European Monitoring Centre for Drugs and Drug Addiction

Spain

Spain Country Drug Report 2019

This report presents the top-level overview of the drug phenomenon in Spain, covering drug supply, use and public health problems as well as drug policy and responses. The statistical data reported relate to 2017 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

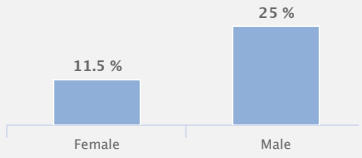
THE DRUG PROBLEM IN SPAIN AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

18.3 %



Other drugs

MDMA	1.2 %
Amphetamines	0.9 %
Cocaine	2.8 %

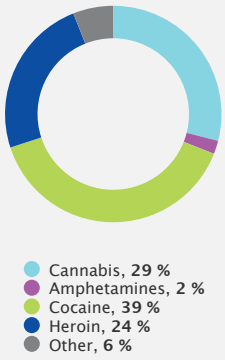
High-risk opioid users

68 297

(46 014 - 90 579)

All treatment entrants

by primary drug



Opioid substitution treatment clients

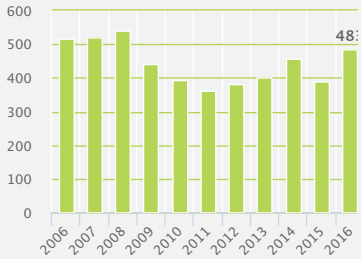
58 749

Syringes distributed

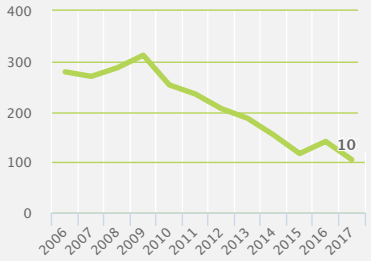
through specialised programmes

1 503 111

Overdose deaths



New HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

389 229

Top 5 drugs seized

ranked according to quantities measu
kilograms

1. Cannabis resin
2. Cocaine
3. Herbal cannabis
4. Heroin
5. Amphetamine

Population

(15-64 years)

30 700 225

Source: Eurostat Extracted on: 18/03/2019

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

National drug strategy and coordination

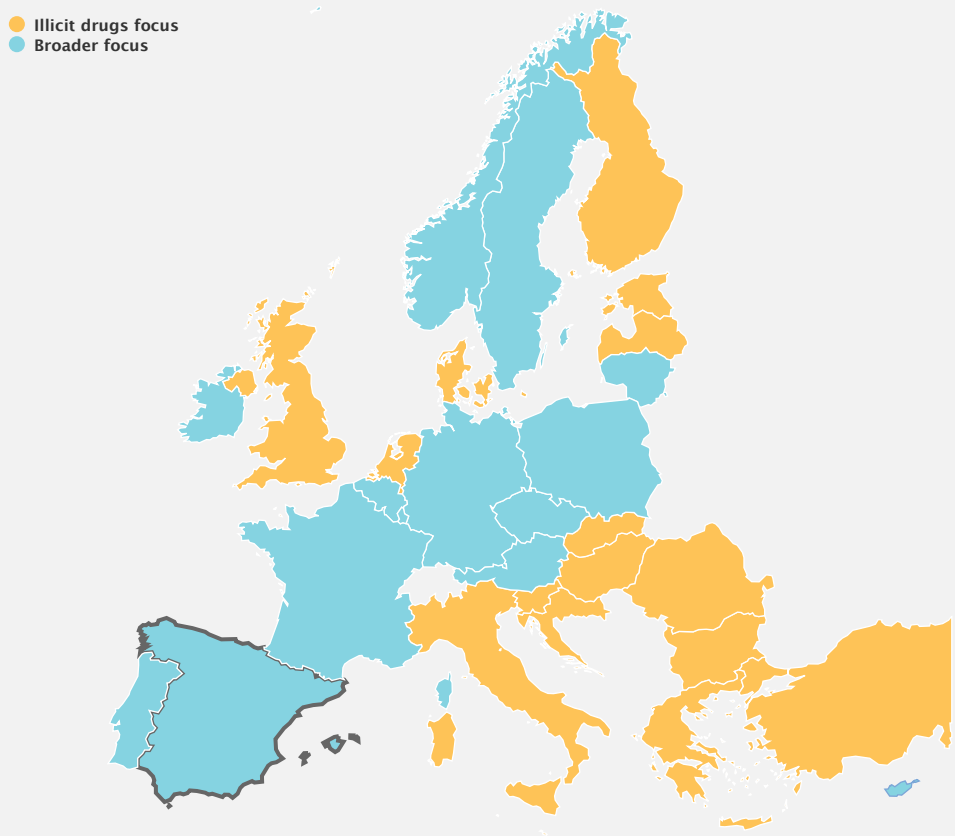
National drug strategy

The Spanish National Strategy on Addictions for 2017-24 addresses illicit drugs, new psychoactive substances, the licit trade in alcohol, tobacco and medicines with addictive potential, and behavioural addiction. The strategy's objectives include delaying the age at first contact with dependence-producing substances and behaviours, reducing their availability and prevalence, and reducing associated harms.

The strategy is built around two basic goals, which are developed in several sub-goals. The first goal seeks to achieve a healthier and better informed society by diminishing drug demand and the prevalence of dependencies as a whole. This includes prevention and risk reduction; integrated and multidisciplinary care; harm reduction; and social integration. The second goal aims to achieve a safer society by diminishing drug supply and controlling those activities that could lead to dependencies. This includes supply reduction, review of legislation, and judicial and law enforcement cooperation at both national and international levels. The strategy will be implemented through two consecutive 4-year action plans, for 2017-20 and 2021-24.

Like other European countries, Spain evaluates its drug policy and strategy using on-going indicator monitoring and specific research projects. Since the evaluation of the National Strategy on Drugs for 2000-08, the Government Delegation for the National Plan on Drugs has used a mixed method approach to final strategy evaluations. A final multi-criterion evaluation of the National Strategy on Drugs for 2009-16 was completed in 2017 by a mixed evaluation team in the context of the development of the new strategy. Indicators were developed and addressed the strategy's principles, objectives, processes and systems, degree of implementation and final results. As part of the consultation process, questionnaires addressing different aspects of the strategy were completed by representatives from the central, autonomous and municipal administrations, civil society and other stakeholders. Indicators related to the strategy's final results, its processes and outputs, the quality of the systems and transversal objectives as well as principles such as equality, equity, gender perspective, social participation and training. The degree of accomplishment of the 14 general objectives was analysed, along with the objectives related to the guiding principles (evidence, social participation, an intersectoral approach, a comprehensive approach, equality and a gender focus).

Focus of national drug strategy documents: illicit drugs or broader



NB: Data from 2017. Strategies with a broader focus may include, for example, licit substances and other addictions.

National coordination mechanisms

At the national level, the Spanish Council for Drug Addiction and Other Addictions is responsible for inter-sectoral collaboration. It seeks to improve the development and implementation of policies and actions related to illicit drug use and other addictions. The Government Delegation for the National Plan on Drugs is the national drug policy coordinator. The Delegate's office is a directorate of the Ministry of Health, Social Services and Equality. It coordinates the institutions involved in delivering the drug strategy at central administrative, autonomous community and local levels.

The Sectoral Conference on Drugs facilitates cooperation between central government and the administrations of the autonomous communities and cities. Chaired by the Minister for Health, Consumer Affairs and Wellbeing, it includes representatives of the central administration and the commissioners of the autonomous communities. The Communities Commission on Drugs, chaired by the Government Delegate for the National Plan on Drugs, reports to the sector conference, which is made up of all the deputy directors-general of the Government Delegation and those responsible for the regional drug plans. There is a drug commissioner in each of the 17 autonomous communities and two autonomous cities (Ceuta and Melilla). They communicate with the Government Delegation through their participation in the Inter-autonomic Commission and the sector conference, and each has an organisation that is responsible for the autonomous community drug plan.

Public expenditure

Understanding the costs of drug-related actions is an important aspect of drug policy. Some of the funds allocated by governments for expenditure on tasks related to drugs are identified as such in the budget (‘labelled’). Often, however, most drug-related expenditure is not identified (‘unlabelled’) and must be estimated using modelling approaches.

Spanish authorities provide annual partial estimates of drug-related public expenditure from the central government and from the autonomous communities and cities. However, the estimates do not cover all sectors and include labelled and unlabelled expenditure. Comparability over time is limited because reporting entities and data collection methods have changed.

A study estimated total drug-related expenditure in Spain in 2012. During that year, total drug-related expenditure ranged between EUR 1 201 million and EUR 1 415 million, which amounted to between 0.12 % and 0.14 % of gross domestic product (GDP). Approximately 60 % was spent on demand reduction initiatives, while close to 40 % was allocated to supply reduction.

Recent data estimate that in 2016 a total of EUR 317.36 million was allocated for drug-related public expenditure, which amounted to about 0.03 % of the GDP. One third of it was spent by the central government, while the remainder was spent by the autonomous communities and cities, who are responsible for delivering healthcare.

Drug laws and drug law offences

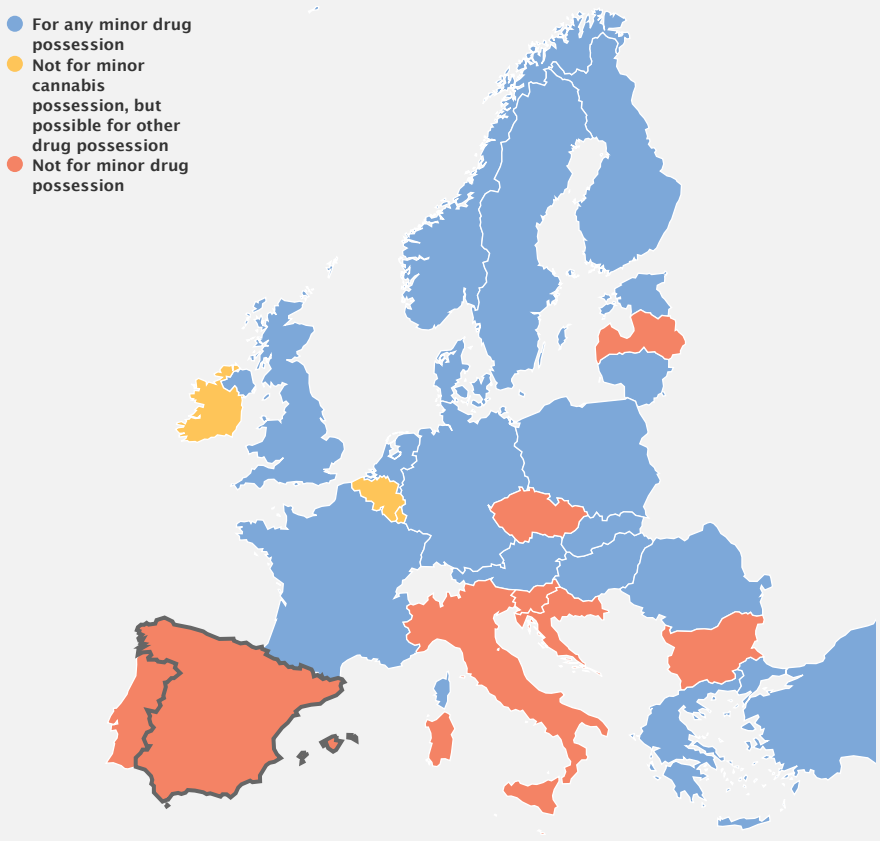
National drug laws

In Spain, consumption or minor personal possession in public places is deemed a (non-criminal) order offence, punishable by fines of EUR 601 to EUR 30 000 (Law on the Protection of Citizens' Security (2015), Article 36). For minors, the fine can be suspended if the offender voluntarily attends treatment, rehabilitation or counselling activities.

Drug trafficking offences and penalties are defined in the Criminal Code, Articles 368-378. Penalty ranges are determined by the seriousness of the health damage associated with the drugs involved and any aggravating or mitigating circumstances, such as selling to minors or the sale of large quantities. Prison sentences ranging from 1 to 3 years can be imposed if the drugs do not cause serious harm to health (such as cannabis), and from 3 to 6 years if they do (such as heroin or cocaine). These sentences may be reduced in mitigating circumstances and increased in specified aggravating circumstances up to 18 years in prison. In all cases, a fine is also imposed and substances, instruments of crime and profits are confiscated; disqualification from professions is also an option. Both legal entities and individuals may be punished. Under Article 376, prison sentences (of up to 5 years) may be reduced if an offender who was dependent on drugs at the time of the crime successfully completes detoxification treatment. With regard to 'cannabis social clubs', in 2015, the Spanish Supreme Court clearly stated that 'organised, institutionalised and persistent cultivation and distribution of cannabis among an association open to new members is considered drug trafficking'. Regional attempts to regulate these clubs have been declared unconstitutional.

New psychoactive substances are controlled by adding them to the lists of substances subject to the Law on the Protection of Citizens' Security and the Criminal Code, as above.

Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Data from 2017.

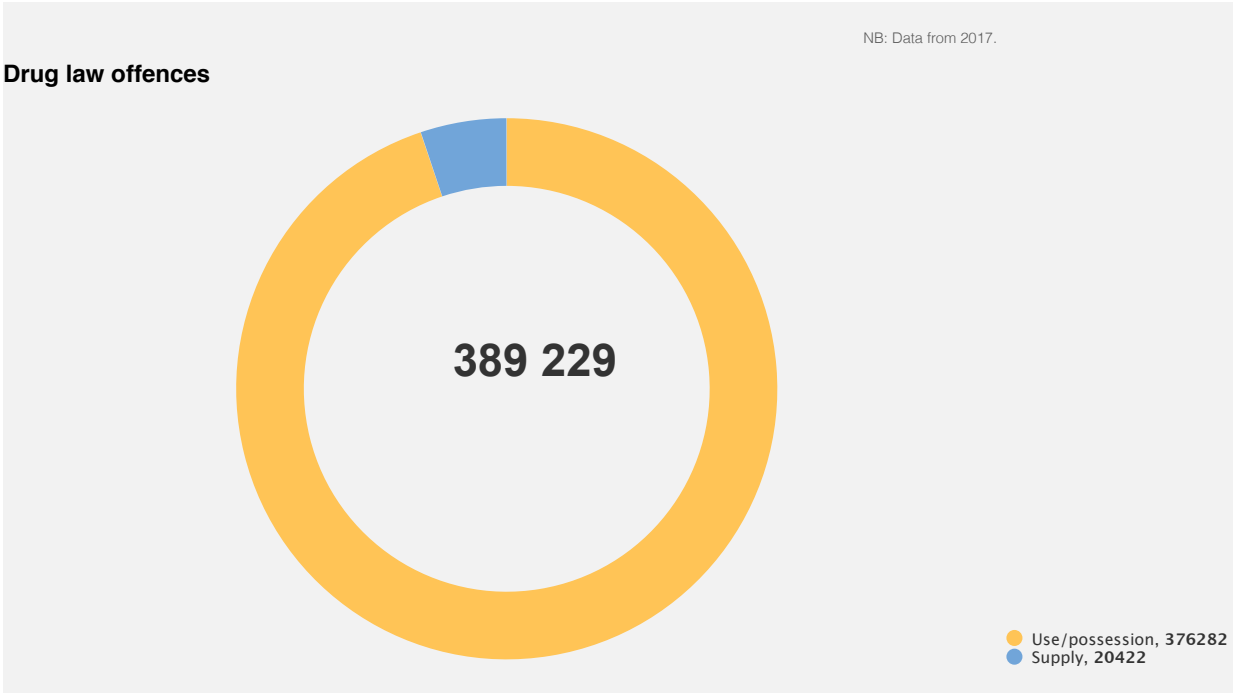
Drug law offences

Drug law offence data are the foundation for monitoring drug-related crime and are also a measure of law enforcement activity and drug market dynamics; they may be used to inform policies on the implementation of drug laws and to improve

strategies.

In Spain, the overwhelming majority of drug law offenders are charged with possession-related offences against the Law on the Protection of Citizens' Security, while the remainder are charged with cultivation, preparation or manufacturing or illicit trafficking crimes under the Criminal Code. In 2017, 8 out of 10 charges were associated with cannabis.

Reported drug law offences and offenders in Spain



Drug use

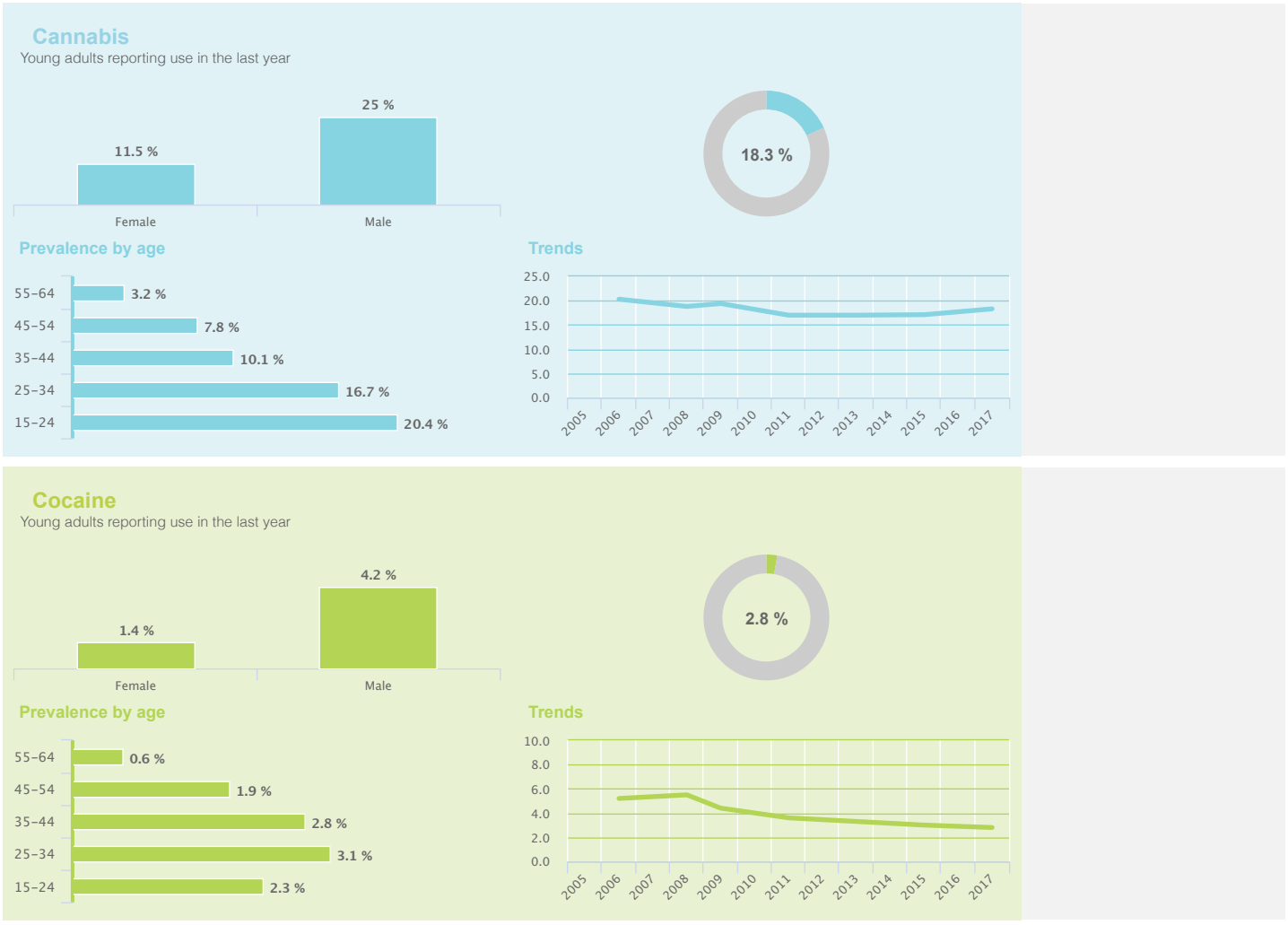
Prevalence and trends

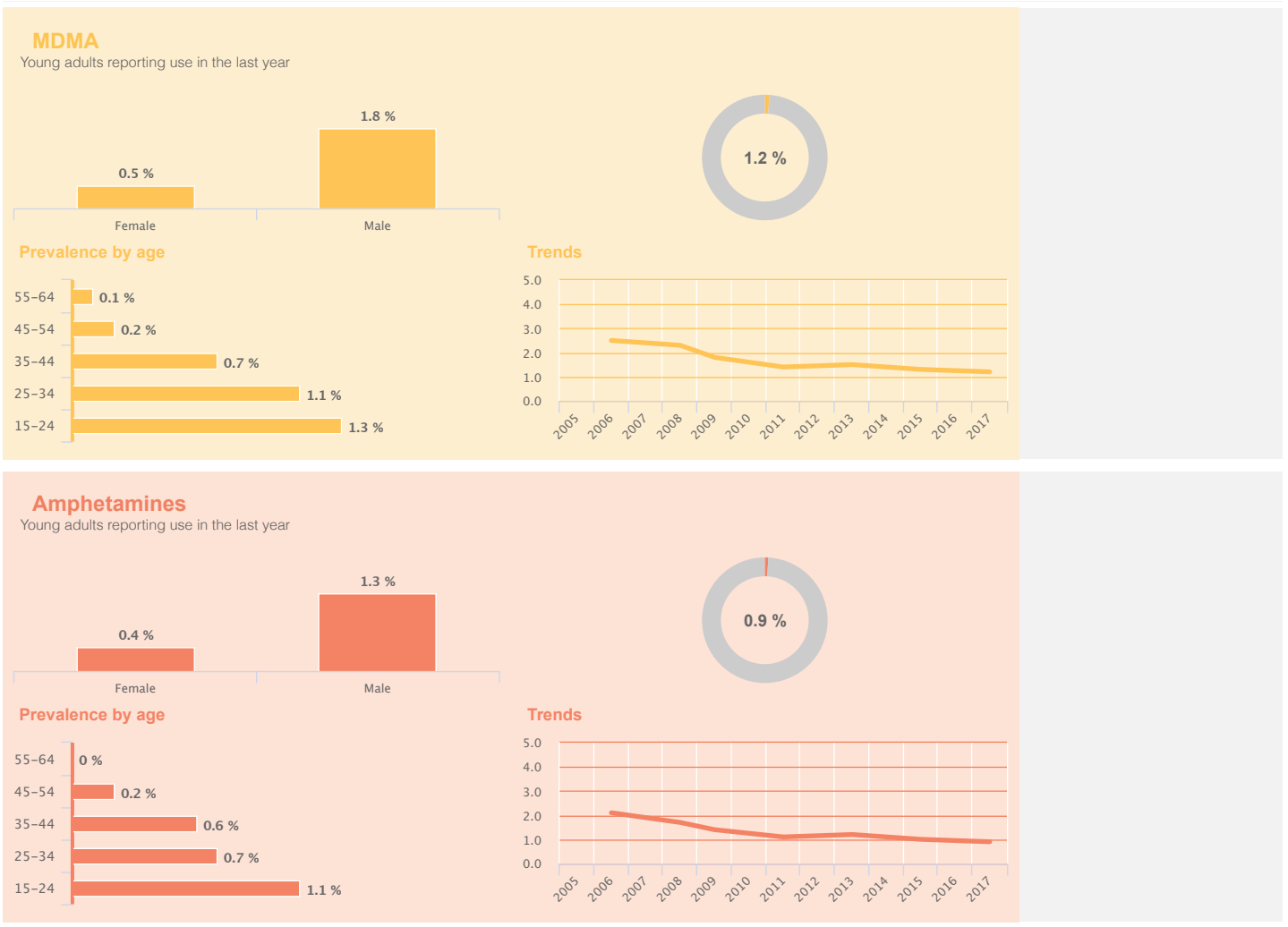
The prevalence of use of illicit substances in Spain has been relatively stable in recent years, with more than one third of the adult population reporting lifetime use of an illicit substance. Cannabis is the most commonly used drug, with use mainly concentrated among adolescents and adults younger than 35 years. The prevalence of use of the most commonly consumed illicit drugs (cannabis and cocaine) showed a downward trend until 2017, when an increase was observed for both substances. The use of all illicit substances remains more prevalent among males than females.

In 2017, 1 in 100 adults aged 15-64 years reported the use of new psychoactive substances. Most users of this type of substance were male and young and reported polydrug use (with other legal and illegal psychoactive substances).

The Spanish cities of Barcelona, Castellón, Madrid, Santiago and Valencia participate in the Europe-wide annual wastewater campaigns undertaken by the Sewage Analysis Core Group Europe (SCORE). This study provides data on drug use at a municipal level, based on the levels of illicit drugs and their metabolites found in wastewater. The results of the 2018 study on stimulant drugs revealed high levels of cocaine metabolites in wastewater samples from all five cities, higher than the levels reported in some other European cities participating in the study. In addition, Barcelona recorded an increase in MDMA/ecstasy, amphetamine and methamphetamine residues between 2011 and 2018. A common pattern across the monitored cities was increased use of cocaine and MDMA at the weekends.

Estimates of last-year drug use among young adults (15-34 years) in Spain

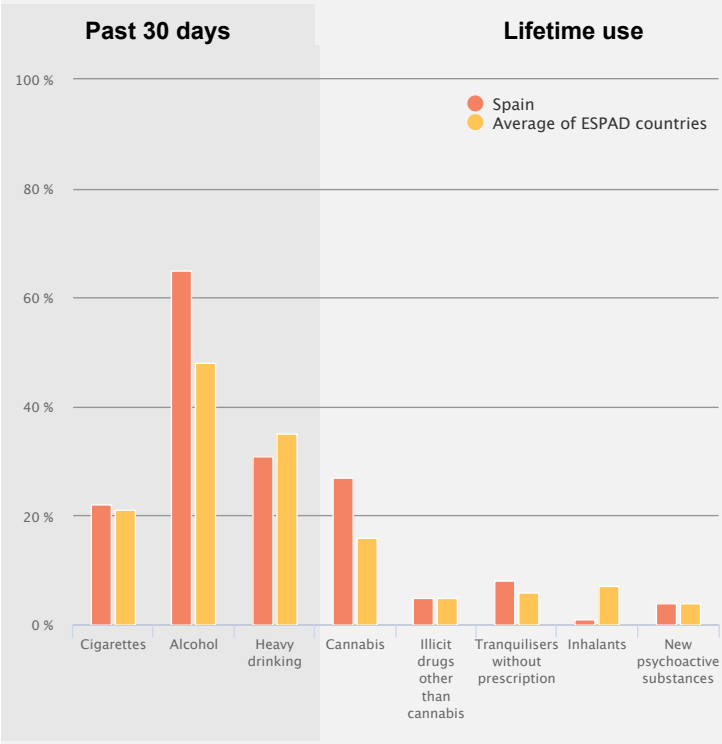




NB: Estimated last-year prevalence of drug use in 2017.

Data on drug use among 14- to 18-year-old students are drawn from the Spanish Survey on Drug Use in Secondary Schools (ESTUDES), which has been conducted every second year in Spain since 1994. The 2016 survey reported that the most commonly used illicit substance is cannabis, with about 3 out of 10 students reporting lifetime use. No changes were observed in the proportion of students who had used cannabis in the preceding 30 days. Lifetime prevalence rates for use of other illicit drugs among students remain well below that for use of cannabis. ESTUDES also supplies data to the European School Project on Alcohol and Drugs (ESPAD), and the 2014 data indicated that prevalence of lifetime cannabis use among Spanish students aged 15-16 years was higher than the ESPAD average (based on data from 35 countries).

Substance use among 15- to 16- year-old school students in Spain



Source: ESTUDES (2014) and ESPAD study 2015.

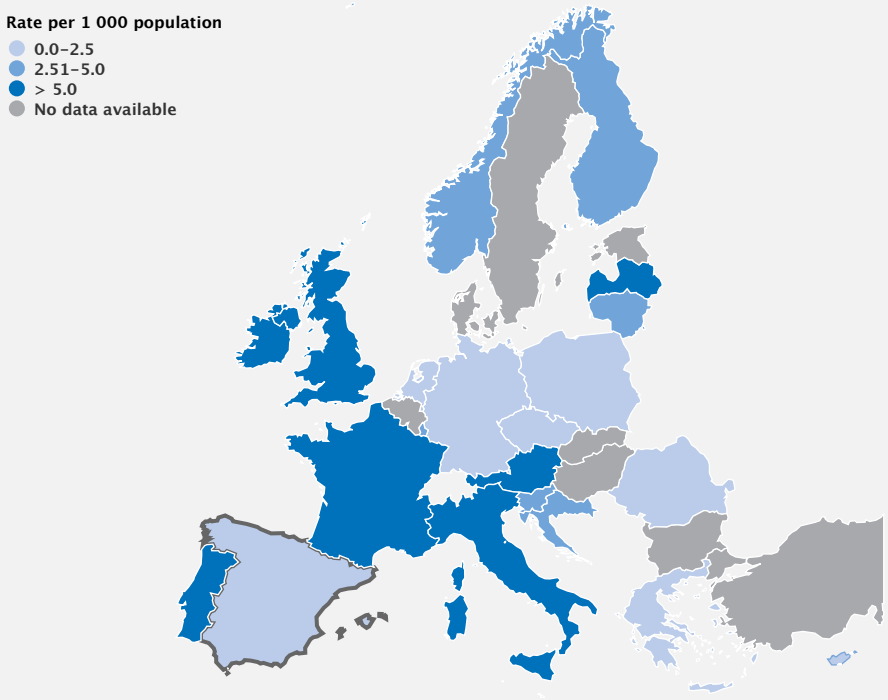
High-risk drug use and trends

Studies reporting estimates of high-risk drug use can help to identify the extent of the more entrenched drug use problems, while data on first-time entrants to specialised drug treatment centres, when considered alongside other indicators, can inform an understanding of the nature of and trends in high-risk drug use.

In Spain, heroin remains the main substance linked to the most serious adverse health and social consequences, such as drug-related infections. The estimated number of high-risk heroin users has shown a decreasing trend between 2010 and the latest estimate in 2016. The prevalence of injecting drug use was estimated to be 0.41 per 1 000 in 2016.

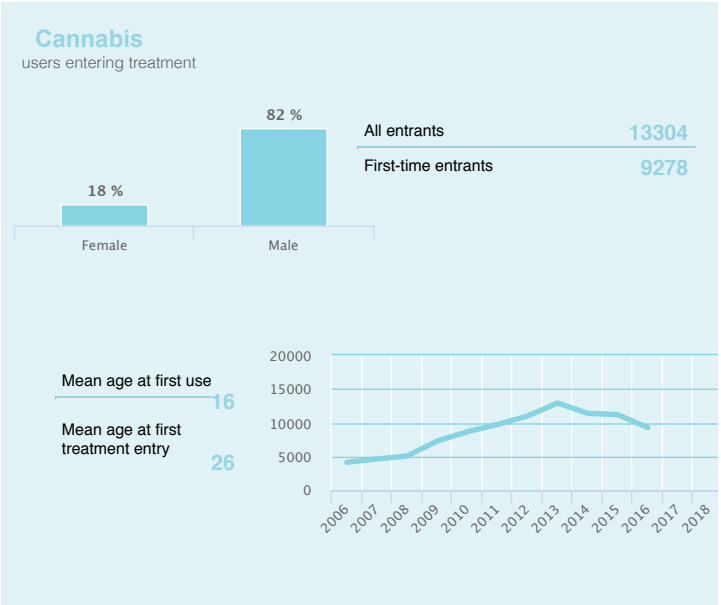
Data from specialised treatment centres indicate that cocaine remains the substance resulting in the highest number of all treatment entries, with the number of first-time clients reporting cocaine as the primary substance of use having increased in 2015 and 2016, following a long period of decline. Only a small proportion of cocaine users entering treatment reported injecting drug use. Further data from treatment centres indicate that, after increasing substantially up to 2013, the number of first-time cannabis treatment demands has since declined.

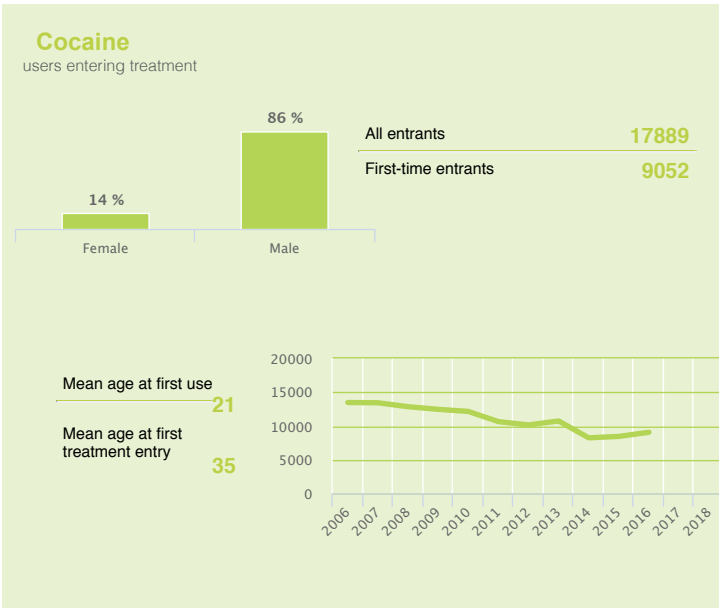
National estimates of last year prevalence of high-risk opioid use

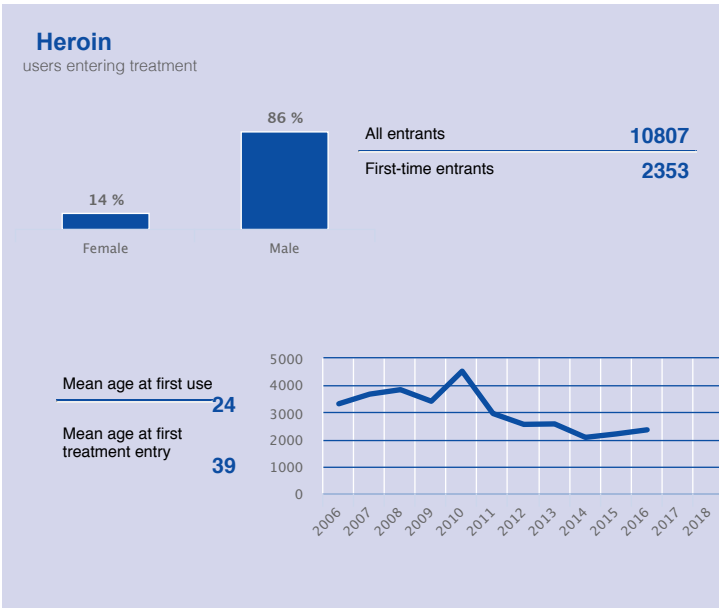


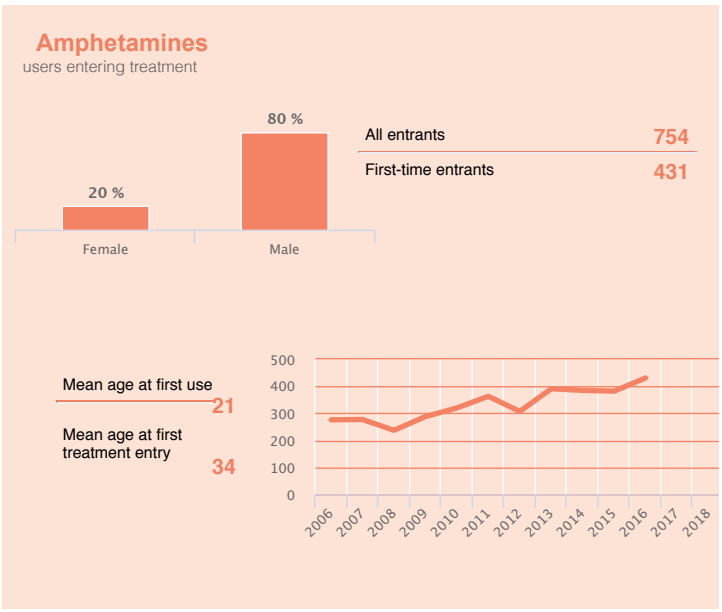
NB: Data from 2017, or the most recent year for which data are available.

Characteristics and trends of drug users entering specialised drug treatment in Spain









NB: Data from 2016. Data are for first-time entrants, except for the data on gender, which are for all treatment entrants.

Drug-related infectious diseases

In the last 20 years, human immunodeficiency virus (HIV) infection has represented one of the main health problems associated with drug use in Spain. However, since the end of the 1990s, a significant decrease has been observed in HIV infection associated with injecting drug use.

Information on HIV, hepatitis C virus (HCV) and hepatitis B virus (HBV) infection among people who inject drugs (PWID) at the national level in Spain is routinely collected through drug treatment centres and prisons and is based on the result of serological tests among those who have injected drugs during their lifetime. In 2016, three quarters of clients knew their HIV or HCV status, while only one third were aware of their HBV status. Although approximately one third of PWID who entered drug treatment in Spain in 2016 and knew their serological status were HIV positive (prevalence), the incidence of HIV infection (newly diagnosed cases) remained low in 2017.

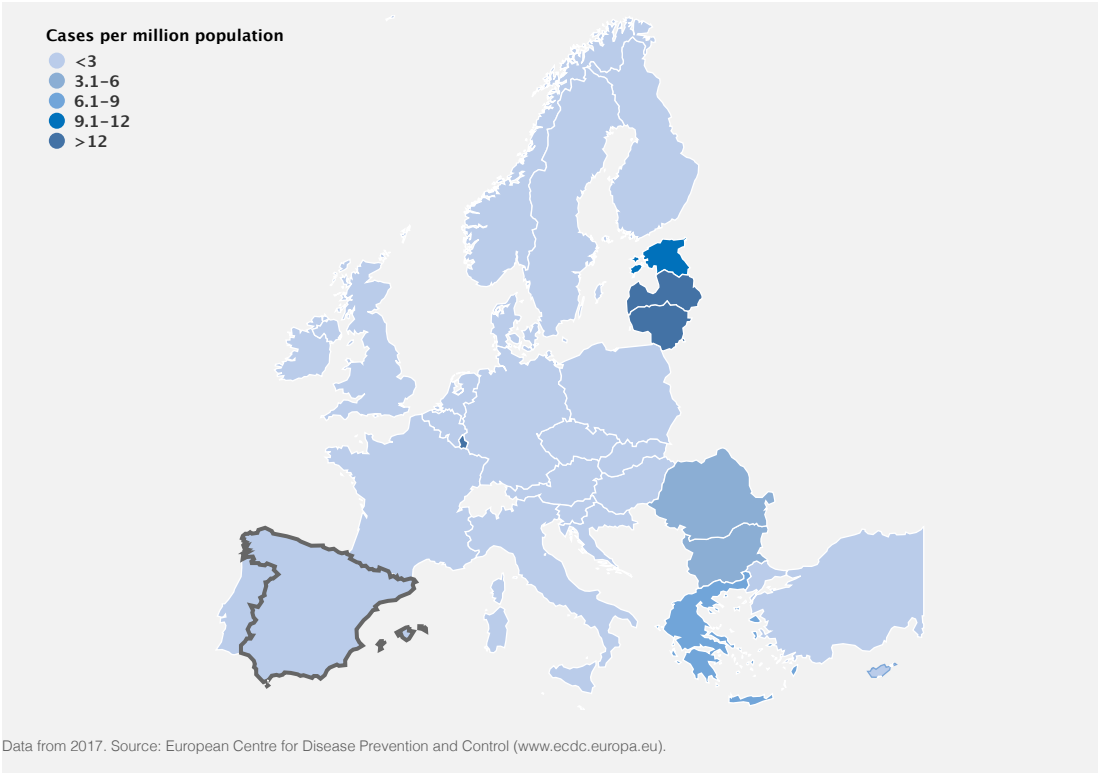
Prevalence of HIV and HCV antibodies among people who inject drugs in Spain (%)

	Region	HCV	HIV
	National	64.4	31.1
	Sub-national	:	:

Data from 2016.

A recently published cohort study reported that up to three quarters of PWID are HCV positive (as determined by the presence of anti-HCV antibodies). With regard to HBV, around one in eight of PWID admitted to treatment who knew their serological status indicated that they were HBV positive (HBs Ag), that is, chronically infected carriers of the hepatitis B virus.

Newly diagnosed HIV cases attributed to injecting drug use



Data from 2017. Source: European Centre for Disease Prevention and Control (www.ecdc.europa.eu).

Drug-related emergencies

Information on drug-related emergencies in Spain originates from the National Plan on Drugs, which monitors hospital emergencies directly caused by non-medical use of psychoactive substances among 15- to 54-year-olds. In 2016, a total of 4 565 emergency episodes related to drug use were notified, the lowest level reported in the past 12 years. Cocaine was the substance most frequently reported as the cause of the emergency episodes, followed by cannabis. The proportion of heroin-related emergencies has decreased by a factor of 4 since 2000. Amphetamines and MDMA/ecstasy were less common causes of drug-related emergencies in Spain in 2016.

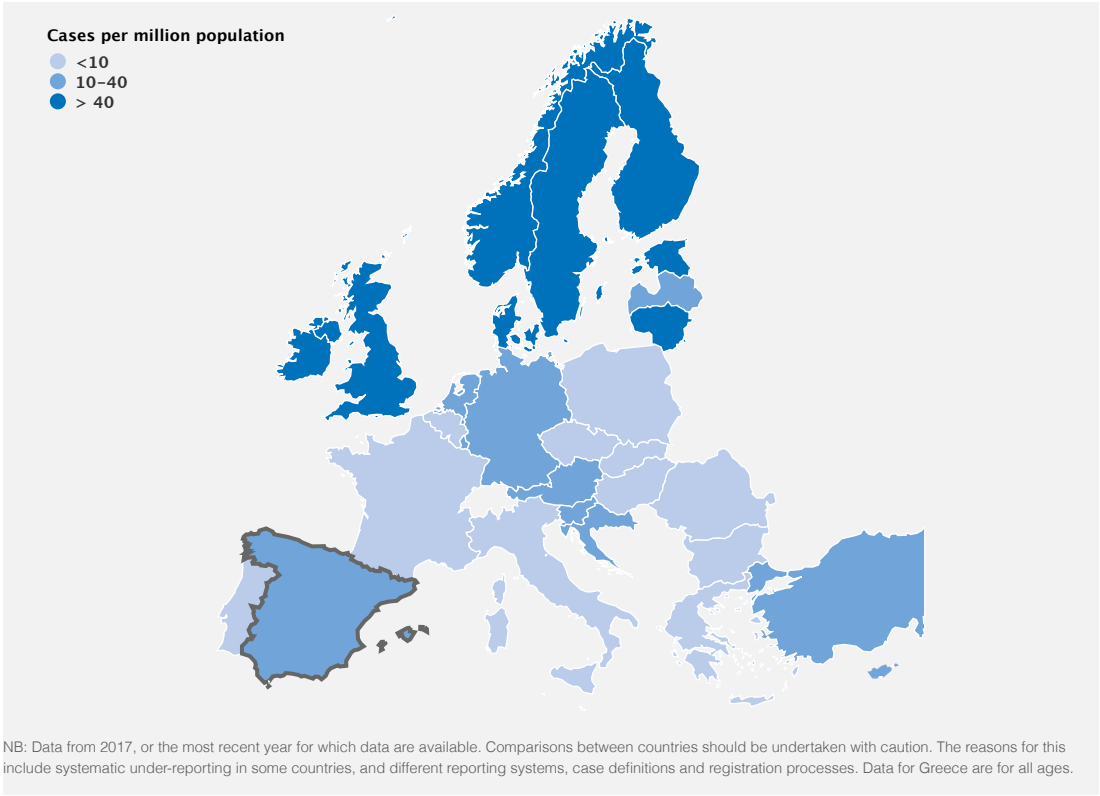
Drug-induced deaths and mortality

Drug-induced deaths are deaths that can be attributed directly to the use of illicit drugs (i.e. poisonings and overdoses).

The 2016 data extracted from the General Mortality Register showed an increase in the number of drug-induced deaths, reaching the highest level since 2008. According to the available toxicological results, in 9 out of 10 cases, the presence of more than one psychoactive substance was detected, which indicates that polydrug use remains common in Spain. The drugs most commonly implicated in drug-induced deaths were opioids, followed by cocaine.

The drug-induced mortality rate among adults (aged 15-64 years) was 16 deaths per million in 2016.

Drug-induced mortality rates among adults (15-64 years)

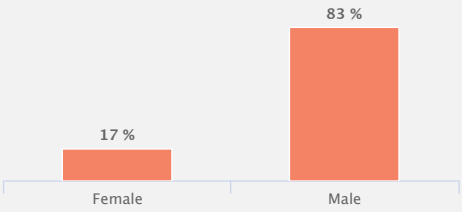


NB: Data from 2017, or the most recent year for which data are available. Comparisons between countries should be undertaken with caution. The reasons for this include systematic under-reporting in some countries, and different reporting systems, case definitions and registration processes. Data for Greece are for all ages.

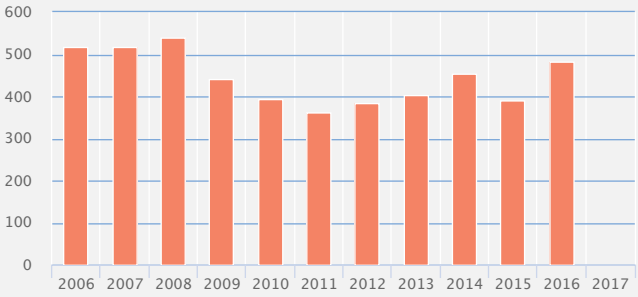
Characteristics of and trends in drug-induced deaths in Spain

NB: Year of

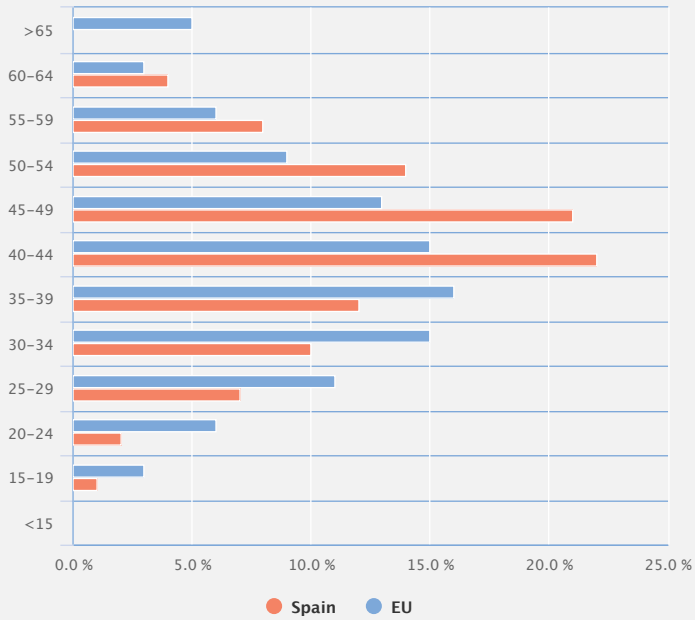
Gender distribution



Trends in the number of drug-induced deaths



Age distribution of deaths in 2016



data 2016

Prevention

In Spain, drug prevention is a priority in the National Strategy on Addictions 2017-24, which provides an organisational and financial framework at the national level and at the level of the autonomous communities through autonomous community drug plans and municipal drug plans. Community-based programmes may also receive funding from monies realised from assets seized from those convicted of illegal drug trafficking and other related offences, and, occasionally, from foundations. The new National Strategy on Addictions 2017-24 is articulated around two major goals: (i) a healthier and better-informed society; and (ii) a more secure society. Prevention objectives, within the first goal, include the reduction of visibility and promotion, limitation of accessibility and reduction of perception of normality.

Prevention interventions

Prevention interventions encompass a wide range of approaches, which are complementary. Environmental and universal strategies target entire populations, selective prevention targets vulnerable groups that may be at greater risk of developing substance use problems and indicated prevention focuses on at-risk individuals.

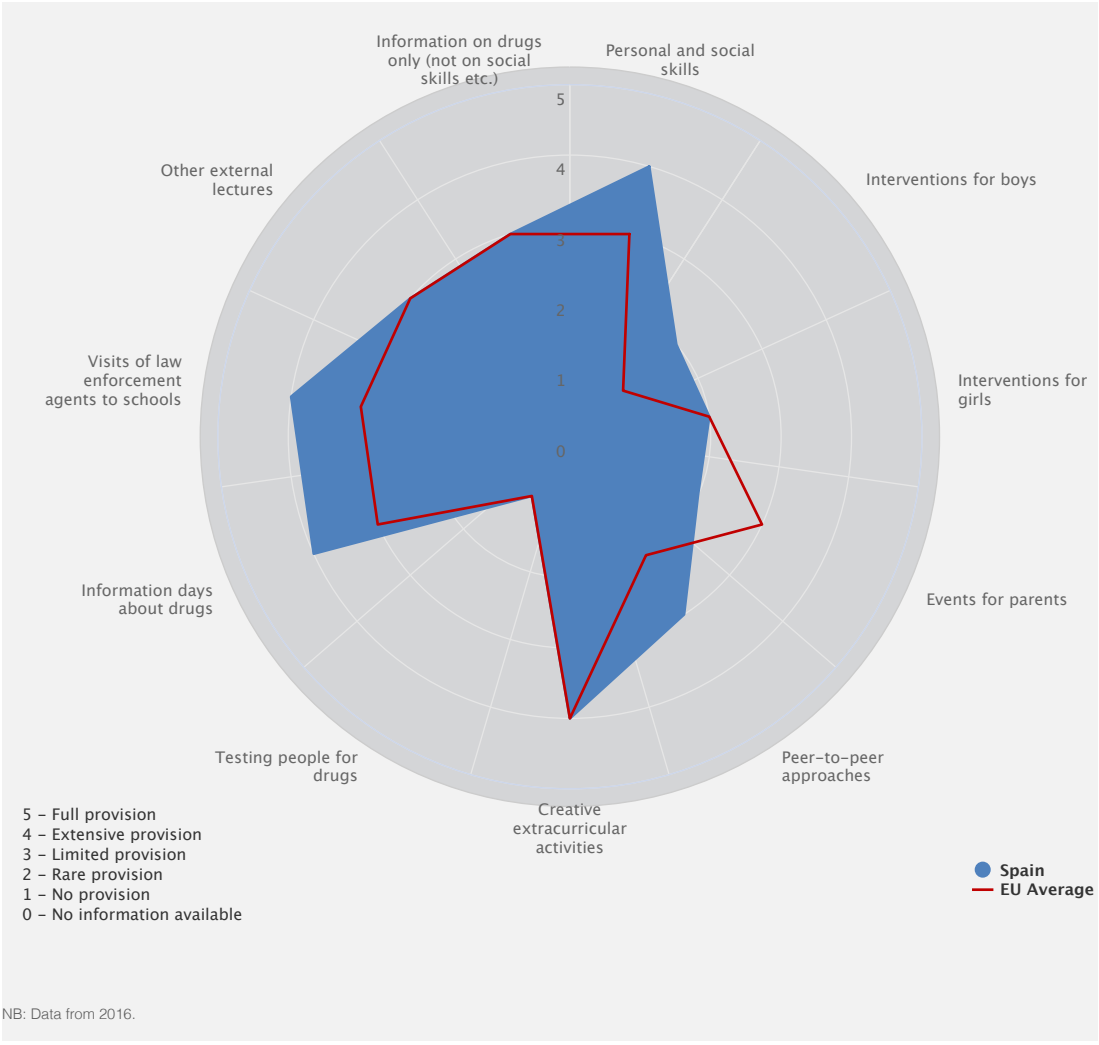
Environmental interventions in Spain are the responsibility of the autonomous communities and municipal drug plans. They focus on promoting safety in the nightlife environment, addressing drunk driving and preventing alcohol consumption among minors. A number of activities are also carried out to limit retail-level trafficking of illicit drugs in schools and leisure zones.

Universal prevention in Spain is mainly implemented in the educational sector, and it is focused on the development of personal and family competences and skills. A wide variety of manual-based prevention programmes in classrooms are used. The Autonomous Community Drug Plans, which are implemented in collaboration with the educational system, set out promotion, implementation and monitoring of drug prevention activities and programmes. In some autonomous communities and cities, the offer is centred on a few accredited programmes; in others, there is much variety, with up to 30 different programmes being used. In recent years, community work promoting the networking of parents associations has been fostered. A particular Spanish feature is the implementation, in all autonomous communities and cities, of alternative leisure-time programmes that seek to promote drug-free entertainment for minors and young people. Prevention programmes in universities have emerged in recent years and focus mainly on information provision and awareness raising, using peer education methods or online delivery. Programmes targeting bars, nightclubs and music concerts are carried out by peer mediators, who work to identify problem drug users and provide information and advice about drugs. Some autonomous communities implement their own specific programmes, such as Platform for Quality Leisure, Q for Quality and Responsible Serving of Alcoholic Beverages.

Selective prevention activities focus on young people in disadvantaged neighbourhoods and those in specific educational or residential centres. Activities include psychosocial attention and development of psychoeducational skills. There are increasingly more alternative leisure programmes of selective prevention focused on minors in high-risk situations.

Indicated prevention activities in Spain are frequently associated with selective prevention activities and address both vulnerable young people and families, aiming to alleviate risk and promote protective factors at an individual level. Several autonomous communities have reported prevention activities focusing on under-age offenders with drug use problems.

Provision of interventions in schools in Spain (expert ratings)



NB: Data from 2016.

Harm reduction

The public health approach has been a predominant feature in Spanish drugs policy in the past 25 years. The current National Strategy on Addictions 2017-24 includes among its key objectives the reduction of harm associated with the use of substances with addictive potential. It seeks to maintain and enlarge the coverage of harm reduction programmes, to improve early diagnosis of infections and to integrate harm reduction transversally, connecting it with primary healthcare, mental health care and services for behavioural addictions. Furthermore, both the 4th Strategic Plan for the Prevention and Control of HIV Infection and Other Sexually Transmissible Infections 2013-20 and the National Plan for responding to Hepatitis C in the Health System 2015 identify people who inject drugs (PWID) as a priority population.

Harm reduction interventions

Harm reduction services are provided by a large network of public facilities, including social emergency centres, mobile units, pharmacies and prisons, and are available throughout Spain, although with varying service profiles in the different autonomous communities.

Most harm reduction programmes include a socio-sanitary service that offers preventive educational interventions, clean needles and syringes and other paraphernalia, testing for drug-related infections, vaccination against hepatitis A and B viruses, and emergency care and assistance for PWID, who are not usually in contact with any assistance intervention.

In 2016, public needle and syringe programmes (NSPs) in Spain distributed more than 1.5 million syringes, which represents a third year of stability after a long-term declining trend that started in 2005. The drop in the number of syringes distributed may be related to a decreased incidence of injecting drug use in Spain. Thirteen facilities for supervised drug consumption are available in the autonomous communities of Catalonia and the Basque Country. In 2016, these facilities served 3 160 clients and dispensed more than 7 % of all syringes given out in Spain (these facilities also operate as large harm reduction centres).

Availablity of selected harm reduction responses in Europe

Country	Needle and syringe programmes	Take-home naloxone programmes	Drug consumption rooms	Heroin-assisted treatment
Austria	Yes	No	No	No
Belgium	Yes	No	Yes	No
Bulgaria	Yes	No	No	No
Croatia	Yes	No	No	No
Cyprus	Yes	No	No	No
Czechia	Yes	No	No	No
Denmark	Yes	Yes	Yes	Yes
Estonia	Yes	Yes	No	No
Finland	Yes	No	No	No
France	Yes	Yes	Yes	No
Germany	Yes	Yes	Yes	Yes
Greece	Yes	No	No	No
Hungary	Yes	No	No	No
Ireland	Yes	Yes	No	No
Italy	Yes	Yes	No	No
Latvia	Yes	No	No	No
Lithuania	Yes	Yes	No	No
Luxembourg	Yes	No	Yes	Yes
Malta	Yes	No	No	No
Netherlands	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	No
Poland	Yes	No	No	No
Portugal	Yes	No	No	No
Romania	Yes	No	No	No
Slovakia	Yes	No	No	No
Slovenia	Yes	No	No	No
Spain	Yes	Yes	Yes	No
Sweden	Yes	No	No	No
Turkey	No	No	No	No
United Kingdom	Yes	Yes	No	Yes

Treatment

The treatment system

In Spain, the overall policy for drug treatment is guided by the National Strategy on Addictions. At the same time, the implementation, management and evaluation of the resources and programmes for providing care for drug users come under the authority of the 17 autonomous communities and two autonomous cities. Each autonomous community is entitled to organise and deliver health interventions in accordance with its own plans, budgets and personnel. Some have integrated treatment for drug use-related problems within primary care units or mental health services, and some have a separate treatment network that retains a connection with the general healthcare system. As a general rule, care is organised on three levels.

The public sector is the primary provider of treatment, followed by non-governmental organisations and private organisations. Drug treatment is mostly funded by the public budget of the central government, autonomous communities and cities and by some municipalities, usually the big cities.

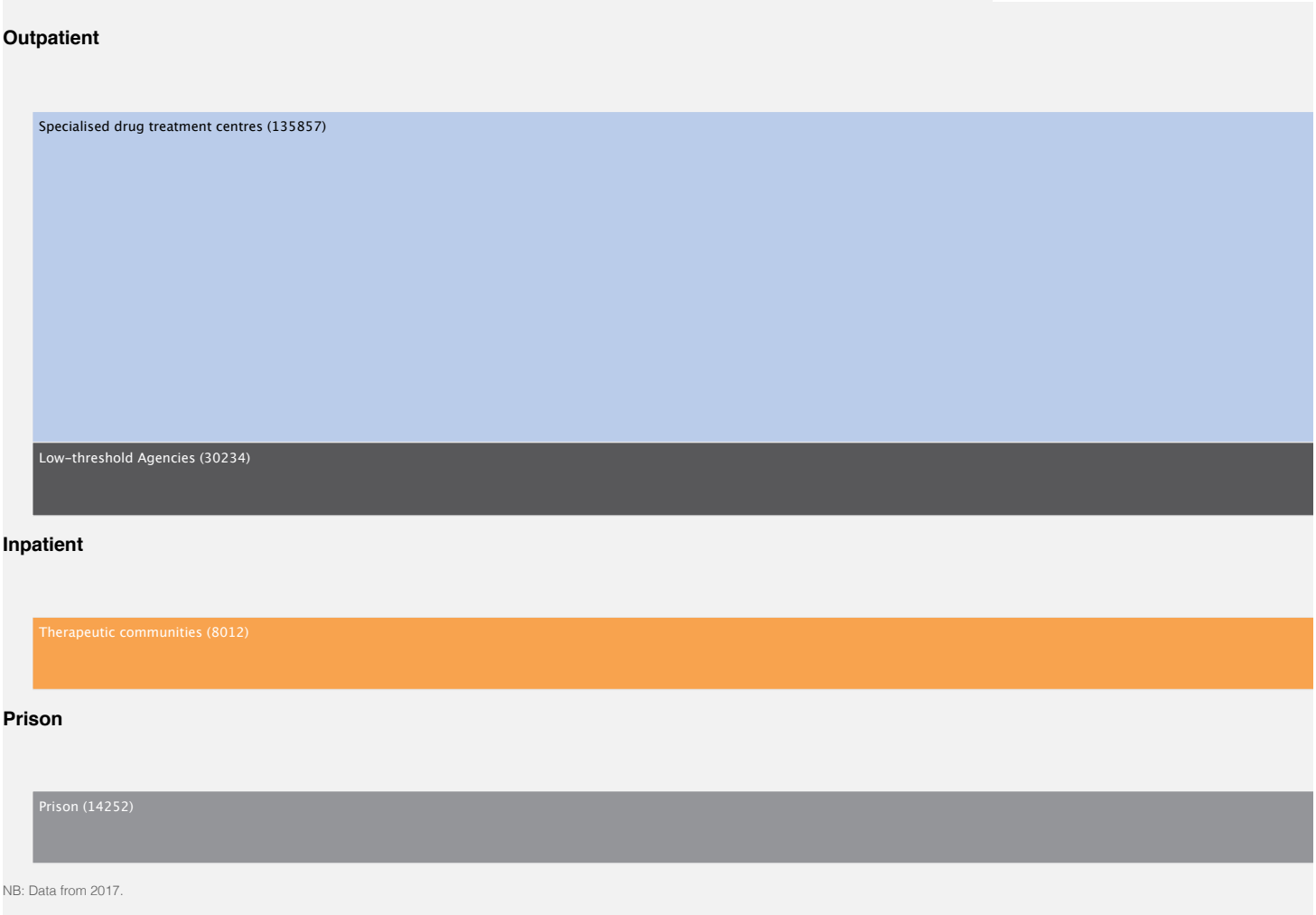
Primary care acts as a gatekeeper to services, the secondary level provides integrated treatment services and tertiary-level care units supply highly specialised and long-term care. A specific drug dependence care network is widely distributed throughout the country. Therapeutic provision comprises outpatient and inpatient treatment networks.

The outpatient network includes low-threshold services, mainly operating at the first care level and providing mental health screening for clients, and specialised drug treatment centres, including mental health units, operating at the secondary level and providing the backbone of the treatment system. A team of multidisciplinary staff usually manages clients in those settings, providing psychosocial treatment, case management and referral to other services.

The inpatient networks include hospital detoxification units, support apartments for treatment and social reintegration, therapeutic communities and penitentiary centres. In Spain, a wide variety of social reintegration programmes and activities are also available, including (i) leisure and social relationship programmes, (ii) training programmes, (iii) residential support programmes and resources (both transitory and permanent) and (iv) employment grants.

In Spain, opioid substitution treatment (OST) is available at around 2 000 specialised outpatient centres, at other health and mental health centres, at inpatient facilities and in prisons. Pharmacies are involved in dispensing medication to patients. Methadone was introduced and licensed as a treatment in 1990, and the treatment is free for clients. Buprenorphine-based medication is offered by the National Health Service, but clients have to contribute to the cost of the medication.

Drug treatment in Spain: settings and number treated



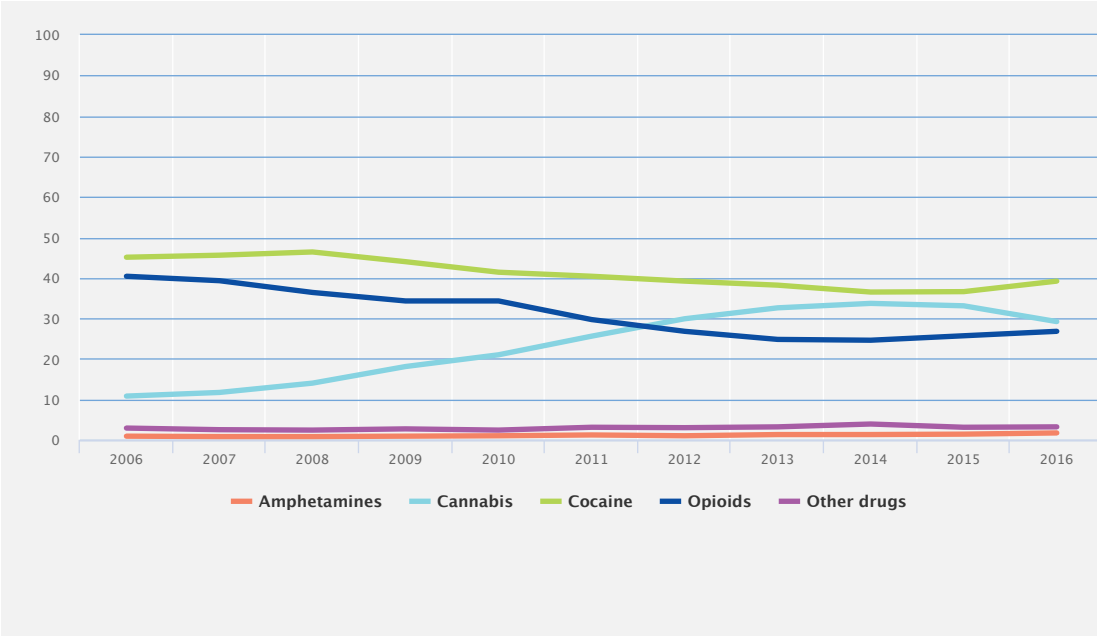
NB: Data from 2017.

Treatment provision

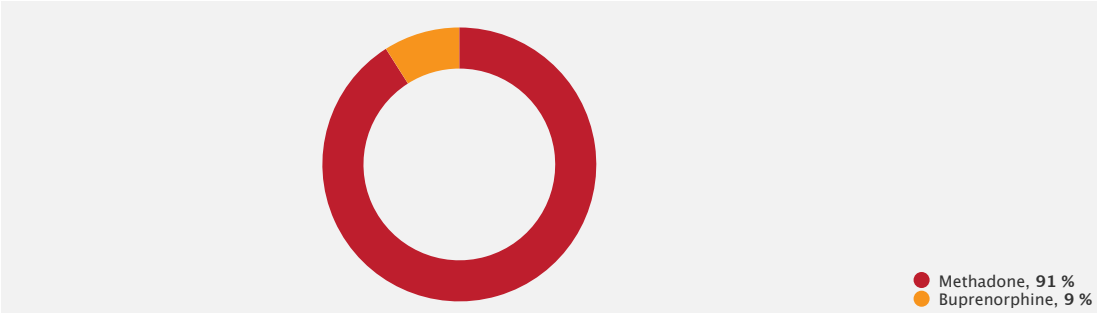
In Spain, nearly 190 000 clients received drug treatment in 2016, the majority of whom were treated in outpatient settings. Over the last decade, the number of clients entering treatment each year has ranged between 47 000 and 53 000. Heroin users remain the largest population receiving drug treatment in Spain, many of whom are long-term recipients of OST. Cocaine is the most commonly reported as the primary drug for which clients enter drug treatment. The long-term trend indicates that the proportion of people entering treatment as a result of heroin use was on the decline up until 2013 and has been stable since then. An increase in cocaine treatment demands was reported in 2015 and 2016.

Methadone maintenance treatment remains the most frequent form of OST, while combined buprenorphine/naloxone is mainly used at low doses for clients who were stabilised on methadone. In 2016, over 58 500 people were prescribed OST in Spain. Since 2002, a declining trend in the number of clients receiving OST in Spain has been reported, which is consistent with other data indicating an overall decline in the number of heroin users in the last two decades.

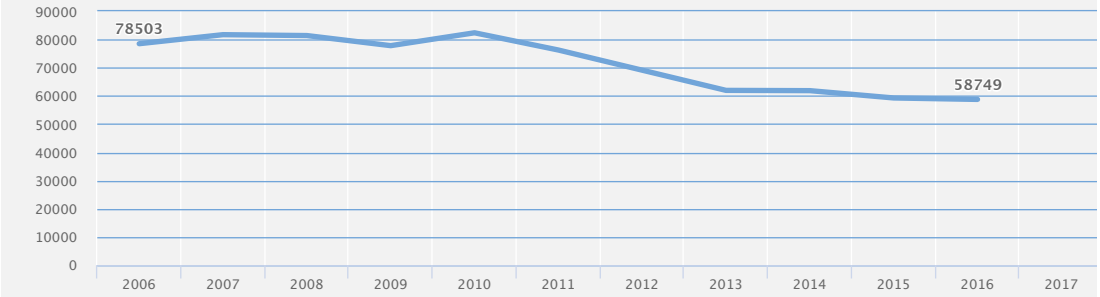
Trends in percentage of clients entering specialised drug treatment, by primary drug, in Spain



Opioid substitution treatment in Spain: proportions of clients in OST by medication and trends of the total number of clients



Trends in the number of clients in OST



NB: Data from 2016.

Drug use and responses in prison

The General Secretariat of Penitentiary Institutions of the Ministry of the Interior is responsible for prison administration in Spain, except in Catalonia. Healthcare provision in prisons is the responsibility of the Ministry of the Interior, although in Catalonia and the Basque Country it is provided by the health services of these autonomous communities. Upon entry into prison, the physical and mental health of a detainee is assessed, and this includes an evaluation of drug use and drug-related problems, drug-related infectious diseases and risk of suicide. Following the assessment, a treatment plan is established.

The 2016 survey on drug use among Spanish inmates used some of the questions included in the European Questionnaire on Drug Use among Prisoners. It indicated that around 40 % of inmates had used cannabis during the 30 days prior to imprisonment, with cocaine and heroin the next most commonly used drugs. Around 6 % of inmates had injected an illicit drug in the 30 days prior to being admitted to prison, with heroin, heroin combined with cocaine, and cocaine the drugs most frequently injected. Around 20 % reported cannabis use in prison, while use of other drugs was less common. Most respondents were polydrug users before entering prison. Around 27 % of those who were injecting drugs at the time of prison entry were human immunodeficiency virus (HIV) positive and 70 % were hepatitis C virus (HCV) positive; one third had an HCV + HIV co-infection. In 2016, more than 200 overdose episodes in prisons were reported.

Prevention and health education programmes are implemented in all prisons and include counselling, drug treatment and harm reduction measures. Drug treatment in prisons is provided in partnership with various prison services (health, psychology, safety, etc.), and in close cooperation with services available outside prison. Detoxification programmes are available and may be undertaken on an outpatient basis, in a day-care centre or in a ‘therapeutic’ module. Methadone maintenance treatment (MMT) is available in Spanish prisons. In 2017, almost 8 000 inmates received MMT, with about one quarter combining it with psychosocial support.

Harm reduction measures available in Spanish prisons include prevention, vaccination and treatment of infectious diseases (HIV and hepatitis), needle and syringe exchange programmes (NSPs) and the distribution of condoms, disinfectant and aluminium foil. NSPs have been available in prisons in Spain since 1997, covering 47 prisons. This number has decreased in recent years, accompanying the reduction in intravenous users and the consequent decreasing demand. The NSPs in prisons received the first European Prize for Good Health Practices in Prisons, awarded by the European Prison and Health Network of the World Health Organization.

Social reintegration programmes offered in prisons provide people who use drugs with the necessary skills to maintain treatment following release and support their reintegration into society.

Quality assurance

The newly adopted Spanish National Strategy on Addiction 2017-24 links scientific evidence, quality and evaluation. For example, quality and evidence constitute two of the eight guiding principles, and evaluation and quality are one of six transversal areas. These principles are strategic objectives within the different action areas. The Autonomous Community Drugs/Addictions Plans also explicitly address quality within their strategies and action plans, particularly in recent years.

At the national level, there is no accreditation system for interventions in demand reduction. At autonomous community level, there are large differences between autonomous communities and action areas. Accreditation criteria are in place at community level for harm reduction and for use of opioids for harm reduction purpose. In the field of prevention, quality assurance is less systematised. Evaluation criteria may also differ between the communities.

All the autonomous community drug plans provide for training activities for professionals, aimed primarily at municipal prevention technicians and healthcare service professionals. Five autonomous communities offer university master's courses on drug dependency and seven offer postgraduate courses. The main non-governmental organisations also have continuous training plans for their staff.

The European Drug Prevention Quality Standards, and many related materials (training courses, implementation guides, etc.), have been translated and adapted.

Drug-related research

In Spain, the Science, Technology and Innovation Act 14/2011 guides the implementation of public policy on science, technology and innovation, and the organisation of actions to foster and coordinate scientific and technical innovation. The Spanish Strategy for Science, Technology and Innovation 2013-20 defines the general scope and main objectives, while the State Plan for Scientific and Technical Research and Innovation specifies the operational tools and funding instruments required to implement research and development activities.

The new State Plan for Scientific and Technical Research and Innovation 2017-20, drafted by the Ministry of Economy, Industry and Competitiveness, has been submitted for public consultation and is going to be implemented through four programmes. One of the programmes aims to analyse 'society challenges', including a 'Strategic Action for Health'. This action is managed by the State Agency of Investigation in agreement with the 'Instituto de Salud Carlos III'. Projects are funded by the general budget of the central government, through public tenders or calls.

The National Strategy on Addictions 2017-24 and its action plans on drugs detail the drug research framework. They put special emphasis on the promotion of research on drugs and addiction, systematic evaluation of programmes and actions, and the use of current evidence in the design of policies and programmes on drugs and addictions. Priority areas of interest include basic clinical, social, epidemiological and methodological research.

The Government Delegation for the National Plan on Drugs is responsible for directing drug-related research activities. The Spanish Observatory on Drugs and Addictions collects, analyses and disseminates statistical and epidemiological data on drug use. Furthermore, the Government Delegation for the National Plan on Drugs channels funds to research projects that are carried out by both public and non-profit-making private research and development centres. Universities and research networks are the main participants undertaking drug-related research. National scientific journals and specialised websites are the main channels for national dissemination of drug-related research findings.

Drug markets

As a result of its geographical location, Spain is one of the EU countries favoured by international drug traffickers for the transit of cannabis resin and cocaine to other European countries. On an annual basis, Spain frequently reports large seizures of cocaine and cannabis resin, in terms of both number of seizures and quantities seized. Cocaine arrives in Spain mainly by sea. It is concealed in shipping containers that come either directly from the producing countries (Colombia and Peru) or via other Central or South American countries.

Most cannabis resin seized in Spain comes directly from Morocco or via the Eastern Mediterranean route, although route this appears to be in decline. Herbal cannabis is also cultivated in Spain; there are indications that domestic production has increased since 2009 and is intended to supply local demand while also destined for other EU countries.

Historically, heroin comes mainly from Pakistan via the Balkan route, although its dominance has reduced in recent years. In 2017, seized heroin was imported mainly from Turkey, Pakistan and Mozambique, either in shipping containers or by air using drug mules. In 2017, the number of seizures and quantity of heroin seized increased.

Overall, the number of drug seizures has increased over the past decade, although in 2017 a decrease was observed. Cannabis products are the most frequently seized drugs in Spain. Despite an overall decline in cannabis seizures in 2017, the annual quantities of cannabis seized from bulk seizures increased, both for resin and herbal cannabis. Cocaine remains the second most seized drug in Spain, and the quantities increased sharply in 2017.

Spain appears to have a stable situation with regard to seizures of synthetic stimulant drugs (amphetamine, methamphetamine and MDMA/ecstasy), with the number of seizures and amounts seized similar to the data reported in 2016.

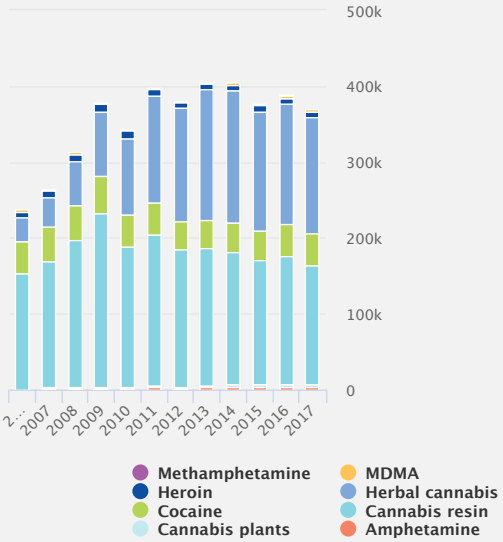
Actions to identify and dismantle international criminal networks involved in the trafficking of drugs are the priority for Spanish law enforcement agencies. This is done by intensive controls in the southern coastal areas and ports; investigating, discovering and confiscating the proceeds of drug trafficking; asset tracing and money laundering investigations; preventing the distribution of illicit drugs within the country; and fostering international cooperation.

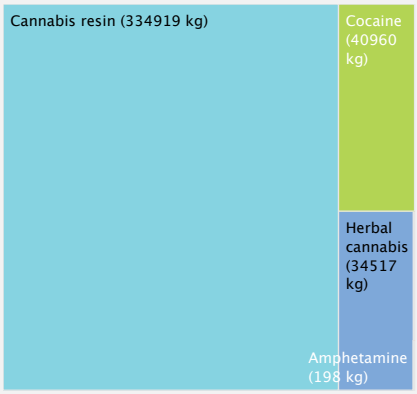
Data on the retail price and purity of the main illicit substances seized are shown in the ‘Key statistics’ section.

Drug seizures in Spain: trends in number of seizures (left) and quantities seized (right)

Number of seizures

Quantities seized





NB: Data from 2017.

Key statistics

Most recent estimates and data reported

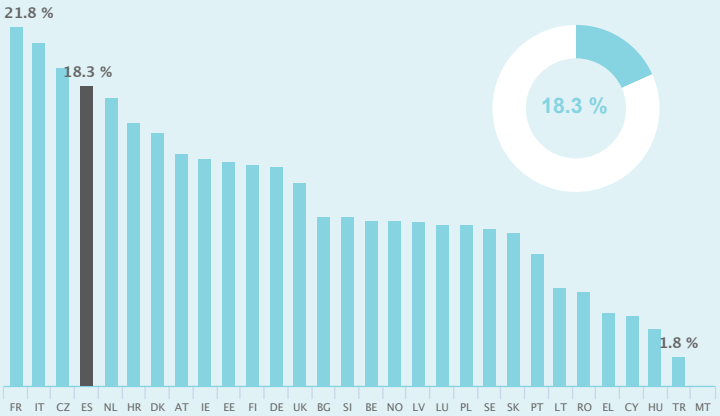
	Year	Country data	EU range Min.	EU range Max.
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	26.6	6.51	36.79
Last year prevalence of use — young adults (%)	2017	18.3	1.8	21.8
Last year prevalence of drug use — all adults (%)	2017	11	0.9	11
All treatment entrants (%)	2016	29.2	1.03	62.98
First-time treatment entrants (%)	2016	40.7	2.3	74.36
Quantity of herbal cannabis seized (kg)	2017	34 517	11.98	94 378.74
Number of herbal cannabis seizures	2017	151 968	57	151 968
Quantity of cannabis resin seized (kg)	2017	334 919	0.16	334 919
Number of cannabis resin seizures	2017	157 346	8	157 346
Potency — herbal (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	65.6
Potency — resin (% THC) (minimum and maximum values registered)	n.a.	n.a.	0	55
Price per gram — herbal (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.58	64.52
Price per gram — resin (EUR) (minimum and maximum values registered)	n.a.	n.a.	0.15	35
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.1	0.85	4.85
Last year prevalence of use — young adults (%)	2017	2.8	0.1	4.7
Last year prevalence of drug use — all adults (%)	2017	2.2	0.1	2.7
All treatment entrants (%)	2016	39.2	0.14	39.2
First-time treatment entrants (%)	2016	39.7	0	41.81
Quantity of cocaine seized (kg)	2017	40 960	0.32	44 751.85
Number of cocaine seizures	2017	42 206	9	42 206
Purity (%) (minimum and maximum values registered)	n.a.	n.a.	0	100
Price per gram (EUR) (minimum and maximum values registered)	n.a.	n.a.	2.11	350
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.3	0.84	6.46
Last year prevalence of use — young adults (%)	2017	0.9	0	3.9
Last year prevalence of drug use — all adults (%)	2017	0.5	0	1.8
All treatment entrants (%)	2016	1.7	0	49.61
First-time treatment entrants (%)	2016	1.9	0	52.83
Quantity of amphetamine seized (kg)	2017	198	0	1 669.42
Number of amphetamine seizures	2017	3 886	1	5 391
Purity — amphetamine (%) (minimum and maximum values registered)	n.a.	n.a.	0.07	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	n.a.	n.a.	3	156.25
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1	0.54	5.17
Last year prevalence of use — young adults (%)	2017	1.2	0.2	7.1
Last year prevalence of drug use — all adults (%)	2017	0.6	0.1	3.3
All treatment entrants (%)	2016	0.2	0	2.31
First-time treatment entrants (%)	2016	0.3	0	2.85
Quantity of MDMA seized (tablets)	n.a.	363 138	159	8 606 765
Number of MDMA seizures	2017	3 569	13	6 663
Purity (MDMA mg per tablet) (minimum and maximum values registered)	n.a.	n.a.	0	410
Purity (MDMA % per tablet) (minimum and maximum values registered)	n.a.	n.a.	2.14	87
Price per tablet (EUR) (minimum and maximum values registered)	n.a.	n.a.	1	40
Opioids				
High-risk opioid use (rate/1 000)	2016	2.2	0.48	8.42
All treatment entrants (%)	2016	26.8	3.99	93.45
First-time treatment entrants (%)	2016	13.3	1.8	87.36
Quantity of heroin seized (kg)	2017	524	0.01	17 385.18
Number of heroin seizures	2017	7 283	2	12 932
Purity — heroin (%) (minimum and maximum values registered)	n.a.	n.a.	0	91
Price per gram — heroin (EUR) (minimum and maximum values registered)	n.a.	n.a.	5	200
Drug-related infectious diseases/injecting/death				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2017	2.3	0	47.8
HIV prevalence among PWID* (%)	2016	31.1	0	31.1
HCV prevalence among PWID* (%)	2016	64.4	14.7	81.5
Injecting drug use (cases rate/1 000 population)	2016	0.41	0.08	10.02
Drug-induced deaths — all adults (cases/million population)	2016	15.7	2.44	129.79
Health and social responses				
Syringes distributed through specialised programmes	2016	1 503 111	245	11 907 416

Clients in substitution treatment	2016	58 749	209	178 665
Treatment demand				
All entrants	2016	45 637	179	118 342
First-time entrants	2016	22 816	48	37 577
All clients in treatment	2016	186 339	1 294	254 000
Drug law offences				
Number of reports of offences	2017	389 229	739	389 229
Offences for use/possession	2017	376 282	130	376 282

EU Dashboard

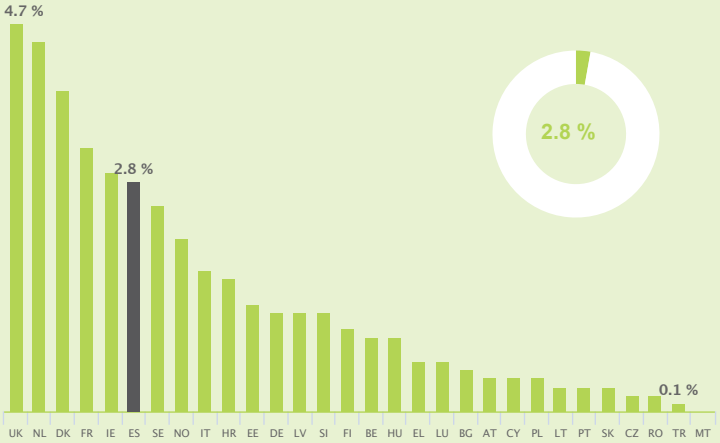
Cannabis

Last year prevalence among young adults (15-34 years)



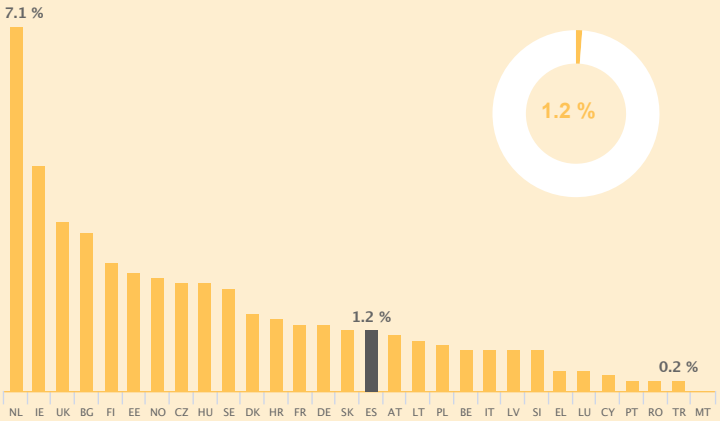
Cocaine

Last year prevalence among young adults (15-34 years)



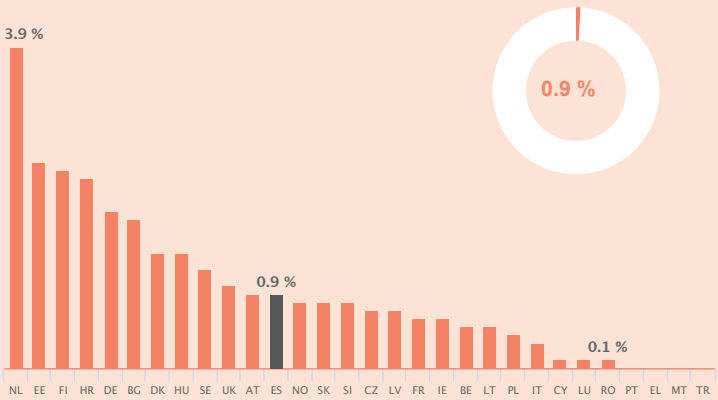
MDMA

Last year prevalence among young adults (15-34 years)



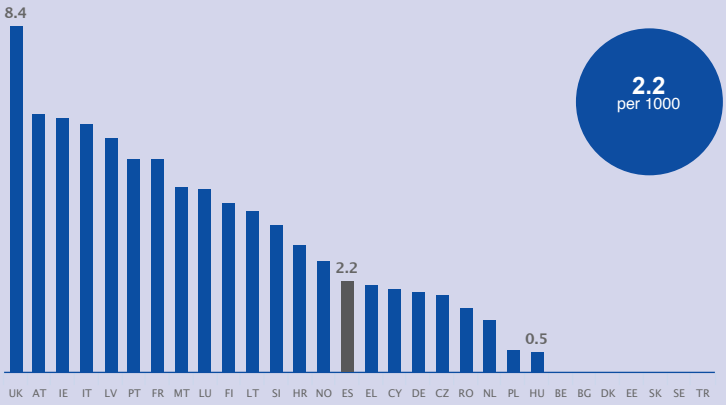
Amphetamines

Last year prevalence among young adults (15-34 years)



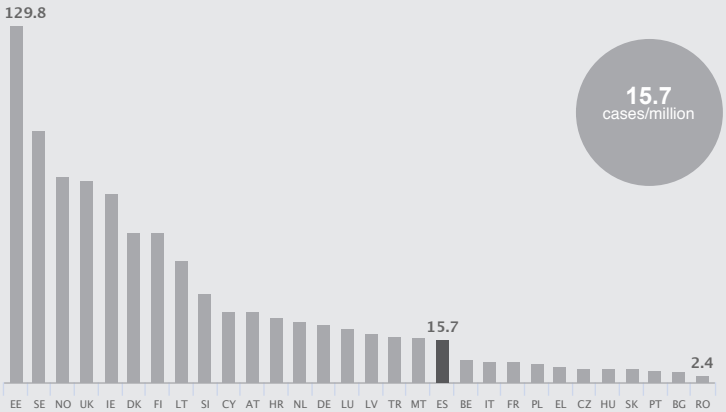
Opioids

High-risk opioid use (rate/1 000)



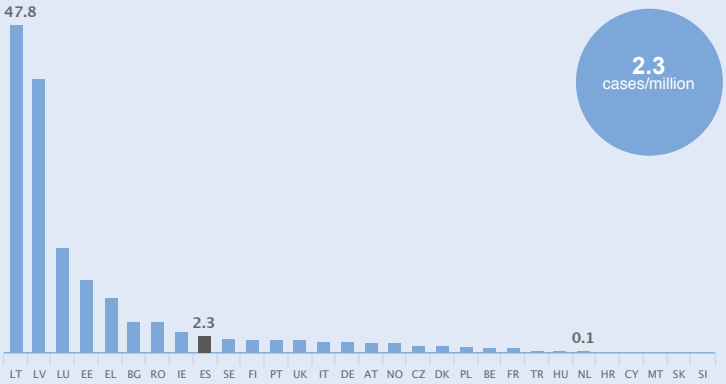
Drug-induced mortality rates

National estimates among adults (15-64 years)



HIV infections

Newly diagnosed cases attributed to injecting drug use



HCV antibody prevalence

National estimates among injecting drug users

NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifcations on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Last year prevalence estimated among young adults aged 16-34 years in Denmark, Norway and the United Kingdom; 17-34 in Sweden; and 18-34 in France, Germany, Greece and Hungary. Drug-induced mortality rate for Greece are for all ages.

About our partner in Spain

The Spanish national focal point is located within the Government Delegation for the National Plan on Drugs, a government organisation under the auspice of the Ministry of Health, Social Policy and Equality. The Government Delegation for the National Plan on Drugs is entrusted with coordination of different aspects of drug policy, ranging from drug trafficking to responses to the drug problem.

Click here to learn more about our partner in Spain .

Spanish national focal point

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ES–28008 Madrid

Tel. +34 91 822 6121

Head of national focal point: Ms María Azucena Martí Palacios

Methodological note: Analysis of trends is based only on those countries providing sufficient data to describe changes over the period specified. The reader should also be aware that monitoring patterns and trends in a hidden and stigmatised behaviour like drug use is both practically and methodologically challenging. For this reason, multiple sources of data are used for the purposes of analysis in this report. Caution is therefore required in interpretation, in particular when countries are compared on any single measure. Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin .