European Monitoring Centre for Drugs and Drug Addiction

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD, SERVICIOS SOCIALES E IGUALDAD
SECRETARÍA DE ESTADO DE SERVICIOS SOCIALES E IGUALDAD
DELEGACIÓN DEL GOBIERNO PARA EL PLAN NACIONAL SOBRE DROGAS

Spain

Country Drug Report 2017

THE DRUG PROBLEM IN SPAIN AT A GLANCE

Drug use

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

Cannabis

17.1 %

11 % 23.1 %

Other drugs

Cocaine	3 %
Amphetamines	1 %
MDMA	1.3 %

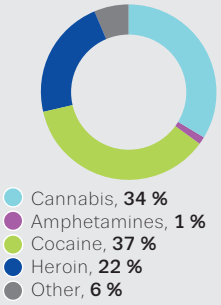
High-risk opioid users

65 322

(48 991 - 81 652)

Treatment entrants

by primary drug



Opioid substitution treatment clients

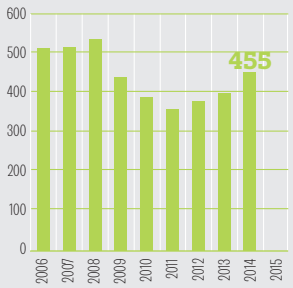
61 859

Syringes distributed

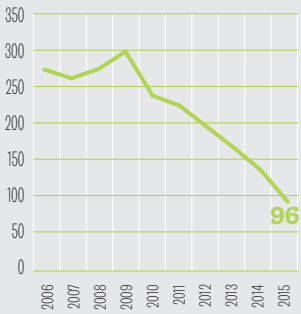
through specialised programmes

1 483 399

Overdose deaths



HIV diagnoses attributed to injecting



Source: ECDC

Drug law offenders

411 157

Top 5 drugs seized

ranked according to quantities measured in kilograms

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

Population

(15-64 years)

30 808 472

Source: EUROSTAT
Extracted on: 26/03/2017

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or reported numbers through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnosis, 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.

About this report

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 2015 (or most recent year) and are provided to the EMCDDA by the national focal point, unless stated otherwise.

An interactive version of this publication, containing links to online content, is available in PDF, EPUB and HTML format: www.emcdda.europa.eu/countries

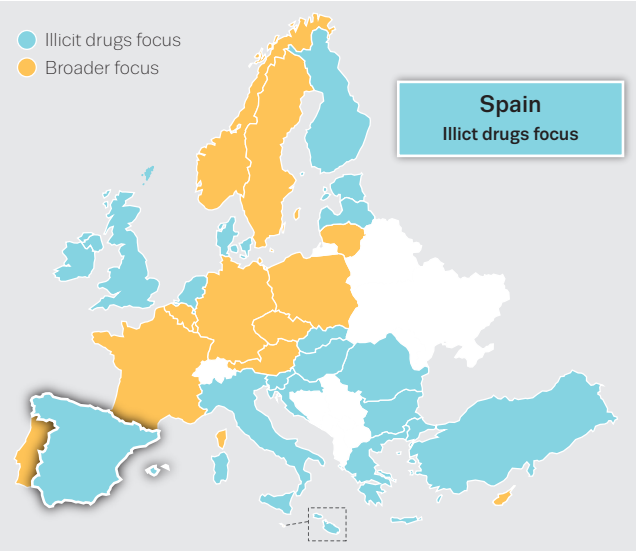
National drug strategy and coordination

National drug strategy

In Spain, the National Drug Strategy (2009-16) primarily focused on illicit drugs but also considered licit substances (Figure 1). Its objectives included reducing the use of licit and illicit substances; delaying the age at first contact with drugs; guaranteeing high-quality assistance adapted to the needs of all people affected by drug use; reducing or limiting the harm caused to drug users' health; and facilitating the social integration of drug users. The strategy was built around five fields of action: (i) demand reduction (prevention, risk and harm reduction, treatment and social reintegration); (ii) supply reduction; (iii) improvement of basic and applied scientific knowledge; (iv) training; and (v) international cooperation. Two consecutive four-year action plans were drawn up to implement specific actions for the periods 2009-12 and 2013-16. A new National Drug Strategy for the period 2017-24 is being developed, and will cover mainly illicit drugs, but also licit substances, such as alcohol.

FIGURE 1

Focus of national drug strategy documents: illicit drugs or broader



NB: Year of data 2015. Strategies with broader focus may include, for example, licit drugs and other addictions.

Like other European countries, Spain evaluates its drug policy and strategy using ongoing indicator monitoring and specific research projects. A mixed methods final internal evaluation of the National Strategy on Drugs (2000-08) was completed in 2008 and examined the strategy's implementation. In 2012, an internal evaluation of the 2009-12 action plan and, in 2014, a mid-term evaluation of the 2013-16 action plan were completed by the Government Delegation for the National Plan on Drugs. A final evaluation of the 2013-16 action plan and a final evaluation of the National Drug Strategy (2009-16) will be completed in 2017 in the context of the development of the new strategy.

National coordination mechanisms

At the national level, the Spanish Council for Drug Addiction and Other Addictions is responsible for inter-sectorial collaboration. It seeks to improve the development and implementation of policies and actions related to illicit drug 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, regional/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, Social Services and Equality, it is made up of representatives of the central administration and the regional ministers of the Departments of the Autonomous Regions. 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 (commonly known as regional drug commissioners). There is a drug commissioner in each of the 17 autonomous communities and in two autonomous

cities (Ceuta and Melilla). They communicate with the Government Delegation through their participation in the Inter-autonomic Commission and the sector conference.

A new National Drug Strategy for the period 2017-24 is being developed and will cover illicit drugs and licit substances, such as alcohol

Public expenditure

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

In Spain, the National Drug Strategy and the action plans have associated budgets but actual expenditure is not reviewed. A 2002 study looked at the social costs of drug use and included an estimate of drug-related expenditure. The study did not, however, distinguish between public and private expenditure.

Spanish authorities provide partial estimates of drug-related public expenditure by central government and by the autonomous communities and cities every year. 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.
In 2013 and 2014, drug-related public expenditure was estimated to represent 0.03 % of gross domestic product. Most of the total of approximately EUR 333 million (about 65 %) was spent by the autonomous communities and cities, while the remaining 35 % was spent by the central government. In 2012, the autonomous communities spent more than four fifths of their expenditure on treatment, while the rest was spent on prevention, research and institutional cooperation. Estimates for the total expenditures of local governments are not available. The available information does not allow the total amount and trends in drug-related public expenditures to be reported.

In 2014, drug-related public expenditure represented 0.03 % of gross domestic product

Drug laws and drug law offences

National drug laws

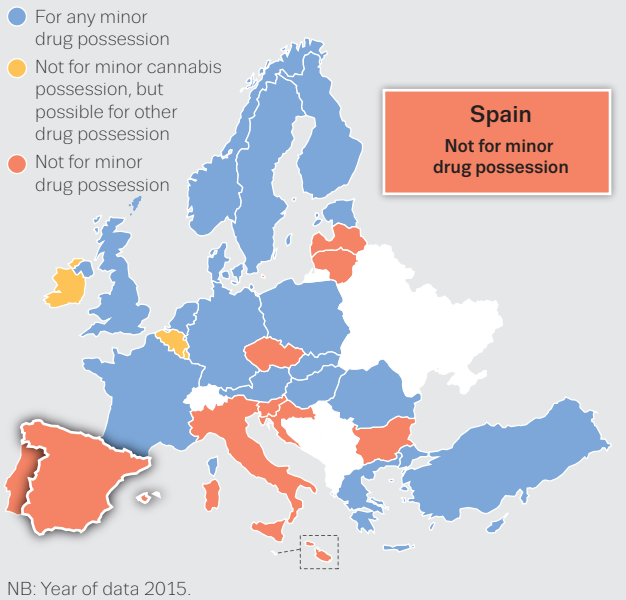
In Spain, consumption or minor personal possession in public places is deemed a serious order offence, punishable by administrative sanctions (Figure 2), with fines of EUR 601 to EUR 30 000 [Law on the Protection of Citizens' Security (2015), Article 36]. For minors, the fine can be suspended if the 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 and mitigating circumstances that may exist, such as selling to minors or the sale of large quantities. Prison sentences ranging from one to three years can be imposed if the drugs do not cause serious damage to health, and can be up to six years if they do. When aggravating circumstances exist, penalties can be up to 21 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 five years) may be reduced if an offender who was dependent on drugs at the time of the crime successfully completes detoxification treatment.

New psychoactive substances (NPS) are controlled by adding them to the lists of substances subject to the Citizens' Security law and the Criminal Code, as above.

FIGURE 2

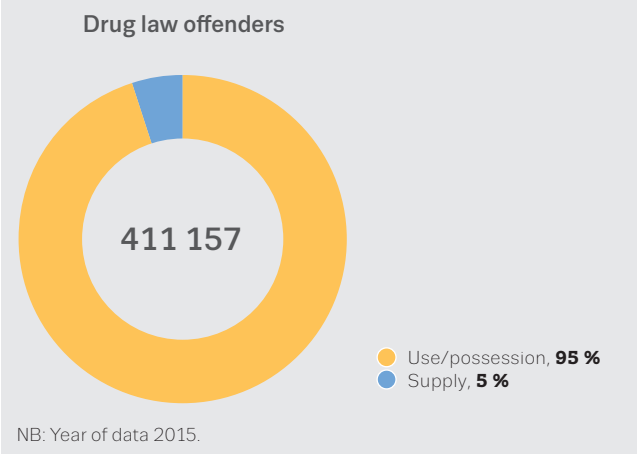
Legal penalties: the possibility of incarceration for possession of drugs for personal use (minor offence)



NB: Year of data 2015.

FIGURE 3

Reported drug law offenders in Spain



NB: Year of data 2015.

Drug law offences

Drug law offence (DLO) 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 penal offences (Figure 3). In 8 out of 10 cases, charges are associated with cannabis.

Drug use

Prevalence and trends

The prevalence of use of illicit substances in Spain has been relatively stable over the last few years, with approximately one third of the adult population reporting lifetime use of an illicit substance. Cannabis, followed by cocaine, is the most commonly used drug, with use mainly concentrated among adolescents and adults below 35 years. Although the latest available data from the 2015 general population study confirm that the prevalence of use of both substances has declined in the last 10 years, the levels of cannabis and cocaine use in Spain remain higher than in other European Union countries.

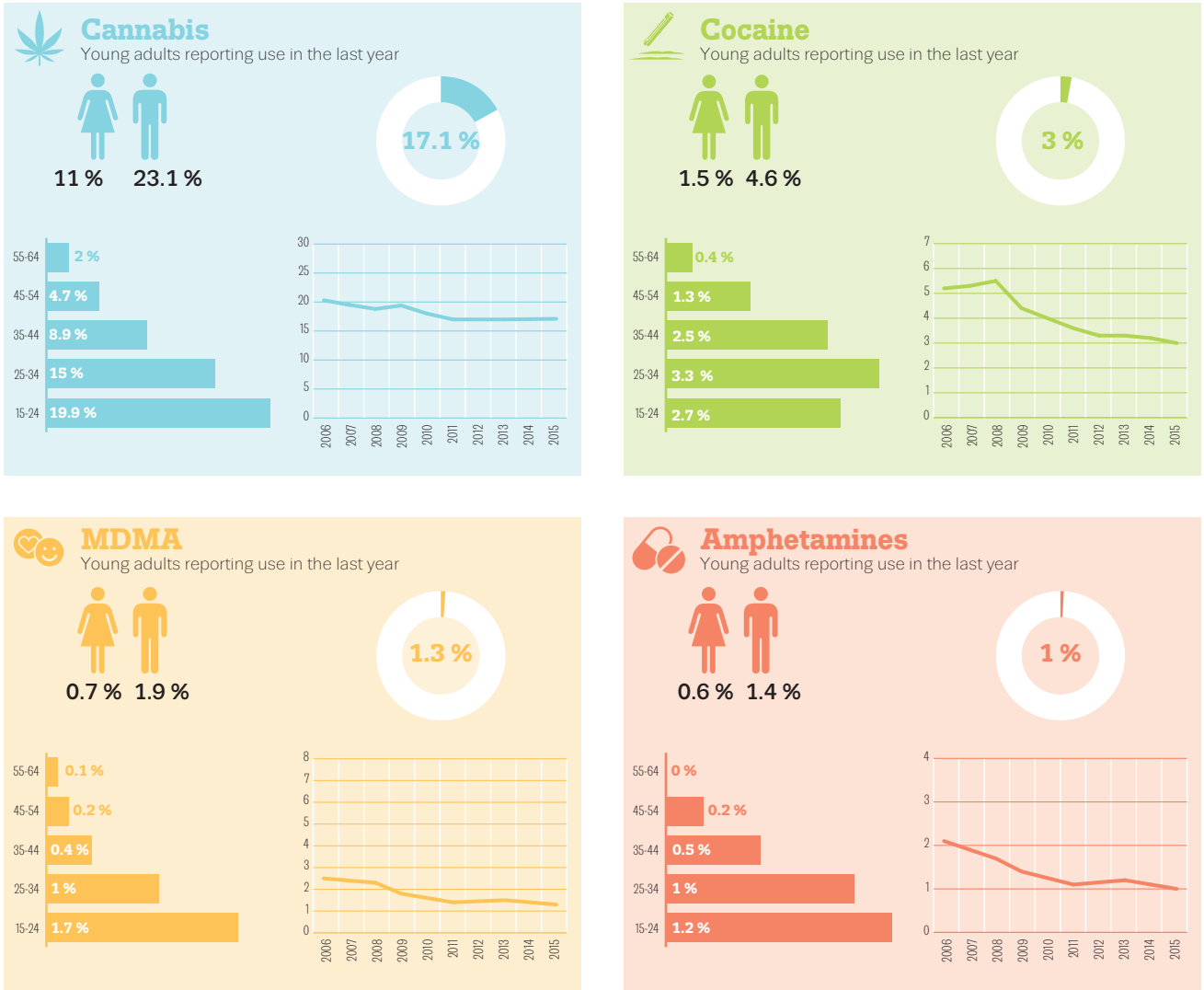
The available data highlight that 'experimentation' with cannabis has become more 'habitual' among today's younger Spanish generation; however, although persistent use remains low, those who continue to use cannabis do so almost daily. The use of all illicit substances remains more prevalent among males than females (Figure 4).

The prevalence of the use of NPS has remained stable since 2011, with about 3.4 % of adults in the 2015 study reporting ever having used NPS. Most NPS users are young males who exhibit patterns of experimental polydrug use. In general, polydrug use remains a very common consumption pattern, especially among those aged 18 and over.

Four Spanish cities (Barcelona, Castellón, Molina de Segura 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 community level, based on the levels of illicit drugs and their metabolites in wastewater sources. The results of the 2016 study on stimulant drugs revealed high levels of cocaine metabolites in wastewater samples from all cities studied, and higher than levels reported from some other European cities participating in the study. In addition, Barcelona recorded an increase in MDMA/ecstasy residues between 2011 and 2016. A common pattern across the monitored cities was an increased use of cocaine and MDMA at weekends.

FIGURE 4

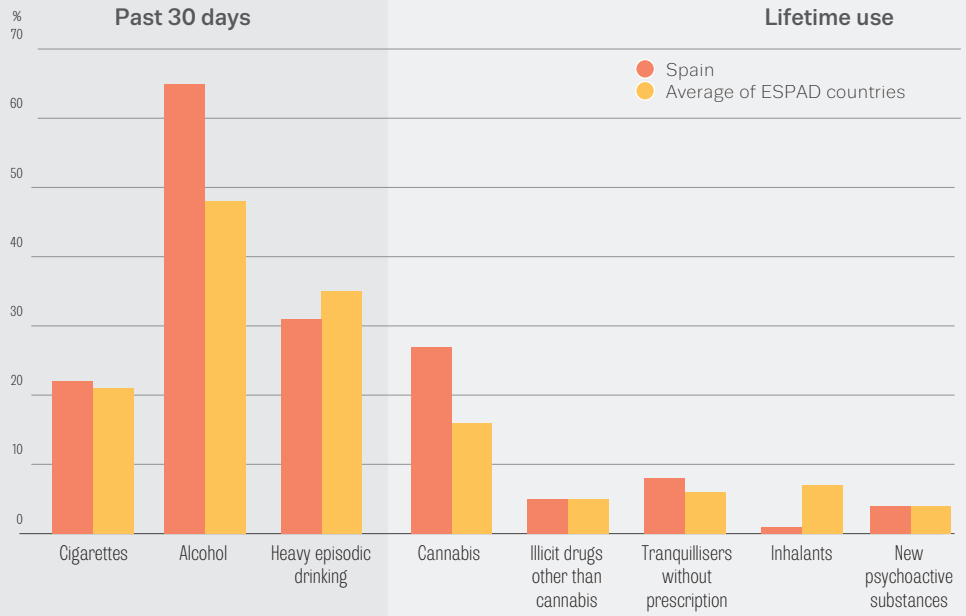
Estimates of last-year drug use among young adults (15-34 years) in Spain



NB: Estimated last-year prevalence of drug use in 2015.

FIGURE 5

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



Source: ESTUDES (2014) and ESPAD study 2015.

Data on drug use among 14- to 18-year-old students come from The programme of State Surveys on Drug Use in Secondary Schools (ESTUDES), which has been conducted every second year in Spain since 1994. The 2014 study confirmed that the most commonly used illicit substance is cannabis, with about 3 out of 10 students admitting to having used it in the past. However, there was a slight increase in the proportion of students who had used cannabis in preceding 30 days (18.6 % in 2014; 16.1 % in 2012). Lifetime prevalence rates for other illicit drugs among the students remain well below that for 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 (35 countries) (Figure 5).

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 understanding on the nature and trends in high-risk drug use (Figure 7).

In Spain, heroin remains the main substance linked to serious adverse health and social consequences, such as drug-related infections. The estimated number of high-risk heroin users has shown a decreasing trend since 2010, and remained stable in 2013-14 (Figure 6). The number of high-risk cocaine users in Spain has been falling since 2009. Injecting drug use has also declined in the last 30 years among those admitted to treatment.

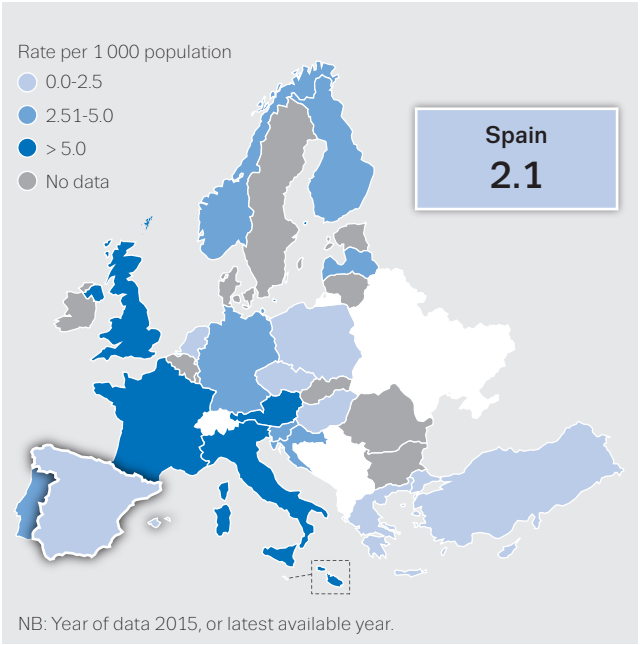
Heroin remains the main substance linked to serious adverse consequences but the estimated number of high-risk heroin users has remained relatively stable

Data from specialised treatment centres indicate that cocaine remains the substance resulting in the highest number of treatment entries, while the number of first-time clients reporting cocaine as the primary substance of use has decreased. Moreover, only a small proportion of cocaine users entering treatment reported injecting drug use.

Additional data from treatment centres indicate that cannabis has progressively become the main primary substance among those who enter the treatment for the first time (Figure 7). This corresponds to the findings of the last general population study, while the 2014 ESTUDES indicated a slight decline in daily cannabis users.

FIGURE 6

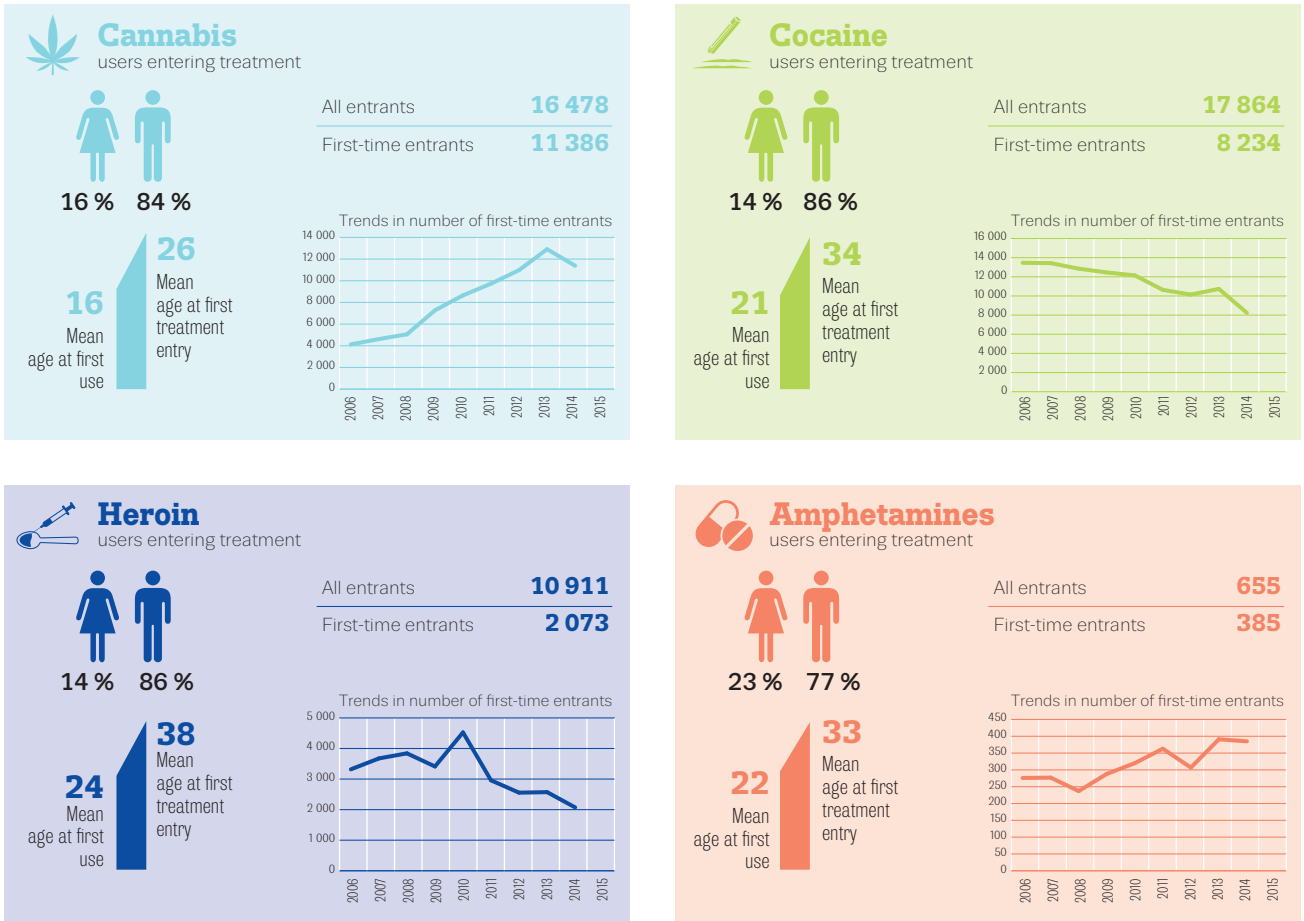
National estimates of last year prevalence of high-risk opioid use



NB: Year of data 2015, or latest available year.

FIGURE 7

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



NB: Year of data 2014. Data is for first-time entrants, except for gender which is for all treatment entrants.

Drug harms

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 (Figure 8).

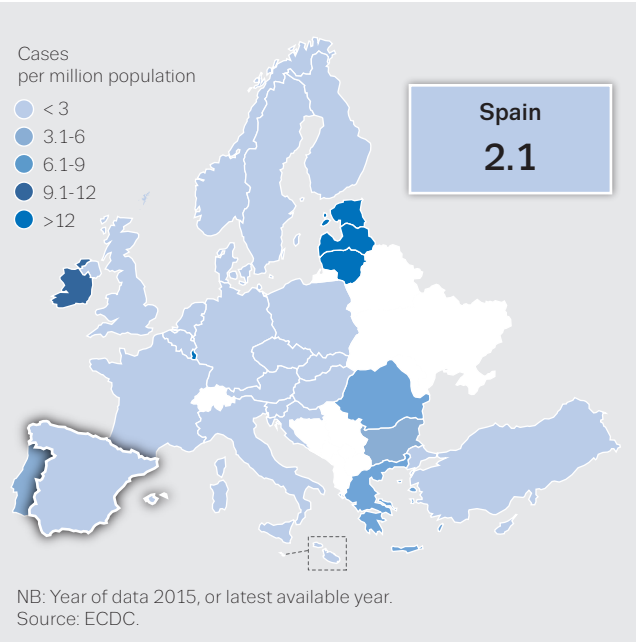
Although the incidence of HIV infection remains low, in 2014, approximately one third of people who have ever injected drugs and entered treatment in Spain were HIV positive. Information on hepatitis C virus (HCV) and hepatitis B virus (HBV) infection among people who inject drugs (PWID) at the national level is routinely collected through the treatment demand indicator, with the first data on self-reported HBV and HCV status available from 2014 (Figure 9). 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).

Drug-related emergencies

Information on drug-related emergencies in Spain originates from the National Plan on Drugs, which was introduced in 1987, and which monitors hospital emergencies directly caused by non-medical use of psychoactive substances among 15- to 54-year-olds. In 2014, 6 441 emergency episodes related to drug use were notified, continuing the rather stable trend seen over the previous five years. Cocaine was the substance most frequently reported as the cause of the emergency episodes, followed by cannabis. The proportion of cannabis-related emergency episodes shows a clear upward trend since 2000, while the proportion of heroin-related intoxications fell by a factor of 3 during the same period. Amphetamines and MDMA were less common causes of drug-related emergencies in Spain in 2014; however, there are some indications of an upward trend in the last five years.

FIGURE 8

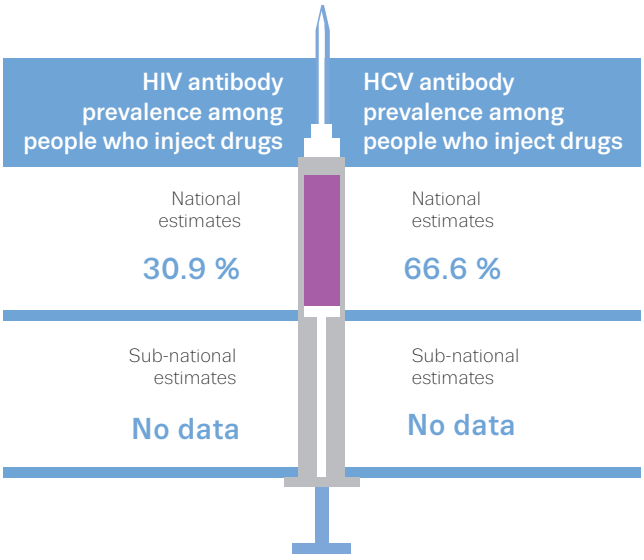
Newly diagnosed HIV cases attributed to injecting drug use



NB: Year of data 2015, or latest available year.
Source: ECDC.

FIGURE 9

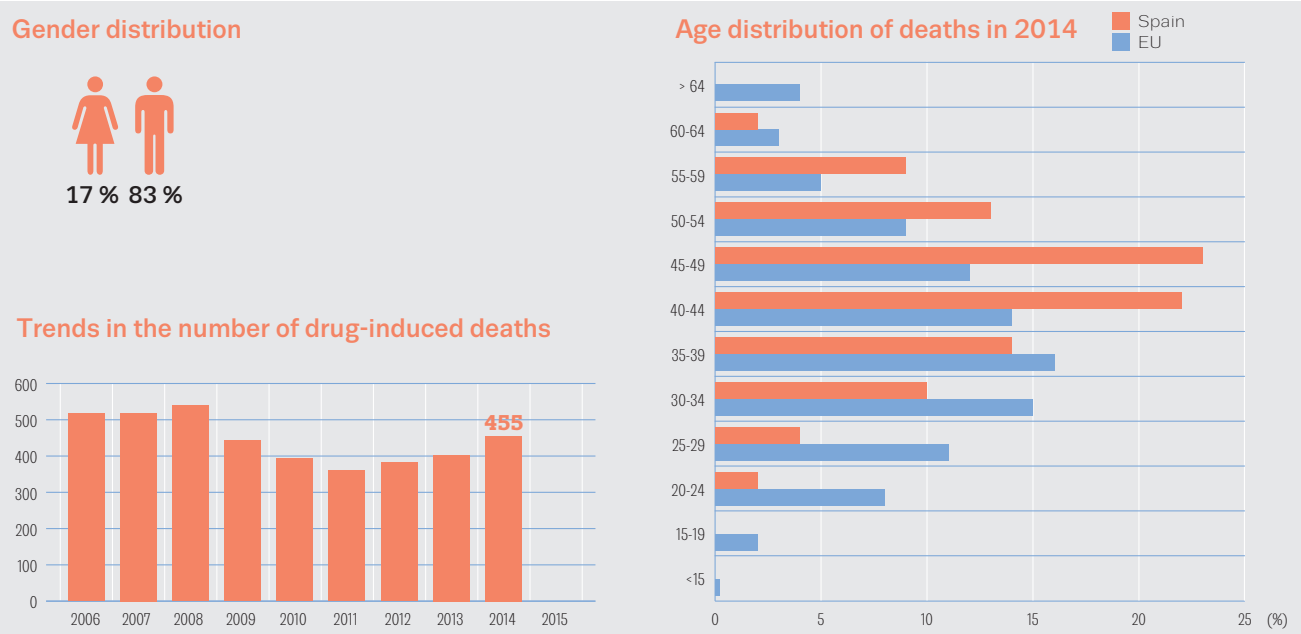
Prevalence of HIV and HCV antibodies among people who inject drugs in Spain



NB: Year of data 2014.

FIGURE 10

Characteristics of and trends in drug-induced deaths in Spain



NB: Year of data 2014.
Source: the General Mortality Register.

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 Special Registry, based on forensic and toxicological sources, indicated stable trends in drug-induced deaths in the last five years, with 556 drug-induced deaths reported in 2014. According to the available toxicological results, opioids, followed by cocaine, were found in the majority of deaths; however, there has been a decrease in the proportion of deaths attributed to both substances in recent years. Most victims were male and more than half were older than 45 years, which mirrors the ageing of the Spanish heroin users' cohort.

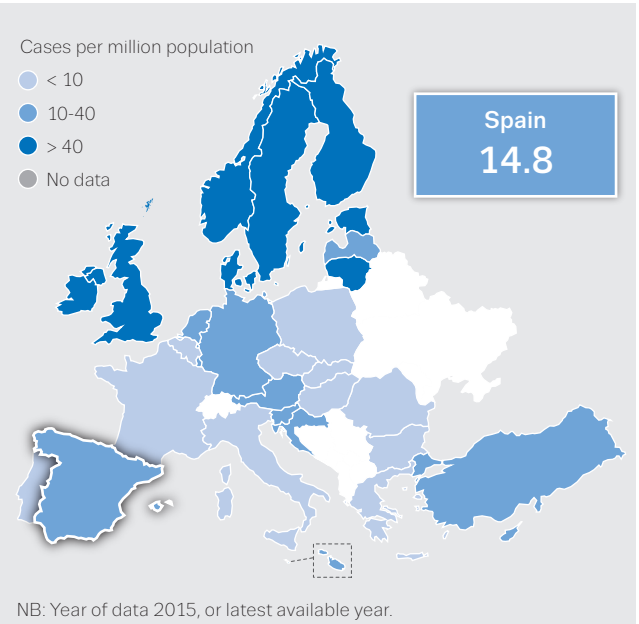
In 2014, the General Mortality Register (GMR) reported 455 drug-induced deaths according to the national definition (Figure 10).

Data from a recent mortality study in Spain suggest that 4 out of 100 overdoses among 18- to 30-year-old heroin users are fatal. Another study examined mortality among a cohort of cocaine users admitted for treatment in Spain. The results indicate that the age-standardised mortality among those who use cocaine and heroin, or only cocaine, is higher than that of the general population.

The drug-induced mortality rate among adults (aged 15-64 years) is 14.8 deaths per million in 2014 (Figure 11), which is lower than the latest estimated European average of 20.3 deaths per million.

FIGURE 11

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



NB: Year of data 2015, or latest available year.

Prevention

In Spain, drug prevention is a priority in the National Strategy on Drugs 2009-16 and the latest action plan, which provided an organisational and financial framework at the national level and at the level of autonomous communities through Autonomic Drug Plans and Municipal Drug Plans. Community-based programmes may also receive funding from the fund of assets seized from illegal drug trafficking and other related offences, and, very occasionally, from foundations. The main features of the prevention policy are a focus on both licit and illicit substances, strong cooperation with the educational system and the recent increase in interventions in selective and indicated prevention. Non-governmental organisations, funded through public calls or tenders, are key to the implementation of prevention activities at the grassroots level.

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 drug use problems and indicated prevention focuses on at-risk individuals.

In Spain, the introduction of environmental prevention measures, such as limiting access to alcohol, is the responsibility of autonomous communities.

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. Reports from the autonomous communities indicate a decrease in school-based programmes in recent years, while the number of family-based interventions has increased. In the educational environment, a wide variety of manual-based prevention programmes in classrooms are used, and extracurricular activities and training are available. Few of these have been evaluated so far (Figure 12).

Community-based prevention programmes organised by health centres are becoming increasingly available in schools and mainly focus on information provision through a range of support materials. Schools provide educational talks for parents, distribute materials and offer orientation and guidance services and informal courses. Increasing numbers of on-line 'parents' schools', which inform parents about drugs and give advice about parenting skills, are available. An initiative for family-based prevention, Prevención Familiar, has been set up as a mutual empowerment initiative with parents' associations, providing materials for professionals and families.

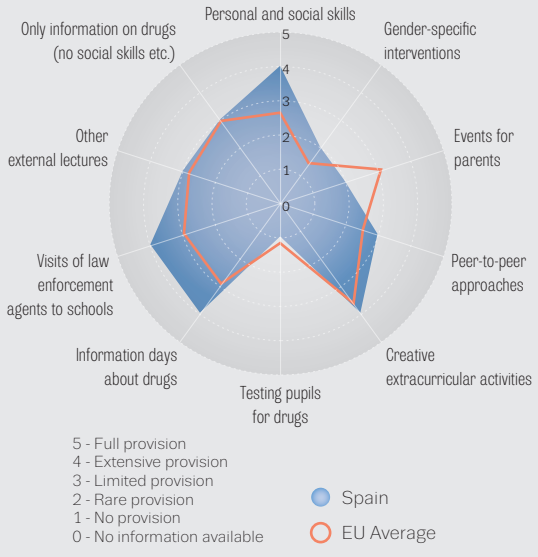
Prevention programmes in universities have emerged in recent years and focus mainly on information provision and awareness raising, using peer education methods or online delivery. Universal community-based prevention programmes are largely provided through alternative leisure programmes in youth clubs, sports centres, schools and community centres, and activities are recreational and sports related. Programmes conducted in places where drug use is common, such as bars, nightclubs and music concerts, are carried out by peer mediators, who work to identify problematic cases and provide information and advice about drugs and their various forms of use. Environmental approaches in this setting are rare. Only a few autonomous communities implement programmes, such as Platform for Quality Leisure in the Balearic Islands, Q for Quality in Catalonia and Responsible Serving of Alcoholic Beverages in Castilla and Leon.

Selective prevention activities focus on young people in disadvantaged neighbourhoods and those in specific educational or residential centres. Selective prevention programmes for families at risk, female former drug users with children and specific programmes for ethnic minorities and for young people with drug use problems and families affected by drug use are available.

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. For example, Empecemos (Let's Begin) is a well-researched indicated prevention programme with promising long-term outcomes for disruptive children in Galicia. Several autonomous communities have reported prevention activities focusing on under-age offenders with drug use problems.

FIGURE 12

Provision of interventions in schools in Spain (expert ratings)



NB: Year of data 2016.

Harm reduction

The reduction of drug-related risk and harm is one of the principal objectives of the National Drug Strategy for 2009-16, and further detailed in four-year action plans for 2009-12 and 2013-16. There is a particular focus on activities that facilitate contacts with PWID, provide information and education, and promote behaviour and practice change. National priorities for the prevention of infectious diseases among drug users include support for needle and syringe programmes (NSPs), voluntary counselling and testing for infections, and hepatitis vaccination programmes.

Harm reduction interventions

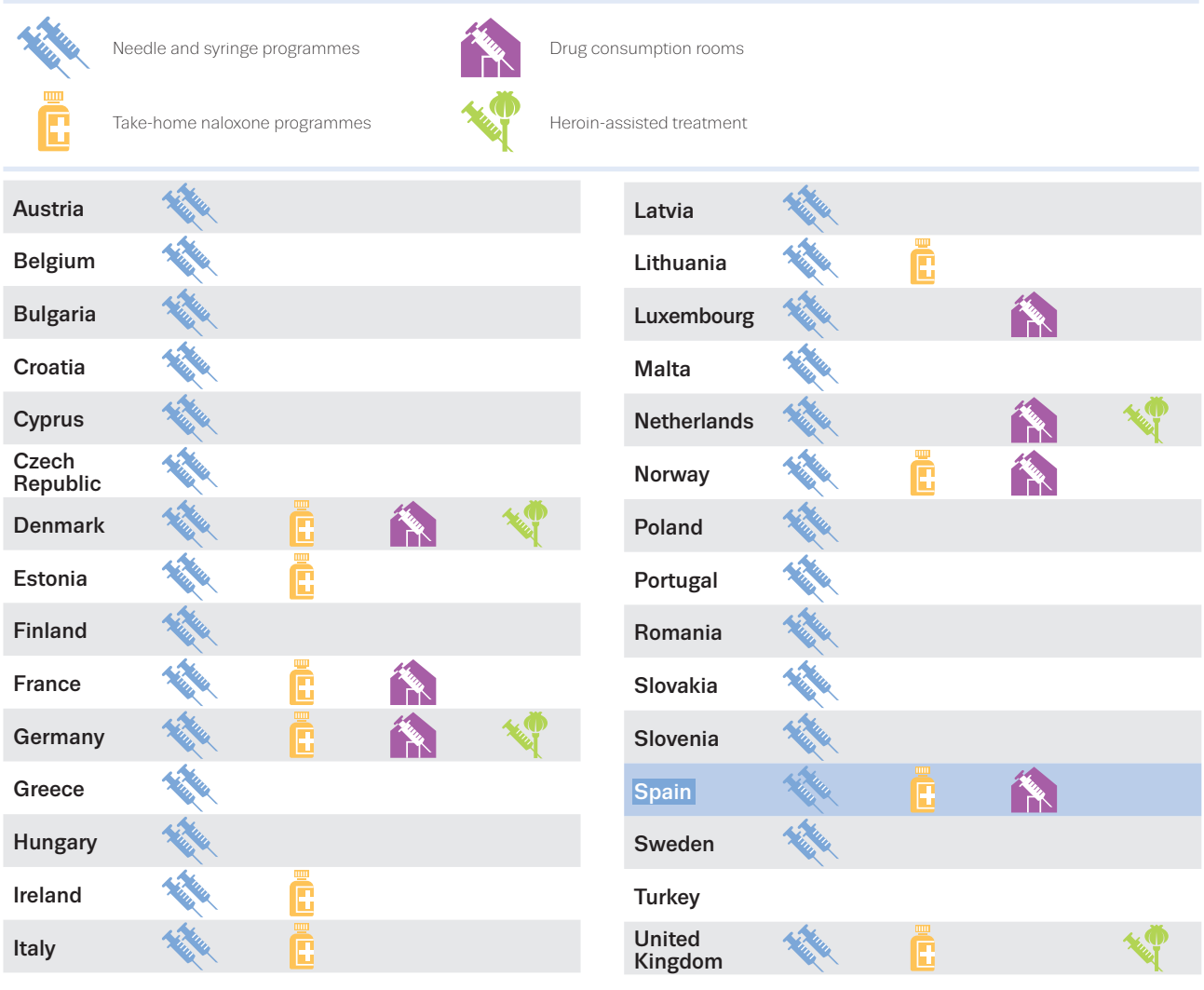
Harm reduction services are provided by a large public network of facilities, including social emergency centres, mobile units, pharmacies and prisons.

Most harm reduction programmes include a socio-sanitary service that offers preventive educational interventions, overdose prevention activities, sterile needles and syringes, testing for drug-related infections, vaccination against hepatitis A virus and HBV and emergency care and assistance to injecting drug users, who are not usually in contact with any assistance intervention (Figure 13).

In 2014, public NSPs in Spain distributed approximately 1.5 million syringes, continuing a declining trend that started in 2005. This trend coincided with the scaling up of opioid substitution treatment (OST), which has been shown by the available evidence to have a positive outcome for treatment retention and reduction in illicit opioid use, reported risk behaviour and drug-related harms and mortality. The drop in the number of syringes distributed is also thought to be the result of a reduction in the prevalence of injecting drug use in Spain. Thirteen

FIGURE 13

Availability of selected harm reduction responses



NB: Year of data 2016.

facilities for supervised drug consumption are available in the autonomous communities of Catalonia and the Basque Country. In 2014, these facilities served 5 900 clients.

In 2014, public needle and syringe programmes in Spain distributed approximately 1.5 million syringes, continuing a declining trend that started in 2005

Treatment

The treatment system

In Spain, the overall policy for drug treatment is guided by the National Drug Strategy. 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 the two cities. Each autonomous community is entitled to organise and deliver health interventions according to 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 level of primary care acts as a gatekeeper, the secondary level provides integrated treatment services, and tertiary-level care units supply highly specialised and long-term care.

The public sector is the primary provider of treatment, followed by non-government organisations (NGOs) 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.

A specific drug dependence care network is widely distributed throughout the country. Therapeutic provision comprises outpatient and inpatient treatment networks.

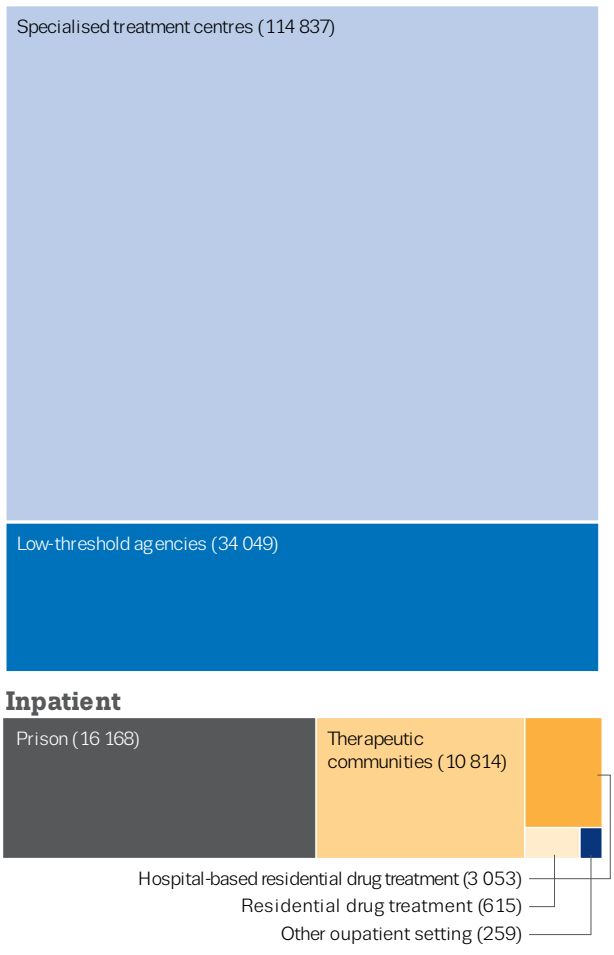
The outpatient network includes low-threshold services, mainly operating at the first care level and providing mental health screening for clients, and specialised drug treatment centres, including mental health units, which constitute the backbone of the treatment system, operating at the secondary level. 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, OST is available at about 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.

FIGURE 14

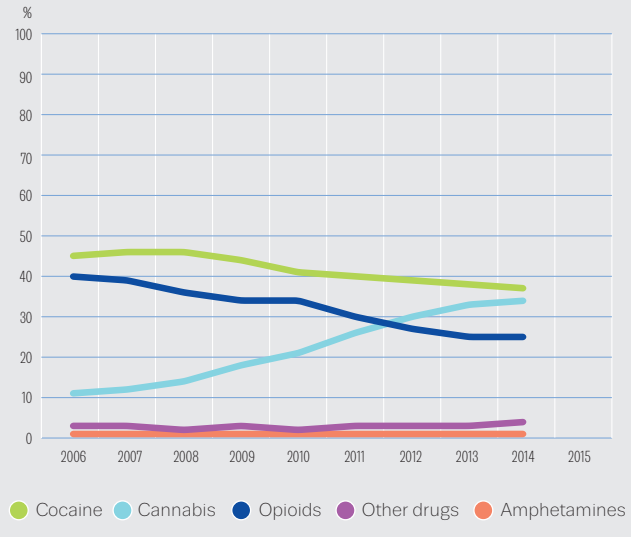
Drug treatment in Spain: settings and number treated



NB: Year of data 2014.

FIGURE 15

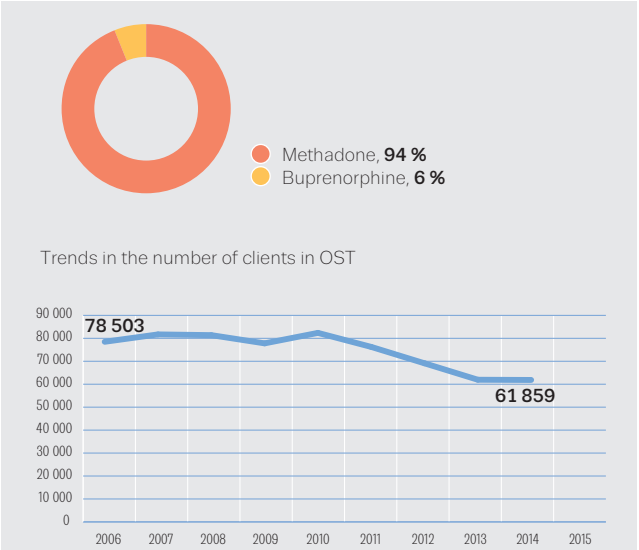
Trends in percentage of clients entering specialised drug treatment, by primary drug, in Spain



NB: Year of data 2014.

FIGURE 16

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



NB: Year of data 2014.

Treatment provision

In Spain, nearly 180 000 drug users received drug treatment in 2014, the majority of whom were treated in outpatient settings (Figure 14). Over the last decade, the number of clients entering treatment each year has ranged between 49 000 and 53 000. Heroin users remain the largest population receiving drug treatment in Spain, many of whom are long-term recipients of OST. However, data on the number of people entering drug treatment show that cocaine remains the most common primary drug among treatment clients entering care, followed by cannabis and opioids. Nevertheless, the proportion of people entering treatment as a result of heroin or cocaine use has declined over the last 10 years, while a progressive increase in cannabis-related demands has been observed; since 2012, the total number of treatment entries due to cannabis use has exceeded those due to heroin (Figure 15). This is mainly attributed to the progressive increase in new treatment entries due to primary cannabis use, as approximately 7 out of 10 clients entering treatment due to primary cannabis use are first-time treatment entrants (Figure 7).

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. 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 (Figure 16).

The proportion of people entering treatment as a result of heroin or cocaine use has declined over the last 10 years, while a progressive and significant increase in cannabis-related demands has been observed

Drug use and responses in prison

The General Secretariat of Penitentiary Institutions of the Ministry of Interior is responsible for prison administration in Spain, except in Catalonia. Healthcare provision in prisons is the responsibility of the Ministry of Interior, although in Catalonia and the Basque Country it is provided by the health services of these autonomous communities.

Drug treatment programmes in prisons are provided in partnership with various prison services (health, psychology, safety, etc.), and in close cooperation with available services outside prisons, such as drug treatment facilities, social services and NGOs. Three organisational structures in each prison are involved in the provision of these services: the commission on drug dependence, the sanitary team and the drug dependence team.

A 2011 survey on drug use among inmates in Spain reported that cannabis was the most common drug used in the 30 days prior to imprisonment (40 %), followed by cocaine (27 %), while heroin use was reported by 14 % of inmates. Injecting drug use was reported by 5 % in the 30 days prior to imprisonment, which was a decrease from 2006 (11 %). Cannabis was the drug most commonly used in prison (21 %), while use of other drugs was much lower and injecting drug use was reported by only 0.4 %. Polydrug use was common among drug users in prison. One third of those who inject drugs in prison are HIV positive and three quarters are HCV positive.

Health programmes implemented in prisons (treatment of HIV, HCV and tuberculosis, vaccinations and mental health) and drug-related intervention programmes — prevention, health education, health mediators (recruited among inmates), harm and risk reduction (syringe exchange, distribution of aluminium foil and condoms, overdose action programme) and treatment of the dependency (opioid substitution, detoxification) — have all contributed to reductions in morbidity and mortality among inmates in penitentiary institutions.

Methadone maintenance treatment constitutes one of the most effective intervention programmes in terms of risk reduction related to opioid use. It is an important part of drug treatment in Spanish prisons, and many drug users benefit from it.

The first needle and syringe exchange programme in a Spanish prison was introduced in Bilbao in 1997, and such programmes are now available in 47 prisons in Spain. The Bilbao programme received the First European Prize for Good Health Practices in Prisons awarded by the European Prison and Health Network of the World Health Organization (WHO).

Special social reintegration programmes offered in prisons provide drug users with the necessary skills to maintain treatment following release and support their reintegration into society.

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Quality assurance

The Spanish National Strategy on Drugs 2009-16 and the action plan for 2013-16 include quality as one of their basic principles and determine objectives related to the promotion of quality. The action plan includes actions directly related to quality. Action 30 focuses on the creation of a portal on Good Practices; and action 31 on criteria for accrediting demand reduction programmes. The remaining actions have the cross-cutting objective of developing of quality criteria in each field of work.

Within the scope of action 30, support was provided for the creation of a portal for prevention programmes based on evidence produced by the organisation Socidrogalcohol. Another good practice portal focusing on reducing demand is under development.

Within the scope of action 31 of the action plan, some minimum quality criteria for demand reduction programmes were approved. In addition, the Government Delegation for the National Plan on Drugs was an associate partner in The European Drug Prevention Quality Standards project. Various NGOs have also initiated processes for promoting good practices for management and work projects, supported by the Government Delegation.

The accreditation of demand reduction programmes in Spain is linked to their funding. Demand reduction programmes and services are funded mainly by the public administration and, to receive public money, they must be accredited (in the case of treatment) or pass through a series of more or less demanding quality filters according to the geographical area in which they are applied.

In addition, in the National Strategy, training is both a cross-cutting theme and a separate heading with associated objectives and actions. One of the aims of the current action plan is to produce a national training plan on drug problems.

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Drug-related research

In Spain, biomedical research and health sciences are important aspects of the national research and development agenda, which comes under the framework of the Spanish Strategy for Science, Technology and Innovation 2013-20 and the National Plan for Scientific and Technical Research and Innovation 2013-16. In addition to those documents, the National Strategy on Drugs 2009-16 calls for improved research in areas of drug use, prevention and treatment, as well as for evaluation of programmes and actions. The research is funded through the general state budget through public tenders or calls.

The Government Delegation for the National Plan on Drugs is the national entity responsible for directing and coordinating drug-related research activities. Priority areas for drug-related research include basic, clinical, social, epidemiological and methodological research. The Action Plan on Drugs 2013-16 promoted (i) surveys of the general population and young high school students; (ii) the compilation of data on treatment, emergencies and mortality; (iii) the strengthening of surveillance systems with new tools and epidemiological indicators on the use of drugs, such as the problematic drug use indicator or the drug-related infectious diseases indicator; (iv) research and analysis of data on drug use and gender, drug use in the workplace, polydrug use, etc.; (v) the dissemination of data from the Information System through publications and online media; (vi) the consolidation of the Early Warning System for the detection of NPS; (vii) research networks with a clinical and preventative focus, integrating the existing drug-related networks and research centres in Spain; and (viii) setting up a portal on best practices.

Recent drug-related studies funded by the Government Delegation focused mainly on basic and clinical research on alcohol, cocaine and cannabis. Priority research lines for the 2016 call for applications included selective and indicated prevention in associated or independent alcohol and cannabis abuse, especially in minors; the social cost of drug problems; improving the quality and results of the therapeutic process; strategies for social and labour reintegration; actions in prison settings; and prevention and intervention in drug dependency in the workplace.

University departments and research networks are the main actors undertaking drug-related research. National scientific journals and specialised websites are the main channels for national dissemination of drug-related research findings.

Recently, the EU-funded Ibero-American Library on Drugs and Drug Addiction (BIDA, in Spanish) was established, and international cooperation in drug research is in place (i.e. with the US National Institute on Drug Abuse).

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Drug markets

Owing to its geographical position, Spain is one of the countries in the European Union that is most targeted by international drug traffickers, especially for the transit of cannabis resin and cocaine to other European countries. Therefore, actions to discover and dismantle international criminal networks involved in the trafficking of drugs are priorities of the Spanish law enforcement agencies and are carried out through intensifying control in the southern coastal areas and ports for packages of drugs; investigating, discovering and confiscating the proceeds of drug trafficking and money laundering; preventing the distribution of illegal drugs within the country; and fostering international cooperation. In this context, Spain remains one of the European countries reporting large seizures of cocaine and cannabis resin, in terms of both number of seizures and quantities seized. According to information from drug law enforcement agencies, seized cocaine generally originates from Colombia, Bolivia and Peru and arrives in Spain directly or via Central or South American countries by sea.

Nearly all cannabis resin seized by the Spanish law enforcement bodies comes directly from Morocco; however, in recent years, the eastern Mediterranean route has emerged for the trafficking of cannabis products, mainly from Morocco. Cannabis is also cultivated in Spain; there are indications that its production has increased since 2009, and is intended to supply local demand as well as being trafficked to other European Union countries.

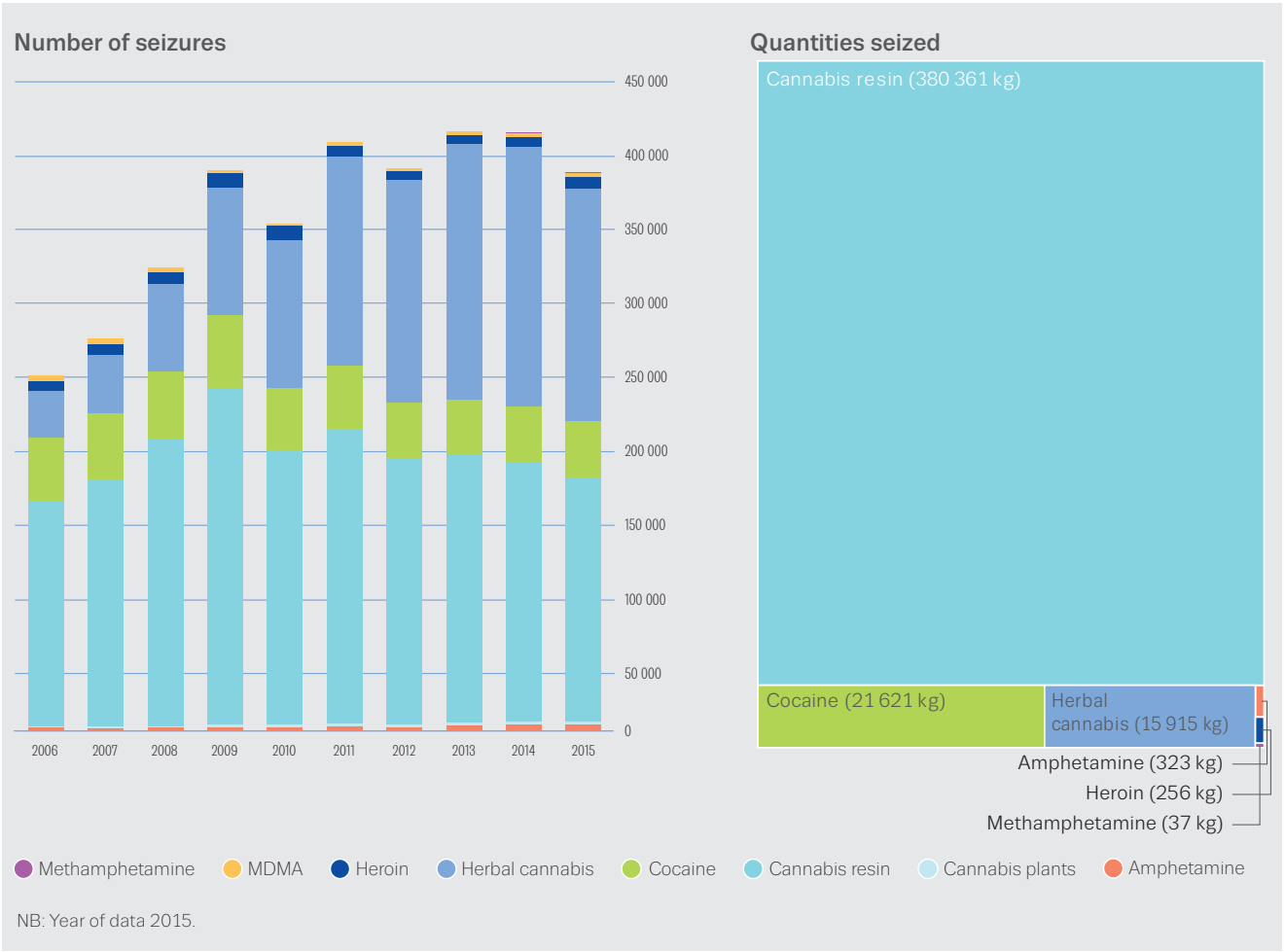
Heroin comes mainly from Pakistan via the Balkan route, and arrives in Spain mainly by air.

Historically, synthetic drugs were mainly smuggled into Spain from the Netherlands and Belgium, while in the recent years there have been seizures of MDMA that was produced in France or Andorra; in 2014, there was a significant seizure (of approximately 400 000 units) of MDMA originating in Bulgaria.

Overall, the number of drug seizures has increased over the past decade, and cannabis products remain the illicit drugs most frequently seized in Spain. An overall decline

FIGURE 17

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



NB: Year of data 2015.

in cannabis resin seizures has been noted since 2009; however, the quantity of resin seized has increased since 2010. In 2015, an increase in the quantity of herbal cannabis from large-scale seizures was reported, while the amounts seized in small-scale seizures were lower than in 2014.

Cocaine remains the second most frequently seized illicit drug, although, since 2009, a declining trend in cocaine seizures has been reported. In 2013-15, an increase in the number of heroin seizures, mainly small scale, was noted. The amount of heroin seized also increased over the same period, but this increase was mainly due to large-scale seizures. Spain reported a reduction in large-scale seizures of synthetic stimulants (amphetamines and MDMA) in 2015 compared with 2014. Small-scale seizures of MDMA in 2015 were lower than in 2014, while seizures of amphetamines have gradually increased since 2013 (Figure 17).

Spain reports mean potency (% of THC) or purity (% or mg per tablet) and average prices for the main illicit drugs. The mean potency for cannabis resin in 2013 was 14.5 % of THC, while for herbal cannabis it was 10.8 % of THC. The mean purity for heroin in 2015 was reported at 33 % and cocaine 42 %. In 2015, the mean price of cannabis resin was around 6 Euro/g, herbal cannabis 5 Euro/g, heroin 58 Euro/g, cocaine – 59 Euro/g, amphetamine 28 Euro/g. The mean price for one MDMA dose was 11 Euro.

Spain is the country reporting the largest seizures of cocaine and cannabis among the EU member States

KEY DRUG STATISTICS FOR SPAIN

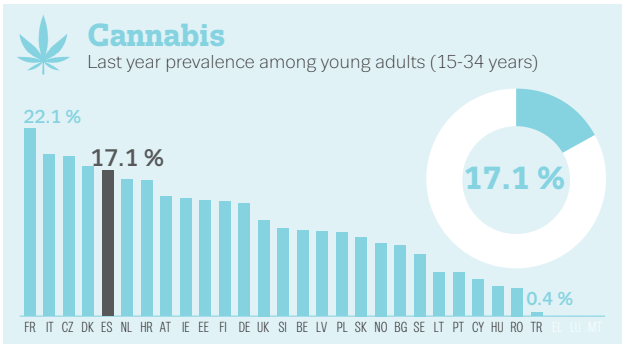
Most recent estimates and data reported

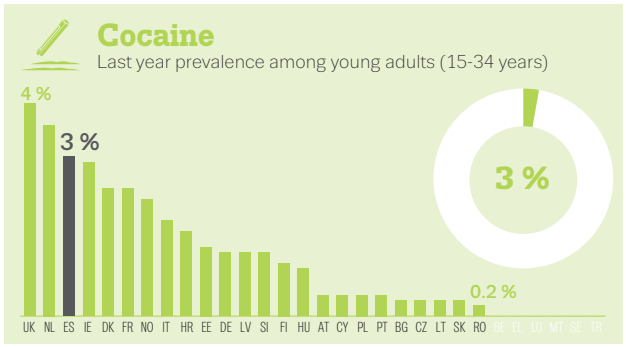
	Year	Country data	EU range Minimum	EU range Maximum
Cannabis				
Lifetime prevalence of use — schools (% , Source: ESTUDES (2014) and ESPAD)	2015	26.6	6.5	36.8
Last year prevalence of use — young adults (%)	2015	17.1	0.4	22.1
Last year prevalence of drug use — all adults (%)	2015	9.5	0.3	11.1
All treatment entrants (%)	2014	34	3	71
First-time treatment entrants (%)	2014	48	8	79
Quantity of herbal cannabis seized (kg)	2015	15 915.4	4	45 816
Number of herbal cannabis seizures	2015	156 984	106	156 984
Quantity of cannabis resin seized (kg)	2015	380 360.9	1	380 361
Number of cannabis resin seizures	2015	164 760	14	164 760
Potency — herbal (% THC) (minimum and maximum values registered)	No data	No data	0	46
Potency — resin (% THC) (minimum and maximum values registered)	No data	No data	0	87.4
Price per gram — herbal (EUR) (minimum and maximum values registered)	No data	No data	0.6	31.1
Price per gram — resin (EUR) (minimum and maximum values registered)	No data	No data	0.9	46.6
Cocaine				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	2.1	0.9	4.9
Last year prevalence of use — young adults (%)	2015	3	0.2	4
Last year prevalence of drug use — all adults (%)	2015	2	0.1	2.3
All treatment entrants (%)	2014	37	0	37
First-time treatment entrants (%)	2014	35	0	40
Quantity of cocaine seized (kg)	2015	21 620.9	2	21 621
Number of cocaine seizures	2015	38 273	16	38 273
Purity (%) (minimum and maximum values registered)	No data	No data	0	100
Price per gram (EUR) (minimum and maximum values registered)	No data	No data	10	248.5
Amphetamines				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1.3	0.8	6.5
Last year prevalence of use — young adults (%)	2015	1	0.1	3.1
Last year prevalence of drug use — all adults (%)	2015	0.5	0	1.6
All treatment entrants (%)	2014	1	0	70
First-time treatment entrants (%)	2014	2	0	75
Quantity of amphetamine seized (kg)	2015	323	0	3 796
Number of amphetamine seizures	2015	4 336	1	10 388
Purity — amphetamine (%) (minimum and maximum values registered)	No data	No data	0	100
Price per gram — amphetamine (EUR) (minimum and maximum values registered)	No data	No data	1	139.8

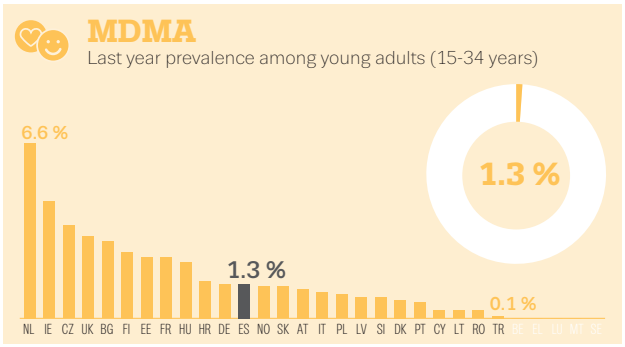
	Year	Country data	EU range Minimum	EU range Maximum
MDMA				
Lifetime prevalence of use — schools (% , Source: ESPAD)	2015	1	0.5	5.2
Last year prevalence of use — young adults (%)	2015	1.3	0.1	6.6
Last year prevalence of drug use — all adults (%)	2015	0.6	0.1	3.4
All treatment entrants (%)	2014	0	0	2
First-time treatment entrants (%)	2014	0	0	2
Quantity of MDMA seized (tablets)	2015	135 110	54	5 673 901
Number of MDMA seizures	2015	2 958	3	5 012
Purity (mg of MDMA base per unit) (minimum and maximum values registered)	No data	No data	0	293
Price per tablet (EUR) (minimum and maximum values registered)	No data	No data	0.5	60
Opioids				
High-risk opioid use (rate/1 000)	2014	2.1	0.3	8.1
All treatment entrants (%)	2014	25	4	93
First-time treatment entrants (%)	2014	11	2	87
Quantity of heroin seized (kg)	2015	256	0	8 294
Number of heroin seizures	2015	7 755	2	12 271
Purity — heroin (%) (minimum and maximum values registered)	No data	No data	0	96
Price per gram — heroin (EUR) (minimum and maximum values registered)	No data	No data	3.1	214
Drug-related infectious diseases/injecting/deaths				
Newly diagnosed HIV cases related to injecting drug use (cases/million population, Source: ECDC)	2015	2.1	0	44
HIV prevalence among PWID* (%)	2014	30.9	0	30.9
HCV prevalence among PWID* (%)	2014	66.6	15.7	83.5
Injecting drug use (cases rate/1 000 population)	2014	0.2	0.2	9.2
Drug-induced deaths — all adults (cases/million population)	2014	14.8	1.6	102.7
Health and social responses				
Syringes distributed through specialised programmes	2014	1 483 399	164	12 314 781
Clients in substitution treatment	2014	61 859	252	168 840
Treatment demand				
All clients	2014	48 926	282	124 234
First-time clients	2014	23 656	24	40 390
Drug law offences				
Number of reports of offences	2015	411 157	472	411 157
Offences for use/possession	2015	390 843	359	390 843

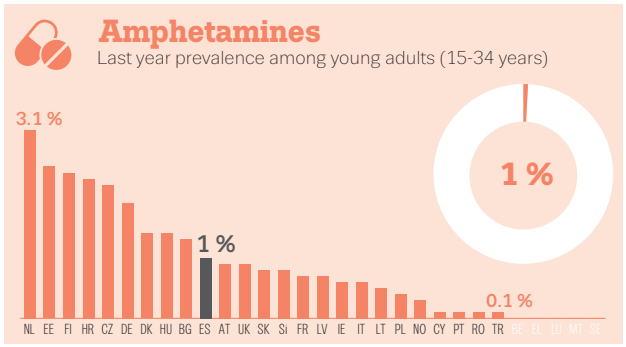
* PWID — People who inject drugs.

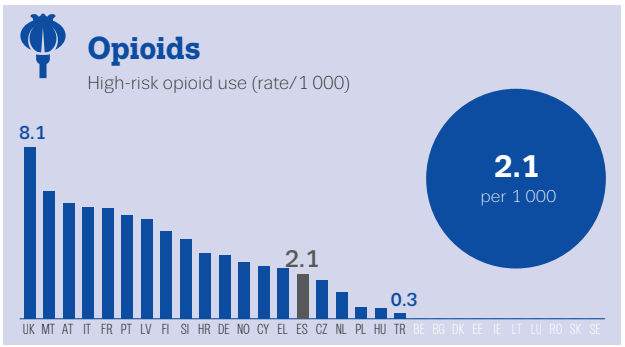
EU Dashboard

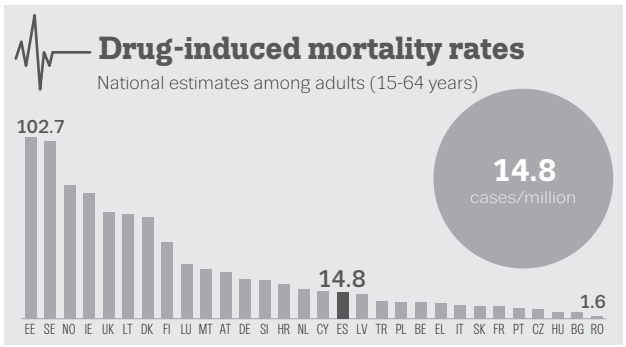


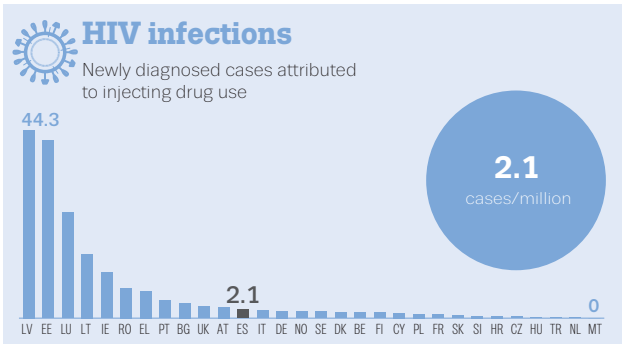


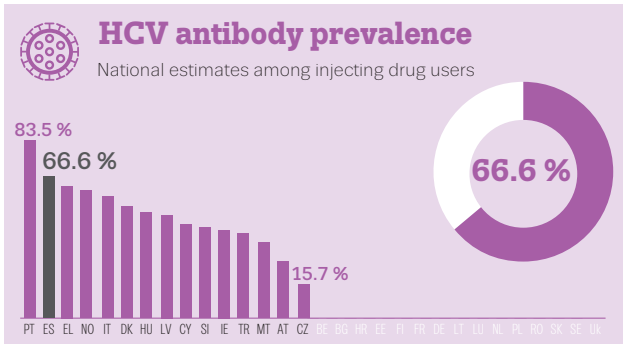












NB: Caution is required in interpreting data when countries are compared using any single measure, as, for example, differences may be due to reporting practices. Detailed information on methodology, qualifications on analysis and comments on the limitations of the information available can be found in the EMCDDA Statistical Bulletin. Countries with no data available are marked in white.

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About the EMCDDA

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is the central source and confirmed authority on drug-related issues in Europe. For over 20 years, it has been collecting, analysing and disseminating scientifically sound information on drugs and drug addiction and their consequences, providing its audiences with an evidence-based picture of the drug phenomenon at European level.

The EMCDDA's publications are a prime source of information for a wide range of audiences including: policymakers and their advisors; professionals and researchers working in the drugs field; and, more broadly, the media and general public. Based in Lisbon, the EMCDDA is one of the decentralised agencies of the European Union.

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.

Government Delegation for National Plan on Drugs (Delegación del Gobierno para el Plan Nacional sobre Drogas)

Plaza de España, 17
E-28008 Madrid
Spain
Tel. +34 91 822 61 25
Fax +34 91 822 60 95
Head of national focal point: Mr Francisco de Asís Babín Vich — relinstipnd@msssi.es

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EMCDDA, Praça Europa 1, Cais do Sodré, 1249-289 Lisbon, Portugal
Tel. +351 211210200 | info@emcdda.europa.eu
www.emcdda.europa.eu | twitter.com/emcdda | facebook.com/emcdda

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