-20	17.9	16.2	11.0	15.7	
>20	15.1	10.8	11.5	12.5	
First-time intake method					***
Smoked	39.7	65.6	88.9	60.8	
Injected	13.8	9.1	4.0	9.8	
Powder snorted through the nostrils	46.6	25.3	7.0	29.4	
Time lapsed between first use and weekly use					***
<1 month	22.8	30.8	43.6	30.3	
1-5 months	31.6	26.7	32.6	29.7	
6-11 months	10.8	8.2	8.3	9.2	
12 months or more	34.8	34.2	15.5	30.8	
Regular intake method at the beginning of weekly use					***
Smoked	40.8	77.7	92.8	67.2	
Injected	25.2	12.7	5.2	15.8	
Powder snorted through the nostrils	34.0	9.6	2.1	17.0	
Change of usual intake method at some point	54.4	43.2	19.1	42.4	***
Most recent intake method change					***
From injected to non-injected	12.3	50.6	82.8	34.3	
From non-injected to injected	87.7	49.4	17.2	65.7	
Frequency of use in the last 12 months					***
Every day	38.7	43.8	61.0	45.4	
5-6 days/ week	8.2	14.5	8.0	10.9	
3-4 days/ week	26.1	17.8	12.5	19.8	
1-2 days/ week or less	26.9	23.9	18.5	23.9	
Usual intake method in the last 12 months					***
Smoked	28.3	82.9	99.0	66.1	
Injected	59.3	16.9	1.0	29.3	
Powder snorted through the nostrils	12.4	0.2	0.0	4.6	
Use of pure heroin or a heroin & cocaine mix in the same dose in the last 12 months					***
Always mixed	7.7	4.1	53.2	14.8	
Mixed most of the time	19.8	30.7	32.9	27.2	
Half the time mixed and half pure	8.6	11.2	8.7	98.0	
Pure most of the time	40.4	48.8	2.3	36.9	
Always pure	23.5	5.1	2.9	11.2	
Type of heroin used in the last 12 months					***
Always white	56.0	0.5	0.0	20.8	
White most of the time	19.5	0.0	0.0	7.2	
Half the time white and half brown	4.9	0.2	0.5	2.0	
Brown most of the time	12.4	2.3	2.0	6.0	
Always brown	7.1	96.9	97.5	64.0	
Most frequent place of use in the last 12 months					***
Houses or shelters where they have lived	26.6	19.4	31.0	24.4	
Open-air public spaces (streets, squares, parks, etc.)	15.1	15.7	28.5	18.1	

Popular areas for drug dealing and consumption	49.7	41.5	0.5	36.2	
Vehicles	1.9	14.3	8.0	8.5	
Other places	6.6	9.1	32.0	12.8	
Most frequent companions while using					***
None (usually consumes alone)	32.1	29.7	47.5	34.2	
Long-term sexual partner	15.7	22.2	10.0	17.4	
Very close friends (not long-term sexual partners)	34.9	16.7	26.5	25.4	
Casual acquaintances (not long-term sexual partners)	14.0	26.2	11.0	18.7	
With other people	3.3	4.9	5.0	4.3	

$ Statistical significance level of the comparison between cities, using chi-square: ns= not significant; * p <0.05; ** p<0.01; *** p<0.001.

Use of drugs other than heroin is reflected in Table 4.3. Cocaine use was almost universal (94.8-99% had used it at least once in the last 12 months), often in free base or crack form or mixed with heroin in the same dose. However, different forms of crack were used in varying proportions according to the city. The prevalence of recent use of free base cocaine was higher in Madrid (89.7%) and Seville (85%) than in Barcelona (62%), and the opposite was true of hydrochloride cocaine (powder cocaine). Similar differences were observed in the use of heroin-free base cocaine and heroin-powder cocaine combinations; the former was predominant in Madrid and Seville, and the latter in Barcelona.

Table 4.3. Prevalence of psychoactive drug use among young users in Barcelona, Madrid and Seville. 2001-2003.

	At least once					Last 12 months				
	Barcelona (n=364)	Madrid (n=427)	Seville (n=200)	Total (n=991)	p$	Barcelona (n=364)	Madrid (n=427)	Seville (n=200)	Total (n=991)	p$
HEROIN										
Heroin+ free base cocaine mixed in the same dose	67.3	94.4	98.5	85.3	***	46.1	86.7	97.0	73.9	***
Heroin + powder cocaine mixed in the same dose	84.1	57.4	48.5	65.4	***	71.4	43.3	34.5	52.0	***
Pure heroin	99.2	99.3	87.0	96.9		98.4	95.3	65.0	90.4	***
COCAINE	100.0	100.0	100.0	100.0	ns	94.8	97.7	99.0	97.5	ns
Free base cocaine	85.2	96.0	93.0	91.4	***	62.0	89.7	85.0	78.6	***
Powder cocaine	97.5	94.6	86.0	93.9	***	89.0	69.1	62.0	75.0	***
OTHER DRUGS										
Ketamine	48.1	10.3	11.0	24.3	***	34.9	4,2	3.0	15.2	***
Ecstasy	83.2	67.9	49.0	69.8	***	50.8	26.5	18.0	33.8	***
Amphetamines	80.5	67.7	37.0	66.3	***	44.1	16.6	11.0	25.6	***
Sedative-hypnotic substances	94.5	94.1	78.5	91.1	***	84.3	86.4	66.0	81.5	***
Street methadone (A)	48.9	45.2	70.5	51.7	***	32.0	29.7	57.0	36.1	***
Opiates other than heroin or methadone	78.0	76.3	28.5	67.3	***	54.4	42.2	12.0	40.6	***
Cannabis	98.9	97.4	95.0	97.5	*	93.1	85.7	87.0	88.7	**
LSD	81.3	74.9	50.0	72.3	***	27.8	10.1	10.5	16.7	***
Volatile inhalants	53.8	51.1	20.6	46.0	***	10.7	6.6	4.5	7.7	*
Others	26.6	14.8	7.5	17.7	***					
ALCOHOL										ns
Does not consume	_	_	_	_	_	20,1	16.7	17.1	18	
Less than 50 ml. of pure alcohol/ day	_	_	_	_	_	49.3	49.4	46.2	48.7	
Between 50 and 99 ml./ day	_	_	_	_	_	14.5	15.5	20.6	16.2	
100 ml./ day or more	_	_	_	_	_	16.2	18.4	16.1	17.1	
TOBACCO										ns
Non smoker	_	_	_	_	_	1.9	2.6	1.0	2	
<10 cigarettes/ day	_	_	_	_	_	15.9	13.6	22.5	16.3	
10-19 cigarettes/ day	_	_	_	_	_	57.1	56.6	48.0	55.1	
20 or more cigarettes/ day	_	_	_	_	_	25.0	27.2	28.5	26.7	
DRUG INJECTION	80.5	65.1	33.0	64.3	***	75.8	48.9	15.5	52.1	***

$ Statistical significance level of the comparison between cities, using chi-square: ns= not significant; * p <0.05; ** p<0.01; *** p<0.001.
(A): This refers to methadone used outside the framework of treatment programmes.

This study confirms that drug injection is no longer a universal phenomenon among young heroin users. Even in Barcelona, where injection is still quite widespread, almost 20% have never injected before and 40.7% regularly use heroin via non-injected methods. Comparing this data to a similar study done in 1995, the conclusion may be drawn that drug injection continues its downward trend (de la Fuente et al. 1997). The largest drop was observed in Seville, where injection is now a minority method; 2 out of every 3 young heroin users there have never injected drugs and 99% regularly consume heroin by smoking. In Madrid, on the other hand, injection as the regular intake method has gone down but recent injection rates have not (last 12 months and last 30 days), which seems to indicate that heroin users there continue to inject sporadically.

There are significant differences between Barcelona and the other two cities with regard to the type of heroin on the market. Brown heroin (base heroin), which can be smoked or injected (after being acidified), is practically the only kind in use in Madrid and Seville, whereas white heroin (heroin hydrochloride), which cannot be smoked, is still predominant among users in Barcelona. Earlier studies showed a close relationship between the kind of heroin in circulation and the predominant intake

method (de la Fuente et al. 1996), which indicates that market factors may be behind the reluctance to change the preferred intake method in Barcelona.

Another relevant find is the widespread use of cocaine among young heroin users in Spain, often in free base or crack cocaine form and/ or mixed with heroin in the same dose. In fact, most of the participants in Seville (86.1%) always or usually consumed a mix of heroin and cocaine. There is also a tendency to use heroin and cocaine in the same chemical form and with the same intake method. In Seville, inhaling heroin and free base cocaine by smoking was predominant, and in Barcelona, these drugs were mostly injected in hydrochloride form. In addition to cocaine, a very high proportion of young heroin users also consumed other drugs such as tobacco, cannabis, alcohol and sedative-hypnotic substances. This kind of polydrug use can increase the risk of certain serious health problems, especially in the case of sedative-hypnotic substances and alcohol which, when used with heroin, can easily induce an overdose. The use of opiates differs from one location to the next: in Seville, the most popular opiate is non-prescription methadone (which may be linked to the use of methadone in pill form in maintenance programmes), while other compounds were used more frequently in Madrid and Barcelona.

The data indicates that young heroin users continue to occupy a particularly underprivileged position on the socioeconomic scale. Their living conditions also remain precarious: over 15% (more than 40% in Barcelona) do not have a permanent residence. Distribution by sex, level of education and professional status does not vary significantly in comparison with that of heroin users admitted for treatment (Government Delegation for the National Plan on Drugs, 2005).

5. DRUG-RELATED TREATMENT

Spain has an extensive network of resources for treating drug-related problems. The majority of treatment resources are out-patient services, although there are also many inpatient centres, known as therapeutic communities, and a smaller number of short-term inpatient treatment units in hospitals

- **TREATMENT SYSTEM**

The treatment system primarily offers assistance for drug addicts in outpatient centres that carry out drug-free programmes and maintenance programmes with opiate substitutes to minimise the harmful effects of drug use.

The autonomous cities and communities (and municipal authorities, in some cases) manage the treatment programmes and resources according to their respective Regional Plans on Drugs.

- **DRUG FREE TREATMENT**

These treatments are provided in the following kinds of centres:

- Inpatient treatments: In Spain, there are two kinds of inpatient centres:

. **Hospitalised detoxification units**. This category includes hospital-style resources dedicated to detoxification on an inpatient basis. In Spain in 2004, a total of 56 units treated 3,620 patients. In the year 2005, information on 38 such units is available, which treated 2,227 patients. (Provisional data supplied by 11 autonomous communities and 1 autonomous city. Information from the remaining 6 autonomous communities and 1 autonomous city has yet to be received.)

. **Therapeutic communities.** These residential centres also work on an inpatient basis. In Spain in 2004, a total of 112 centres treated 5,935 patients. Information available for 2005 indicates that 97 such centres treated a total of 3,974 patients. (Provisional data supplied by 11 autonomous communities and 1 autonomous city. Information from the remaining 6 autonomous communities and 1 autonomous city has yet to be received.)

- 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. These centres may work to achieve total abstinence or other intermediary objectives. In Spain in 2004, a total of 533 outpatient centres treated 77,183 patients. In 2005, available data indicates that 388 centres treated 51,931 patients. (Provisional data supplied by 11 autonomous communities and 1 autonomous city. Information from the remaining 6 autonomous communities and 1 autonomous city has yet to be received.)

- **MEDICALLY ASSISTED TREATMENT**

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

- Substitution treatment: The goal of centres offering methadone maintenance symptoms programmes is to substitute withdrawal symptoms from opiate addiction with the therapeutic use of methadone hydrochloride. In 2004, a total of 2,221 centres treated 86,017 patients.

In 2005, the available data indicates that 60,019 patients have received this kind of treatment. (Provisional data supplied by 11 autonomous communities and 1 autonomous city. Information from the remaining 6 autonomous communities and 1 autonomous city has yet to be received.)

Clinical trials with heroin

2 clinical trials have been carried out over the course of 2005 in Catalonia and Andalusia by prescribing diacetylmorphine (heroin). Patients in these trials received medical, psychological and social assistance.

Treatment with buprenorphine

3 buprenorphine treatment programmes operated over the course of 2005 in Madrid and Aragon, treating a total of 24 patients.

6. HEALTH CORRELATES AND CONSEQUENCES

- ### DRUG RELATED DEATHS AND MORTALITY OF DRUG USERS

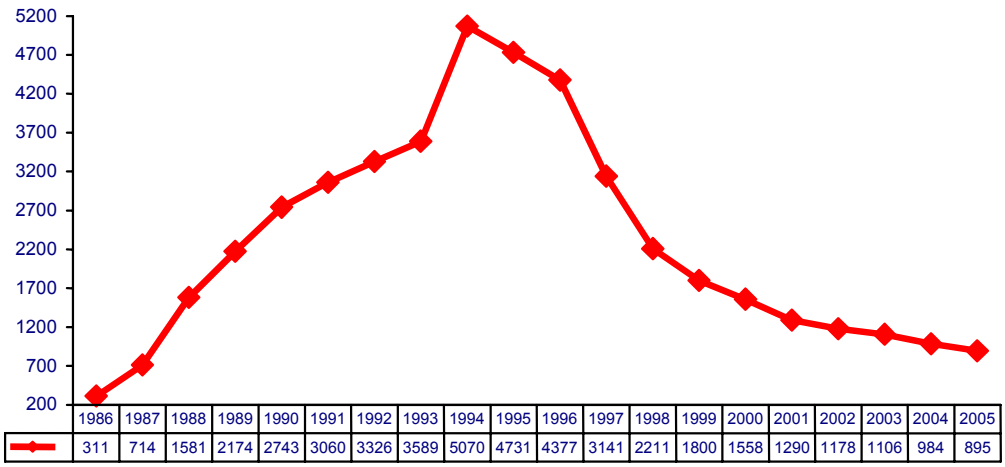
The information of this section is contained in the 2005 Spanish National Report.

- ### 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 31 December 2005, there have been a total of 72,099 AIDS cases registered in Spain, of which 45,447 (63.0%) were related to drug injection. It is estimated that 1,873 new AIDS cases were diagnosed in Spain in 2005 (data adjusted due to notification delays), 47.8% of which (50.9% among men and 37.3% 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 2005 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 2005 (National Epidemiology Centre, Carlos III Health Institute, 2006b). 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.

Figure 6.1. Evolution of diagnosed aids cases associated with injected drug use (number). Spain, 1986-2005*.



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
	311	714	1581	2174	2743	3060	3326	3589	5070	4731	4377	3141	2211	1800	1558	1290	1178	1106	984	895

(*) Updated on: 31 December 2005. Data adjusted for notification delay.
SOURCE: Ministry of Health and Consumer Affairs. National AIDS Register.

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 fell rapidly up until 1996, when signs of stabilisation or extremely slow decline began to appear. In 2003-2004 the Records of New HIV infections covered 8 of 19 Autonomous Communities. It is estimate that currently the number of new cases of HIV infections in Spain is between 2,000 and 3,500 cases per year (50-80 cases per million inhabitants). In about 20-25% of these cases, the transmission mechanism could be injecting drugs, and the rest could be due to sexual relations. (National Epidemiology Centre, Carlos III Health Institute, 2006b)

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. A recently presented cohort study of heroin users under 31 years old performed in Madrid, Barcelona and Seville between 2001 and 2006 indicates that the incidence of HIV infection among injectors was very high (4.5 per 100 persons-year –PY--, CI 95%: 2, 9-6, 7, in a very recent study of young injecting heroin users as part of the *Itinere* Project), which once again suggests that the decrease in drug injection-related HIV cases is primarily due to the decrease in the number of injectors. Until now, HIV infection among non-injecting heroin users was thought to be rare, but the latest data provided by *Itinere* shows a very high incidence among young heroin users in Seville (3.4/100 PY; CI 95%: 0, 9-8,7). This serves to highlight the importance of sexual transmission and the need to pay closer attention to injecting and HIV-positive couples (Vallejo F et al. 2006).

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 (Castilla & de la Fuente L. 2000)

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.

Among injecting heroin users detected between 2001 and 2003 within the framework of the *Itinere* Project, the prevalence of HIV infection was 20.8% in Barcelona, 22.2% in Seville, and 34.9% in Madrid, with a significant drop in prevalence between 1995 and 2001-2003 in Barcelona and Seville but not in Madrid. The differences in the situation and evolution of the three cities have been associated with the delay in introducing

methadone maintenance treatments (MMT) in Madrid (de la Fuente L. et al. 2006). The prevalence among non-injecting heroin users was 4.0% for all three cities, and women in this group were much more likely to become infected (Barrio G. et al. 2006).

Additionally, Spanish 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 33.5% in 2000 and 25.4% in 2004. 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% in 1996 to 37.5% in 2004) than among those under age 25 (where has gone from 20.3% to 3.6%). What is more, 2004 data indicates that women who had recently injected had a higher HIV prevalence than men (31.2% and 24.1% respectively). However, when interpreting this data, it is important to remember that serological status with regard to HIV was unknown in 27.6% of the 9,728 recent injectors admitted to treatment in 2004 (Government Delegation for the National Plan on Drugs, 2005).

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 and reinforced. 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 incidence rate greater than 4%.

Viral hepatitis

Viral hepatitis has 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 (Brugal M.T et al. 2005a). 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 from the *Itinere* Project indicate that among young injecting heroin users from Madrid, Barcelona and Seville, infection is still relatively widespread (with a prevalence of infection between 20 and 35%) (Bravo MJ et al. 2005). 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. However, although VHB vaccination

has been recommended since 1982 for at-risk individuals (which obviously includes heroin users), a recent study shows that young heroin users in Madrid, Barcelona and Seville are not well protected against the virus, and that many do not take advantage of the vaccines offered at health care centres (de la Fuente L. et al. 2005a).

Current major 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 (Bassani et al. 2004;Muga et al. 2006). 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 (Bassani, Toro, de la, Brugal, Jiménez, & Soriano 2004). 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%) (Wiessing L et al. 2004) (www.emcdda.eu.int).

The *Itinere* data also shows that the incidence of VHC infection among young injecting heroin users continues to be very high (34,8/100 PY; CI 95%: 26-46) (Vallejo F, Toro C, Brugal M.T, de la Fuente, Soriano V, Jiménez R, Ballesta R, & Bravo MJ 2006).

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 a significant demand for treatment of chronic liver diseases, with the public health care costs that this will imply in future years for Spain, even if the number of injectors decreases. In fact, the interferon and ribavirins needed for one year of HCV treatment are currently estimated to cost around 16,000 € (Bruguera & Forns 2006).

Risk behaviours

In Spain, there is still a high prevalence of infection and risk behaviours among drug injectors, particularly the practice of sharing injection materials other than needles, such as containers or syringes for dissolving or dividing up the drug, filters, liquid used to clean syringes, etc.

- **PSYCHIATRIC CO-MORBIDITY (DUAL DIAGNOSIS)**

A recent study determined the prevalence of psychiatric co-morbidity in a population of young heroin users contacted outside the health-care context in Barcelona. A psychiatric evaluation was completed with the semi-structured Psychiatric Research Interview for Substance and Mental Disorders (PRISM). The study showed that young heroin users recruited on the street presented a high prevalence of psychiatric co-morbidity which was unrelated to past treatment history. Of 149 individuals evaluated, 93% received a diagnosis of heroin addiction and 71% of cocaine addiction. Thirty-two percent of the subjects had never been treated for substance use. Around two-thirds (67.1%, 95% CI: 59.6-74.7%) of the sample had lifetime psychiatric co-morbidity, with antisocial personality and mood disorders being the most frequent conditions (33% and 26%, respectively). Mood, anxiety and eating disorders were more common among women than men. There were no differences with regard to psychiatric co-morbidity

between patients who had been treated previously for drug use and first-time patients, although co-morbidity was lower among those currently in treatment (Rodríguez-Llera et al. 2006).

The preliminary data provided by the *Itinere* Project show that young cocaine users who consume drugs regularly have a high psychiatric co-morbidity rate. In fact, 43.6% present some type of co-morbidity: 30.8% related to Axis I DSM-IV diagnoses (mood or eating disorders, anxiety or psychosis), 5.3% related to Axis II diagnoses (personality disorders) and 7.5& related to both axes (Herrero MJ et al. 2006).

- **OTHER DRUG-RELATED HEALTH CORRELATES AND CONSEQUENCES**

The information for this section is contained in the 2005 Spanish National Report.

7. RESPONSES TO HEALTH CORRELATES AND CONSEQUENCES

- **PREVENTION OF DRUG-RELATED DEATHS AND PREVENTION AND TREATMENT OF DRUG-RELATED INFECTIOUS DISEASES**

Harm reduction programmes are aimed at drug addicts who continue to use drugs, and attempt to minimise harm (transmission of the human immunodeficiency virus, hepatitis B and C) related to drug use. They also attempt to diminish the risk of drug-related death (overdose).

These programmes include:
- The "Social Emergency Centres"
- The "Mobile Units"
- The "Pharmacy Offices"
- The "Safe injection or venipuncture rooms"

The number of these resources and the patients treated throughout 2005 are reflected in the following table:

Table 7.1. Number of specific resources and the patients treated throughout 2005

SPECIFIC RESOURCES	NUMBER OF UNITS	PATIENTS TREATED
Social emergency centres	33	13,015
Mobile units	27	10,946
Pharmacy Offices	950	522
Safe injection or venipuncture rooms	6	10,492

Provisional data supplied by 11 autonomous communities and 1 autonomous city. Information from the remaining 6 autonomous communities and 1 autonomous city has yet to be received.

The "syringe exchange programmes" (seps). These programmes occupy a place of special importance among the strategies aimed at damage control for parenteral drug use. In Spain in 2004, 46.314 drug users have been treated, 4.939.250 syringes have been exchanged; 26 social emergences centres, 26 mobile units and 2.485 pharmacies have participated to develop those programmes. In Spain in 2005, these programmes were active at 1,054 syringe exchange points and attended a total of 27,740 users. A total of 2,823,949 syringes and/ or sanitary kits were exchanged. (Provisional data supplied by 11 autonomous communities and 1 autonomous city. Information from the remaining 6 autonomous communities and 1 autonomous city has yet to be received.)

- **INTERVENTIONS RELATED TO PSYCHIATRIC CO-MORBIDITY**

In Spain, psychiatric co-morbidity is treated at both health-care centres for drug addicts and at mental health centres. Moreover, in the year 2005, 166 "Dual Pathology Care Programmes" treated a total of 7,985 drug-addicted patients suffering from psychiatric co-morbidity.

- **INTERVENTIONS RELATED TO OTHER HEALTH CORRELATES AND CONSEQUENCES**

No new information available.

8. SOCIAL CORRELATES AND CONSEQUENCES

- ### SOCIAL EXCLUSION

No new information available.

- ### DRUG-RELATED CRIME

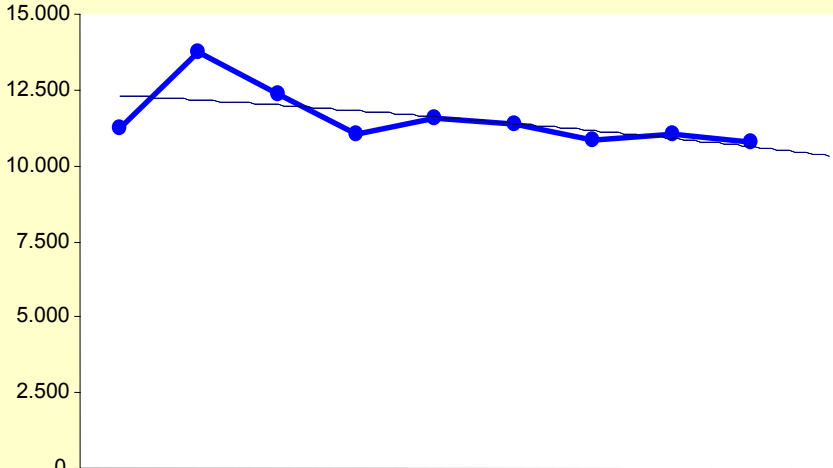
Evolution of the total number of registered crimes. Evolution of the number of registered drug trafficking crimes.

In 2005, there were a total of 10,795 registered drug trafficking offences.

In quantitative terms, drug trafficking offences traditionally represent a small percentage of all crimes. During the period studied, the numbers have oscillated between 1.43% (in 1998) and 1.10% (in 2002); a stabilising trend has been observed in the last five years, limiting these kinds of offences to the narrower interval of between 1.10% and 1.21% of all registered crime.

Most drug trafficking crimes are detected as a result of standard police investigations, and very few arrests are made based on individual reports or accusations. For this reason, the volume of crimes detected in this area is substantially less than what could reasonably be expected. Drug trafficking has higher levels of undetected offences than in other criminal activities and is harder to detect, thus making it more difficult to evaluate the exact nature and scope of the threat it poses.

Figure 8.1. Total number of registered drug-trafficking offences 1997-2005

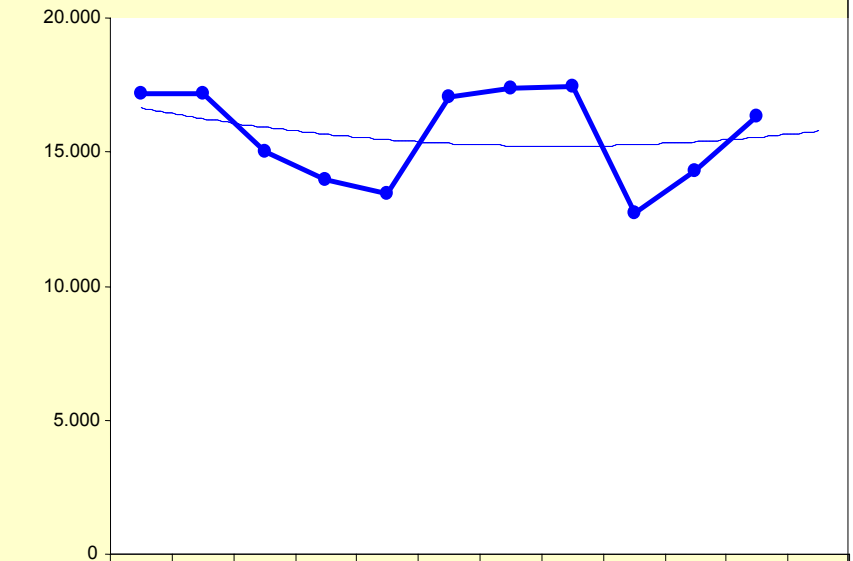


	1997	1998	1999	2000	2001	2002	2003	2004	2005
Total registered offences	957.214	965.731	961.787	923.269	1.015.640	1.036.710	955.802	936.457	891.116
Drug trafficking offences	11.214	13.769	12.389	11.032	11.547	11.370	10.851	11.015	10.795
Percentage Drug crimes/ All crimes	1,17%	1,43%	1,29%	1,19%	1,14%	1,10%	1,14%	1,18%	1,21%

General evolution of drug trafficking arrests

Since 1995, the number of drug trafficking arrests has oscillated between the 12,718 recorded in 2003 and the 17,430 arrests registered in 2002, with a slight overall downward trend that appears to have changed after the increase registered between 2000 and 2002, and particularly following the increase in 2005 to a total of 16,299 arrests (an estimated 14.2% increase from 2004). [1]

Figure 8.2. Total number of illegal drug trafficking arrests, 1995-2005



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Arrests	17.173	17.178	14.992	13.967	13.430	17.067	17.380	17.430	12.718	14.267	16.299
Variation from the previous year		0,03%	-12,7%	-6,8%	-3,8%	27,1%	1,8%	0,3%	-27,0%	12,2%	14,2%

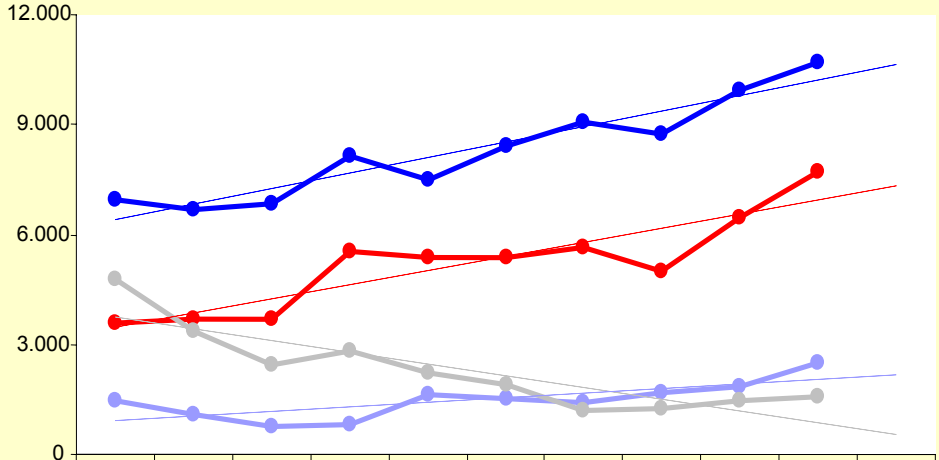
Evolution of arrests by drug trafficking

The following table and graph show a marked upward trend in the number of arrests for trafficking in every type of drug except opiates. However, up until 2002, arrests for trafficking in hallucinogens and psychotropic substances were less numerous than arrests for trafficking in opiates, and even in recent years the numbers for both drug types are quite similar. [2]

[1] The drop observed in 2003 is primarily due to the change in the way data was received and processed, ushered in by the introduction of the System for the Analysis, Evaluation and Application of Data on Drugs (Spanish acronym - SENDA).

[2] It is important to note that an arrest made for trafficking in various substances is registered as ONE arrest for EACH OF THE SUBSTANCES CONFISCATED. It is also possible that arrests have been made for trafficking in substances that do not belong to any of the principal categories reflected here. This means that the sum of arrests for each drug category may differ from the sum of all arrests, which is not the result of an error in calculation. In any case, adding up the arrests of each different drug category is useless because the sum obtained will NOT give the total of all arrests made and therefore is of no interest.

Figure 8.3. Number of arrests by type of drug 1996 - 2005

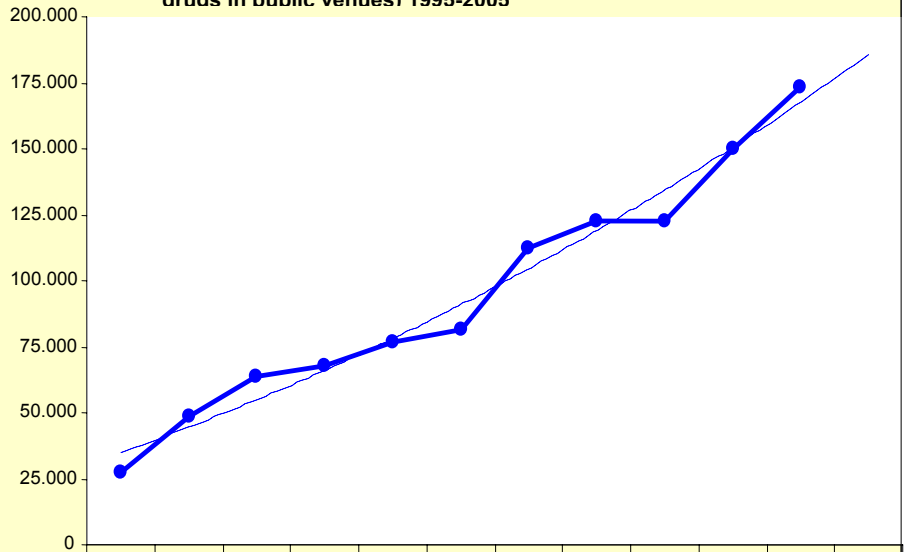


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Cannabis & derivatives	6.940	6.666	6.853	8.133	7.518	8.408	9.042	8.769	9.941	10.704
Hallucin./ psychotropic	1.483	1.098	783	800	1.617	1.513	1.408	1.680	1.869	2.484
Cocaine & derivatives	3.597	3.670	3.675	5.523	5.377	5.372	5.633	4.997	6.453	7.718
Opiates	4.775	3.377	2.436	2.845	2.243	1.914	1.214	1.236	1.486	1.561

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

Since 1996, the number of charges for the violation of OL 1/1992 has risen steadily, showing an almost linear tendency on a steep upward incline. In 2004, the number of charges was triple the number recorded in 1996. In 2005, the number of charges reached an all-time high (173,096), registering a 15.25% increase since the previous year.

Figure 8.4. Charges of infringment of organic law 1/1992 (possession or consumption of drugs in public venues) 1995-2005

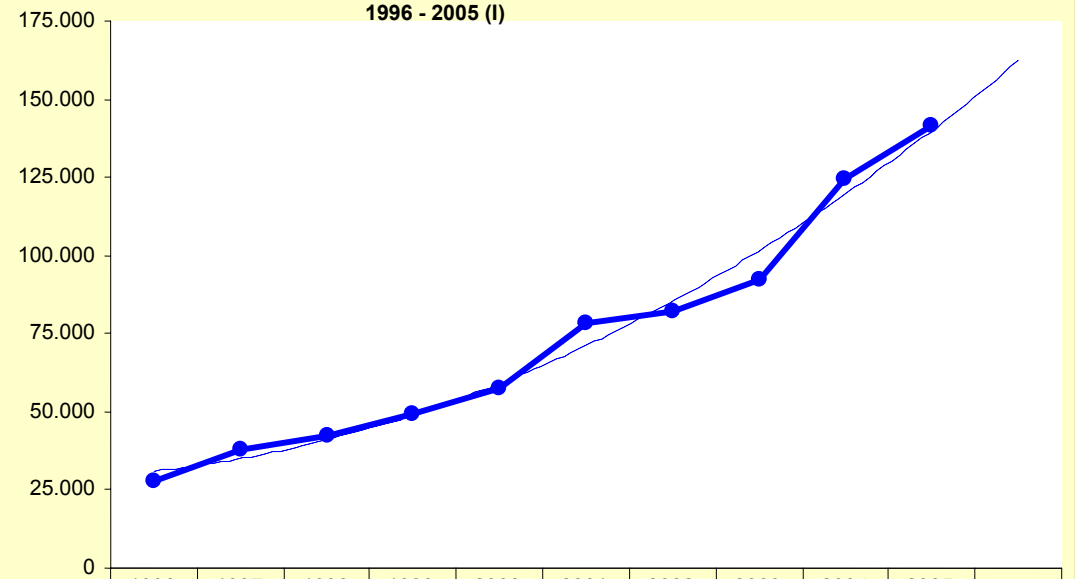


	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Charges	27.145	48.529	63.855	67.677	76.564	81.302	112.270	122.285	122.634	150.193	173.096
Variation from the previous year		78,78%	31,58%	5,99%	13,13%	6,19%	38,09%	8,92%	0,29%	22,47%	15,25%

Evolution of charges by drug type

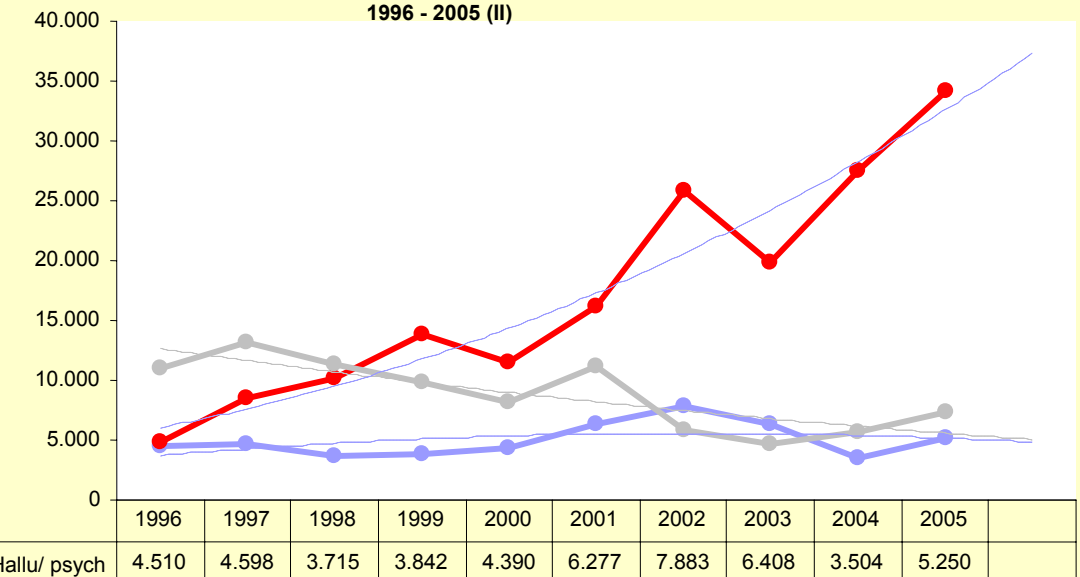
The following table and graph show a marked upward trend in the number of charges related to cannabis and cocaine substances, as well as a moderate decline in the number of charges registered for opiates and a slightly oscillating up-and-downward trend in charges related to hallucinogens/ psychotropic substances.

Figure 8.5. Number of charges by drug type 1996 - 2005 (I)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Cannabis	28.007	37.593	42.472	48.991	57.395	78.629	81.949	92.322	124.268	141.464

Figure 8.6. Number of charges by drug type 1996 - 2005 (II)



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Hallu/ psych	4.510	4.598	3.715	3.842	4.390	6.277	7.883	6.408	3.504	5.250
Cocaine	4.814	8.524	10.151	13.802	11.422	16.196	25.905	19.766	27.493	34.156
Opiates	11.016	13.100	11.321	9.910	8.089	11.145	5.916	4.622	5.591	7.255

- **DRUG USE IN PRISON**

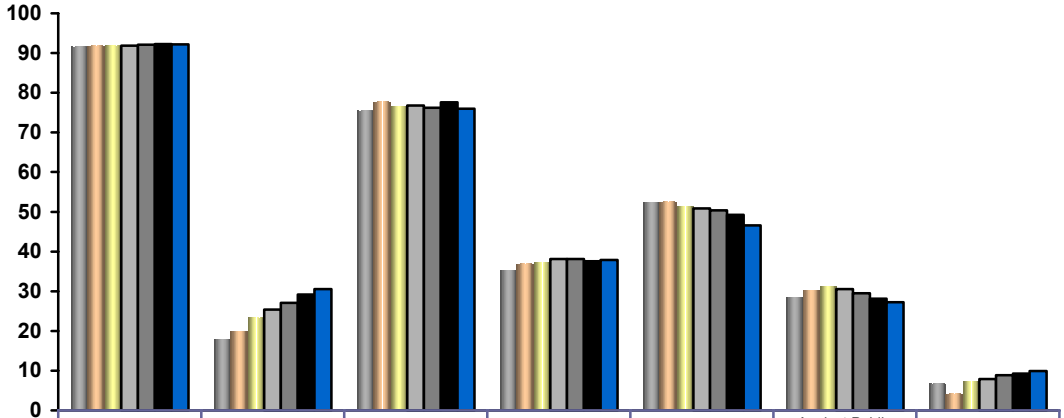
Statistics: 2005

Statistics of Prison Population. Source: General Directorate of Penitentiary Institutions (Data corresponding to prison population in Catalonia are included)

The number of inmates in penitentiary centres has followed an upward trend; this increase affects both the number of sentenced inmates and those under preventive detention. Of the total increase observed during the year 2005 with regard to 2004, 78.3% is due to a rise in the number of foreign prisoners and 21.7% to Spanish ones. On 31st December 2005 there were **61,054** persons in jail compared with **59,375** in 2004.

Figure 8.7. shows the characteristics of prison inmates during the period 1999-2005:

Figure 8.7. Evolution in the prison population profile. Spain, 1999-2005 (%).



	Males	Foreigners	Convicts	Age: 31-40*	Against Property*	Against Public Health*	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
2005	92,2	30,5	76	37,9	46,6	27,23	9,9

(*) Percentage of convicted prison population.
SOURCE: Government Delegation for the National Plan on Drugs. Based on the Ministry of Interior's penitentiary statistics.

- **The prison population is predominantly male (92.2%),** with an increasingly rising percentage of foreigners (30.5%). Also, in recent years this population has been getting older, 62.1% of sentenced inmates being between the ages of 31 and 60, with an average age of 36.3.

- **According to the type of crime**, during the period 1999-2005, as can be seen in Figure 1, the number of persons sentenced for breach of socio-economic order went down, whereas the number of persons sentenced for crimes against human life rose. This fact may be influenced by age and repeat crime variables,

given that studies indicate that as the offenders grow older, the kind of crime committed changes. It is true that other factors may also be involved.

The predominant types of crimes are still, in the first place, crimes against property (46.6 % of prison population), followed by public health crimes (27.23% of prison population). According to gender variable, 47.26 % of the men were incarcerated for crimes against property, while 44.7 % of the women were imprisoned for public health crimes.

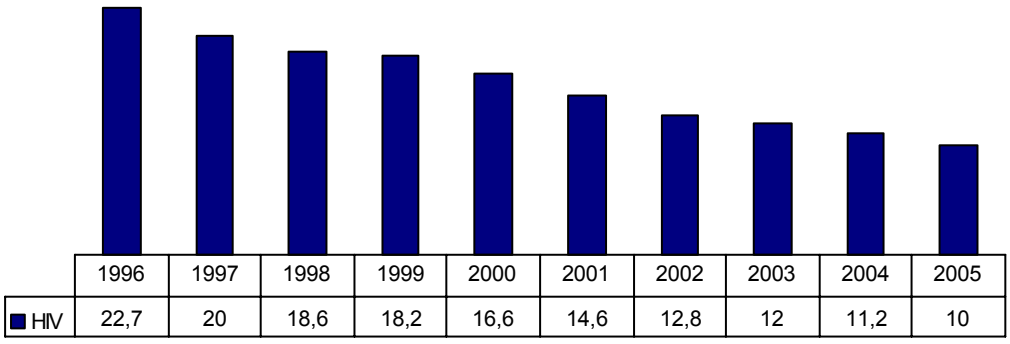
Up until now, in the Spanish penal system, the connection between heroin use and crimes against property had been observed, but the violent nature of the crimes among this group was not emphasized.

Statistics: prevalence of diseases associated with drug use in 2004. Source: Health Records from Penitentiary Health Care. Data corresponding to the prison population in Catalonia are not included.

- Prevalence of **HIV**: 10.0% of the total prison population commended to the General Directorate of Penitentiary Institutions. The main form of HIV transmission continues to be the sharing of syringes for the intravenous injection of drugs in both sexes.

  According to Figure 8.8., the downward trend of the prevalence of HIV continues to occur in the penitentiary environment. The incidence of AIDS has gone down in both sexes and women continue presenting lower rates than men.

Figure 8.8. Evolution in the prevalence of HIV in prison population. Spain, 2001-2005*(%).

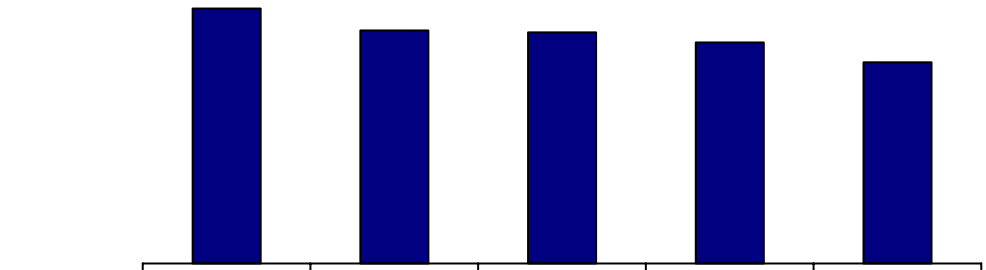


	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
HIV	22,7	20	18,6	18,2	16,6	14,6	12,8	12	11,2	10

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

- Prevalence of **hepatitis C**: 33.0% of the total prison population under the General Directorate of Penitentiary Institutions. According to Figure 8.9., the downward trend of the prevalence of HIV continues to occur in the penitentiary environment.

Figure 8.9. Evolution in the prevalence of hepatitis C in prison population. Spain , 2001-2005.



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

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

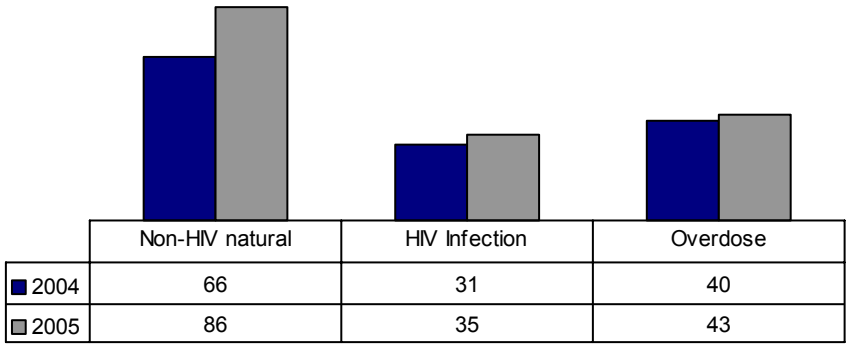
- Prevalence of inmates undergoing **antiretroviral** treatment under the General Directorate of Penitentiary Institutions: 6.0% of the whole prison population.

- Prevalence of **tuberculosis**: 0.21% of the total prison population under the General Directorate of Penitentiary Institutions is following treatment for tuberculosis.

- **Deaths due to overdose in penitentiary centres.** The prison population of Catalonia is not included.

  During the year 2005, 43 inmates have died of an overdose in penitentiary centres, 35 from HIV infection, and 86 from non-HIV natural causes. See Figure 8.10.

Figure 8.10. Causes of death among the Prison Population. Spain, 2004-2005



	Non-HIV natural	HIV Infection	Overdose
2004	66	31	40
2005	86	35	43

SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the General Directorate of Penitentiary Institutions.

Statistics: Nationwide Survey on Health and Drugs among Prison Inmates (ESDIP) 2006.

During the year 2005, this survey was prepared and its fieldwork was carried out. It is a survey funded and promoted by the Government Delegation for the National Plan on Drugs, in collaboration with the General Directorate of Penitentiary Institutions (Ministry of Interior) and the Secretariat of Penitentiary Services of the Regional Government of Catalonia.In the Spanish prison environment only two nationwide surveys on drugs have been conducted:

- **Therapeutical assessment of the drug addict who is admitted to prison, 1994**. Government Delegation for the National Plan on Drugs, in collaboration with the General Directorate of Penitentiary Institutions.
- **Study on Drug Addicts who are admitted to prison: use and risk practices, 2000**. National AIDS Plan and General Directorate of Penitentiary Institutions.

The current survey presents as novelties with regard to these studies mentioned the inclusion of all the prisons of Spain in the fieldwork (including prisons in Catalonia, the only Autonomous Community that has had powers transferred in this matter); the translation of the questionnaire into Arabic and its application through interpreters speaking Arabic; and the over-representation of women in order to be able to carry out the survey according to the gender variable.

The top-priority aim sought by conducting this survey is to know the consumption of psychoactive substances in prison inmates and the risk practices associated, **before being admitted to prison and while they are confined.** Likewise, to observe the variation of these conducts with regard to the survey carried out in 2000.

The population to which the results can be extrapolated (reference population) is the population of the 77 penitentiary centres. On 31st December 2005, there were 61,054 prisoners in these centres, 56,291 (92.2%) were men and 4,763 (7.8%) women.

The criteria used for inclusion have been the following:

- Detainees in preventive prison and convicts sentenced to custodial sentences.
- Detainees classified as second level, first level and with no classification.
- Prison population speaking Spanish or Arabic.

In accordance with these criteria, the population from which the final sample was taken (sampling frame) was 55,912 inmates confined to 66 penitentiary centres. It is a highly exhaustive sampling frame well adjusted to the reference population. The estimated size was 5,000 interviews (4,200 men and 800 women), who, in accordance with the previous studies, would enable us to ensure a minimum sample of 1,500 inmates who had consumed heroin and / or cocaine during the month prior to their admittance to prison and 1,000 drug injectors also in the previous month in order to study consumption patterns and risk conducts. The real size of the sample has been 4,934 valid questionnaires.

The distribution of the sample was carried out under the following parameters:

- **Penitentiary centre:** Proportional to the number of inmates of each centre.
- **Gender:** Women were over-represented, with a final number of 803 interviews, which represents 16.3% of the valid sampling. (As it can be seen, women represent 7.8% of the penitentiary centre).
- **Classification of the inmate**.
- **Nationality**.

The instrument used for collecting the information has been the face-to-face interview that has involved the design of a questionnaire standardized with versions in Spanish and in Arabic, including Arab interpreters. The questionnaire consists of 209 items divided into the following blocks:

- Sociodemographic characteristics
- Penal characteristics
- Perception of state of health
- Use of substances, including tobacco and alcohol
- Injected use
- Risk practices

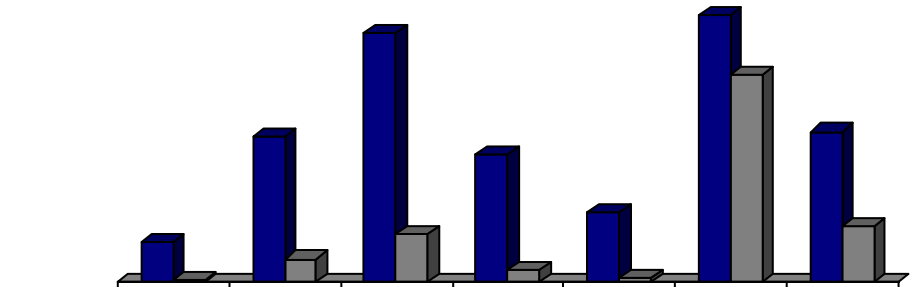
A pilot test of the questionnaire was conducted in the “Madrid 1” and “Madrid 2” penitentiary centres in order to validate it.

Currently results are being analysed, and they are to be presented next year.

Statistics: Use of psychoactive substances in juvenile delinquents. Source: the study “Analysis of the situation of protection and reform centres in the area of prevention” completed by the Centre for Social Promotion Studies (CEPs), 2004.

In the year 2004 the Government Delegation for the National Plan on Drugs (GDNPD) 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 8.11):

Figure 8.11. Consumption prevalence of psychoactive substances in reform centres. Spain, 2004.



	Heroin	Cocaine	Cannabis	Pills	Glue	Tobacco	Alcohol
Some 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: GDNPD. "Analysis of the situation of protection and reform centres in the area of prevention" by the Centre for Social Promotion Studies (CEPs), 2004.

- The use of psychoactive substances is high; especially tobacco, alcohol and cannabis.
- In general, consumption is higher among males, except for cocaine, solvents and tobacco, with similar intake levels

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 GDNPD 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

It is true to say that 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".

Likewise, 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**

The following table provides the data from 2005 corresponding to 12 autonomous communities and 1 autonomous city.

Table 9.1. Social reintegration programmes. Type, number of programmes and number of users. Spain, 2005

	Number of programmes and/ or centres	Number of users
Treatment centres with social reintegration activities and/ or programmes	213	-
Social reintegration activity and/ or programme centres (without treatment)	49	-
Residential treatment centres with social reintegration programmes (therapeutic communities)	80	-
Residential care resources	78	956
Educational programmes	302	4,545
Programmes for integration into working life	352	2,267

SOURCE: GDNPD. Data corresponding to the Regional Plans on Drugs for all Autonomous Communities and Cities, except: Balearic Islands, Canary Islands, Valencia, Galicia, Basque Country and Melilla.

This data cannot be compared to the 2004 figures because some of the communities that have yet to submit their data, such as the Region of Valencia, have extensive networks of social reintegration resources and therefore represent a significant portion of all national users.

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

These resources and programmes continue to meet the description provided in previous reports.

- **PREVENTION OF DRUG RELATED CRIME**

Delinquency is a complex phenomenon that cannot be approached only in terms of penal repression; it also requires intervention in the social conflicts that cause it. Therefore, the penitentiary policy is to be considered as part of the State's security and social policies. The GDNPD is developing performances in the following scopes of the penal system:

- **Interventions in the Juvenile Justice System.** The youngest offenders (14-18 year-olds) can be subject to measures of therapeutic confinement and outpatient treatment for substance abuse, in accordance with Minors' Liability Law 5 / 2000. Since this law came into effect, the Autonomous Communities are making a considerable effort to develop programmes targeting this population: Galicia has extended its advisory programme to the population with penal problems to this sector of the population as well; Castilla y León, Extremadura and Navarra have implemented therapeutic programmes in reform centres for juvenile delinquents; Catalonia has intensified its preventive and assistance programmes aimed at this community; and La Rioja is developing a programme targeting this population.

- **Interventions at Police Stations and Courts**. Over the past few years there has been an increase in assistance programmes for incarcerated drug addicts, which has led to an increase in confined drug addicts who are following treatment.

- **Interventions on a penitentiary scale**. Promotion of availability and readiness of treatment.

Table 9.2. Assistance programmes to detainees at police stations and courts. Spain, 2005.

Type of programme	Autonomous Communities implementing the programmes and that report the data obtained
Assistance Programmes to Drug Addicts at Police Stations*	Andalucía, Cantabria, Cataluña, Ceuta and Comunidad Valenciana.
Assistance Programmes to Drug Addicts in Courts*	Asturias, Extremadura, Castilla-La Mancha, Castilla-León, Galicia[&] Murcia[&] and Comunidad Valenciana.
Assistance Programmes to Detainees in Court.	Balearic Islands and Basque Country
Legal Advisory Programmes.	Castilla-León.

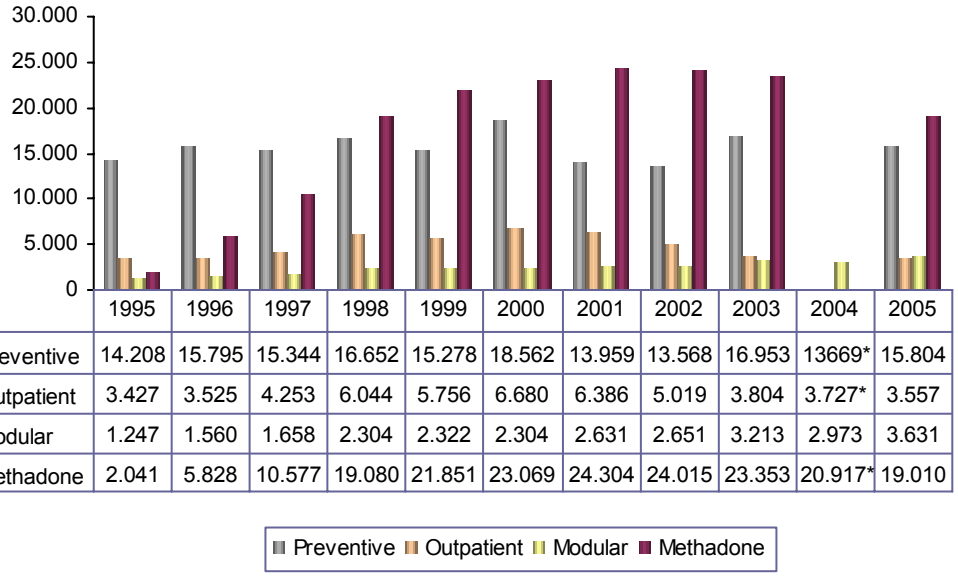
(*)There may be a specific device at police stations and in courts, or mobile units of the drug addict assistance network used.
(&) Galicia and Murcia, mobile units that go to police stations and courts.
SOURCE: data provided by Autonomous Plans on Drugs

Assistance to drug users in prisons. Data on penitentiary centres in Catalonia not included.

In recent years there has been a spectacular increase in the number of inmates/year that have received treatment, with significant health, organisational and regulatory consequences in penitentiary centres.

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

Figure 9.1. Evolution in the number of inmates in drug-addiction programmes. Spain, 1995-2005.



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

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

- Detoxification. Detoxification programmes are offered to everyone who is diagnosed as a drug addict upon entering prison and who has not been entered in a methadone treatment programme. The number of inmates included in regulated detoxification during 2005 was 1,868 drug addicts incarcerated in 56 penitentiary centres managed by the Central State Administration (Ministry of Interior. General Directorate of Penitentiary Institutions). Prevalence as of 31st December 2005 was determined to be 0.13% of the prison population

- Drug-free programmes. This type of therapeutic treatment was given to 7,188 inmates in 2005.

- Outpatient detoxification programmes. Treated inmates live alongside the rest of the prison population and use the centre's general resources. **During 2005, this treatment was given to 3,557 inmates in 65 penitentiary centres, with a prevalence as of 31st December 2005 of 3.11%** of the prison population.

- Detoxification programmes in specific treatment spaces. These programmes take place in a specific space within the centre – they can be either day centres or treatment modules for staying overnight in the same space.

  During 2005, 3,268 inmates from 25 penitentiary centres participated in the treatment module programme, with a prevalence as of 31st December 2005 of 2.56% of the prison population. 363 inmates participated in the day centre

programme at 9 different penitentiary centres, with a prevalence of 0.31% of the prison population

a) Substitution treatment

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

During 2005, a total of 19,010 inmates from 66 penitentiary centres have received methadone treatment, with a prevalence as of 31st December 2005 of 15.32%.

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.

b) Harm-reduction 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.

  15,804 inmates from all penitentiary centres **managed by the 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 inmates who are carrying diseases.

  .- Hepattis B vaccinations.

  .- Hepatitis treatments.

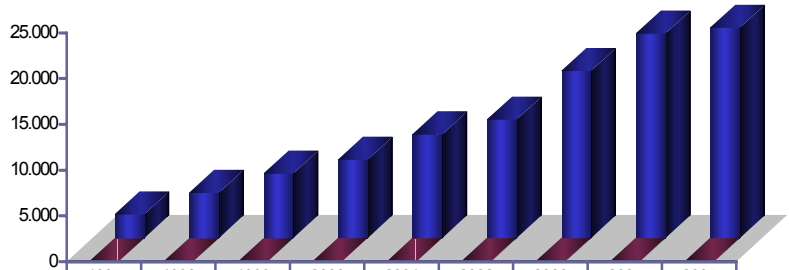
  .- Application of the tuberculosis prevention and control programme, whose basic objective is the early detection and treatment of both the infection and the disease in the prison population. Application of Directly Observed Treatment (DOT).

  .- 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. In 2005, **there were 34 penitentiary centres** with registered users (Figure 9.2). During this same year, 22,989 syringes were distributed at centres belonging to the central administration.

  These experiences have shown that these programmes can be applied in the penitentiary system, without causing distortions or direct problems in the area of regulations.

Figure 9.2. Evolution in syringe exchange programmes in penitentiary centres. Spain, 1997-2005.



	1997	1998	1999	2000	2001	2002	2003	2004	2005
Number of centres with users	1	2	4	9	11	27	39	37	40
Number of syringes distributed*	2.582	4.943	7.056	8.584	11.339	12.970	18.260	22.356	22.989

SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the General Directorate of Penitentiary Institutions and Services of Catalonia.
* Some data missing regarding Catalonia.

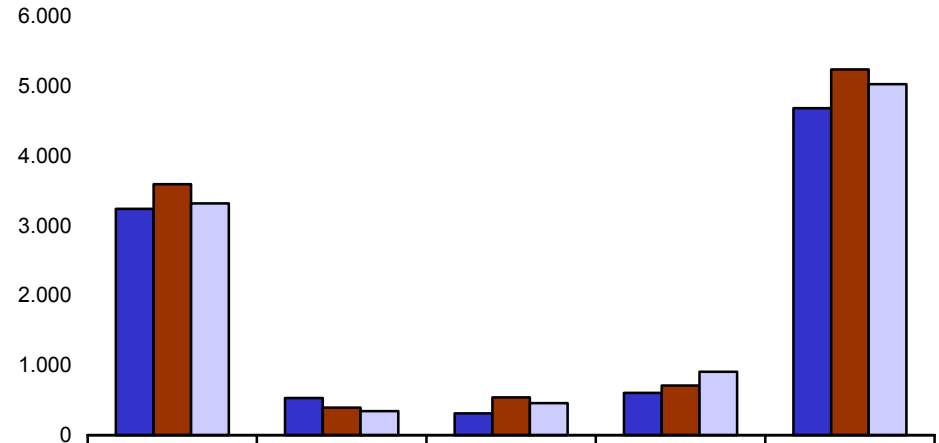
c) **Community links** (pre-release, units and release, working with families, throughcare, therapeutic communities for offenders outside the prisons, involvement of community health structures). See Figure 9.3.

- Therapeutic communities for offenders outside the prisons

  During 2005, 4,693 inmates have been brought from penitentiary centres to treatment:

  .- A total of 604 inmates to external outpatient centres.
  .- A total of 3,244 inmates to external methadone programmes.
  .- A total of 531 inmates to external therapeutic communities.
  .- A total of 314 inmates to other detoxification/ withdrawal resources.

Figure 9.3. - Drug addicts referred from Penitentiary Centres to community treatment centres. Spain, 2005.



	Treatments with methadone	Therapeutic communities	Others Withdrawal	Outpatient centres	Total
2005	3.244	531	314	604	4.693
2004	3.600	393	540	712	5.245
2003	3.323	346	460	908	5.037

SOURCE: Government Delegation for the National Plan on Drugs. Data provided by the General Directorate of Penitentiary Institutions

A decrease has been observed in the number of persons referred (in 2004, 5,245 persons were referred to community resources), in spite of the increase in referrals to therapeutic communities. In this sense, it is necessary to highlight the fall in the number of prisoners attended in methadone programmes, both inside penitentiary centres and in community resources. This change in the demand of services, increases in the number of participants in drug-free programmes compared with the decrease in participants in substitution programmes could mean a change in the inmates' consumption pattern.

e) **Specific training**

Training professionals who work in the prison environment. Training 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 2005, the General Directorate of Penitentiary Institutions has organised training activities in a centralised fashion, dealing with aspects of prevention and health care, which were attended by a total of **1,337 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 2005, 8,471 inmates have begun Professional Occupational Education courses and 1,140 inmates have opted for Work Life Insertion programmes. It is estimated that 50% of these students were drug addicts.

Alternatives to prison for drug users

During the year 2005 Royal Decree 515/2005 has come into effect, establishing the circumstances for community service sentences and permanent tracing, certain security measures, as well as the suspension of applying custodial sentences. This Royal Decree commends follow-up functions of these measures to the penitentiary social services.

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

- **Penitentiary Social Services of the Central Administration.** During 2005, courts have reported **a total of 1,347 alternative sentences** to the Penitentiary Social Services, (in 2004: 609 were reported). **95.1%** of these treatments were as outpatients.

- **Basque Country Statistics:** Report on Services for Assistance with Serving Sentences and Social Reintegration, 2005. **A total of 1,022 alternative measures** (in 2004: 761), of which 442 were new. These measures were applied to 630 people, 91% male. Of all the measures enforced 2.83% were revoked (in 2004: 7.09%). 85% of all the measures were applied to people with problems of drug-addiction (in 2004: 82.65%).

10. DRUG MARKETS

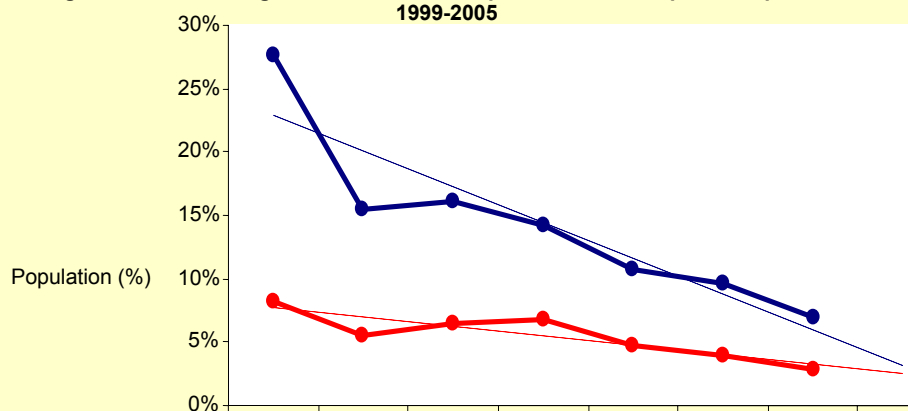
- **AVAILABILITY AND SUPPLY**

Drugs as a social problem and drugs as a personal problem

The social importance attached to the drug problem has appreciably and consistently diminished, going from 27.7% in 1999 to 7% in the present year 2005 (the information provided in this section was supplied by the opinion barometers of the Sociological Research Centre or CIS). In terms comparable with other variables, in this past year *drugs* were mentioned by Spanish citizens as the eighth most important social problem, having occupied seventh, fifth and third place in previous years.

Drugs have also lost importance as a personal problem, falling from 8.2% to 2.9%. In 1999, individuals surveyed ranked *drugs* as their fifth most important personal problem, and in 2005, it was ranked thirteenth.

Figure 10.1. The "drug" variable as a social problem and as a personal problem 1999-2005



	1999	2000	2001	2002	2003	2004	2005
Drugs (Social problem)	27,7%	15,6%	16,1%	14,2%	10,7%	9,7%	7,0%
Variable ranking	3	3	3	5	7	7	8
Drugs (Personal problem)	8,2%	5,6%	6,6%	6,8%	4,7%	3,9%	2,9%
Variable ranking	5	7	7	7	11	11	13

Annual median

Note: The ranking of the "drug" variable is part of the complete list of problems reflected in the CIS opinion barometer, which in 2005 included 32 variables.

The gap between the importance attached to drugs as a social problem and its importance as a personal problem has narrowed from 19.5% in 1999 to 4.1% in 2005, which appears to indicate that people who are not affected personally by drugs tend not to perceive drugs as a social problem.

Table 10.1. Difference between percentage of citizens who perceive drugs as a social problem and those who perceive drugs as a personal problem.

Year	
1999	19.5%
2000	10.0%
2001	9.6%
2002	7.4%
2003	6.0%
2004	5.8%
2005	4.1%

In any case, the available data for 2005 shows that the social perception of drugs as a problem has lost importance since 1999 and has been overshadowed by other recurring issues and current problems that capture the public eye for a limited period of time and later fade into the background. The *social problem of drugs* can be considered a recurring issue that is shuffled to one side every time a new problem arises that generates concern or general alarm among citizens.

In addition, the data regarding *drugs as a personal problem* seems to indicate that the number of people who consider it a personal problem is decreasing, just when the data on drug use indicates that a greater percentage of the population is affected by this problem.

The coexistence of these two phenomena can be explained by the development of a process of collective habituation, tolerance or acceptance of the existence of drugs (whether legal or illegal) as an *inevitable* part of social life.

- **SEIZURES**

The evolution of quantities of **cannabis resin** confiscated over the past five years shows a constant and significant upward trend, although there was a slight downward turn in 2005 that can be attributed to the global decrease of land used for growing cannabis.

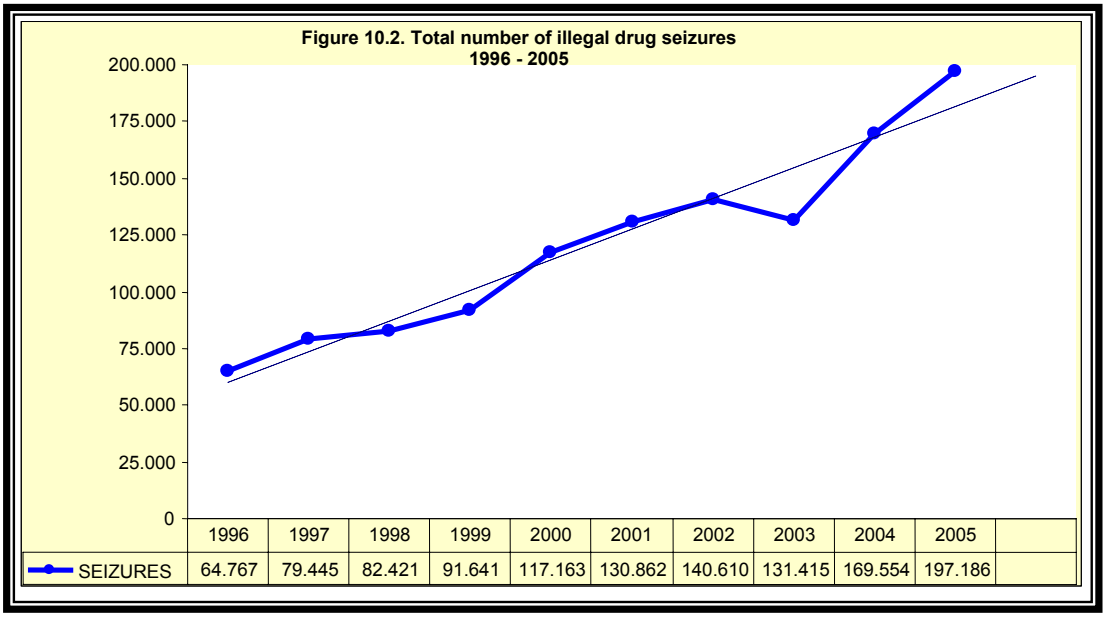
The evolution of seized quantities of **cocaine** over the past five years has fluctuated notably. This pattern is consistent with the fact that most of the quantities are confiscated in a very limited number of raids, and also with the fact that drug organisations are forced to change their distribution modus operandi as a result of the efficiency of law enforcement officials, which in turn temporarily diminishes the efficiency of the law until the new distribution methods are discovered and blocked.

The evolution of **MDMA-ecstasy** seizures since 2000 is similar to that of cocaine; on a graph, its curve is characterised by a zigzag line that reflects improvements in law enforcement operations and the consequent changes in drug distributors' operating methods. Nevertheless, this initial pattern appears to have been altered by the low quantities obtained in seizure raids conducted in 2004 and 2005.

The evolution of **heroin** confiscations shows a downward trend, attributable to a drop in supply due to the lower production and consumption levels indicated by market demand factors.

Number of drug seizure operations

The pattern and number of drug confiscations over the past ten years reflects the results of a sustained effort in the war against illegal drugs. A total of 197,186 drug seizures were performed in 2005 – 50% more than the previous year.



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
SEIZURES	64.767	79.445	82.421	91.641	117.163	130.862	140.610	131.415	169.554	197.186

Quantities seized

Cocaine

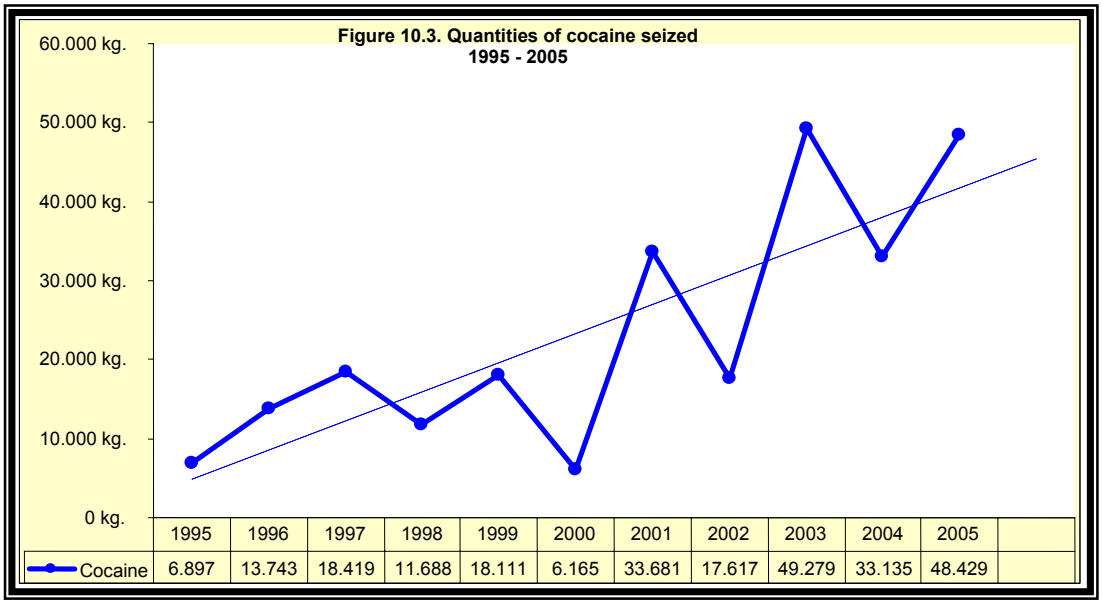
A total of 48,429 kilos of cocaine were confiscated in 2005.

The graph displays a zigzag pattern with a clearly upward trend, consistent with a scene in which:

- Most of the quantities confiscated were seized in a limited number of operations, primarily as a result of large-scale operations against sizeable contraband consignments on ships in the open sea.

- Drug organisations are forced to change their distribution modus operandi as a result of the efficiency of law enforcement officials and institutions.

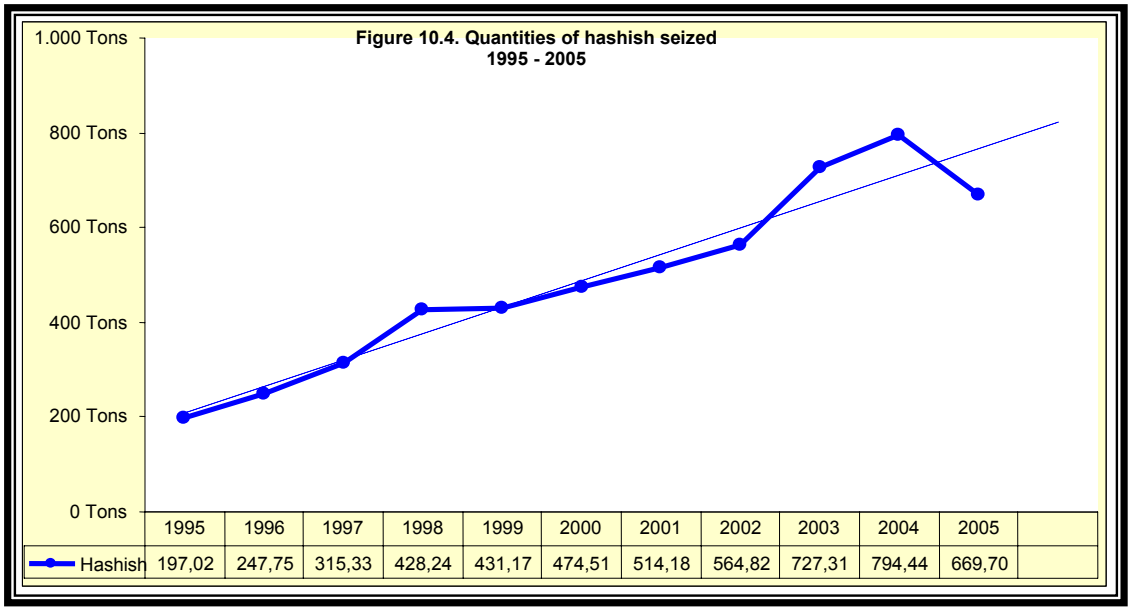
- This efficiency is temporarily reduced until the new distribution methods are detected and blocked by law enforcement operatives.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	
Cocaine	6.897	13.743	18.419	11.688	18.111	6.165	33.681	17.617	49.279	33.135	48.429	

Hashish

A total of 669,700 kilos of hashish resin were seized over the course of 2005. The evolution of quantities confiscated over the past decade shows a clear upward trend, although there was a slight downward turn in 2005 – possibly a consequence of the parallel descent in worldwide cannabis cultivation.



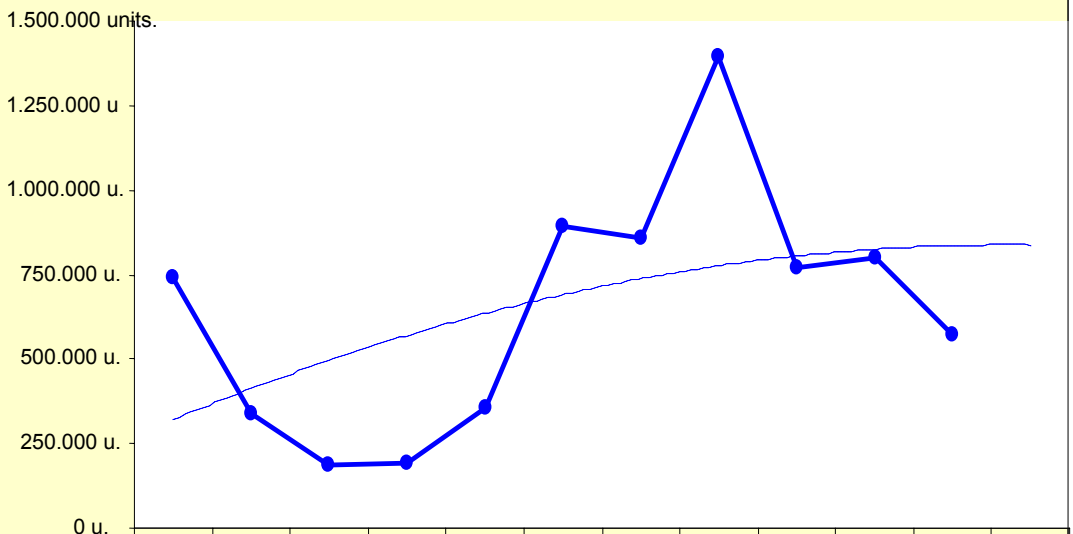
	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Hashish	197,02	247,75	315,33	428,24	431,17	474,51	514,18	564,82	727,31	794,44	669,70

MDMA-Ecstasy

The adjoining graph can be interpreted in two separate segments. Between 1995 and 1999, consumption is progressively hidden, following a period in which these substances enjoyed a relatively *positive social image*, which made it more difficult to detect and prosecute trafficking activities.

Between 1999 and 2004, institutional procedures of investigation and **preventive control improve, while informative campaigns are intensified** to warn young people of the dangers associated with these substances. From 2000 onwards, the graph begins to resemble that of cocaine, characterised by the zigzag pattern that reflects improvements in law enforcement operations and the consequent changes of the distributors' modus operandi. However, the negligible quantities confiscated in 2004 and 2005 appear to have altered this pattern.

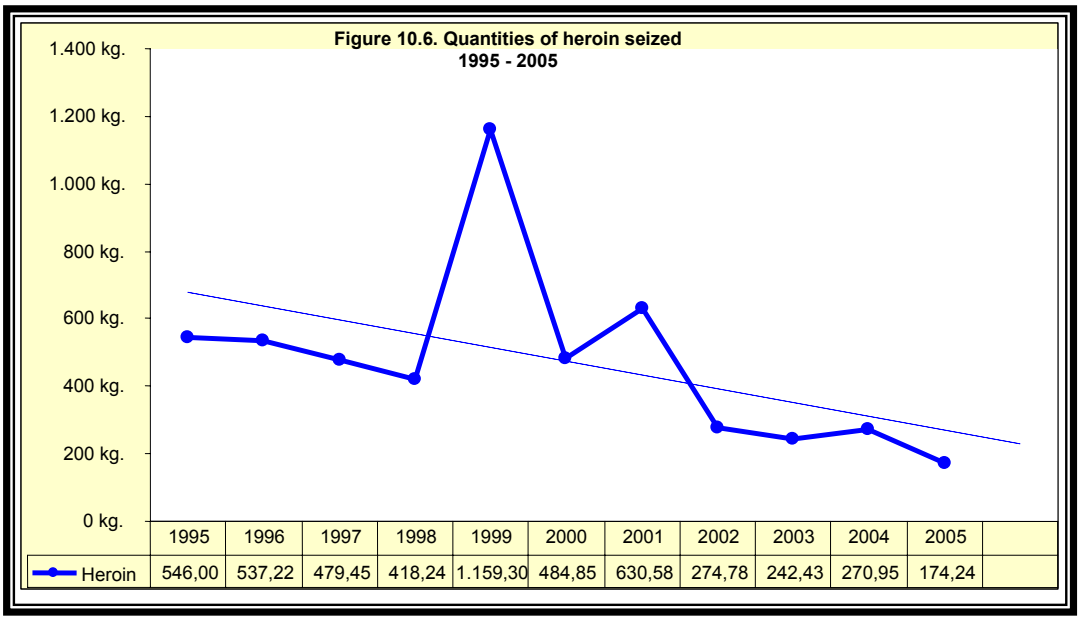
Figure 10.5. Quantities of MDMA-Écstasy seized 1995- 2005



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
MDMA-Ecstasy	739.511	340.444	184.950	194.527	357.649	891.562	860.164	1.396.142	771.875	796.833	572.871
Variation previous year		-53,96%	-45,67%	5,18%	83,86%	149,28%	-3,52%	62,31%	-44,71%	3,23%	-28,11%

Heroin

The evolution of heroin seizures shows a downward trend attributable to a decrease in supply caused by the decline in heroin consumption indicated by market factors. This downward trend was confirmed in 2005; following a small rise to 11.76% in 2004, the total volume of confiscated heroin has dropped to 174.24 kilos – 35.69% less than in 2004.



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Heroin	546,00	537,22	479,45	418,24	1.159,30	484,85	630,58	274,78	242,43	270,95	174,24

- **PRICE/PURITY**

The period in which the price and purity of the various substances was studied covers up to the year 2005.

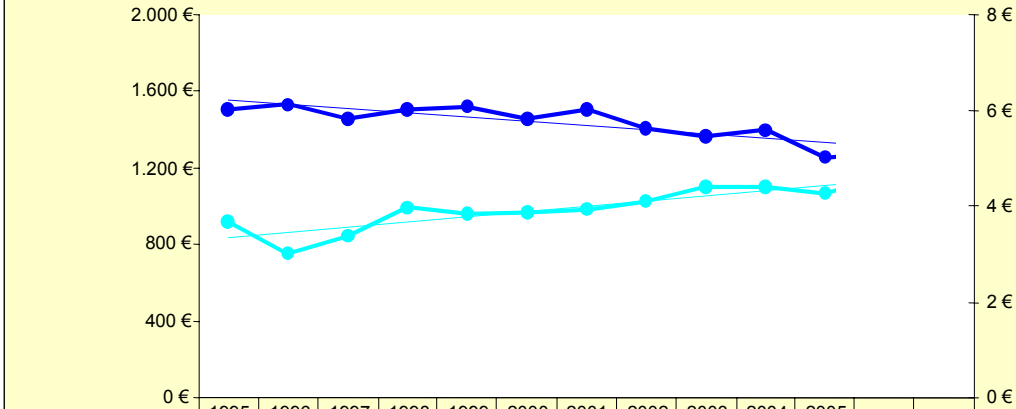
Hashish

The available data shows a tendency toward price containment with a slight downward trend of the price per kilo and a slight upward trend in the price per gram. However, in the face of increasing demand, it is quite remarkable that the prices tend to remain stable in absolute terms and are even lowered when compared with the general increase in the cost of living. This is even more remarkable when we consider the increase in the quantity of THC in the samples analysed, which indicates an increasing quality of the resin that illegal distributors are offering to consumers. The fact that this process is occurring as less and less resin is being produced in North Africa (as mentioned in part B) is also quite interesting.

According to the available data, we are faced with a market in which raw production is decreasing, demand is increasing, and prices are remaining fixed.

In 2005, the average price of hashish was 4.26 € per gram and 1,255 € per kilo, with an average purity of 13.1% THC content.

Figure 10.7. Evolution of prices and purity of hashish resin 1995-2005



	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005		
Price per kilo	1.502	1.532	1.454	1.503	1.518	1.456	1.504	1.407	1.362	1.398	1.255		
Price per gram	3,68	3,01	3,37	3,98	3,84	3,87	3,92	4,09	4,41	4,39	4,26		
Purity						7,8%	10,2%	12,0%	13,0%	13,1%	13,1%		

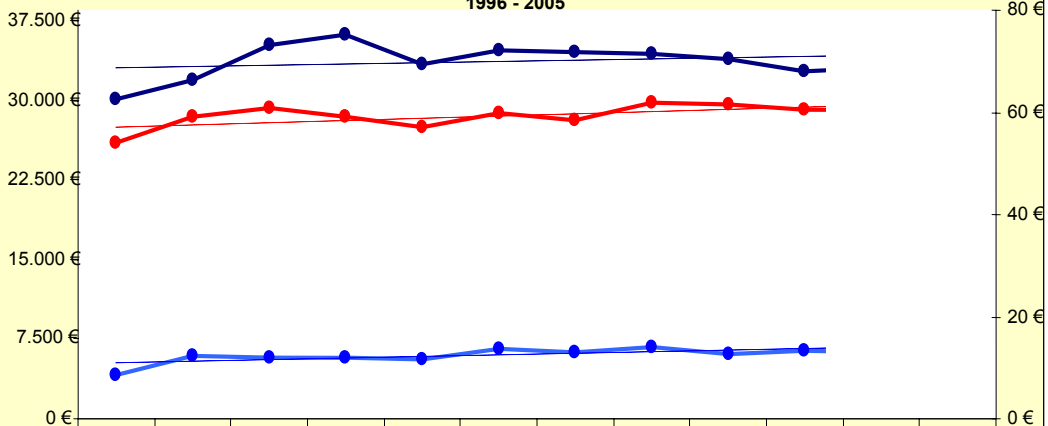
Cocaine

The available data shows a distinct trend of constant price maintenance, with nominal rises that, since 1996, have increased the dose price by 54%, the gram price by 12.1% and the kilo price by 10.1%. These annual increases are actually lower than the rise in the consumer price index; therefore, we can safely assert that the relative prices of cocaine at every level have either remained stable or have dropped in a market of increasing demand, as indicated by the rise in the prevalence of cocaine use and the total number of users.

The average price of cocaine in 2005 was 13.30 € per dose, 60.8 € per gram and 32,758 € per kilo.

Between 2004 and 2005, the price per kilo has experienced a 3.5% drop in absolute terms, while the price per gram has gone down 1.7% and that of the dose has decreased by 4%.

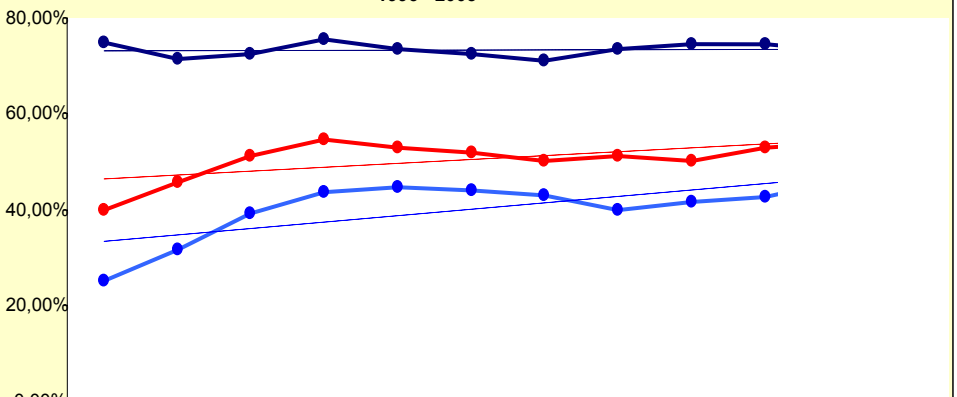
Figure 10.8. Cocaine prices per dose, gram and kilogram 1996 - 2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Per kilo	30.051 €	31.854 €	35.159 €	36.211 €	33.358 €	34.641 €	34.570 €	34.364 €	33.949 €	32.758 €
Per gram	54,09 €	59,20 €	60,93 €	59,05 €	57,16 €	59,71 €	58,30 €	61,90 €	61,65 €	60,58 €
Per dose	8,41 €	12,32 €	11,95 €	12,10 €	11,70 €	13,62 €	13,15 €	13,93 €	12,79 €	13,30 €

On the other hand, purity has shown a slight upward trend. In the period between 1996 and 2006, the purity of cocaine in kilos has increased by 2.1%, in grams by 18.7%, and in doses by 46%. However, from 2004 to 2005, the kilo purity did not vary, while the gram purity increased by 6% and that of the dose by 2.4%.

Figure 10.9. Cocaine purity in kilos, grams and doses 1996 - 2005



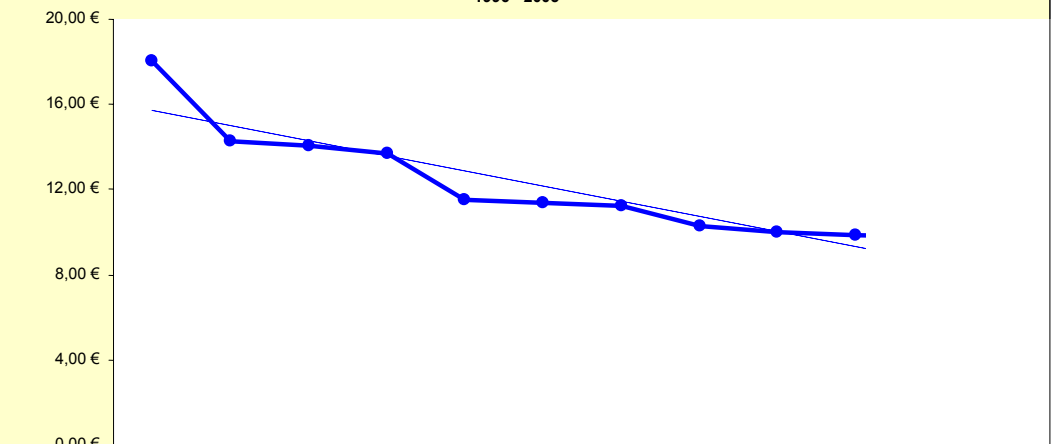
	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Kilo purity	75,0%	71,5%	72,5%	75,5%	73,5%	72,5%	71,0%	73,5%	74,5%	74,5%
Gram purity	40,0%	45,5%	51,0%	54,5%	53,0%	52,0%	50,0%	51,0%	50,0%	53,0%
Dose purity	25,0%	31,5%	39,0%	43,5%	44,5%	44,0%	43,0%	40,0%	41,5%	42,5%

MDMA-Ecstasy

The price of ecstasy has displayed a consistent downward trend since the first year in which it was recorded. From 1996 to 2005, the price has dropped more than 45%, although this decrease has been more moderate since 2000.

A decrease in prices is consistent with a decrease in demand, but it is important to note that the downward trend is a recurring phenomenon since 1995, regardless of the variations in the prevalence of use that have been observed. In addition, the possible use of adulterating substances or the straightforward substitution of MDMA for other amphetamine derivatives or hallucinogens with similar effects may also be conditioning the price decrease.

Figure 10.10. MDMA-Ecstasy prices 1996 - 2005

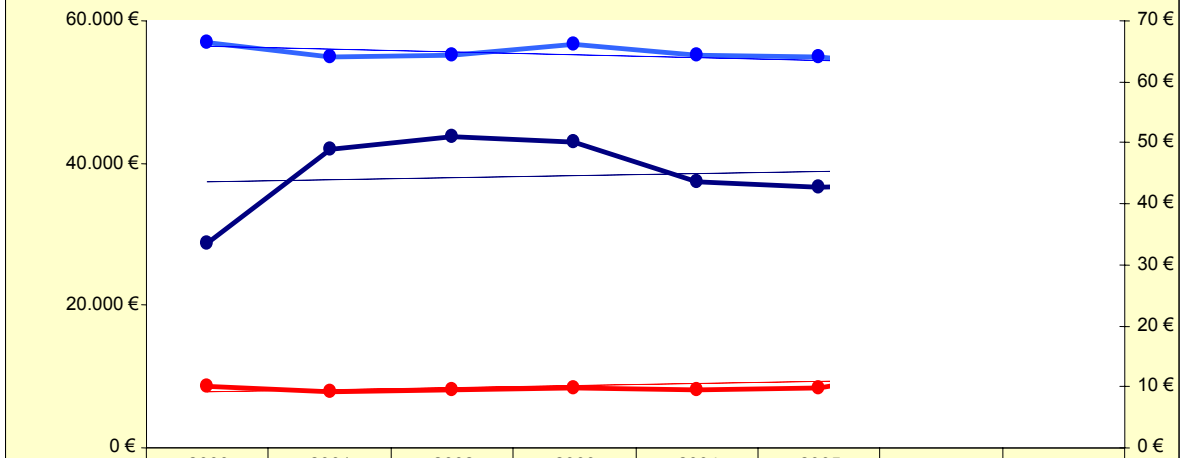


	1996	1997	1998	19999	2000	2001	2002	2003	2004	2005		
Prices	18,03 €	14,27 €	14,05 €	13,67 €	11,52 €	11,35 €	11,24 €	10,28 €	10,02 €	9,82 €		

Heroin

The available data shows a price containment trend with a very slight drop over the past two years in the price per kilo.

Figure 10.11. Heroin prices per dose, gram and kilogram 2000 - 2005



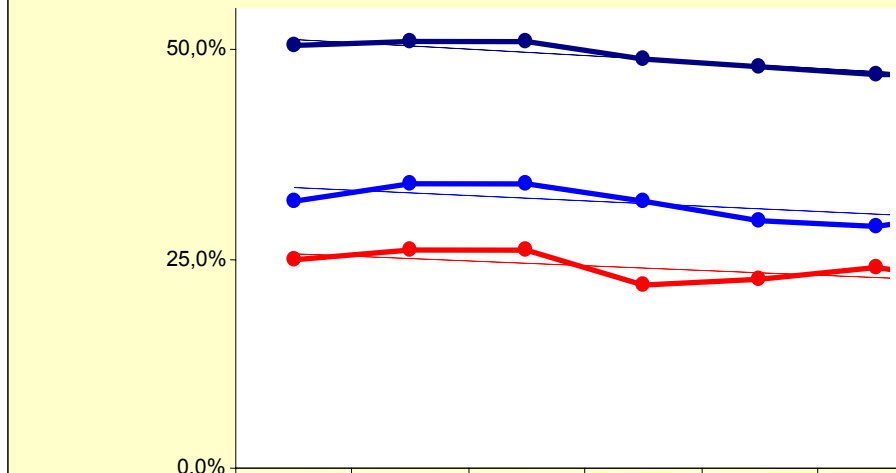
	2000	2001	2002	2003	2004	2005		
Per kilo	28.727 €	41.966 €	43.740 €	42.885 €	37.320 €	36.560 €		
Per gram	66,38 €	63,96 €	64,50 €	66,05 €	64,25 €	64,10 €		
Per dose	10,22 €	9,22 €	9,52 €	9,85 €	9,62 €	9,77 €		

In relative terms, prices have gone down 4.4% for doses and 3.4% for grams between 2000 and 2005, while the price per kilo went up 27.3% over the same period.

Between 2004 and 2004, the price of doses increased by 1.6% (up to 9.77 €), while the price of grams remained practically the same (at 64.10 €) and the price per kilo went down by 2 % (to 36,560 €).

With regard to purity, the overall decreases of 4%, 9.4% and 6.9 % for doses, grams and kilos respectively over the 2000-to-2005 period appear to have levelled off in the last two years. The trend was reversed in purity of doses, and very small decreases were registered in the purity of grams and kilos (1.7% and 2.1% respectively).

Figure 10.12. Heroin purity in doses, grams and kilograms 2000 - 2005



	2000	2001	2002	2003	2004	2005		
Kilo purity	50,5%	51,0%	51,0%	49,0%	48,0%	47,0%		
Gram purity	32,0%	34,0%	34,0%	32,0%	29,5%	29,0%		
Dose purity	25,0%	26,0%	26,0%	22,0%	22,5%	24,0%		

The upturn in prices at the *retail* level (per dose) and a slight price increase at the *wholesale* level, along with the gradual decrease in purity in kilos and doses, suggests a decrease in supply combined with an overall drop in demand, although increases in the areas of experimental and occasional use have been registered.

PART B: SELECTED ISSUES

This year three specific issues have been studied which focused on the study of drug consumption among minors, where possible those under the age of 15: cocaine and crack, situation and responses, and drugs and driving.

With regard to the first specific issue, the information contributed by Spain is focused on the age range from 14 to 15, as the National Survey on Drug Use among Students in Secondary School (EESTUDES) includes information from the age of 14.

According to this survey, the substances most used by adolescents of 14 years of age in the last 10 years were alcohol and tobacco, followed by cannabis, a substance which has seen an increasing level of consumption for this age range. The consumption of other substances by the population of 14 years of age has remained at very low levels. As regards gender, the level of consumption of tobacco and alcohol is higher in girls than in boys of this age, and the substances which are consumed at an earlier age are inhalable or volatile drugs (11.6 years of age), tobacco (12.1 years of age and alcohol (12.7 years of age).

In relation to the second specific issue, a detailed study has been carried out looking at the situation of cocaine consumption in Spain and the possible responses to this situation.

In recent years, cocaine consumption in Spain has increased considerably, as have the problems associated with it (hospital emergencies, treatments, etc.). This consumption is mainly in the form of powder or salt.

Consumption of crack is not very widespread among the general population. However, it is very frequent among heroin users, in particular those who smoke it.

A clear increase has also been seen in the amount of cocaine confiscated and arrests for trafficking or possession of this drug.

Lastly, the third specific issue is focused on the study of drugs and driving, in particular existing relevant information on driving under the influence of cannabis and/or benzodiazepines.

The new Law 17/2005, 19 July, regulating the points-based driving licence and modifying the amended text of the law on traffic, motor vehicle circulation and road safety, is of particular importance in this area

Article 5 of this new Law establishes a new list of offences, including as a very serious offence, driving under the influenced of not only alcoholic drinks but also drugs, psychotropic agents, stimulants and any other substances with similar effects. Furthermore, any refusal to comply with the obligation of all vehicle drivers to undergo the tests which are established for the detection of possible intoxications of alcohol, drugs, psychotropic agents, stimulants and other similar substances is also considered to be a serious offence.

In Spain however, tests are not currently carried out on drivers to detect the consumption of these substances, with the exception of alcohol.

In the area of prevention special mention should be made of the “Framework Collaboration Agreement between Interior and Health and Consumer Affairs Ministries for the Prevention of Traffic Accidents”, signed on 28 July 2005.

11. DRUG USE AND RELATED PROBLEMS AMONG VERY YOUNG PEOPLE

- **DRUG USE AND RELATED PROBLEMS AMONG VERY YOUNG PEOPLE (<15 YEARS)**

In the National Survey on Drug Use among Students in Secondary School (EESTUDES), which has been carried out in Spain on a biannual basis since 1994, the youngest population (below the age of 15) is represented by 14 year-olds; the latter, in turn, are representative of the population segment of that age, since in Spain education is obligatory until the age of 16, and therefore, except for rare cases, all teenagers that age are part of the educational system.

That is why the EESTUDES survey, although it is not a special study, permits us to observe the behaviour of a very young segment of the population regarding drugs, that of 14 year-olds. In the table below there is a summary, per gender, of consumption prevalence of the different substances corresponding to this segment of the population, during the last 12 months.

Consumption prevalence for drug use among 14-years old

Alcohol and Tobacco

Over the past 10 years the substances most widely consumed by 14 year-old teenagers have been alcohol and tobacco, although, the consumption prevalences of both have had a downward trend, reaching their lowest in 2004. This year 59.2% had used alcohol “at least once in their lifetime”, and tobacco 42.1%, “in the last 12 months” 57.9% and 15.5%, respectively, and “in the last 30 days” 38% alcohol and 6.9% tobacco.

Cannabis

Following alcohol and tobacco the substance most widely consumed among 14 year-old Spanish teenagers is cannabis, a substance whose consumption prevalence is on the rise. In 1994 the consumption prevalence “at least once” was 6.3%, that of the consumption “over the past 12 months” 5.3% and that of the consumption “in the last 30 days” 4.0%. These prevalences had gone up to 19.6%, 17.2% and 10%, respectively, in 2004.

Other substances

The consumption of the rest of substances on the part of 14 year-olds remains at very low levels, their prevalences being about 1% and more often less.

Table 11.1 Evolution in consumption prevalences of psychoactive substances in the 14 year-old age group in the last 12 months. Spain 1994-2004.

	In the last 12 months																	
	1994			1996			1998			2000			2002			2004		
	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F	Total	M	F
Tobacco	18.0	12.8	23.0	18.5	11.6	24.0	19.0	14.5	23.2	17.2	12.9	21.0	13.4	10.9	15.7	15.5	10.1	20.7
Alcohol	67.7	66.8	68.6	64.3	62.3	65.9	67.9	67.1	68.5	51.5	48.9	53.9	52.0	49.4	54.4	57.9	55.6	60.0
Hypnosedatives	3.0	2.4	3.5	3.2	2.7	3.6	3.3	2.6	3.8	3.7	2.9	4.3	3.2	2.6	3.8	2.7	2.4	3.0
Cannabis	5.3	5.8	4.9	8.5	9.3	7.9	1.4	11.9	1.,9	1.9	11.5	1.3	1.9	1.1	1.,8	1.2	1.8	1.,7
Ecstasy	0.8	0.9	0.8	1.2	1.2	1.2	1.0	1.3	0.7	1.3	1.6	1.1	1.0	1.1	0.9	0.3	0.5	0.2
Hallucinogens	1.5	1.8	1.2	1.4	1.4	1.5	2.1	2.4	1.8	1.5	1.8	1.1	1.1	1.4	0.9	0.5	0.7	0.3
Amphetamines	1.2	1.3	1.2	1.1	1.2	1.0	1.7	1.9	1.5	1.2	1.5	1.0	1.1	1.6	0.6	0.5	0.7	0.3
Cocaine	0.4	0.5	0.4	0.4	0.4	0.4	1.7	2.2	1.3	1.0	0.8	1.2	1.1	1.3	0.9	0.9	1.2	0.6
Heroin	0.2	0.3	0.1	0.2	0.2	0.2	0.7	1.0	0.4	0.2	0.4	0.0	0.3	0.3	0.2	0.3	0.4	0.1
Volatile Inhalants	1.5	1.7	1.2	1.4	1.4	1.4	2.6	3.4	1.8	1.7	1.9	1.5	1.7	1.8	1.5	1.4	1.5	1.3

SOURCE: National Survey on Drug Use among Students in Secondary School

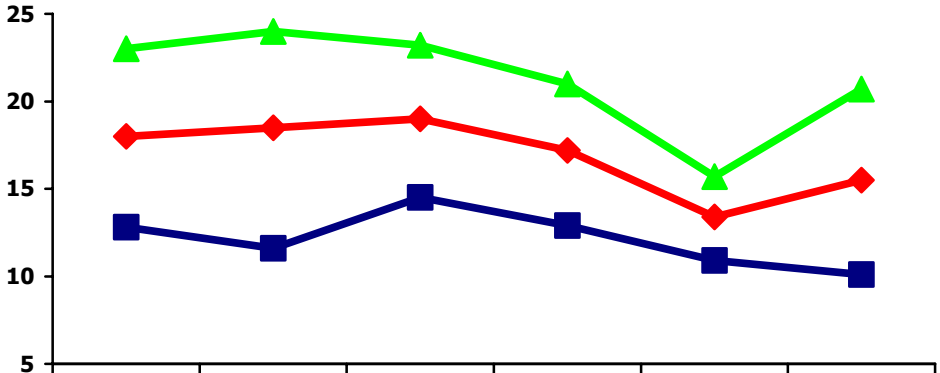
Differences per gender

With regard to alcohol and tobacco among 14 year-olds, the prevalence of girl drinkers is, since 1994 (first year observed), significantly higher than boys. In 2004, 61.3% of girls of this age had consumed alcohol “at least once”, 60% “in the last 12 months” and 40.1% “in the last 30 days”, in comparison with 57%, 55.6% and 35.8%, respectively, of the boys. The differences according to gender are especially significant regarding the consumption of tobacco “at least once in their life" (47.2% of girls and 36.5% of boys) and the consumption of tobacco “in the last 12 months" (20.7% of girls and 10.1% of boys) and not so much regarding consumption “in the last 30 days” (girls 8.9% and boys 4.7%).

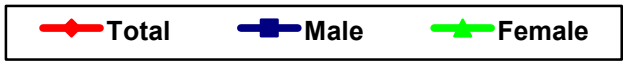
Likewise, a higher level of use of hypnosedatives can be seen among the girls, although, in this case, the differences between consumption prevalence per gender are minimum. In 2004 the consumption prevalence “over the past 12 months” in the case of girls was only 0.6% more than the boys and that of the “past 30 days” was 0.9%.

As for the rest of substances, the prevalence of consumption in boys is higher than the girls’, although only slightly.

Figure 11.1. Evolution in tobacco consumption prevalence over the past 12 months among 14 year-olds (percentage). Spain, 1994-2004

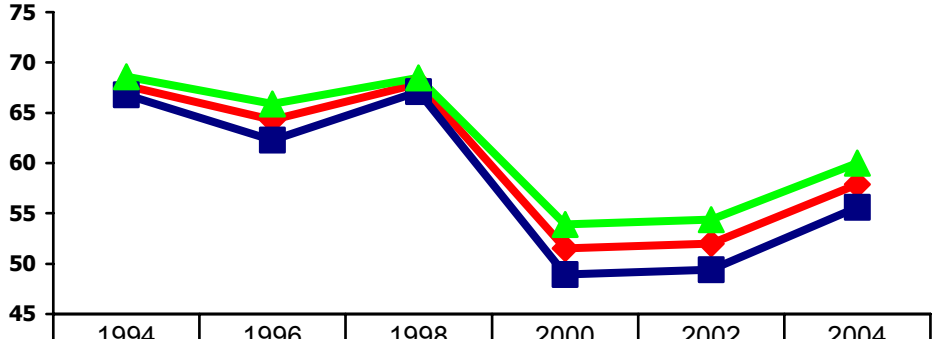


	1994	1996	1998	2000	2002	2004
Total	18	18,5	19	17,2	13,4	15,5
Male	12,8	11,6	14,5	12,9	10,9	10,1
Female	23	24	23,2	21	15,7	20,7



SOURCE: National Survey on Drug Use among Students in Secondary School. 1994-2004

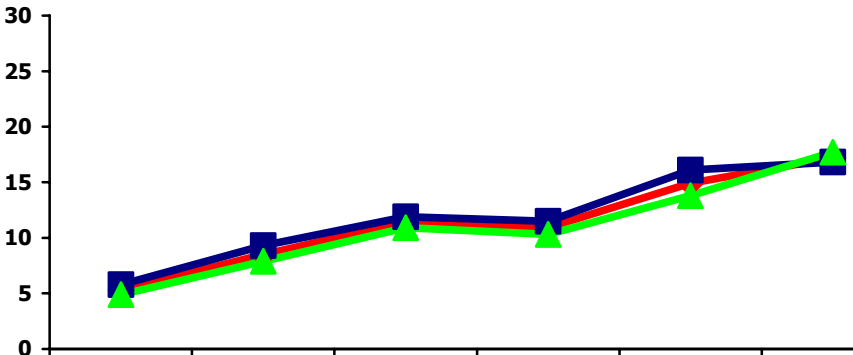
Figure 11.2. Evolution in alcohol consumption prevalence over the past 12 months among 14 year-olds (percentage). Spain, 1994-2004.



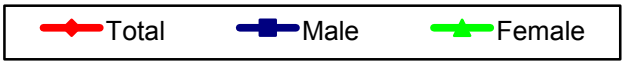
	1994	1996	1998	2000	2002	2004
Total	67,7	64,3	67,9	51,5	52	57,9
Male	66,8	62,3	67,1	48,9	49,4	55,6
Female	68,6	65,9	68,5	53,9	54,4	60

SOURCE: National Survey on Drug Use among Students in Secondary School. 1994-2004

Figure 11.3. Evolution in cannabis consumption prevalence over the past 12 months among 14 year-olds (percentage). Spain, 1994-2004.

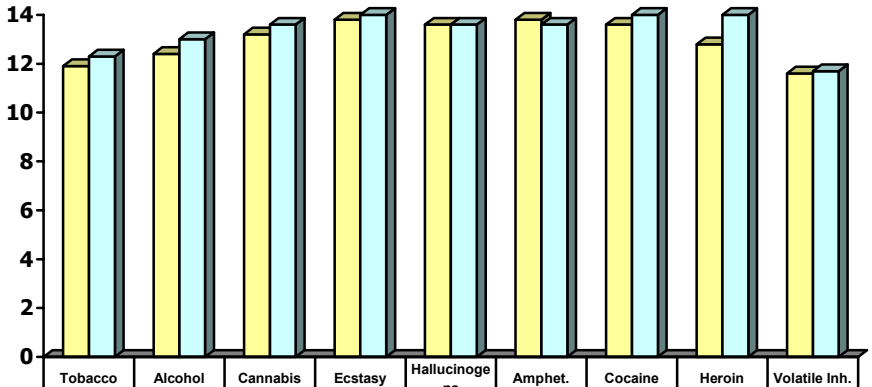


	1994	1996	1998	2000	2002	2004
Total	5,3	8,5	11,4	10,9	14,9	17,2
Male	5,8	9,3	11,9	11,5	16,1	16,8
Female	4,9	7,9	10,9	10,3	13,8	17,7

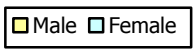


SOURCE: National Survey on Drug Use among Students in Secondary School. 1994-2004

Figure 11.4. Average age of initiation for using psychoactive substances among 14 year-olds. Spain, 2004.



	Tobacco	Alcohol	Cannabis	Ecstasy	Hallucinogens	Amphet.	Cocaine	Heroin	Volatile Inh.
Male	11,9	12,4	13,2	13,8	13,6	13,8	13,6	12,8	11,6
Female	12,3	13	13,6	14	13,6	13,6	14	14	11,7



SOURCE: National Survey on Drug Use among Students in Secondary School. 1994-2004

Average age of initiation

The substances whose consumption begins at an earlier age are volatile inhalants (11.6 years), tobacco (12.1 years) and alcohol (12.7 years). As for the rest of substances, initiation has started only very recently, the average ages at which they are first taken being 13 (heroin) and 13.8 (ecstasy).

With regard to the differences in the age of initiation according to gender, it can be observed that it is lower among males (excepting the consumption of amphetamines). In any case, the differences between both genders in this aspect are not really very significant.

- **CORRELATES AND CONSEQUENCES OF SUBSTANCE USE AMONG VERY YOUNG PEOPLE**

Young people usually have a key function in manifestations of delinquency related with drugs in the community and, at the same time, they are victims of that delinquency. That is why prevention and treatment in this population are crucial in order to control the use of drugs and delinquency, especially among problematic youths.

In this sense, the importance of the juvenile justice system as the point of derivation to treatment must not be underestimated. The youngest offenders (14-18 year olds) can be the object of measures for therapeutic admission and treatment at health clinics for substance abuse.

Legal framework

Organic Law 5/2000, 12th January, regulating the criminal liability of minors, has sought to respond to the problem to deal with juvenile delinquency through special legislation.

The scopes of application of this law are persons over the age of 14 and younger than 18 who have committed crimes or offences. In certain cases it shall also be applied to those over the age of 18 and younger than 21. Therefore, the following scope of competency will be defined:

The Public Bodies that are responsible for social services are those that are in charge of dealing with those situations in which minors have a lack of legal protection. Likewise for those offenders under the age of 14.

The Juvenile Courts assume the responsibility of passing judgment and establishing measures regarding these youngest offenders between the ages of 14 and18.

Minors aged 14-18 shall be criminally liable when they have committed crimes or offences considered as such in the Penal Code and when none of the grounds for exemption of criminal liability set forth in penal law apply.

However, in the case of the youngest offenders to whom the circumstances set forth in Sections 1, 2 and 3 of Article 20 of the Penal Code apply, should the need arise, the therapeutic measures laid down in the Law shall be applied. Therefore, with regard to the subject of drug addiction dealt with in Section 2 of this Article (full intoxication and withdrawal symptoms as grounds for exemption from criminal liability), in these cases **therapeutic internment or outpatient treatment shall be applicable**. The Law

provides for the adoption of precautionary measures during the educational process in these cases.

Minor offenders and drug consumption

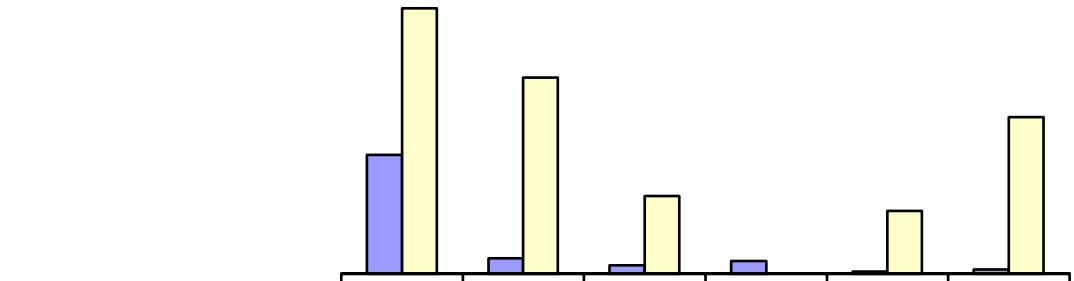
The Government Delegation for the National Plan on Drugs has prioritized actions targeting this population, taking into account the scarce information available on the use of drugs in minors and has subsidized researches on drug use in imprisoned minors:

- The study ***"Delinquent Minors Using Drugs in Reform Centres". 2002. Advisory Service for Confined Drug Addicts.*** The study has been carried out in 26 centres in 8 Autonomous Communities on a sample of 489 minors.

  In accordance with the data presented in this study, 52.14% of the target group studied declared they had used psychoactive substances at some time in their life, and 50.2% in the last 30 days; 53.9% of the minors who admitted using substances stated they had done so by smoking in the last 30 days.

  The substances they say they have used most were cannabis, cocaine and alcohol and, in general, they are "polyconsumers".

Figure 11.5. Type of psychoactive substances consumed. Group of consumers who are confined to reform centres according to principal drug (%). Spain, 2002.

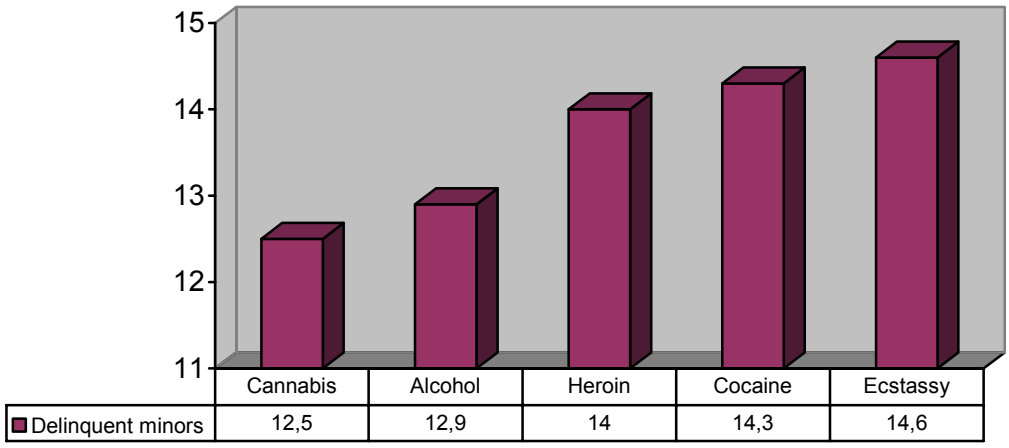


	Cannabis	Cocaine	MDMA	Ketamine, amphetamines..	Heroin	Alcohol
Consumption in last 30 days	43,7	5,6	3,2	4,8	0,8	1,6
Consumption at some time in their life	97,6	72,1	28,6		23,1	57,7

SOURCE: Government Delegation for the National Plan on Drugs. Data taken from the study "Delinquent Minors Using Drugs in Reform Centres" SAJIAD, 2002.

The average ages of initiation declared were 12.5 for cannabis, 12.9 for alcohol and 14.3 for cocaine:

Figure 11.6. Ages of initiation in consumption of psychoactive substances in minors confined to reform centres (average age of initiation).



SOURCE: Government Delegation for the National Plan on Drugs. Data taken from the study "Delinquent Minors Using Drugs in Reform Centres SAJIAD, 2002.

- In 2004 the GDNPD subsidised the study ***"Analysis of the Situation of Protection and Reform Centres in the Area of Prevention", by the Centre for Social Promotion Studies, 2004***. The study has been carried out in 23 reform centres in 4 Autonomous Communities on a sample of 300 confined offenders. The study results regarding the consumption of drugs have been the following:

  .- There is a high level consumption of psychoactive substances, especially tobacco and cannabis, more than 90% of the sample has consumed these substances at some time in their life; 68.7% has consumed tobacco weekly and, approximately a third, cannabis. Nearly 54% admitted having used cocaine at some time.

  .- In general, consumption is higher in boys, except for cocaine, solvents and tobacco, with very similar intake levels.

  The descriptive data from these surveys emphasise the basic needs for intervention: treatment of antisocial behaviour and the consumption of drugs. In the same sense, the study ***"Evaluation of Relapse in Minors Released from the L´Alzira Rehabilitation Centre"*** (Forcadell et al. 2003) concludes that interventions have to be aimed at improving psychosocial support, the problem of drug consumption, and encouraging prosocial behaviour and acquaintances.

It is clear that the importance of the juvenile justice system as the derivation point to treatment is not to be underestimated. Therefore, amongst the procedural guidelines laid down by the Government Delegation for the National Plan on Drugs, we have that of developing programmes targeting confined minors in collaboration with the Autonomous Regions Drug Plans.

- **POLICY AND LEGAL DEVELOPMENT**

Tobacco

Within the framework of government legislation, 2005 has been a key year since Law 28/2005 was approved, on health measures against smoking and regulating the sale, supply, consumption and the publicity of tobacco products. This Law came into effect on 1st January 2006.

With regard to the restrictions covered in this Law, in the case of minors, Article 3 states the prohibition of selling or giving persons under the age of 18 tobacco products, as well as any other similar product and inducing them to smoke. Likewise, the sale of tobacco by persons under the age of 18 is also forbidden. Neither are persons under the age of 18 allowed to use cigarette vending machines.

Article 7 states the total prohibition of smoking in certain places amongst which are centres offering social services, leisure centres and places of entertainment for minors, with the exception of outdoor areas.

According to Article 5, the sale or supply of tobacco products is not permitted in centres offering social services or leisure centres for minors.

On the other hand, it sets forth that establishments authorized to sell and supply tobacco products must display signs in a visible place stating the prohibition of selling tobacco to persons under the age of 18.

The Law establishes a series of offences for non-compliance with this law and their corresponding sanctions. With regard to the prohibitions established for minors, the following will be considered serious offences:

- Selling or giving minors tobacco products or products imitating them and inducing them to smoke, as well as sweets, soft drinks, toys and other objects that look like tobacco products and which may appear attractive for the minor.

- Allowing persons under the age of 18 to use cigarette vending machines.

- In these cases the person held responsible shall be the proprietor of the premises, centre or establishment in which the offence is committed or, in their absence, the employee who is in charge at the time or the person who has given the product to the minor.

The failure to have or display in a visible place the signs stating the prohibition of selling tobacco to minors in those establishments authorized is regarded a minor offence.

Infringement of this Law entails a series of sanctions ranging from €601 to €10,000 for major ones and €30 to €600 for minor ones.

It is expressly stated that maximum sanctions will be imposed when the damage is suffered by or the person affected is under age and minimum sanctions will apply when the offences are committed by a minor.

The Law also sets forth that when the criminal liability of minors is shown to be effective, their legal or common-law parents, tutors, foster parents, guardians shall be held jointly liable, in this order. The economic sanction in this case may be replaced by

reeducational measures determined by the corresponding autonomous legislation, upon consent of the above-mentioned persons and once the minor has been heard.

Alcohol

There is no nationwide legislation to prevent the consumption of alcoholic beverages by minors; however, there is on an Autonomous Community level.

The only legislation currently existing on a national scale is:

- Organic Law 1/1992, 21st February, on the Protection of Citizen's Safety, Article 26 d) which considers a minor offence the admission of legally under-age persons to public or entertainment establishments when their admission is forbidden and the selling or serving of alcoholic beverages to them.

- Law 34/1988, 11th November, on General Advertising, which lays down certain prohibitions regarding the publicity of alcoholic beverages.

However, a new law is being prepared in order to fill this legal vacuum, as the damages caused to health by consuming alcohol are much more serious for minors since they are still growing and developing.

There is also growing concern regarding the high rates of alcohol consumption among teenagers, the average age of initiation becoming increasingly lower, currently being approximately the age of 13.7 according to the latest surveys on the school population. There has also been a rise in the amount of alcohol consumed, in the frequency of drinking and in the equal proportion of alcohol consumption between boys and girls.

In order to deal with this problem, a series of measures focusing on prevention and promoting healthy lifestyle habits and restricting the sale, consumption and publicity of this type of drinks among minors are being studied.

In line with this, preventive aspects must be taught from school, in order to develop alternative leisure activities without alcohol for these young people, as well as the early detection at health centres of problematic alcohol consumption. The sale of alcohol to persons under the age of 18, as well as its consumption by minors on the street and in public areas also has to be forbidden. Furthermore, and in order to avoid the availability of alcohol to minors, it is intended that premises wishing to sell alcohol and those on which its consumption is not allowed are to have a specific license and, also, they will not be able to do so between 10 p.m. and 8 a.m.

On the other hand, the advertising of alcoholic beverages shall not target minors, nor shall it appear in public transport, places intended for minors or in the vicinity of centres of education. In addition to this, restrictions must be imposed affecting radio advertisements, the printed press and other media, and the restrictions already applicable to television shall be completed, no adverts for any kind of alcoholic beverage being permitted between 6 a.m. and 10 p.m.

As for the Autonomous Communities, practically all have some legislation regarding the reduction of the damage caused by alcohol consumption to minors, either specifically or by means of broader regulations such as laws for minors, on drug addiction or protection of citizens' safety. Limitations vary regarding the minimum age for getting alcoholic beverages, prohibitions and limitations on their sale and consumption, and prohibitions and limitations on their promotion and publicity.

- **PREVENTION AND TREATMENT**

Research Projects

Programme for the prevention of drugs in the family: parenting skills programme for drug dependants in treatment. Balearic Islands University:

This is a research project to evaluate the effectiveness of a selective family prevention programme, adapted from the Strengthening Families Programme (SFP), and aimed at mothers and fathers on methadone maintenance programmes.

It is implemented over 14 sessions lasting between 2 and 3 hours, and consists of three sub-programmes:

- One for the parents focused on the development of educational skills
- Others for the development of the sons or daughters' skills
- A joint training programme for parents and children.

The research is being developed in four phases over a 4 year period. The first year (2005) has been devoted to producing the programme materials. The research is being approached as a quasi-experimental model with non-equivalent control groups. It is anticipated that it will be implemented with a total of five experimental groups, each made up of a maximum of 11 participants.

Selective prevention programme: "Let's begin": multi-component intervention for behavioural problems in primary education. Santiago de Compostela University.

The programme is aimed at children between the ages of 8 and 10 with disruptive behavioural problems in the classroom (impulsiveness, aggressiveness, attention problems, hyperactivity.). It consists of 3 components:

- Component for parents (12 sessions). Training programme in educational techniques for parents, which seeks to promote educational styles

- Component for children. Consists of 19 group sessions in three modules:
  .- *Emotions*
  .- *Cognitive skills* for perspective taking and problem solving
  .- *Social skills* relating particularly to empathy, non-verbal communication and forming friendships

- Component for teachers. (8 sessions) Focused on providing teachers with the necessary skills to deal with the disruptive behaviour of children, promoting positive behaviour and improving communication with parents in order to establish coherent and coordinated action guidelines between the family and the school.

An initial pilot study was undertaken in the Faculty of Psychology at Santiago de Compostela University (September-December 2004). Five families from the Santiago de Compostela area with children whose behavioural problems had been detected by counsellors in various centres took part in the study.

From January to June 2005, the components of the programme were implemented in various primary education centres. In total, 21 children, 26 families and 33 teachers have been reached through the implementation of the programme. It has also enabled

the feasibility of the different components of the programme to be verified, and helped improve its coordination, whilst providing initial results on its efficiency and its reception by parents and teachers.

Selective and appropriate prevention programmes

Selective prevention programme aimed at the "Dedalo" family area

- **Target group**: Families with pre-adolescent children (aged between 9 and 13) where there is a risk for the parents or the children, and problems of adaptation and performance at school and early and persistent behavioural problems have been detected which, due to their intensity, do not require a specialised therapeutic intervention. Its purpose is to help parents deal effectively with some of the difficulties posed by the education of their children.
- **Components**: Family: including three types of sessions:
  .- Sessions for the parents.
  .- Sessions for the children.
  .- Sessions in which the parents and children jointly participate.
- **Length of the programme:** 4 months: thirteen weeks plus a monitoring session for the parents one month after the standard sessions have been completed.
- **Number and length of the sessions:** During this period a total of 20 sessions of 90 minutes each are undertaken, which are divided up as follows: 10 sessions for parents, 6 for children and 4 joint sessions in which the parents and the children participate. The parents therefore participate in a total of fourteen sessions and the children in a total of ten.

In addition to this, in some Autonomous Regions actions are being undertaken for the early detection, intervention and, if applicable referral, of minors with substance abuse problems who do not fulfil the dependency criteria, or minors with behavioural problems or problems getting along with people at school and/or with their family. These interventions are usually carried out in a coordinated fashion by:

- School counsellors, who are responsible for the detection of risk cases
- Family educators, who report to the City Councils
- Drug prevention experts

These interventions are usually carried out in the educational centre itself by specialised professionals with the support of the school counsellor. The highest risk cases are referred in order for an appropriate intervention to be carried out with the collaboration of the Social Services (child and family assistance services) and Mental Health Services of the area.

Professional training

The Spanish Paediatrics Association of Primary Attention provides training for paediatrics of primary Attention in order to prevent drug use in minors. Similar training is also provided by Medical Societies of Primary Attention in Spain.

12. COCAINE AND CRACK – SITUATION AND RESPONSES

- **PREVALENCE, PATTERNS AND TRENDS OF COCAINE AND CRACK USE**

Cocaine use among the general population

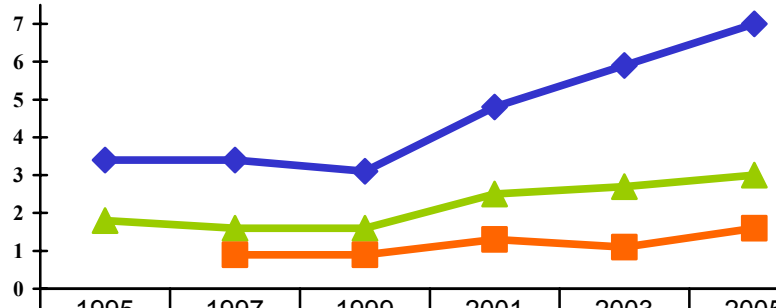
Cocaine in the form of salt (hydrochloride) or “powder cocaine” is clearly the second most widely-taken illegal psychoactive drug in Spain: in 2005 7.0% of the 15-64 age group has taken it at some time, 3.0% has done so during the last year and 1.6% the last month.

In 2005 the prevalence of consumption of powder cocaine during the last 12 months was rather a lot higher in males (4.6%) than in females (1.3%) and in the 15-34 age group (5.2%) than in the 35-64 year one (1.3%). The average age of initiating consumption of this substance was found to be 20.6 years, being practically identical in men and in women.

The consumption of free-base cocaine or “crack " is much less widespread: in 2005, 0.6% of the 15-64 age group has used it at some time in their life, 0.2% over the last year and 0.1% during the last month. Experimentation with this substance is much more widespread among men than women. 1.1% of men had tried this drug compared to 0.2% of women. The average age for age of initiation was 20.8 years.

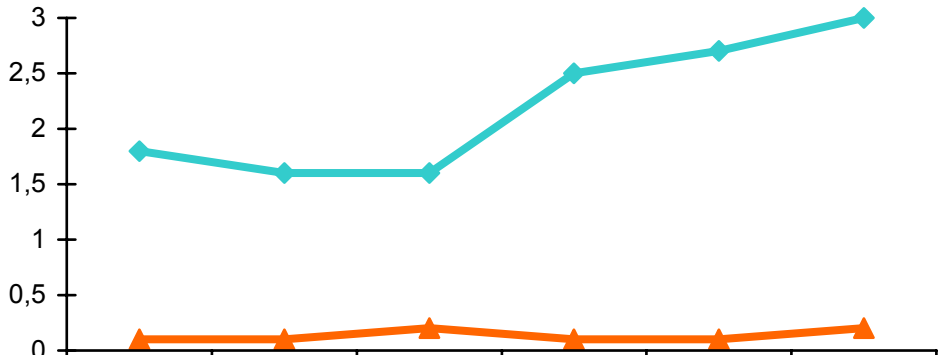
As for temporal trends, the prevalence of powder cocaine has increased spectacularly over the past years; the proportion of consumers in the last 12 months has gone from 1.8% in 1995 to 2.7% in 2003 and 3.0% in 2005. On the contrary, the prevalence of consumption of free-base cocaine (crack) has remained stabilized at very low levels. The increase in the consumption of powder cocaine has affected both sexes in a different way. Over the last years, consumption has significantly increased in men, going from 3.8 % in 2001 to 4.6% in 2005, while it has remained stabilized among women (1.3%) (Figures 12.1-12.3).

Figure 12.1. Proportion of powder cocaine users among 15-64 year olds. Spain, 1995-2005.



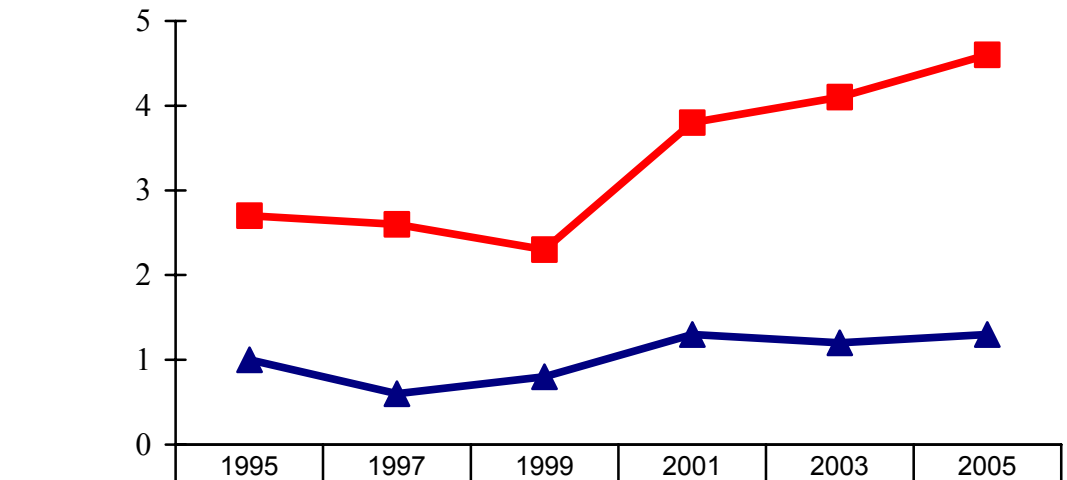
	1995	1997	1999	2001	2003	2005
Some time	3,4	3,4	3,1	4,8	5,9	7
Last 12 months	1,8	1,6	1,6	2,5	2,7	3
Last 30 days		0,9	0,9	1,3	1,1	1,6

Figure 12.2. Proportion of users of powder cocaine and crack in the last 12 months among the 15-64 age group. Spain, 1995-2005.



	1995	1997	1999	2001	2003	2005
cocaine	1,8	1,6	1,6	2,5	2,7	3
crack	0,1	0,1	0,2	0,1	0,1	0,2

Figure 12.3. Proportion of users of powder cocaine among the 15-64 age group according to gender. Spain, 1995-2005.



	1995	1997	1999	2001	2003	2005
Male	2,7	2,6	2,3	3,8	4,1	4,6
Female	1	0,6	0,8	1,3	1,2	1,3

During the period 1997-2005 the perception of risk regarding cocaine consumption has remained relatively stable on a high level (Table 12.1).

Table 12.1. Evolution in the proportion of the population between the ages of 15-64 who think that each consumption behaviour may lead to quite a number/a great deal of problems (%). Spain, 1997-2005

	1997	1999	2001	2003	2005
Habitually use cocaine	98.5	99.2	97.9	98.5	98.7
Sometimes use cocaine	93.5	95.4	93.3	93.1	95.0

Cocaine use among school students

Cocaine can come in the form of salt (generally hydrochloride) or in its base form. However, in the questionnaire of the Spanish school survey EESTUDES both were asked at the same time.

Just as it occurred in the home survey, in EESTUDES, cocaine is clearly the second most widely used illegally traded drug among 14-18 year-old secondary school students in Spain following cannabis. In 2004, 9% had taken it at least once, 7.2% in the 12 months prior to the survey and 3.8% in the last 30 days. The use was generally of a sporadic nature (2.4% had used it 1 or 2 days in the last 20 days), the proportion of people taking it habitually being low. In fact, only 0.2% had used it for 20 days or more in the 30 previous days. In 2004 consumption was rather a lot higher in males (9.4% had used it in the 12 previous months) than in females (5.1%) (Table 12.2) (Government Delegation for the National Plan on Drugs 2005).

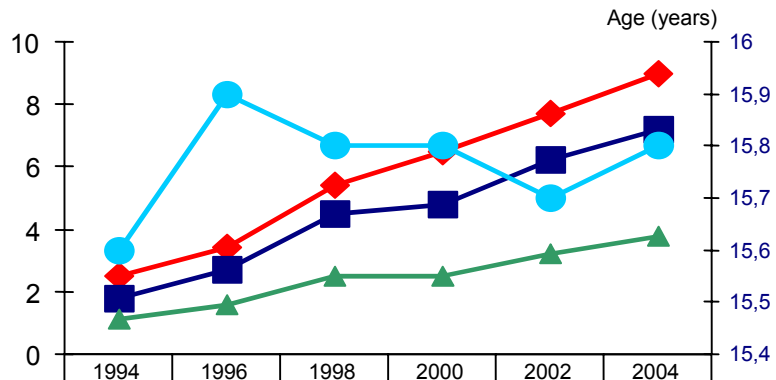
Table 12.2. General characteristics of cocaine use in secondary school students between the ages of 14 and 18 (Percentages), according to gender. Spain, 1994-2004

	1194		1996		1998		2000		2002		2004	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Number of respondents	**10415**	**10374**	**8867**	**9668**	**8224**	**9341**	**10147**	**9777**	**12964**	**13946**	**12864**	**13076**
Prevalence of cocaine use some time 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%**

The differences between genders were less than those that appeared in the home interview survey for the 15-34 age group. As for the consumption prevalence of cocaine, it is maybe the drug that presents greater inequality per age among the students. In fact, the prevalence of its use during the 12 previous months was 0.9% among 14 year-olds and 18.5% for 18 year-olds, and the prevalence in the 30 previous days was 0.5% and 11.1%, respectively. An important proportion of the students declared that they had suffered negative consequences at some time attributable to the consumption of cocaine at some stage in their life, most frequent problems being with sleep (44.1%), memory losses (14%), sadness or depression (12.6%), and economic problems (11.8%).

With regard to the temporary evolution of its consumption, the indicators show a very important increase in its consumption prevalence during the period 1994-2004 (Figure 12.4). The prevalence during the past decade has increased between 3.5 and 4 times, depending on the indicator considered. No other substance has seen such a great rise. This increase has had a similar result in males and females, and has been more significant in 17-18 year-old students (mainly 17 year-olds) than in younger ones. On the other hand, the average age of initiation of consumption remained relatively stable (Figure 12.4).

Figure 12.4. Prevalence of cocaine use and age of initiation in secondary school students between the ages of 14 and 18. Spain (%), 1994-2004

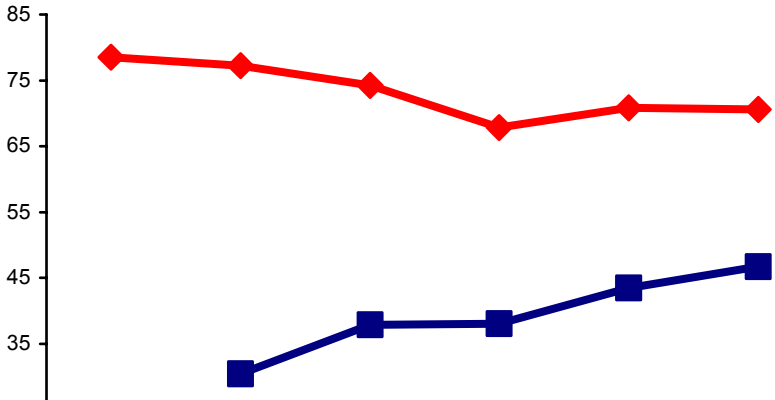


	1994	1996	1998	2000	2002	2004
Once in lifetime	2,5	3,4	5,4	6,5	7,7	9
Last 12 months	1,8	2,7	4,5	4,8	6,2	7,2
Last 30 days	1,1	1,6	2,5	2,5	3,2	3,8
Age of initiation	15,6	15,9	15,8	15,8	15,7	15,8

SOURCE: National Survey on Drug Use among Students in Secondary School 1994-2004

The risk factor perceived by 14-18 year-old students regarding cocaine use fell during the period 1994-2004, while the availability perceived rose (Figure 12.5).

Figure 12.5. Perceived risk of cocaine use and perceived availability of cocaine among secondary school students between the age 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: National Survey on Drug Use among Students in Secondary School. 1994-2004

Prevalence and patterns of use among specific populations

Heroin Users

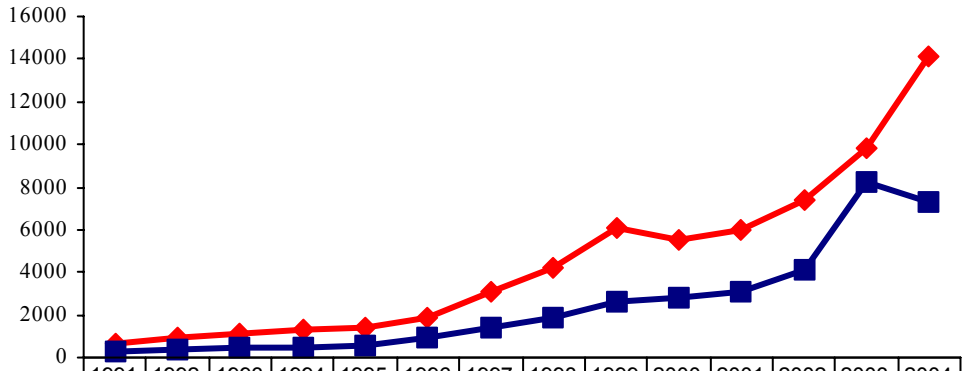
The consumption of cocaine among heroin users is a very widespread trend in Spain, being almost universal, with the added difficulty that they usually use forms of rapid absorption such as intravenous injection or through the pulmonary-lung route. In a study carried out in 2001-2003 on regular heroin users aged 30 or younger in the cities of Madrid, Barcelona and Seville (The *Itinere* Project) practically all the participants (94.8%-99% had used some form of cocaine in the last 12 months (recent use), and it was very frequent to use free-base cocaine or crack, or mixed with heroin in the same dose. However, the extent of the different forms of cocaine varied greatly according to the city. The recent use of free-base cocaine (crack) was higher in Madrid (89.7%) and Seville (85%) than in Barcelona (62%), and the opposite occurred with cocaine hydrochloride (powder cocaine). Similarly, differences were observed in the use of mixed base cocaine-heroin, and powder cocaine-heroin, the former prevailing in Madrid and Seville, and the latter in Barcelona (de la Fuente L, Brugal M.T, Ballesta R, Barrio, Bravo M.J., Domingo-Salvany A, Silva T, Ambrós M, & Grupo del Proyecto Itínere 2005b).

- **PROBLEMS RELATED TO COCAINE AND CRACK USE**

Treatment demand for cocaine

The number of people admitted for cocaine treatment over the last few years has increased alarmingly. The number of admissions for cocaine treatment has risen from 681 in 1991 to 14105 in 2004 (practically following an exponential growth tendency since the year 2000). On the other hand, the number of admissions due to cocaine abuse or dependency with previous treatment for this drug rose between 1991 and 2003, but has dropped slightly in 2004 (Figure 12.6).

Figure 12.6. Evolution in the number of people treated for cocaine abuse or addiction in Spain, 1991-2004.



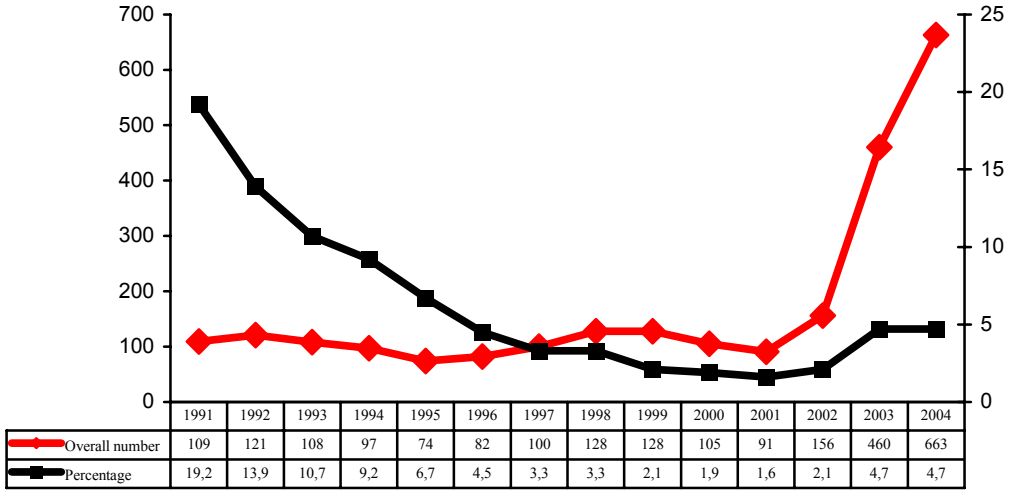
	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Treated for 1st time	681	932	1146	1265	1415	1892	3129	4174	6126	5499	5977	7438	9782	14105
Previously treated	262	367	431	491	516	932	1402	1838	2576	2773	3046	4155	8206	7328

SOURCE: GDNPD. Spanish Drug Monitoring Centre (OED). Treatment Indicator.

In 2004, in Spain, cocaine was already the illegal drug that caused the greatest number of admissions for treatment due to psychoactive substances abuse or addiction, with 40.5% of the admissions, followed by heroin (38.3% and cannabis (12.1%). If we take the data on the first-time admissions the differences in favour of cocaine are even greater. In fact, in this case, cocaine is the drug that caused most first-time admissions (53.9%), followed by cannabis (20.3%) and heroin (14.6%).

Regarding those admitted for cocaine treatment, the principal routes of taking it is nasally or sniffing (over 70%), followed by pulmonarily or smoking (11-18%, depending on the autonomous community), and by injection (6%). The proportion of admissions for cocaine by injection as the principal route of taking it declined between 1991 and 2001, the percentage of first-time admissions dropping from 19.2% in 1991 to 1.6% in 2001, and then increasing to 4.7% in 2004. However, the evolution in the overall number of first-time admissions for cocaine treatment with this consumption pattern has followed a different trend, remaining more or less stable between 1991 (109 persons) and 2001 (91 persons), and then shooting up to 663 persons in 1994 (Figure 12.7). This increase is possibly reflecting the impact of those who used to inject that are being treated with opiates and who are now beginning treatment for cocaine. Nevertheless, it will be necessary to be attentive to this phenomenon.

Figure 12.7. Evolution of the number and percentage of persons treated for the first time in their life for cocaine abuse or addiction preferably using injection as via of administration. Spain, 1991-2004.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Overall number	109	121	108	97	74	82	100	128	128	105	91	156	460	663
Percentage	19,2	13,9	10,7	9,2	6,7	4,5	3,3	3,3	2,1	1,9	1,6	2,1	4,7	4,7

The percentage has been calculated regarding the number of first-time admissions for cocaine.
SOURCE: GDNPD. Spanish Drug Monitoring Centre (OED). Treatment Indicator.

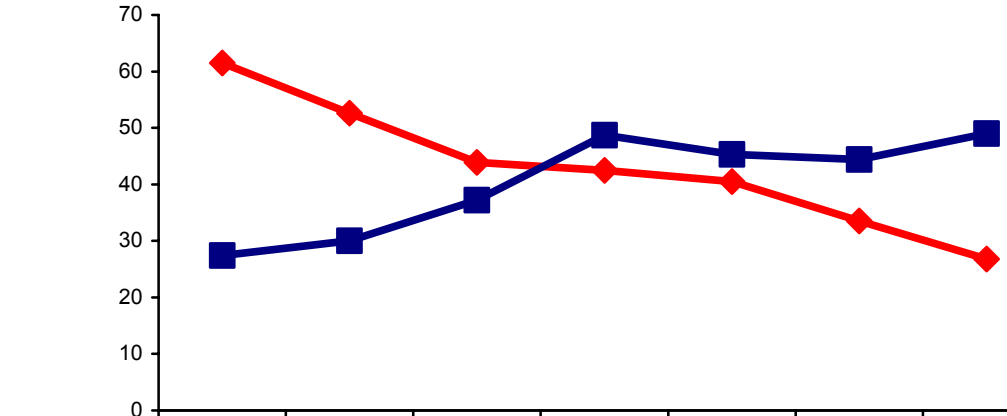
Other problems related to cocaine use

Cocaine in hospital emergencies

In Spain, since 1999, cocaine is the most frequently mentioned drug in hospital emergencies in consumers of illegal drugs. In 2002 it was mentioned in the medical history of 49.0% of emergency cases due to acute reaction to psychoactive substances, followed by alcohol (39.0%) – in spite of it being recorded only when mentioned alongside other drugs-, hypnosedatives (34.1%), heroin (26.8%), cannabis (22.8%), and other opiates or unspecified opiates (17.7%).

Furthermore, there has been an increase in the number of mentions of cocaine, although since 1999 there has been a slowing down in the rising tendency of the mention of this drug (27.3% in 1996, 48.1% in 1999, 45.3% in 2000 and 49.0% in 2002). (Figure 12.8).

Figure 12.8. Evolution in the proportion of emergencies due to acute reaction after using psychoactive substances with reference to heroin or cocaine. Spain, 1996-2002.



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

SOURCE: GDPND. Spanish Drug Monitoring Centre (OED). Emergencies Indicator.

Data after 2002 show a continuous increase in references to cocaine. In the city of Barcelona, which has a stable indicator coverage, the number and proportion of cocaine references rose from 747 (28.6%) in 1996 to 2342 (57.1%) in 2003 and 2593 (63.9%) in 2004 (Brugal M.T, Queralt, Graugés, García V, & Vecino C 2005b).

When interpreting the previous data it is necessary to bear in mind that they are mentions of consumption of these drugs in medical histories, and not a case of the emergencies having been caused by (or being related to) their consumption. However, when the drugs that the doctor related to the emergency are exclusively considered, the situation is similar, the most frequently related substances being: cocaine (44.7% of emergencies), alcohol (35.4%), hypnosedatives (30.1%), and heroin (21.4%). As one emergency can be related to the consumption of several substances, the total can be more than 100%. Considering the evolution during the period 1996-2002, the same trends are appreciated as in the case of the cocaine mentioned with or without relation to the emergency.

Of the 1288 episodes of hospital emergencies mentioning cocaine recorded in 2002, 77.2% corresponded to males, and the average age was 30. The most frequent diagnoses were acute intoxication (51.9%) or acute psychopathological reactions (25.4%). 0.1% died in the emergency wards, 7.3% required hospital admittance and 4.7% were transferred to another centre.

As for the route for taking cocaine mentioned in the emergency wards, the most frequent in 2002 were through the pulmonary-lung route (52.5%), nasally (29.2%) and by injection (19.6%). However, as it was pointed out with regard to the treatment, “inhalation” has been interpreted as through the lung as many professionals and consumers probably use this term to refer to taking it nasally or by sniffing. During the period 1996-2002 a fall in the trend for the use of this drug by injection was also observed (50.4% in 1996, 21.1% in 2001 and 19.6% in 2002) and an increase in its use

by the pulmonary-lung route (28.0% in 1996, 47.8% in 2001 and 52.5% in 2002), although it seems that since 2001 this process has slowed down.

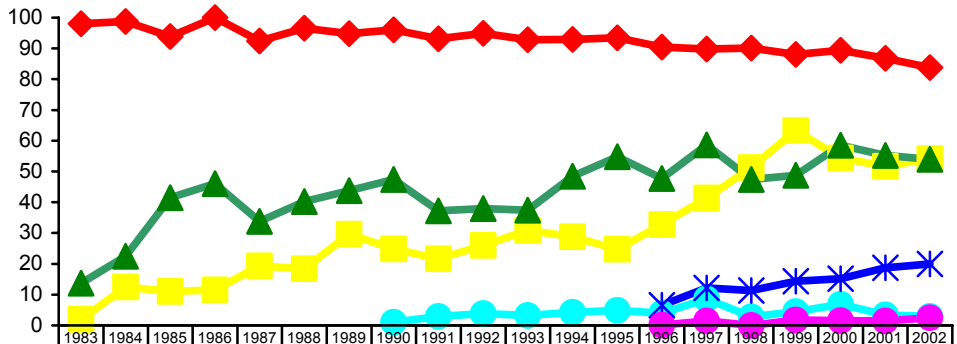
The diagnoses in emergencies related with cocaine depend on the use or not of other drugs. Among those that do not use opiates, now a majority, psychiatric side-effects prevail (mainly anxiety attacks and psychosis) or organic (mainly tachycardia and thoracic pain), and acute intoxications (Barrio Elk et al. 1998; Brugal MT 2000; Sanjurjo et al. 2006). The most serious side-effects are brain and cardiovascular accidents, including arrhythmias and acute coronary events (Muga et al. 1994). There can also be frequent damage caused by external causes. In this sense, the data from the Itinere Project show that the risk of accidents for regular young cocaine users is twice that of the general population of the same age (Sánchez F et al. 2006).

Drug-related deaths and cocaine

The impact of cocaine on mortality is basically unknown, because the implication of this drug in some deaths of a cardiovascular or cerebrovascular nature is often not suspected or investigated. On the other hand, neither is a full toxicological investigation performed in all accidental deaths. In order to know this impact, in the future it will be necessary to carry out mortality cohort studies in large groups of consumers undergoing treatment.

A specific mortality record exists in Spain since 1983 based on forensic surgeons and toxicology laboratories, but neither is it easy to attribute specific deaths to cocaine, since other substances such as opiates or hypnosedatives often simultaneously show up in toxicological analyses. In any case, the proportion of deaths in which cocaine was present has increased over the last years (Figure 12.9)

Figure 12.9. 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
Amphetamines								1	2,9	3,8	3,2	4,3	4,9	4	8,6	2,8	4,5	6,9	3,4	2,9
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: GDPND. Spanish Drug Monitoring Centre (OED). Mortality Indicator.

- **RESPONSES AND INTERVENTIONS TO COCAINE AND CRACK USE**

The same responses as those for the rest of illegal drugs are under way, basically programmes for prevention, easy access to free treatment for addicts and social rehabilitation. There are specialized programmes directed to psychostimulant users that specifically help persons with problems associated with the consumption of this type of substances. Over the past years, both the number of programmes and that of people attended have increased significantly (Figures 12.10 and 12.11), going from 596 patients in 2001 to 1905 in 2004.

Figure 12.10. Evolution in the number of programmes directed to psychostimulant users in Spain. 2004-2004.

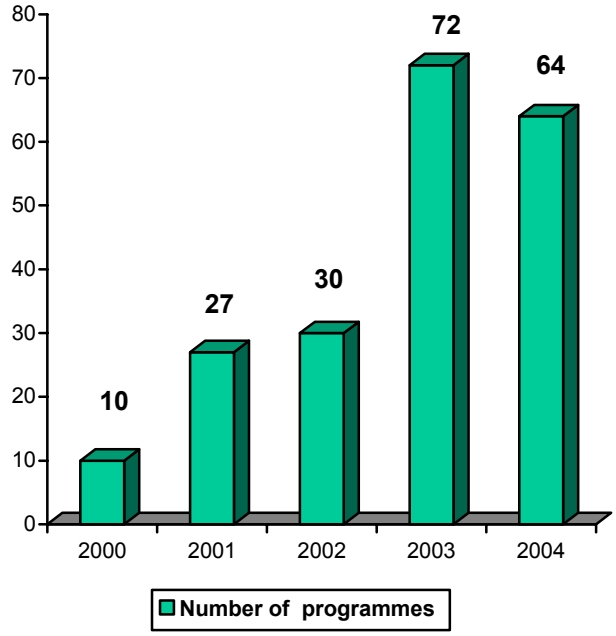
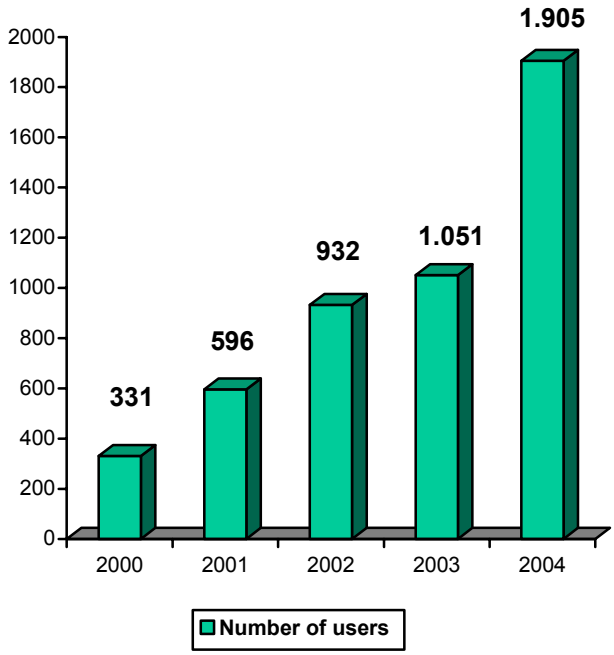


Figure 12.11. Evolution in the number of users who have been through programmes directed to psychostimulant users in Spain, 2000-2004.



- **COCAINE-RELATED CRIME AND COCAINE AND CRACK MARKETS**

Cocaine-related crime

Arrests for cocaine trafficking or possession for trafficking show an upward trend, going from 4766 in 2000 to 7718 in 2005. Reports for violation of Organic Law 1/1192 (use of drugs in public) also show a clearly upward trend, going from 11422 in 2000 to 34156 in 2005 (Tables12.3. and 12.4).

Table 12.3. Evolution in the number of arrests for cocaine trafficking or possession for trafficking. Spain 1998-2005.

	1998	1999	2000	2001	2002	2003	2004	2005
Arrests	3,675	3,918	5,377	5,372	5,633	4,997	6,453	7,718

SOURCE: Ministry of Interior

Table 12.4. Evolution in the number of reports for use of this drug in public. Spain 1998-2005.

	1998	1999	2000	2001	2002	2003	2004	2005
Reports	10,151	13,802	11,422	16,196	25,905	19,766	27,493	34,156

SOURCE: Ministry of Interior

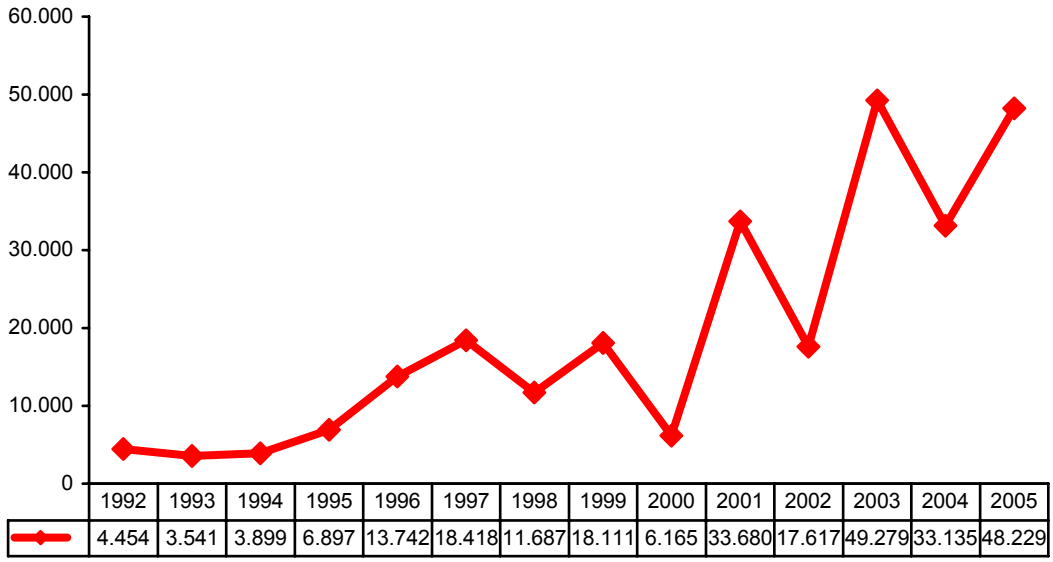
Cocaine markets

Cocaine is the second most widely consumed illegal substance in Spain, following hashish resin. It is usually presented in the form of cocaine hydrochloride, white, fine crystalline powder. Its classic form of consumption in Spanish addicts is by sniffing. Other routes of consumption, such as intravenous injection, whether of cocaine hydrochloride or of this substance mixed with heroin (speed ball), are not very significant.

Most of the cocaine seized in Spain has its origin in Colombia, and it is transported to Spain in several ways, mainly aboard vessels, a change in the direct routes between America and Spain in favour of other indirect ones with stopovers in West Africa having been detected. Other routes are through containers hidden in legal goods traffic; by means of drug traffickers on commercial flights, and through non-commercial private planes (sports or professional).

The amounts of cocaine seized show a classic saw-tooth graph with a clear upward trend (Figure 12.12).

Figure 12.12. Evolution in the amount of cocaine (kilogrammes) seized in Spain, 1992-2005.

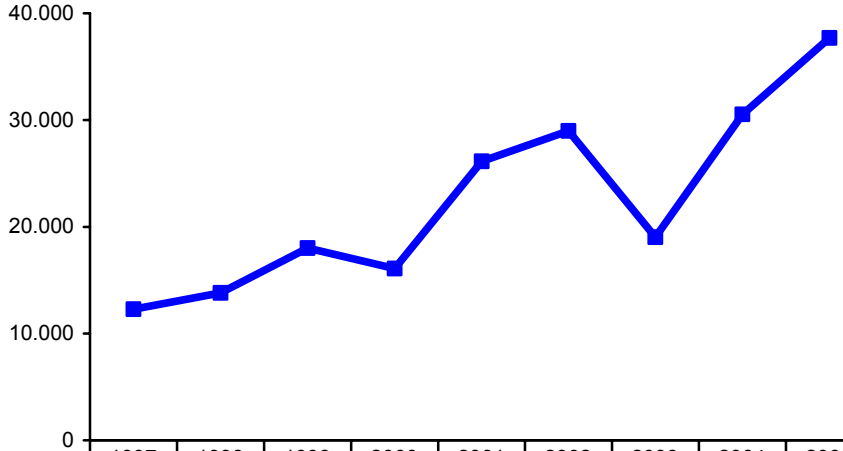


	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
	4.454	3.541	3.899	6.897	13.742	18.418	11.687	18.111	6.165	33.680	17.617	49.279	33.135	48.229

SOURCE: Ministry of Interior

The amount of cocaine seizures has risen progressively during the period 2000-2005, going from 16140 in 2000 to 37707 in 2005 (Figure 12.13).

Figure 12.13. Evolution in the number of cocaine seizures. Spain, 1997-2005.

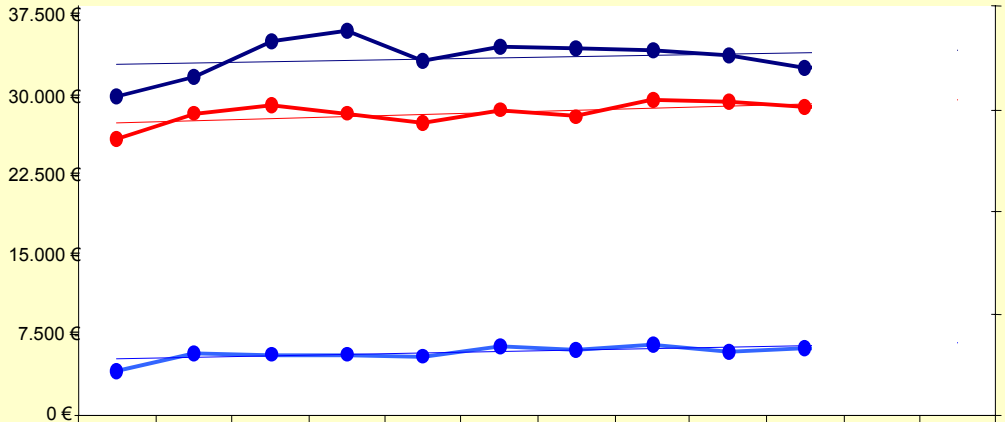


	1997	1998	1999	2000	2001	2002	2003	2004	2005
Number of seizures	12.276	13.818	18.006	16.080	26.127	28.986	19.016	30.528	37.707

SOURCE: Ministry of Interior

The price of cocaine on the retail market (dose and grammes) has remained relatively stable during the period 2001-2005, around €58-62 / g. As for its price on the wholesale market (Kg), it has fallen slightly, going from €34,640 /Kg in 2001 to €33,364 /Kg in 2005.

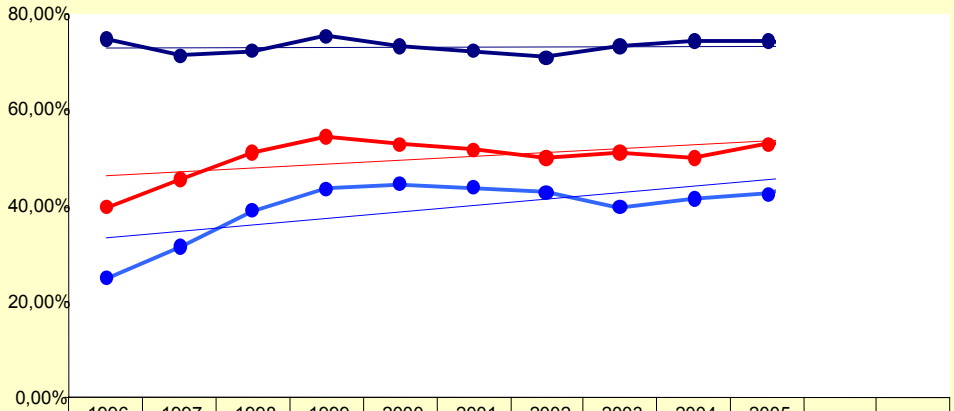
Figure 12.14.Cocaine prices per dose, gramme and kilogramme 1996-2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Per Kg	30.051 €	31.854 €	35.159 €	36.211 €	33.358 €	34.641 €	34.570 €	34.364 €	33.949 €	32.758 €
Per g	54,09 €	59,20 €	60,93 €	59,05 €	57,16 €	59,71 €	58,30 €	61,90 €	61,65 €	60,58 €
Per dose	8,41 €	12,32 €	11,95 €	12,10 €	11,70 €	13,62 €	13,15 €	13,93 €	12,79 €	13,30 €

As for its purity, a slight upward trend can be observed, which during the period 1996-2005 is reflected in an increase of 4.2% in kilos, 16.5% in grammes and 34.9% in doses.

Figure 12.15. Cocaine purity per dose, gramme and kilogramme 1996-2005



	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005
Purity of kg	75,0%	71,5%	72,5%	75,5%	73,5%	72,5%	71,0%	73,5%	74,5%	74,5%
Purity of g	40,0%	45,5%	51,0%	54,5%	53,0%	52,0%	50,0%	51,0%	50,0%	53,0%
Purity of dose	25,0%	31,5%	39,0%	43,5%	44,5%	44,0%	43,0%	40,0%	41,5%	42,5%

Crack markets

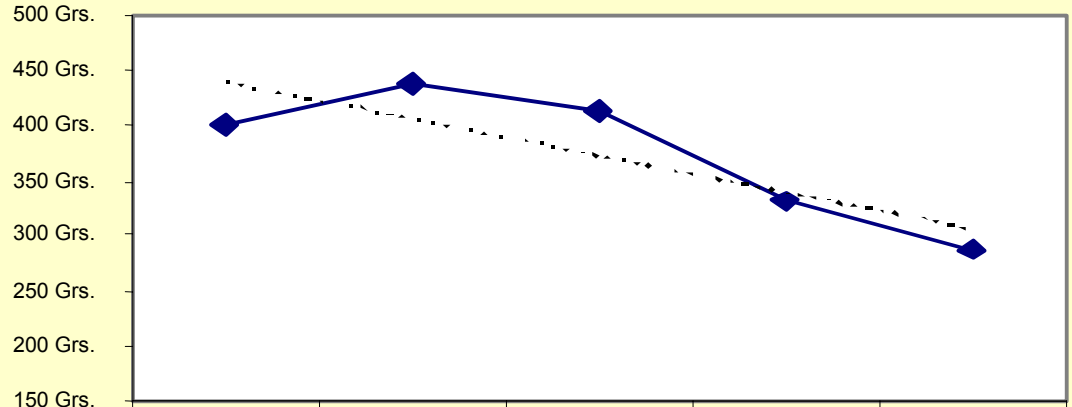
Crack is a free base variety of cocaine that is elaborated by adding an alkaline substance, such as bicarbonate of soda, crack being obtained by precipitation in the form of crystals or "rocks". Its easy elaboration means that it is produced in small household laboratories. It is either smoked or inhaled. Its consumption in Spain is very limited.

With specific regard to persons reported and arrested for offences or crimes related with crack, there are accurate statistics since 2003. In 2005 124 persons were arrested for offences related with crack trafficking, 16.78% lower than the 149 persons arrested in 2004. Likewise, in 2005 a total of 282 persons were reported for possession and/or consumption of crack in public places, with a 196.84% increase regarding the 95 reported in 2004.

There are no data regarding the evolution in crack prices and purity in Spain, due to the scarce extension of its consumption and its localization.

Regarding crack seizures, they are very scarce and they show a clear downward trend, confirming the minimum relative importance of their consumption in Spain within the cocaine group.

Figure 12.16. Evolution in amounts of crack seized in Spain 2001-2005



2001	2002	2003	2004	2005
401	438	412,89	331,22	287,42

13. DRUGS AND DRIVING

- **POLICY**

Within the framework of national legislation, in 2005 Law 17/2005, 19 July, was adopted implementing penalty points on driving licenses and modifying the articles of the Road Traffic Law regarding the circulation of motor vehicles and road safety.

Article 5 of the new Law establishes a new list of offences; amongst those classified as being "very serious", when they are not acts that possibly constitute offence, are the following:

- "*Driving on roads covered by this Law after having consumed alcoholic beverages with concentrations of alcohol in the blood higher than those legally permitted, and, in any case, driving under the effects of narcotics, psychotropics, stimulants and any other substance of a similar nature.*

- *Failure to comply with the obligation of all vehicle drivers of undergoing the tests established in order to detect possible intoxications caused by alcohol, narcotics, psychotropics, stimulants and other substance of a similar nature, and those of other road users when involved in an accident"*

According to Article 6, very serious offences shall be sanctioned with a fine of between €301 and €600 euros and the withdrawal of one's driving licence shall be imposed for the minimum term of one month and a maximum of three months.

Also in accordance with Annex II of this Law, both types of offences shall imply losing 6 points on one's driving licence.

On the other hand, the Government Delegation for the National Plan on Drugs considers it is necessary to establish and coordinate a series of measures regarding the various factors related with the consumption of alcohol and other drugs, driving and road safety in Spain.

Therefore, and during the years 2004 and 2005, the Government Delegation for the National Plan on Drugs, has taken part, in collaboration with Central Government Bodies, and in accordance with the powers corresponding to each one, in several working groups to regulate common action plans. Amongst these groups, it is necessary to highlight:

- Meetings have been held between representatives from the Government Delegation for the National Plan on Drugs, the Department of Public Health and the Traffic Department (DGT) of the Ministry of Interior, in order to draw up a **"Collaboration Agreement between the Ministry of Interior and the Ministry of Health and Consumer Affairs for the Prevention of Traffic Accidents"**, which was signed on 28th July 2005.

Amongst its clauses, this Agreement considers the purpose of establishing the general framework of collaboration between the Ministry of Interior and the Ministry of Health and Consumer Affairs, to encourage and promote actions regarding prevention of traffic accidents and to reduce the seriousness of injuries caused by them.

It also considers the establishment of specific objectives, for example:

- The reduction of traffic accidents related with the consumption of alcohol and other psychoactive drugs, by means of the joint development of preventive measures for the promotion and protection of health.
- Encourage the use of passive safety measures for the general public, with special emphasis on more vulnerable communities.
- Improve the quality of health information and promote the joint running of health and police databases.
- Inform and raise the awareness of public opinion.

Likewise, a specific **Collaboration Agreement** has been drawn up **between the Ministry of Interior and the Ministry of Health and Consumer Affairs, for the development of specific actions during the year 2005 aimed at preventing traffic accidents and reducing the seriousness of injuries caused by them, under the protection of the Framework Agreement.** This agreement was signed on the same date as the aforementioned one.

The Agreement gives priority, for the year 2005, to a series of specific actions, the content of which is detailed in it and which are grouped in the following work areas classified as top-priority:

- Sources of information and surveillance systems.
- Promotion of health. Intervention on risk factors related with harmful conducts: alcohol, drugs and medicines.
- Prevention. Preventive intervention supplied by centres of primary health care as well as appropriate qualifications for driving.
- Attending the victims.
- Education.

Therefore, and bearing in mind that traffic accidents are one of the main problems of public health in developed countries, and that many factors have to be taken into account regarding their cause, the Government is going to organise an intersector, multidisciplinary and coordinated plan.

It has also taken part in other working groups: “Leisure and Driving”, “Filling Gaps” and “GT47”.

Finally, we must point out that collaboration has been given, together with the Directorate General for Traffic (DGT), for initiating the study “Onsite and laboratory determination of drugs in saliva as procedures for evaluating the influence of drugs of abuse and psychodrugs in road safety", a study that is in a first phase has been initiated by the Directorate General for Traffic itself.

- **PREVALENCE AND EPIDEMIOLOGICAL METHODOLOGY**

In Spain there are no mandatory tests to detect cannabis and benzodiazepines for drivers.

- **DETECTION, MEASUREMENT AND LAW ENFORCEMENT**

Although driving under the influence of drugs is considered a criminal offence in our current Penal Code (Article 379) and a possible administrative infringement in road safety and traffic legislation (Articles 12 and 65.5.a) of the Road Safety Law, the General Traffic Regulation (GTR) (Articles 27 and 28), there are currently no officially approved and reliable testing devices to show the presence of drugs in drivers and, if applicable, their influence on driving.

A good example of the above-mentioned is that neither penal or procedural regulations make the slightest mention of them, and with regard to administrative regulations, Article 28 of the GTR states, *"The tests will usually consist of the medical examination of the person in question as well as the clinical analyses that the forensic surgeon or another experienced doctor or medical staff at the health centre or medical establishment to which the former is transferred, deem to be more appropriate."*

Up until 2004, the European Union has financed the programme known as ROSITA (Road Site Testing Assessment), for evaluating devices that may enable tests to be carried out in order to prove the presence of drugs in drivers on the road, through saliva, in which Spain participated through the University of Santiago's College of Legal Medicine and in collaboration with the Traffic Safety Administration Units in Galicia.

As for the training of specialists for learning how to detect drugs (saliva, urine and blood tests, on the road, at the police station, headquarters and laboratory), no courses have been carried out yet.

- **PREVENTION**

In Spain there are various training programmes for people who work at nightclubs, including doormen. These include the programmes developed by various City Councils, such as the following:

- the Barcelona City Council has put into practice **a pilot training programme for the responsible serving of alcoholic drinks**, the aim of which is to provide professionals in the catering sector with effective resources enabling them to prevent problems related to the alcohol consumption of their customers. Due to its characteristics, this programme is defined as a selective intervention which forms part of the overall aim to reduce the risks in the region.

- The Pamplona City Council, in collaboration with the "Proyecto Hombre" NGO, is developing a training programme for professionals from leisure establishments for the responsible serving of alcohol. In this programme the catering staff are provide with training in order to improve their ability to detect risk situations caused by alcohol in minors, customers who are already intoxicated or people who are going to drive.

- The Burgos City Council, as part of the Municipal Drug Dependency Plan, has a programme called "Alcohol: With or without....but always with common sense" aimed at advising educators, monitors and people interested in the development of programmes for the prevention of alcohol consumption.

Other examples of these types of training programmes organised by NGOs include the following:

- Energy Control, which operates by training nightclub staff, including doormen. This NGO has produced two documents in relation to this area:

  .- Guide to the Responsible Serving of Alcohol: Material aimed at people working in nightclubs relating to the responsible serving of alcohol, with specific information on alcohol and how to handle emergency situations related to intoxication, violence and the driving of vehicles.

  .- Prevention and Safety Guide in Music and Dance Establishments: material which is of use to all those who, as the organisers of music and dance establishments, wish to agree and evaluate organisational recommendations for health and safety and prevention of alcohol consumption in nightclubs and at major music events.

- Hazkunde, which develops similar projects but only in the Basque Country. It has a programme called Discosana, which is focused precisely on this area, and is aimed at reducing risks. http://www.hazkunde.com/.

With regard to media campaigns, in 2005, the Directorate General for Traffic carried out a special campaign for the intensification of breath tests, accompanied by TV, press and radio advertisements and messages on information boards on the roads with the slogan “Not a single drop of alcohol at the wheel”.

The Ministry of Health and Consumer Affairs also initiated two campaigns, one in 2004 and another in 2005.

The first, under the theme “Alcohol takes its toll”, was devoted to highlighting the risk of drinking alcohol and driving. Static advertising and TV and radio advertising were used for this campaign, and advertising postcards were distributed in leisure establishments and universities across the country. Numerous public (City Councils and Autonomous Regions) and private organisations, media and NGOs collaborated on the campaign.

The second, with the slogan “What do you want from alcohol?” follows the same line as the previous one. It is also aimed at the prevention of problems resulting from alcohol consumption among young people. The intention is to make young people aware of the harmful effects of alcohol consumption and in particular to reduce alcohol consumption combined with driving.

In Spain, there is also a specific prevention programme developed in driving schools and which became part of the EDDRA database in 2005.

This programme covers the Galician Autonomous region, and includes a number of municipal areas. It is run by the respective city councils and the Galicia Plan on Drugs. Its main aim is to reduce the number of fatal accidents directly related to the consumption of alcohol and other drugs. For this purpose the intention is to provide the target group (young people aged between 16 and 25) with a programme of real information on the consequences of consuming drugs when driving, promoting healthier lifestyles.

The programme, which has been running since 1 January 1997, takes place in the facilities of the driving schools and is imparted by psychologists through a series of

talks/discussions in which the various aspects related to the consumption of alcohol and other drugs and their effects on driving motor vehicles are explained.

In addition, a training programme is currently being run in Valladolid which is also aimed at teachers from driving schools in the city and the province. It is called “Alcohol, Drugs and Driving” and is imparted by teachers from the Faculty of Medicine. The intention of this programme is to look at different theoretical aspects concerning the effect of alcohol and drugs on driving, as well as seeing how different control devices work.

PART C: BIBLIOGRAPHY AND ANNEXES

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15. ANNEXES

- LIST OF GRAPHS USED IN THE TEXT

PART A: NEW DEVELOPMENTS AND TRENDS

2. Drug Use in the Population

surroundings (percentage of population between the ages of 15 and 64 frequently or very frequently finding the situations described in the neighbourhood or town where they live). Spain, 1997-2005.
- Table 2.10. Assessment by the population between ages 15 and 64 of different measures to attempt to solve the drug problem (per cent). Spain, 1997-2005.
- Figure 2.17. Assessment by the population between ages 15 and 64 of different measures to attempt to solve the drug problem (per cent of those who feel the measure is very important). Spain, 1995-2005.

4. Problem Drug Use
- Figure 4.1. Number of patients treated for heroin abuse or addiction in Spain, 1991-2004.
- Figure 4.2. Number of patients treated for cocaine abuse or addiction in Spain, 1991-2004.
- Figure 4.3. Admissions for treatment for cannabis abuse or addiction (absolute numbers). Spain, 1996-2004
- Figure 4.4. Admissions for treatment for sedative-hypnotic drug abuse or addiction (absolute numbers). Spain, 1996-2004.
- Figure 4.5. Proportion of patients treated for abuse or addiction to heroin, cannabis, cocaine, and other stimulants in Spain, 2004.
- Figure 4.6. Number and percentage of first-time patients treated for heroin abuse or addiction that preferably used the intake method of injection. Spain, 1991-2004.
- Figure 4.7. Number and percentage of first-time treated patients for cocaine abuse or addiction, that preferably are intravenous users. Spain, 1991-2004
- Figure 4.8. Number of injectors admitted for treatment for drug abuse or addiction in Spain, 1996-2004.
- Table 4.1 average age and distribution of patients admitted to treatment for drug abuse or addiction in spain, by age (per cent). Spain, 2004.
- Table 4.2. Patterns of heroin use among young users in Barcelona, Madrid and Seville. 2001-2003.
- Table 4.3. Prevalence of psychoactive drug use among young users in Barcelona, Madrid and Seville. 2001-2003.

6. Health Correlates and Consequences
- Figure 6.1. Evolution of diagnosed aids cases associated with injected drug use (number). Spain, 1986-2005.

7. Responses to Health Correlates and Consequences
- Table 7.1. Number of specific resources and the patients treated throughout 2005

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- Figure 8.1. Total number of registered drug-trafficking offences 1997-2005
- Figure 8.2. Total number of illegal drug trafficking arrests, 1995-2005
- Figure 8.3. Number of arrests by type of drug 1996 - 2005
- Figure 8.4. Charges of infringment of organic law 1/1992 (possession or consumption of drugs in public venues) 1995-2005
- Figure 8.5. Number of charges by drug type 1996 - 2005 (I)
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- Figure 8.7. Evolution in the prison population profile. Spain, 1999-2005 (%).
- Figure 8.8. Evolution in the prevalence of HIV in prison population. Spain, 2001-2005*(%).
- Figure 8.9. Evolution in the prevalence of hepatitis C in prison population. Spain , 2001-2005.
- Figure 8.10. Causes of death among the Prison Population. Spain, 2004-2005
- Figure 8.11. Consumption prevalence of psychoactive substances in reform centres. Spain, 2004.

9. Responses to Social correlates and Consequences
- Table 9.1. Social reintegration programmes. Type, number of programmes and number of users. Spain, 2005
- Table 9.2. Assistance programmes to detainees at police stations and courts. Spain, 2005.
- Figure 9.1. Evolution in the number of inmates in drug-addiction programmes. Spain, 1995-2005.