NATIONAL DRUGS STRATEGY

2009-2016

FINAL EVALUATION REPORT

GOBIERNO DE ESPAÑA
MINISTERIO DE SANIDAD
SECRETARÍA DE ESTADO DE SANIDAD
DELEGACIÓN DEL GOBIERNO PARA EL PLAN NACIONAL SOBRE DROGAS

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LIST OF ABBREVIATIONS:

AGE: General State Administration.

AR: Autonomous Region.

CITCO: Counter-Terrorism and Organised Crime Intelligence Centre.

COPOLAD: Cooperation Programme between Latin America, the Caribbean and the EU on Drugs.

DGPNSD: Government Delegation for the National Drugs Plan.

DGT: Directorate General for Traffic.

EC: European Commission.

EDADES: Household Survey on Drugs.

E.S.O.: Compulsory Secondary Education.

ESTUDES: School Drugs Survey.

EU: European Union.

FEMP: Spanish Federation of Municipalities & Provinces.

HCV: Hepatitis C Virus.

HIV: Human Immunodeficiency Virus.

IDU: Injecting drug user.

INE: National Statistics Institute.

INT: National Toxicology Institute.

MAEC: Ministry of Foreign Affairs and Cooperation.

MIR: Ministerio of Interior.

NDP: National Drugs Plan (PNSD).

NDS: National Drugs Strategy.

NGO: Non-governmental Organisation

OAS: Organisation of American States.

OEDA: Spanish Observatory on Drugs and Addictions.

PAD: Regional Drugs Plan.

Q. DGPNSD: Government Delegation for the National Drugs Plan Questionnaire.

Q. PAD: Regional Drugs Plans Questionnaire.

RIOD: Network of Ibero-American NGOs working on drug addictions.

SC: Scientific Society.

S.G. II.PP: Secretariat General for Prisons.

TF: Task force.

UN: United Nations.

WHO: World Health Organisation.

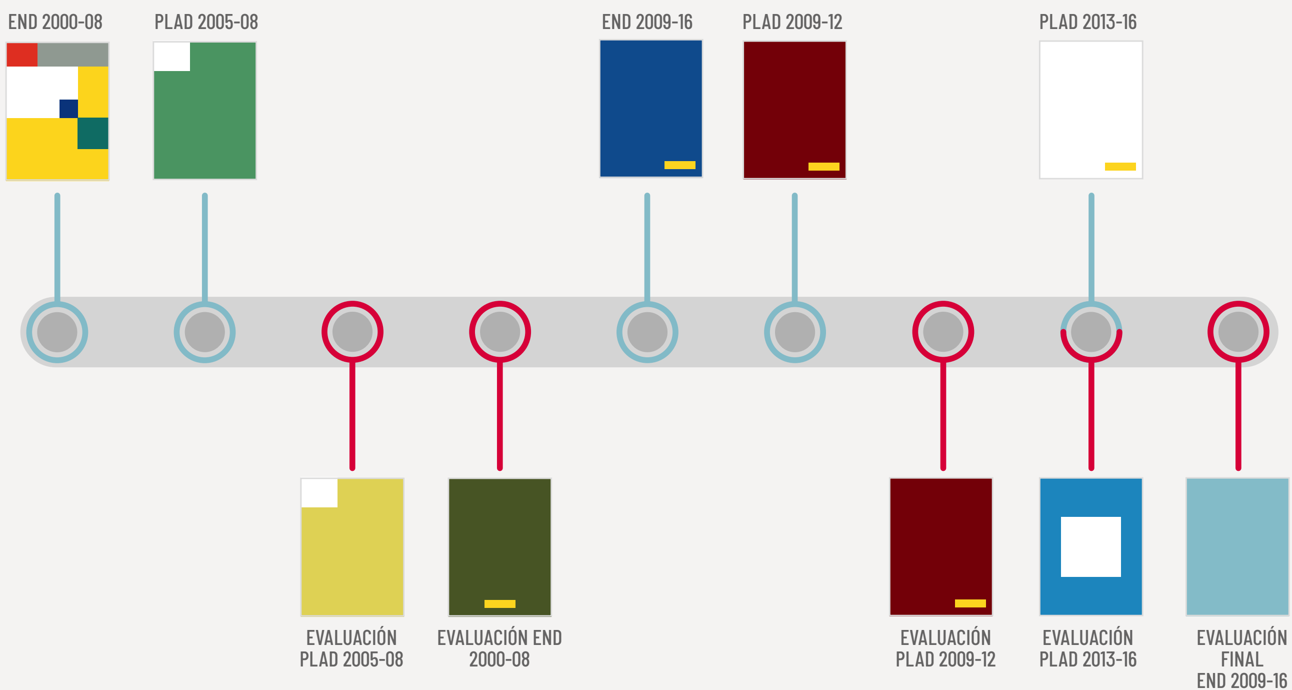
1
INTRODUCTION

1. INTRODUCTION

In recent years, the evaluation of public policies has become an essential requirement of government action for two reasons. One, the need to know more about the effects of the actions taken and about the mechanisms that explain them and two, the obligation to be held accountable to society for the use made of public resources.

This is the fifth evaluation exercise carried out by the Government Delegation for the National Drugs Plan [*Delegación del Gobierno para el Plan Nacional sobre Drogas*, DGPNSD], so providing further consistency and continuity to its track record of designing, developing, implementing and evaluating its policies.

Drugs Policies and their evaluation (2000-2016)



The National Drugs Strategy 2009-2016 (NDS) [Estrategia Nacional sobre Drogas 2009-2016 (END)] includes a proposal for its evaluation, the purpose of which is to make a value judgement on the strategy using a scientific approach. With this aim in mind, a General Objective has been set under theme 6, Improving Knowledge, which is "*Further the systematic evaluation of programmes and actions as an instrument enabling the validation of the activities carried out*". There is also a specific chapter (Chapter 6) devoted to the evaluation of the strategy itself in which the criteria and general procedure for that evaluation are laid down. Those criteria are:

1. Evaluation of the efficacy or effectiveness in the achievement of objectives as well as the efficiency of the resources and mechanisms employed to achieve the goals.
2. Guarantee of the credibility and robustness of the data and its results through the adoption of an objective and high-quality methodology. The best way to do that is by taking a mixed approach, including the collaboration of external agents to guarantee both of these two aspects.
3. Participation in the evaluation of all the stakeholders in the Strategy including, inter alia, the public administrations (different levels of government), non-governmental organisations, scientific societies, consumer associations, trade unions and patients.
4. Analysis of its contribution to the promotion of ultimate values such as equity, equality and quality of life.
5. Establishment of the ideal periods to undertake the assessment, including a baseline evaluation, mid-term or intermediate assessment and a final evaluation that offers an overview of the results obtained and of the mechanisms that explain them.
6. Inclusion of mechanisms that enable more knowledge to be gained about the causality relationships including an analysis of contextual factors that help with their understanding.

To guarantee the objectivity of the whole process and of its conclusions, the decision was taken to request the collaboration of the Regional Drugs Plans (PADs) and of the Universidad Autónoma de Madrid, a university that had worked with us in previous evaluations and a task force (TF) was set up to design and implement the evaluation.

The process started in November 2016 with the creation of the task force, the design of the methodology, the selection of indicators and the development of consultation instruments. It ended in May 2017 when the final report was produced.

2

EVALUATION OBJECTIVES, METHODOLOGY AND PROCEDURES

2. EVALUATION OBJECTIVES, METHODOLOGY AND PROCEDURES

The steps followed in the evaluation process are shown in the flow diagram below

1. The first step was the **creation of a Task Force** (TF), coordinated by the Government's Delegation for the National Drugs Plan (DGPNSD), which included 11 representatives from the Regional Drugs Plans (PADs), and one representative from the Universidad Autónoma de Madrid.
2. In Step two, the TF decided to carry out an objectives-based evaluation. Then the questions the evaluation would have to answer were determined, starting off with the more global objectives and followed by specific questions related to each one of the National Drugs Strategy (NDS) objectives. The following general questions were proposed:
   a. Have the objectives of the NDS been achieved?
   b. What are the reasons why they were/were not achieved?
   c. How relevant are the objectives looking ahead to the future?
   d. What proposals for improvement have come out of the evaluation? Are there any additional objectives to be included in the new NDS?
   e. What has the impact of the NDS been on the development of policies and programmes?

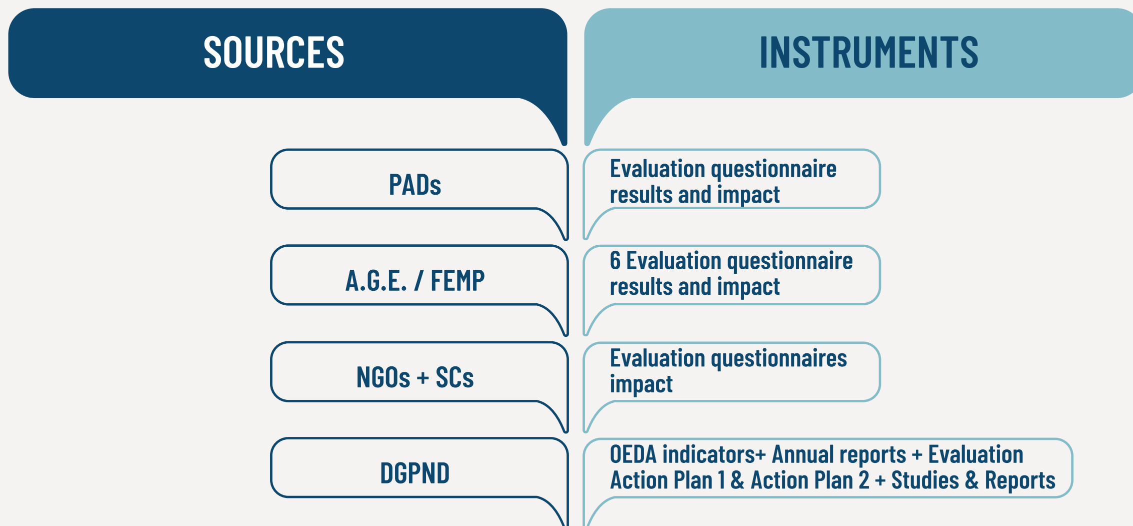
   Those questions were the basis for other more specific questions defined for each objective (Chart 1)

Chart 1: Examples of evaluation questions prepared by the Task Force

THEME	GO	QUESTIONS TO BE ASKED	INSTRUMENTS/SOURCES
1. Coordination	1. Coordination	1. Are there sufficient coordination mechanisms between the PADs and the DGPNSD? 2. Are there any projects on which the Autonomous Regions (ARs) coordinate? 3. Is there any exchange of information and technology transfer among the ARs? 4. Is there any exchange of information and technology among the NGOs? 5. On a regional level, are there any coordination structures and mechanisms with other departments in the regional government: education; social services; health system; police..?	• PAD Evaluation questionnaire • NGO Evaluation questionnaire
2. Demand reduction	2. Awareness-raising	• Has social awareness of the drugs problem increased among the general population? • Has awareness of drug-related problems increased in the school environment? • Has the perception of the risks associated with drugs use increased among adolescents?	• CIS/ OEDA/ARs

3. Step three was the selection of **sources and the design of consultation instruments** (Annexe 2) to answer the evaluation questions. Instruments were developed and tailored to each source consulted, taking into account the information they were supposed to gather from each one (Chart 2).

Chart 2. Diagram of sources and instruments used



In total eight different questionnaires were developed (Chart 3) and common scoring scales were established for aspects relating to coordination, territorial coverage of programmes and for programme accreditation procedures (Chart 4).

4 & 5. **The consultation and information-gathering process** (steps 4 & 5) lasted for approximately four months (November 2016-February 2017) and more than 100 representatives of bodies attached to different levels of government, from scientific societies and from NGOs took part in it (Annexe 1).

6. For the **data analysis** (step 6) the 14 general objectives of the strategy were reviewed and they were ordered in a hierarchy and split into groups of four types of objectives:

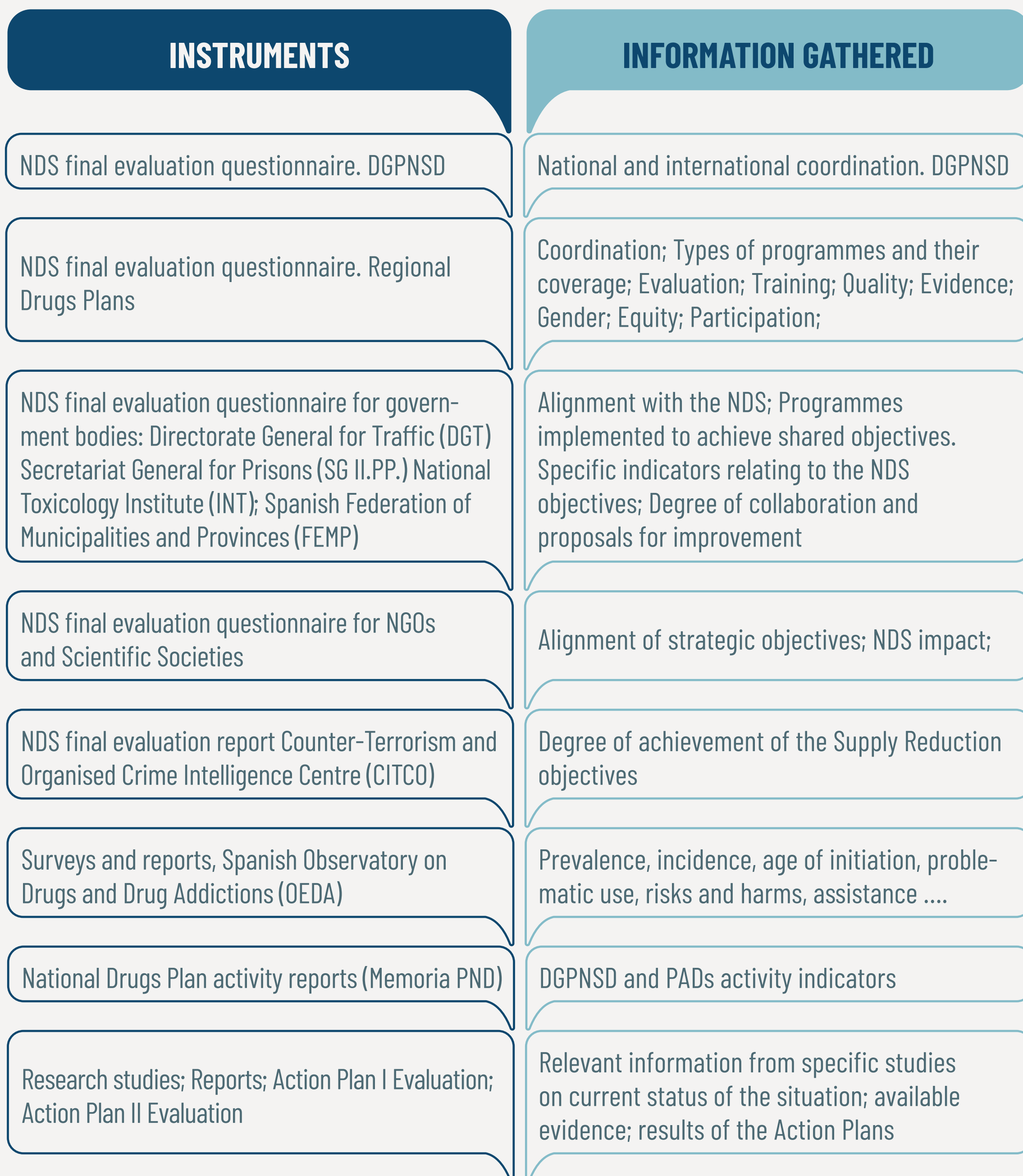
- **Ultimate objectives:** (objectives 4, 5 and 6) delay the initiation age for drug use, reduce drug use and reduce the risks and harms associated with it. The main source of this type of indicators is the Spanish Observatory on Drugs (OEDA), although data have also been incorporated from other entities like the National Toxicology Institute or the Directorate General for Traffic (DGT).

- **Processes and products objectives:** (objectives 2, 3, 7, 8, 9 and 10), which reflect activities carried out in the areas of supply and demand reduction, in order to achieve the final results.

  In this case different indicators have been used:
    - Types and territorial coverage of programmes
    - Types and number of resources and services
    - Population coverage of programmes and services

- **Cross-cutting objectives:** (objectives 2, 11, 12, 13, 14) which affect the development of the previous ones and therefore indirectly impact the final outcomes or results.

Chart 3. Instruments, sources and information gathered in the NDS 2009-2016 Final Evaluation



INSTRUMENTS	INFORMATION GATHERED
NDS final evaluation questionnaire. DGPNSD	National and international coordination. DGPNSD
NDS final evaluation questionnaire. Regional Drugs Plans	Coordination; Types of programmes and their coverage; Evaluation; Training; Quality; Evidence; Gender; Equity; Participation;
NDS final evaluation questionnaire for government bodies: Directorate General for Traffic (DGT) Secretariat General for Prisons (SG II.PP.) National Toxicology Institute (INT); Spanish Federation of Municipalities and Provinces (FEMP)	Alignment with the NDS; Programmes implemented to achieve shared objectives. Specific indicators relating to the NDS objectives; Degree of collaboration and proposals for improvement
NDS final evaluation questionnaire for NGOs and Scientific Societies	Alignment of strategic objectives; NDS impact;
NDS final evaluation report Counter-Terrorism and Organised Crime Intelligence Centre (CITCO)	Degree of achievement of the Supply Reduction objectives
Surveys and reports, Spanish Observatory on Drugs and Drug Addictions (OEDA)	Prevalence, incidence, age of initiation, problematic use, risks and harms, assistance ....
National Drugs Plan activity reports (Memoria PND)	DGPNSD and PADs activity indicators
Research studies; Reports; Action Plan I Evaluation; Action Plan II Evaluation	Relevant information from specific studies on current status of the situation; available evidence; results of the Action Plans

- **Objectives linked to the guiding principles of the NDS:** equity, social participation, intersectoral dimension, gender, and others.

Information was gathered for each one of these objectives through a set of indicators grouped into the following types:

- **Indicators of final outcomes** (objectives related to drug use and the harms associated with or stemming from it). The main source of this type of indicators is the Spanish Observatory on Drugs (OEDA), although data from other entities like the National Toxicology Institute or the DGT have also been incorporated.

Chart 4: Scoring scales used in the NDS final evaluation questionnaire (PADs; DGPNSD)

COORDINATION (0-3)	TERRITORIAL COVERAGE (0-4)	ACCREDITATION (0-4)
0: No coordination.	**0: No coverage.**	**0: No criteria exist.**
1: Low level of coordination: ad hoc meetings.	**1: Low:** only in a few key locations.	**1: Low:** Quality evaluation criteria exist and are published.
2: Medium level of coordination: working groups to work on ad hoc projects.	**2: Medium:** coverage in quite a lot of key locations but not in the majority of them.	**2: Medium:** Instruments exist to evaluate the criteria but they are not scored.
3: High level of coordination: collaboration agreements. Stable working groups to work on coordinated projects, written coordination protocols.	**3: High:** coverage in most key locations but not in all of them.	**3: High:** Instruments exist to evaluate them and they are scored.
	4: Total: coverage in all the key locations measured in population terms.	**4: Total:** The programmes and services are accredited in line with quality criteria.

- **Process indicators**, related to the types and territorial coverage of the programmes that are implemented, related to objectives 2,3,7 y 8, extracted from the evaluation questionnaire on the regional drugs plans.
- **Product indicators**, related to the population coverage of the programmes, with data from the National Drugs Plan annual reports and the AGE questionnaires.
- **Indicators related to the quality of the system:** quality criteria, portfolio of services, catalogues of programmes, evaluation, human resources, etc., with data taken from the final questionnaire on the regional drugs plans.
- **Indicators of the cross-cutting objectives and of the action principles:** mainstreaming the gender perspective, equity social participation, training.

  In order to make the information as objective and concrete as possible scoring scales were used in the questionnaires prepared for the evaluation (Chart 4).

The following **analyses** were then made with all of the information that had been gathered:

- The **initial situation was compared with the final situation** using the indicators for which information was available for the years corresponding to the start (2009) and the end of the strategy (2016).
- The **process, product and cross-cutting objectives were matched up with the final objectives** of the strategy; i.e. the idea was to see how what was done (what programmes were rolled out, how many people they reached, what the implementation quality was, etc.) linked up to what was achieved (chart 5).
- An **analysis was made of whether what was done matched the needs** and the characteristics of the drug use situation and its consequences in order to thus identify any relevant and suitable objectives with a view to the new Strategy.

Chart 5: Hierarchy of NDS 2009-2016 objectives (and guiding principles)

2 Promote social awareness about risks and damages

3 Increase personal abilities and skills

7 Guarantee quality and standardized assistance

8 Facilitate social integration

9 Increase the effectiveness of supply control and illegal markets

10 Increase money laundering control mechanisms

4 Delay the age of initiation

5 Decrease consumption

6 Reduce associated harms

1 Optimize coordination and cooperation

11 Improve research

12 Promote the evaluation of programs

13 Improve the training of professionals and volunteers

14 Optimize international coordination

Guiding principles: Evidence, Social participation, intersectorality, integrity, equity, gender

Chart 6: Analysis diagram of the NDS 2009-2016 evaluation indicators.

3

RESULTS OF THE OBJECTIVES-BASED EVALUATION DEGREE OF ACHIEVEMENT OF THE NDS GENERAL OBJECTIVES

GENERAL OBJECTIVE 1:

OPTIMISE COORDINATION AND COOPERATION

DEGREE OF ACHIEVEMENT OF THE NDS GENERAL OBJECTIVES

General Objective 1: Optimise coordination and cooperation

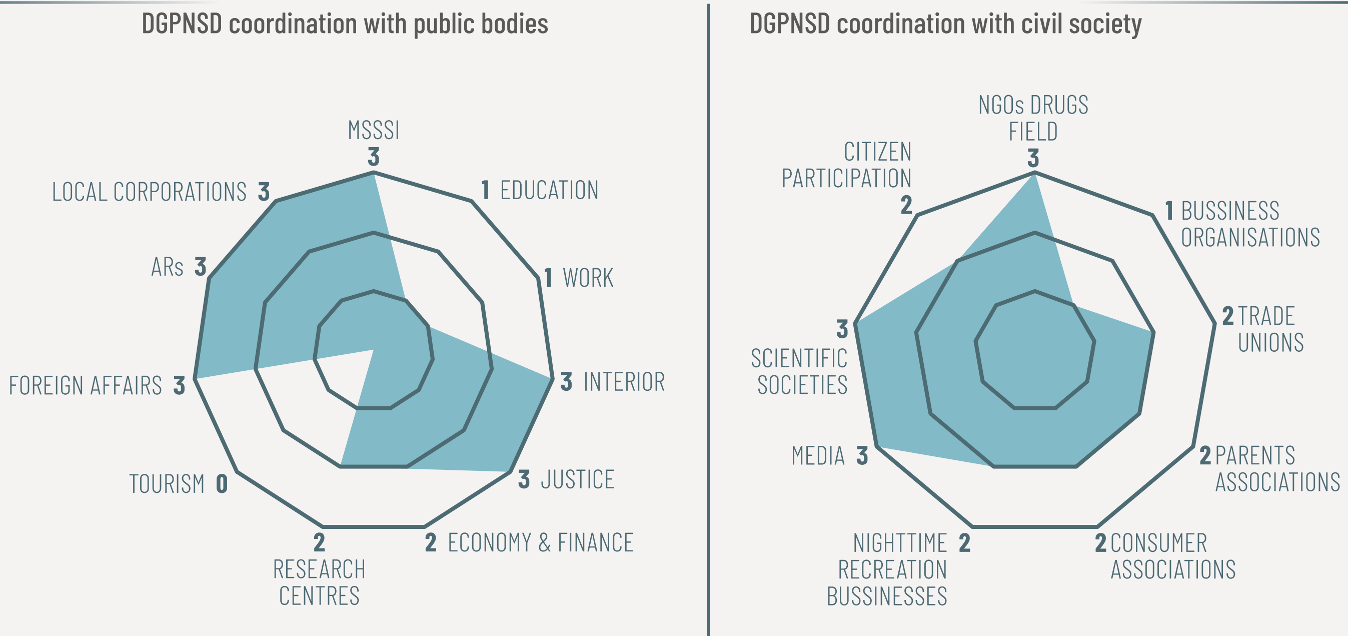
The drugs sector has always been known for its high level of coordination, both internal (between the different Drugs Plans and with the NGOs in the sector) and external (with other bodies with related areas of responsibility) coordination. This is due to the multidimensional conceptual vision of the phenomenon in drugs policies. Over the years the way that drugs phenomenon has evolved has led to increasingly broader coordination encompassing more and more sectors.

In order to evaluate coordination, the most relevant sectors and bodies in the different levels of government and in civil society were taken into account in line with the strategic objectives set. The degree of coordination of both the DGPNSD and the PADs with each one of them has been assessed in line with a scoring scale established to make that evaluation more objective (see scoring scale. Chart 4 Methodology). The results were as follows.

DGPNSD coordination

The level of coordination between the DGPNSD and other public bodies is high, especially with the Regional and Local Drugs Plans and with the Ministry of Interior. However, there are sectors where coordination should be strengthened: Employment (for integration into the job market), Education (for prevention in schools) or Tourism (for prevention in recreational settings), for instance. There is also a good level of coordination with civil society, especially with the NGOs working on drugs, with scientific societies and with the media. The recently-created Spanish Council for Drug Dependence and other Addictions [*Consejo Español de Drogodependencias y otras Adicciones*] has improved overall coordination. Likewise, the implementation methodology of the 2nd Action Plan linked to the NDS has contributed to more coordinated work through the creation of working groups to implement actions. This working model has proven to be effective in improving coordination and generating synergies between the different actors.

Figure 1.1: DGPNSD Coordination (DGPNSD) (Max: 3)



PAD coordination

The profiles of coordination between the PADs (Figures 1.2 and 1.3) and other sectors are very heterogeneous depending on:

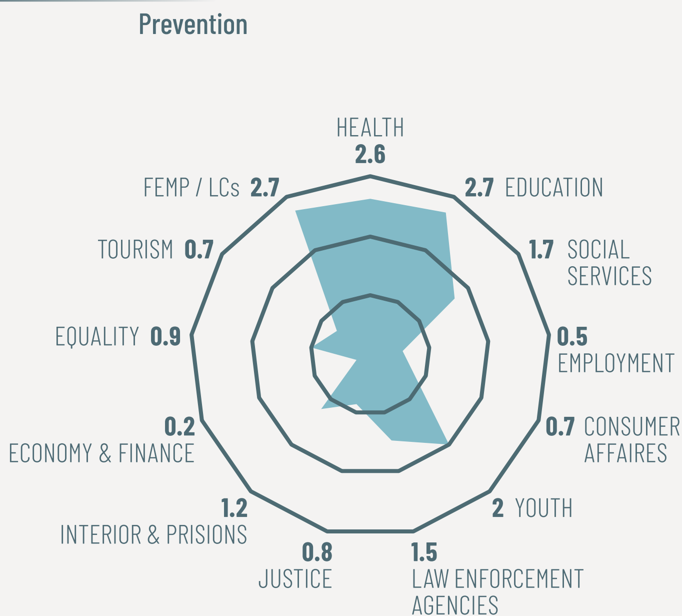
- The number and type of bodies they coordinate with and the intensity of the coordination. The diversity in the location of the coordination office or the department responsible for the drugs plan in each region probably has an influence here.
- The intervention areas (prevention, assistance, social incorporation): the coordination profiles are specific for each one of them:
    - in Prevention there is particularly good coordination with Health, Education and Local Corporations;
    - in Assistance, with Health;
    - in Social Incorporation, there is a lower degree of coordination with all of the sectors.

In general, coordination in the drugs sector is still very broad and intense; nevertheless, there is room for improvement with:

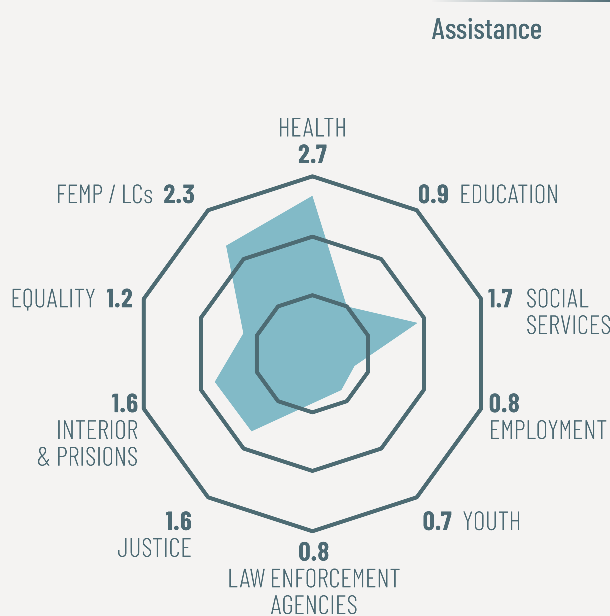
- **The education system,** in order to promote prevention in schools and training for teachers (there are lots of prevention activities carried out in schools without any coordination with the PADs (programmes run, teachers trained …)
- **The employment sector,** both with the corresponding level of government and with business organisations because coordination with trade unions is good. This coordination should focus on three objectives: reduce low job productivity associated with the early death and hospitalisation of drug users, (Rivera, 2016), prevent workplace accident risk situations associated with drug use (INT mortality indicator) and facilitate integration into the workplace of people with a drug dependence.
- **The health system,** in order to improve and complete the organic and functional integration of assistance provision for drug dependences in the health system and with special attention given to the assistance of infectious diseases in the drug addict population as well as to mental health problems. Also, for early detection and preventive intervention.
- **The Ministry of Interior,** for the coordination of the recreational and educational plans with the PAD prevention activities in these settings; with the **DGT** for the training of driving school instructors and accident prevention programmes. With **IIPP (prisons authority)**, in order to extend the existing coordination protocol that guarantees the continuity and integral nature of the assistance provided to and the social incorporation of drug addicts.
- Between the **Regional Drugs Plans,** following the model of the 2nd Action Plan 2009-16, for the exchange of best practices, the standardisation of information and evaluation systems and consensus on criteria and services portfolios.

Figure 1.2. Coordination profiles Autonomous Regions-Public bodies. PADs average score (Source: PADs).

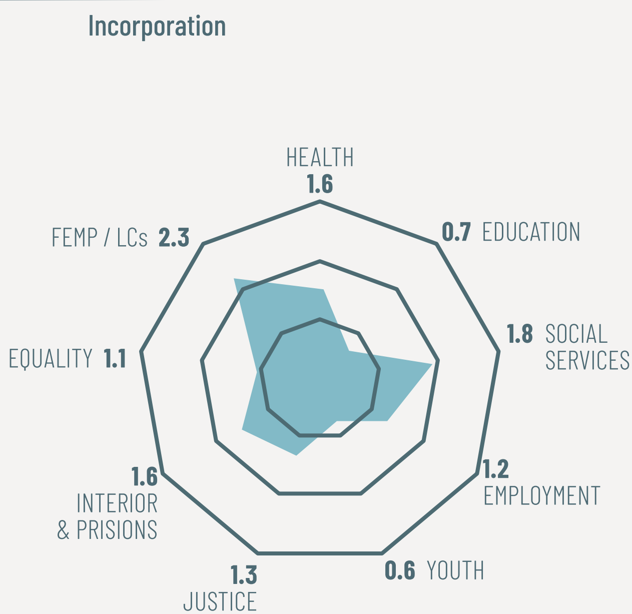
Prevention



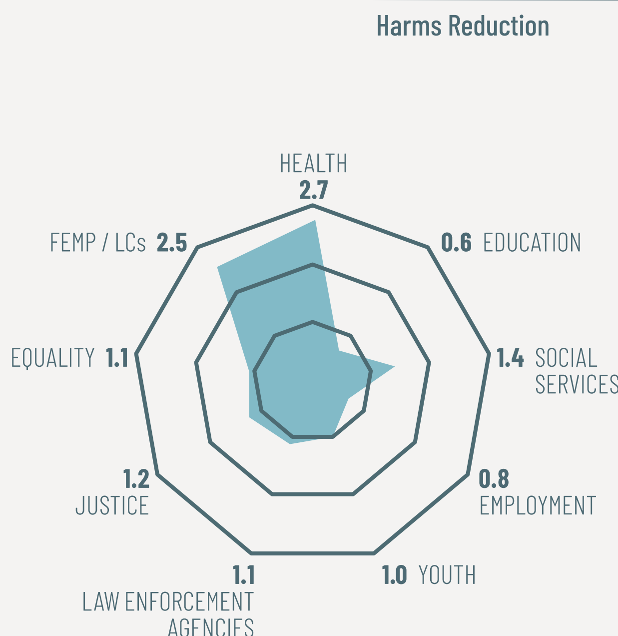
Assistance



Incorporation



Harms Reduction



COORDINATION (0-3)

0: No coordination.

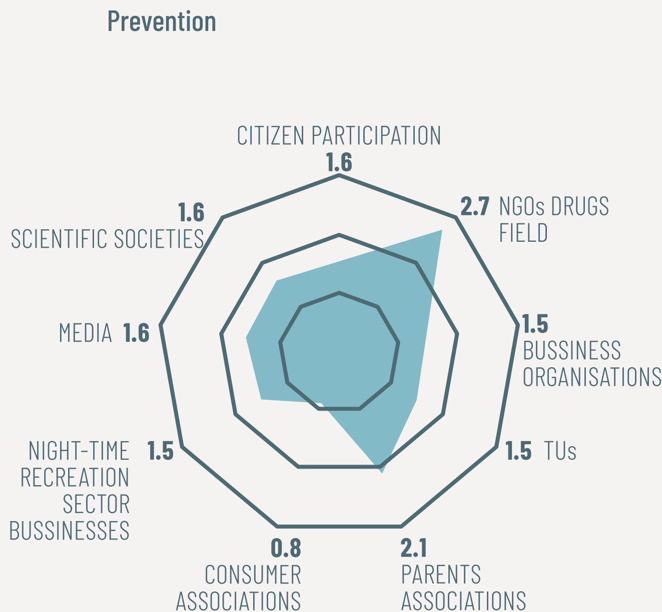
1: Low level of coordination: ad hoc meetings.

2: Medium level of coordination: working groups to develp ad hoc projects.

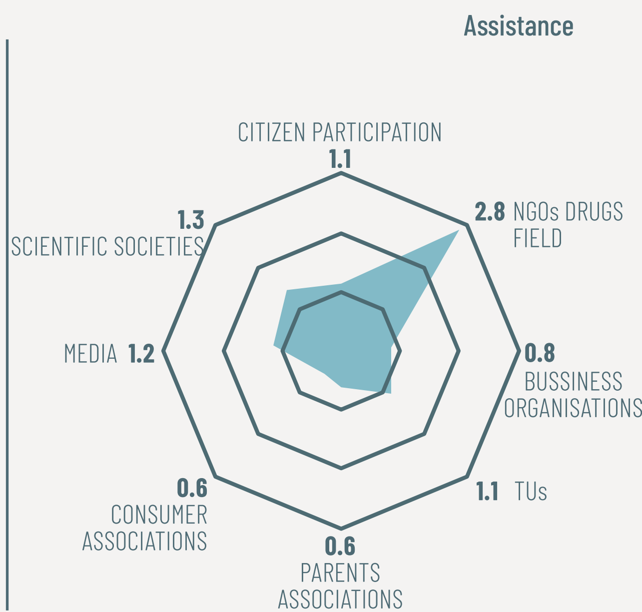
3: High level of coordination: collaboration agreements; stable working groups to develop coordinated projects, written coordination protocols.

Figure 1.3. Coordination Profiles Autonomous Regions-Civil Society. PADS Average score (Source: PADs).

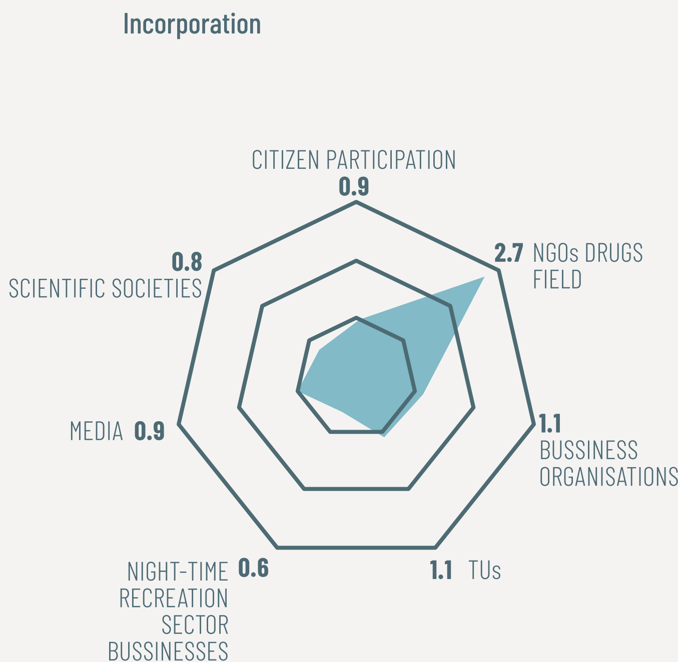
Prevention



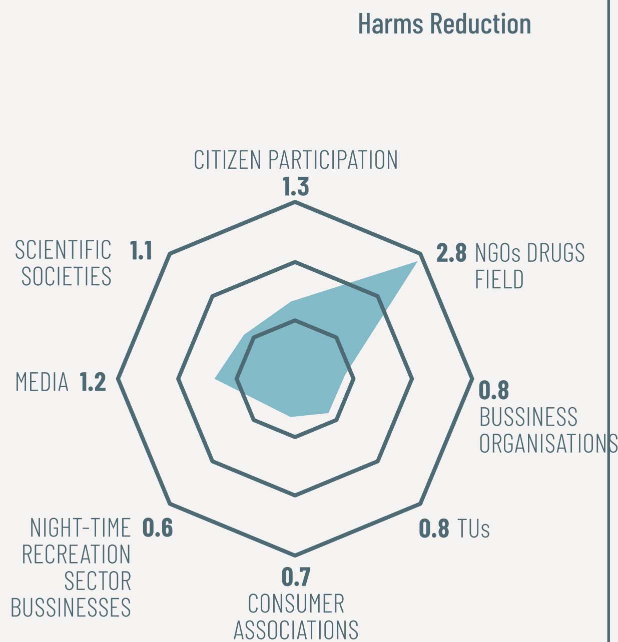
Assistance



Incorporation



Harms Reduction



COORDINATION (0-3)

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3: High level of coordination: collaboration agreements; stable working groups to develop coordinated projects, written coordination protocols.

CONCLUSIONS

The drug addictions sector is a highly coordinated sector, both between public institutions and with civil society.

At a regional level, the coordination profiles are heterogeneous and in addition they differ depending on the intervention area concerned:

1. In Prevention, coordination is particularly good with Health, Education and Local Corporations.
2. In Treatment, with Health.
3. In Social Incorporation, the degree of coordination is lower with all sectors.

RECOMMENDATIONS

Coordination needs to be improved at a regional level, essentially in the Social Incorporation area and with Scientific Societies in all areas.

At central government level coordination could be improved with Education, Employment and Tourism, and citizen participation could be strengthened.

Collaborative projects between PADs should be promoted as this would help to achieve synergies and harness the strengths of the different regions.

GENERAL OBJECTIVE 2:

RAISE SOCIAL AWARENESS ABOUT RISKS AND HARMS

General Objective 2: Raise social awareness

One of the objectives proposed by the NDS is the promotion of social awareness about the harms and costs associated with drugs use and so increase risk perception and encourage society to take joint responsibility in the response to the problem.

To achieve this objective, government institutions and NGOs in the sector perform an important role by providing information and explaining the issue in different settings: schools and health centres websites, recreational settings, workplaces, the media, social media…..

Types of programmes and their territorial coverage

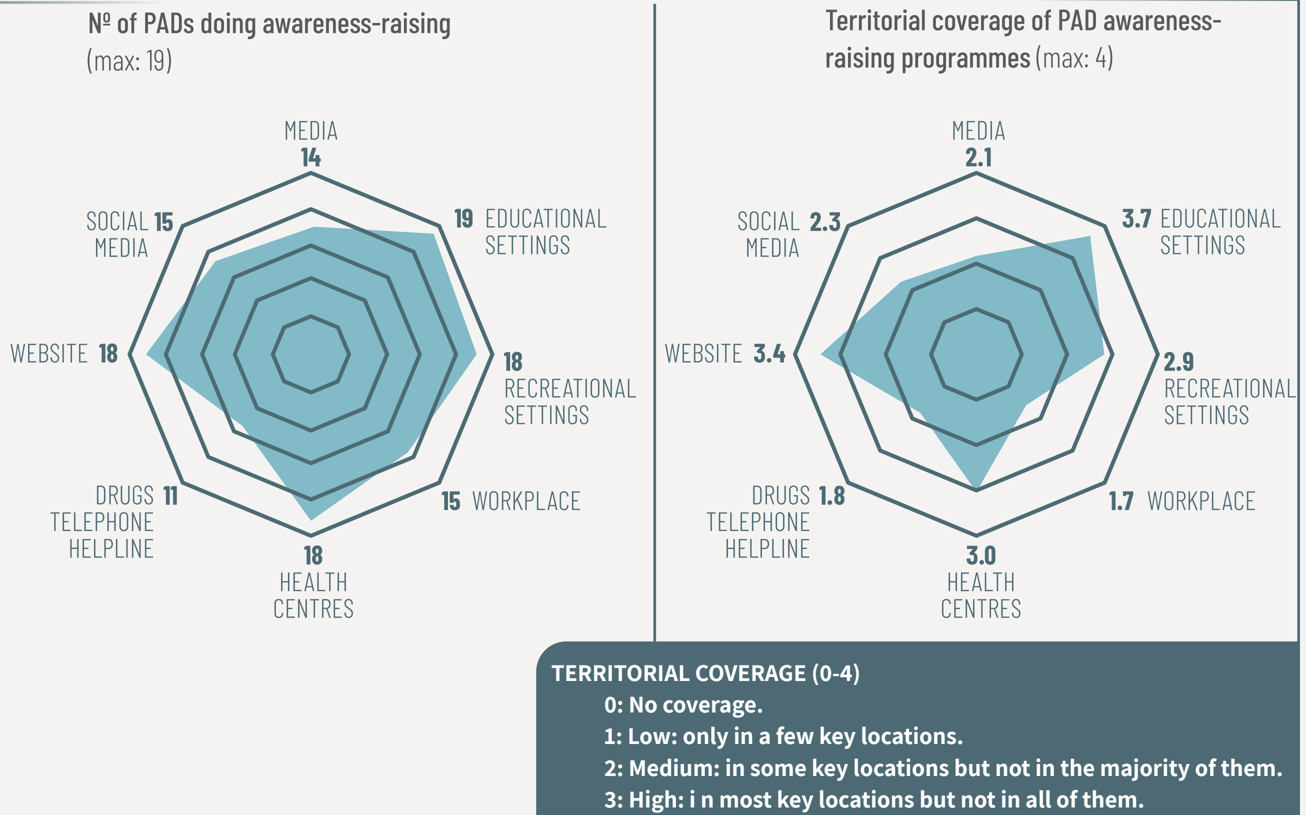
Awareness-raising programmes and activities can be classified in two broad categories depending on the channel used to disseminate the information:

- Activities in the media.
- Community awareness-raising activities carried out in health centres, schools or recreational settings, with a social marketing focus.

There are different communication profiles among the PADs: 10 of them are more concerned with community awareness-raising, eight do similar work in both formats whereas only one (Catalonia PAD) is more clearly oriented towards the media.

Awareness-raising through the media has switched from traditional media formats to the Internet. The community awareness-raising work with the greatest coverage is the work done in schools, followed by health centres and recreational settings.

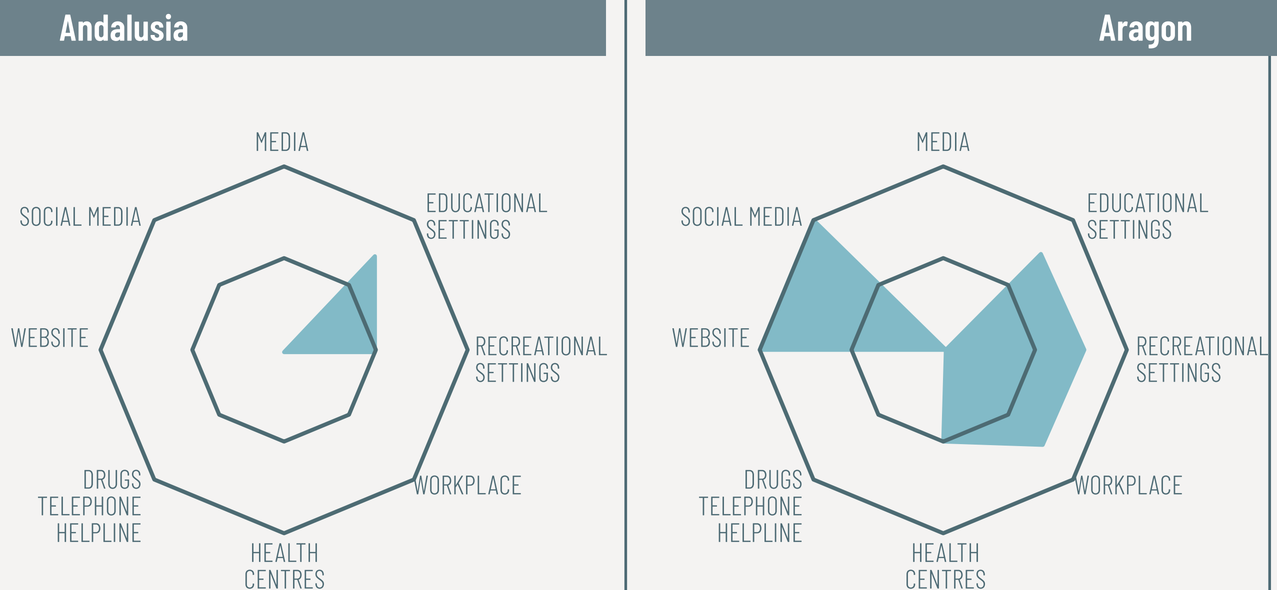
Figure 2.1. Autonomous Region awareness-raising programmes. (Source: PADs)



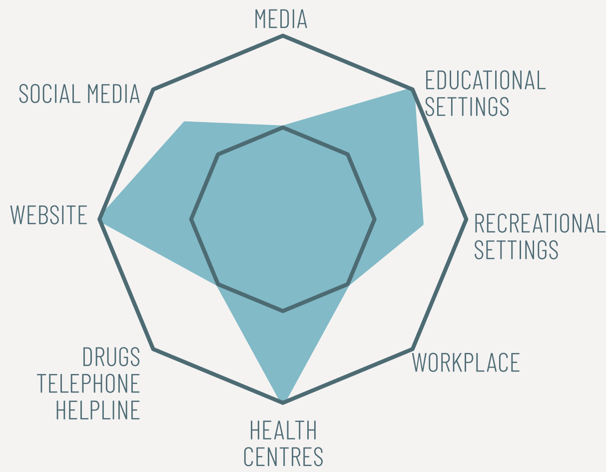
TERRITORIAL COVERAGE (0-4)

- **0: No coverage.**
- **1: Low: only in a few key locations.**
- **2: Medium: in some key locations but not in the majority of them.**
- **3: High: i n most key locations but not in all of them.**

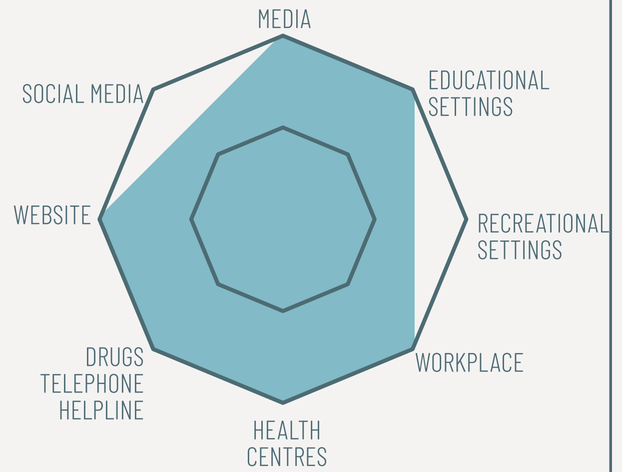
Figure 2.2. Profiles of Autonomous Region Information and Awareness-raising programmes (Source: PADs)



Cantabria



Castile and Leon



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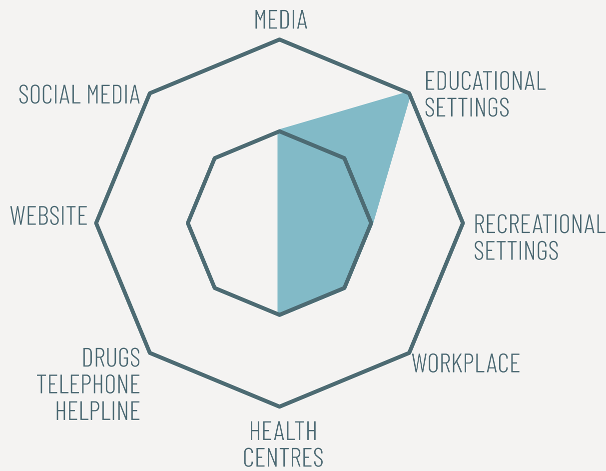

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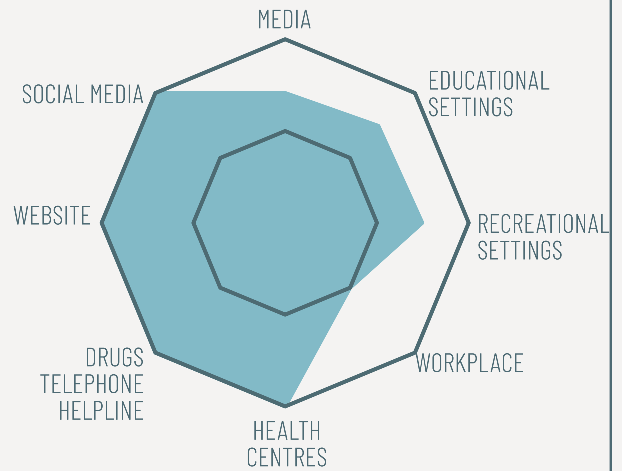
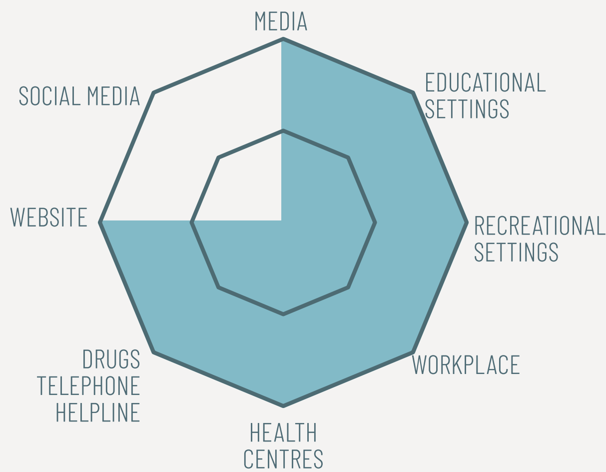
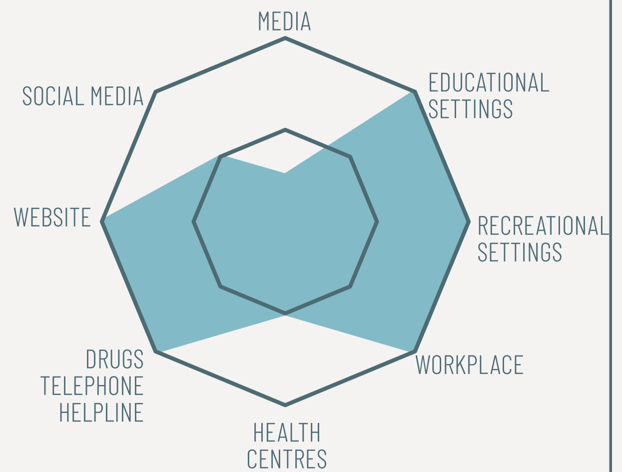


Ceuta



Community of Madrid



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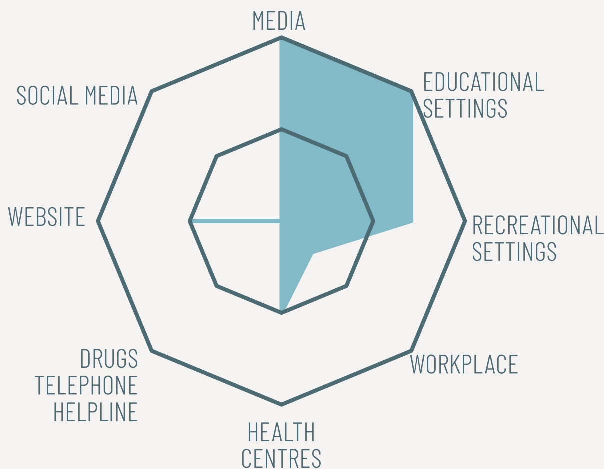
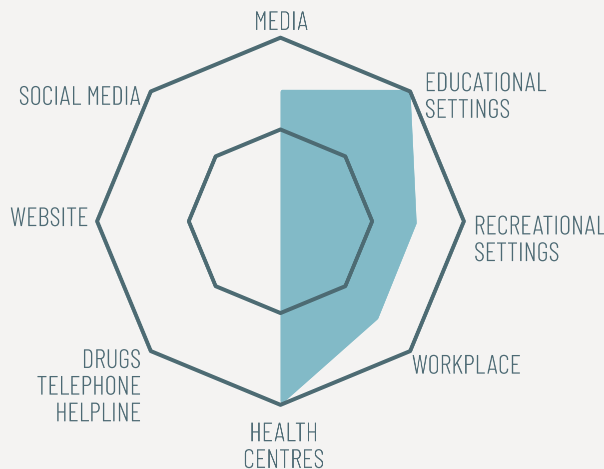


Extremadura



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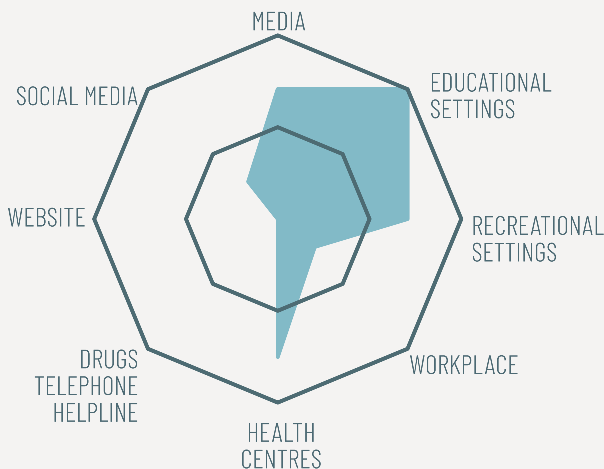

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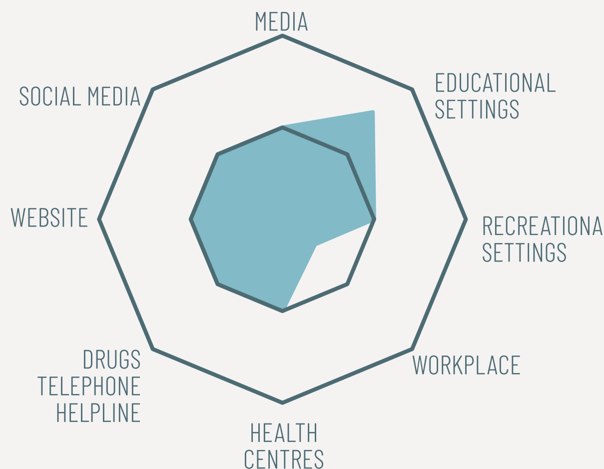
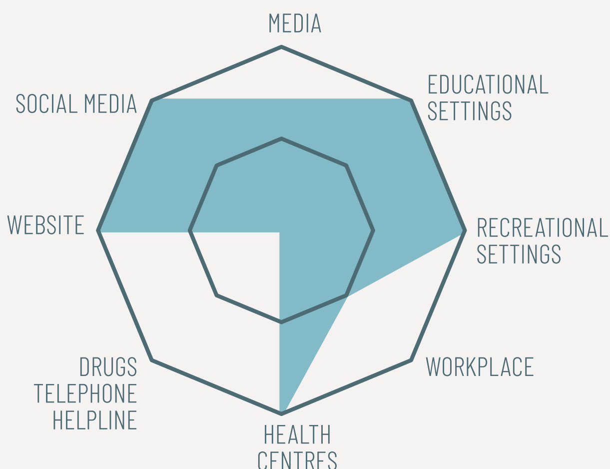
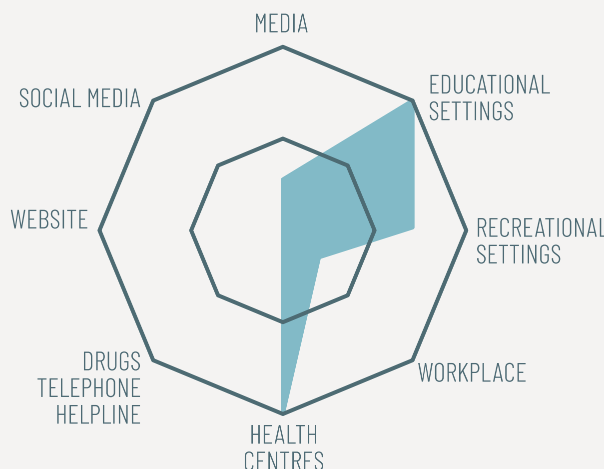


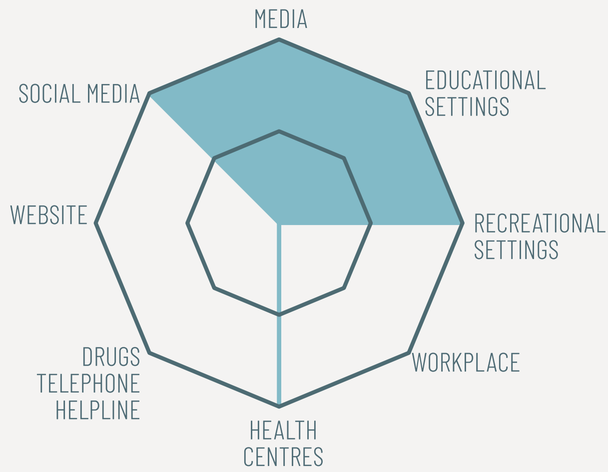
Canary Islands



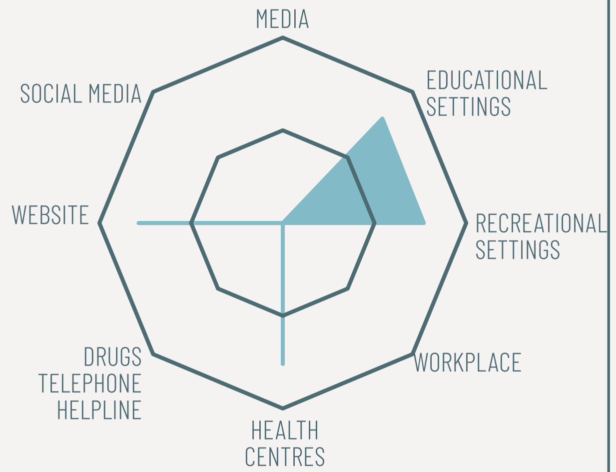
La Rioja



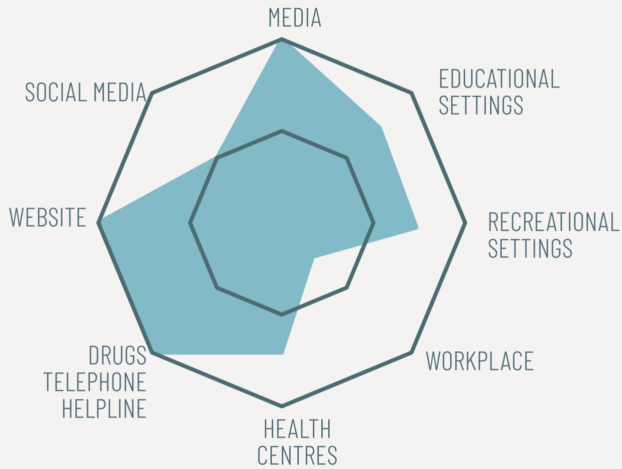
Melilla



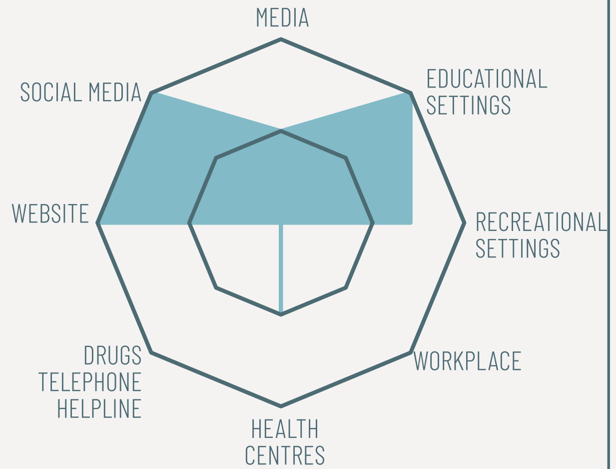
Navarre



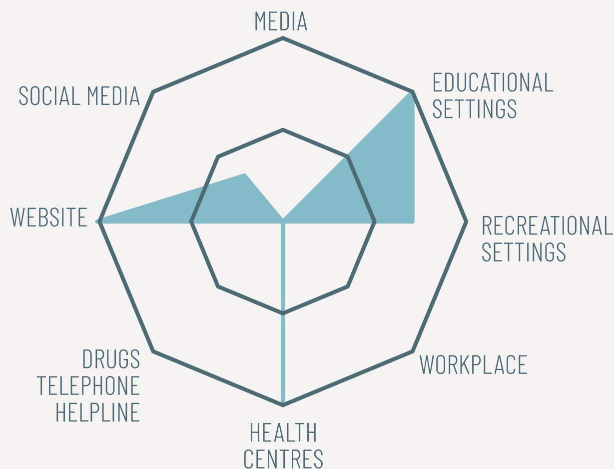
Basque Country



Principality of Asturias



Region of Murcia



Population coverage

It is very hard to know what the actual coverage of awareness-raising activities is given that there are no direct indicators for it. However, we can find out the perception citizens have about how much information they have; their assessment of the sources through which the information reaches them, as well as their perception of the risk and the problem of drugs in general.

There are no data on the amount of information the general population has but there are data regarding adolescents attending school. According to the ESTUDES survey of school pupils in compulsory secondary education (E.S.O.) aged between 14 and 18, these secondary school students feel they have sufficient information about drugs and related risks although somewhat less than in 2009 (Fig. 2.3). It is hard to know what the quality of the information received is because the sources are very diverse, both for adults and for adolescents. In the case of adults, their primary source of information is through the media, whereas for the younger generation their main source of information are teachers or their own families (Fig. 2.4; 2.5).

Figure 2.3. Information about drugs among adolescents: percentage of adolescents who feel sufficiently well Informed (OEDA)

Amount of information about drugs among adolescents

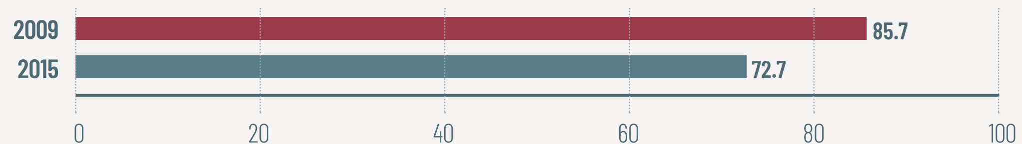


Figure 2.4. Information sources. General population (OEDA 2013) (%)

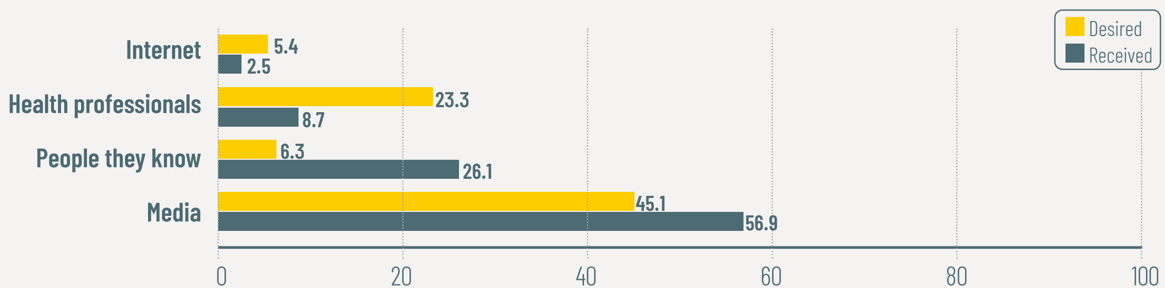
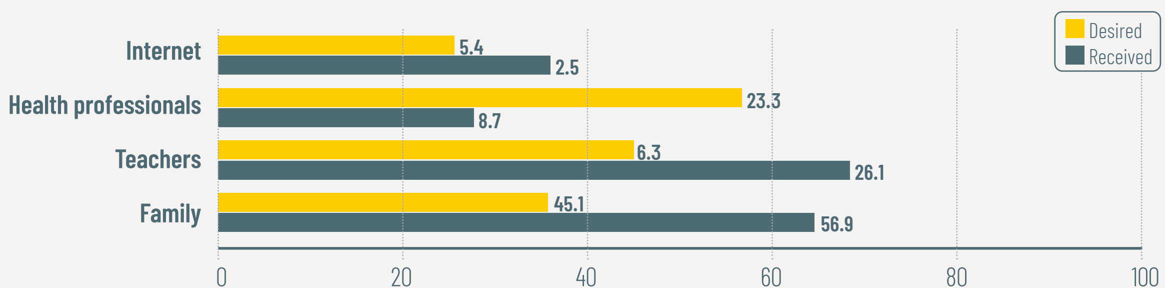


Figure 2.5. Information sources. School pupils (OEDA 2014) (%)



There are certain discrepancies between the sources of information preferred by the population and the actual sources through which they receive information: health professionals seem to be the most credible source for school pupils and yet this is the source through which they receive the least information.

Figure 2.6. Perception of the importance of the drugs problem (OEDA)(%)

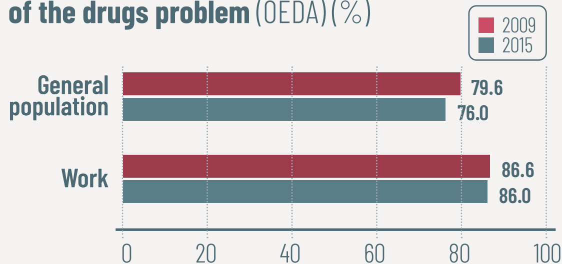
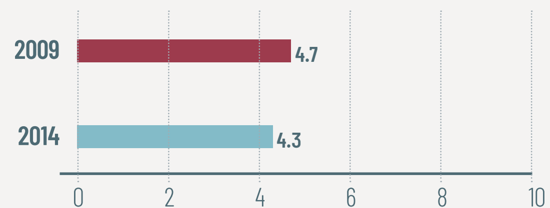


Figure 2.7. Degree of concern of teachers (OEDA)(%)



Although CIS data tell us that the drugs problem is not one of the main issues of concern for Spaniards, according to the DGPNSD surveys drugs are still a major problem for more than 75% of the population (Fig. 2.6.). It is also relatively high on the list of concerns of teachers, scoring 4.3 out of 10 (Fig. 2.7.). Nevertheless, in all cases the concern about drugs has fallen during the roll-out period of the strategy, coinciding too with a trend towards stabilisation of drugs use.

The changes in the perception of risk related to drugs use have levelled off in almost all cases, both among adolescents and in the general population (Fig. 2.8). Nevertheless, one relevant point to be highlighted is the low perception of risk about alcohol consumption and cannabis use among adolescents which despite the upturn recorded since 2009, is still a lot lower than in the case of the general population. As far as the measures to solve the drugs problem are concerned, education is still the preferred proposal; legalisation of cannabis is a measure with a growing level of acceptance, above all among the younger generations. (Fig. 2.10; 2.11).

Figure 2.8. Perception of drug use in the general population

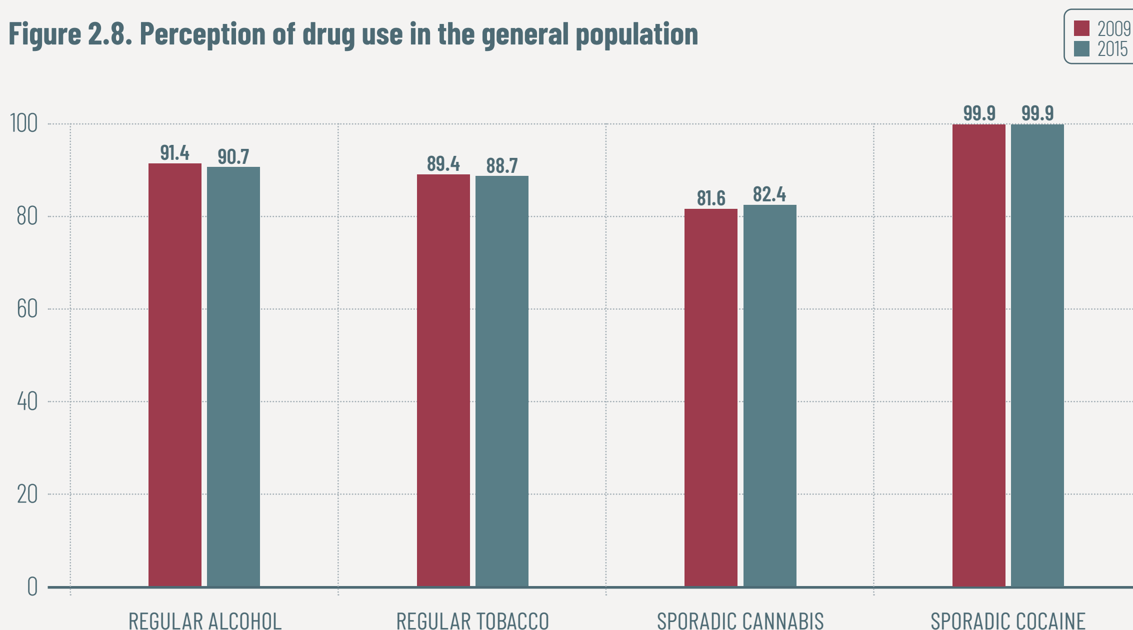


Figure 2.9. Perception of drug use in the adolescent population (OEDA) (%)

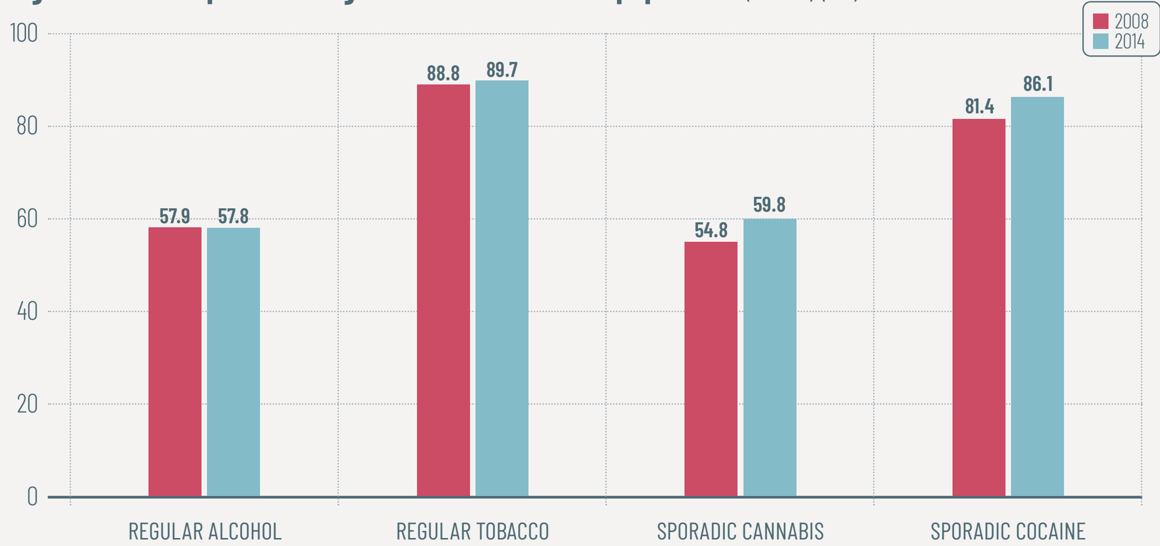


Figure 2.10. Measures to solve the drugs problem in the general population (OEDA) (%)

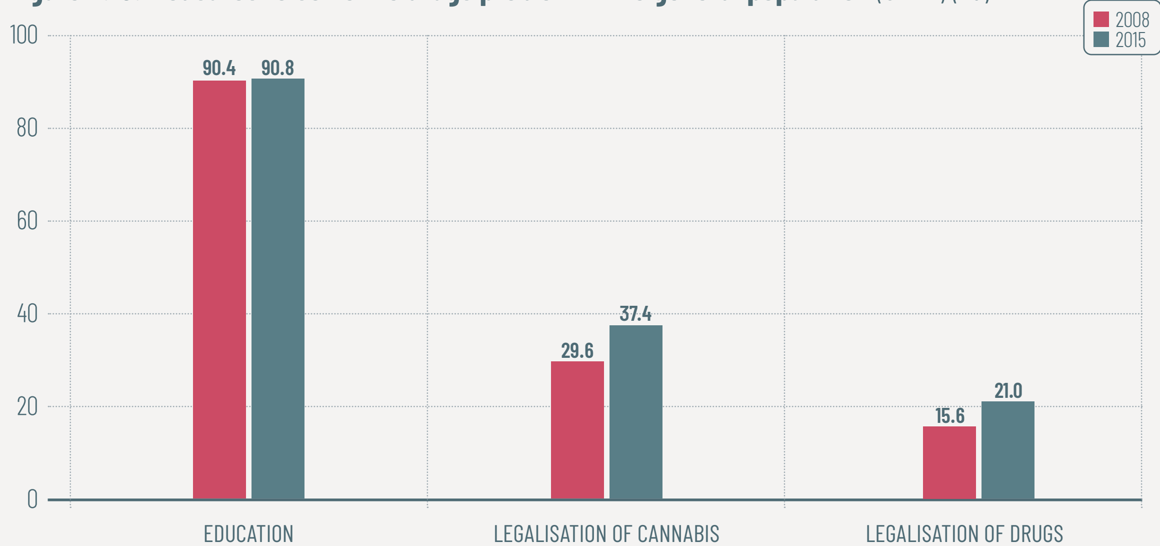
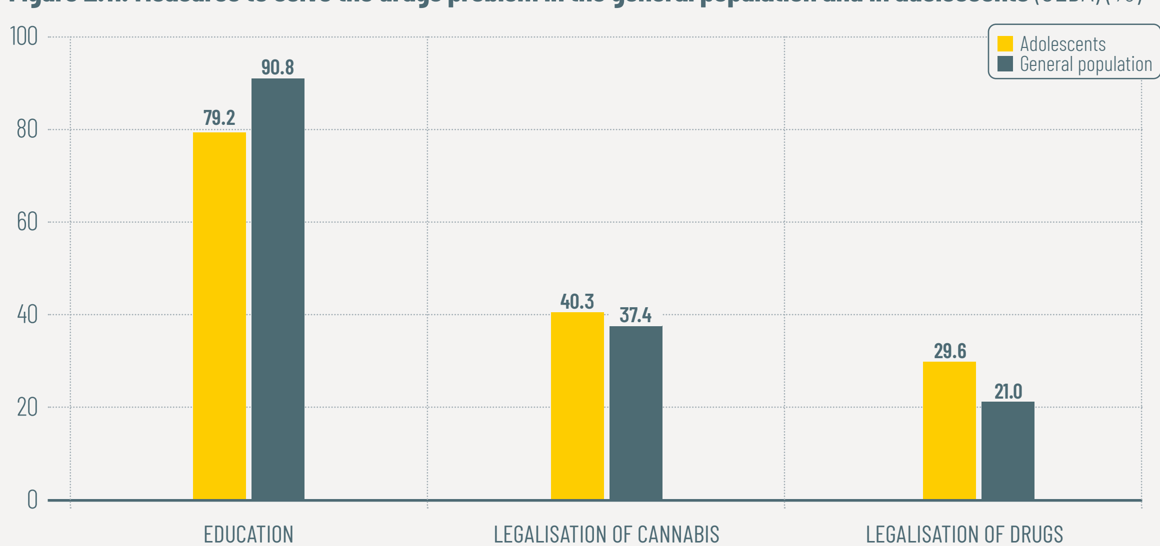


Figure 2.11. Measures to solve the drugs problem in the general population and in adolescents (OEDA) (%)



CONCLUSIONS

All the PADs run awareness-raising activities in schools, on their websites and to a lesser extent through the mainstream media which nevertheless is the main source of information on drugs for the population.

The population at large receives information on drugs through a number of different channels, with different quality standards and levels of credibility.

There is a discrepancy between the informative and awareness-raising activities run by the PADs and the sources of information preferred by adolescent girls and boys: health professionals are their preferred source of information and Internet the least preferred.

There has been an increase in the risk perception in adolescents although it is still low for alcohol consumption and cannabis use and significantly lower than in the general population.

RECOMMENDATIONS

Emphasis must continue to be placed on raising awareness of risks, especially among adolescents, and changing the perception of “normality” about the use of certain substances (alcohol abuse and use of cannabis).

Consensus in the messages conveyed is still a priority. The Action Plan on Drugs 2013-16 Communication Plan could be a platform for such a consensus.

On the basis of the preferences of citizens in general, the role of health professionals as a source of information about the risks related to drug use needs to be enhanced.

GENERAL OBJECTIVE 3:

DEVELOP PERSONAL SKILLS AND ABILITIES

General Objective 3. Develop personal skills and abilities.

One of the objectives proposed by the NDS is to increase personal resilience skills and abilities to resist the drugs on offer and the determining factors of problematic behaviours related to them. To achieve this goal the drug addictions sector implements programmes targeted primarily at adolescents and young people and at mediators who do intervention work with these population groups.

Types of programmes and their territorial coverage

Traditionally these programmes would focus mainly on the school setting but over time they have been extended to encompass many other sectors. Now they cover numerous contexts, strategies and target population groups.

In line with the number of PADs that implement programmes and with their territorial coverage (see score, chart 4. Methodology) we can talk about three categories of programmes (Figure 3.2.):

1. Programmes that seem to make up a **basic portfolio** that is common to all the autonomous regions and with extensive coverages: this group would encompass school, family and community programmes; alternative recreation programmes and programmes for children at risk

2. Programmes that are run in **most regions but not in all of them:** programmes in universities, the work environment and early detection and intervention

3. Programmes that exist in **some regions but not in most of them:** programmes for pregnant women and traffic accident prevention programmes.

Figure 3.1. Autonomous Regions prevention programmes (Source: PADs)

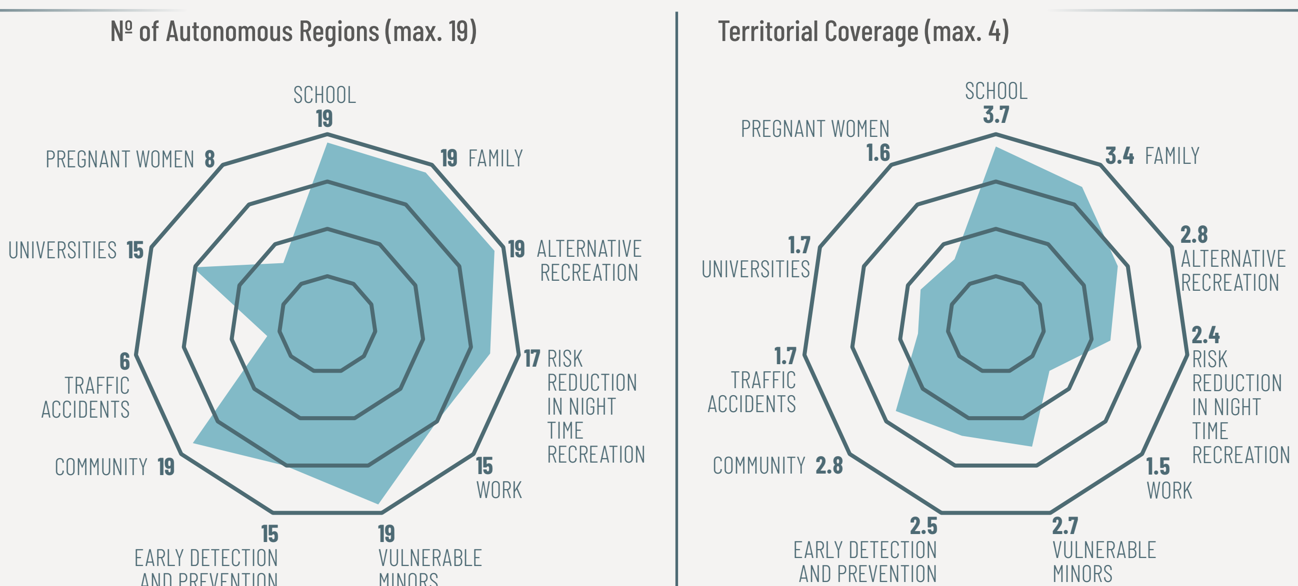
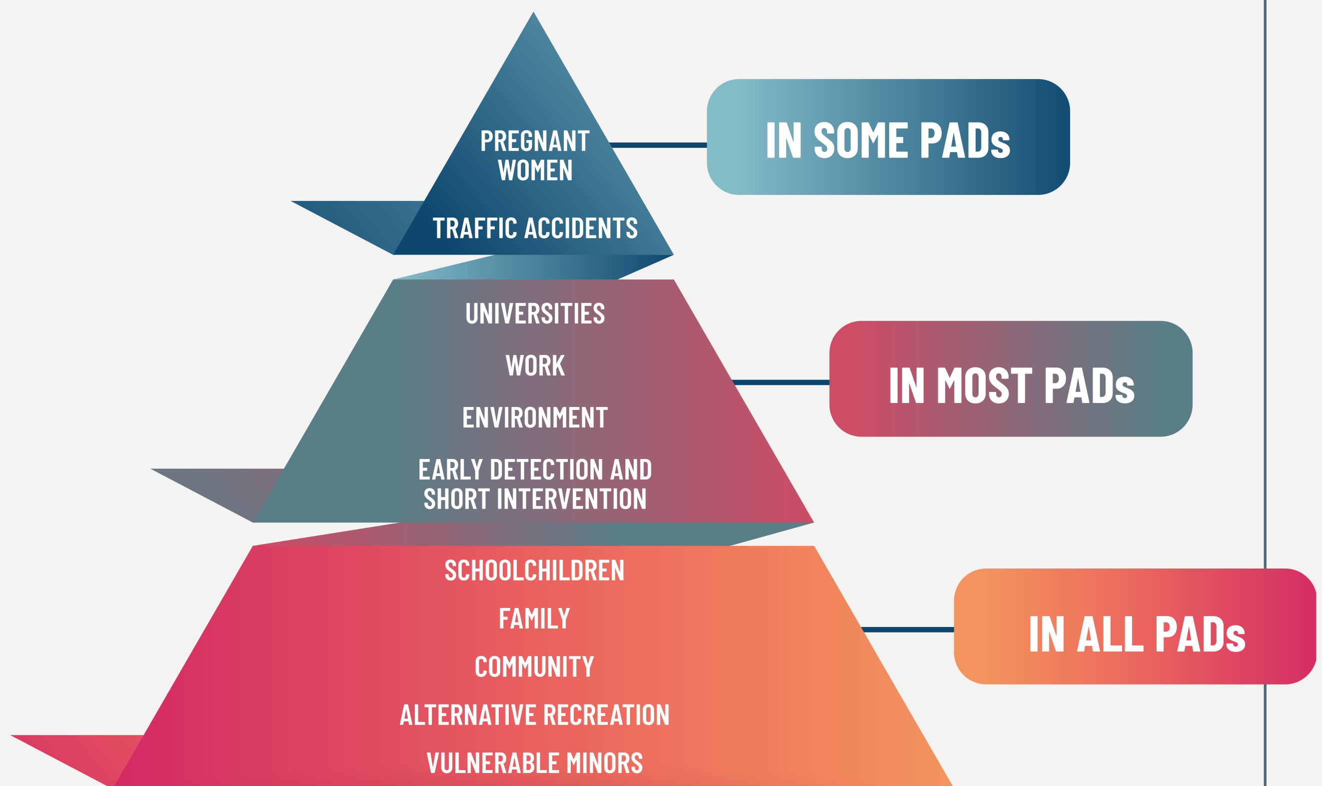


Figure 3.2. Distribution of Autonomous Region prevention programmes. (Source PADs)



According to this classification we can make a distinction between **three types of profiles of PADs:**

- Higher profile: PADs that include more programmes than most or with greater coverages: Catalonia, Castilla y León, Ceuta and Melilla
- Medium profile: PADs with similar coverage and/or types to the national average: Andalusia, Aragón, Bas que Country, Canary Isles, Extremadura, Galicia
- Reduced profile: PADs with less coverage and/or fewer types than the national average: all the other autonomous regions.

The school setting is still the main focus of most of the programmes with actions targeted at pupils and also their families. The priority strategy is education in skills for schoolchildren and training in educational guidance for families.

Population coverage

Two broad categories can be drawn up in line with the population groups covered

- First, high coverage programmes that include universal programmes run in schools and recreational settings (alternative recreation programmes) with coverages of more than 100,000 people nationwide.
- Second, all of the other medium and low coverage programmes, under 100,000 people, such as family programmes, programmes for vulnerable minors (high territorial coverage programmes) and all other programmes.

Figure 3.3. Participants in prevention programmes in Spain 2009-2016.
(Memoria PND, National Drugs Plan report)

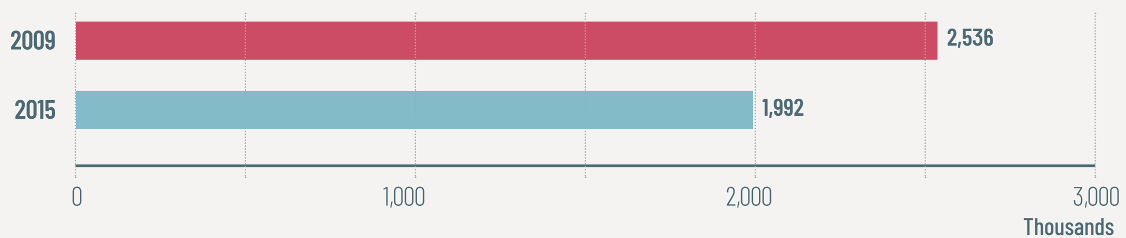
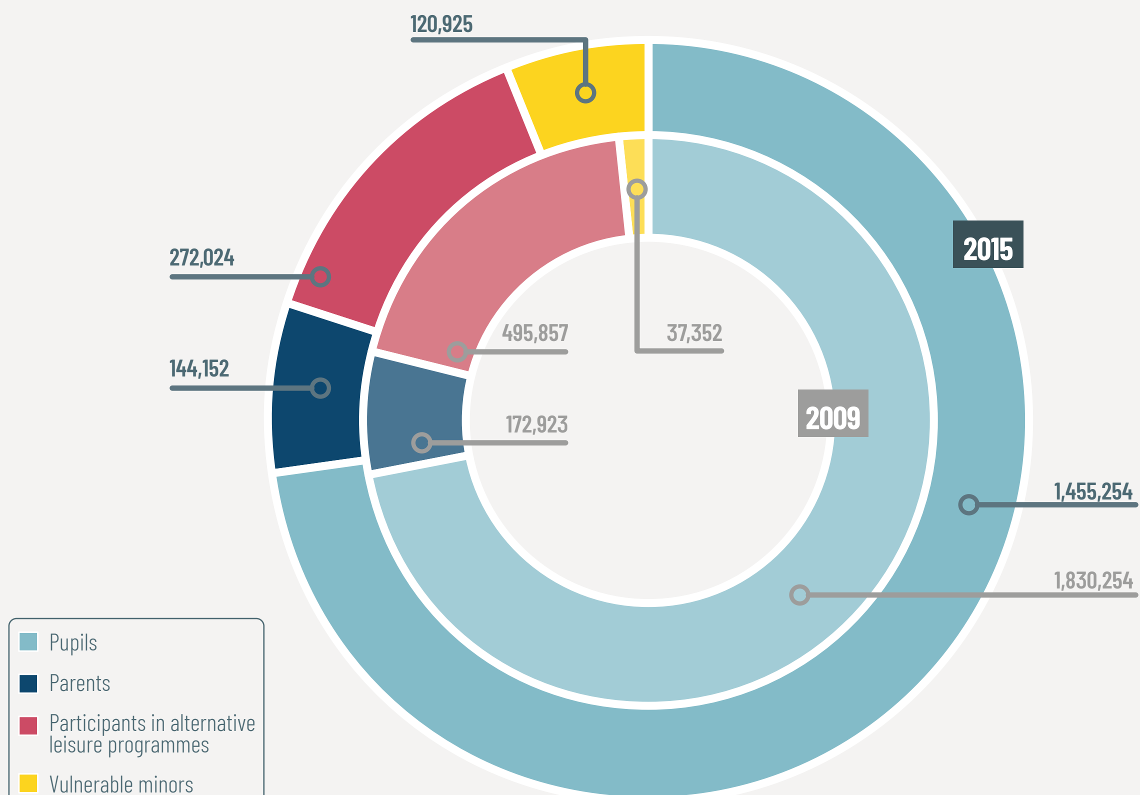


Figure 3.4. Main beneficiaries of prevention programmes in Spain 2009-2015 (Source: Memoria PNSD)

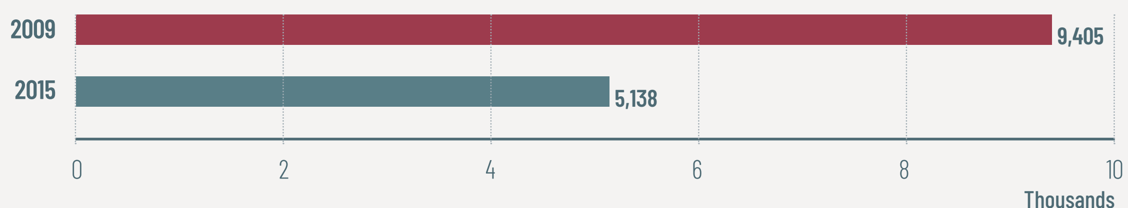


As far as trends are concerned, there has been a fall in the total number of participants in prevention programmes.

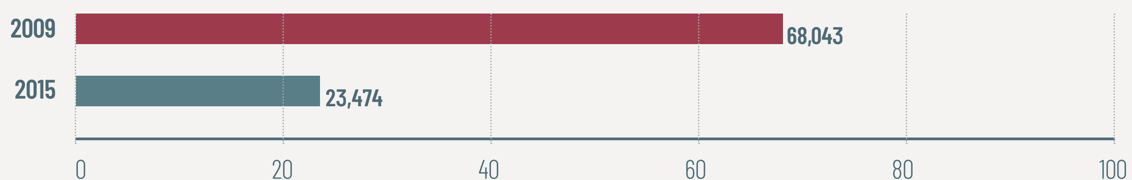
- These falling numbers can be explained by budget cuts in the prevention area (see Fig. 17.3; chapter on Budgets), but might also be caused partly by the decline in the population that particularly affects the age ranges of the potential and main target groups of the programmes: schoolchildren*. Whatever the case, the school population percentage covered by prevention programmes has definitely fallen, from 42.8 % in 2009 to 32.4 % in 2015.
- School programmes are the most widespread programmes and the programmes covering the largest population group although their coverage has fallen significantly.
- In general, there is less prevention work done in the educational environment: the number of participating schools and teachers running the programmes has fallen.
    - Training activities, however, are continuing and on the rise, which seems to indicate that teachers are interested in the topic.

Figure 3.5. Prevention in schools. 2009-2015 (Source: Memoria PND)

1. Schools with prevention programmes



2. Teaching staff who run programmes



3. Teaching staff trained in prevention

* *According to MEC data, the school population in the second cycle of Infants, Primary and ESO fell by 310,000 pupils between 2009-2016.*
https://www.educacionyfp.gob.es/servicios-al-ciudadano/estadisticas/no-universitaria/alumnado/matriculado.html

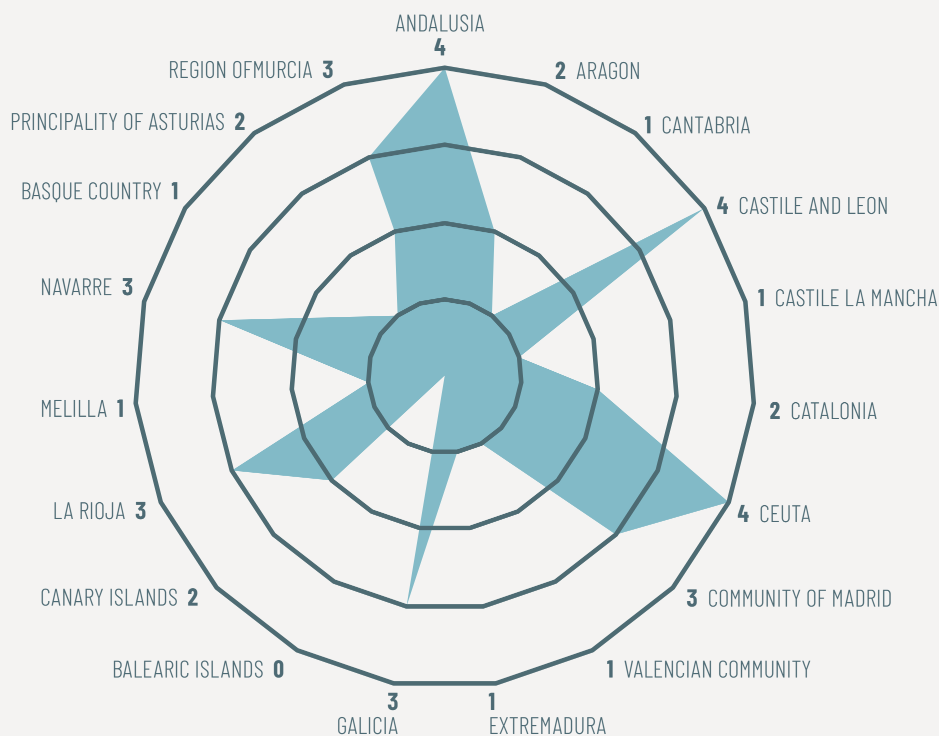
- This interest coincides with the degree of concern about drugs within this group (Fig. 2.7. Social awareness-raising)
- The alternative leisure or recreation programmes which are also rolled out extensively have recorded a fall in coverage.
- In spite of their territorial scope, family programmes have recorded significantly lower, albeit stable, coverage figures.
- The only programmes that have seen notable increases in their coverage are the programmes targeted at vulnerable minors.

Quality

The quality standard in the prevention area is medium: a little over half of the PADs have prevention services portfolios and/or prevention programmes catalogues.

The average accreditation level depending on the scoring scale used matches the following definition: *"There are instruments to evaluate quality criteria but they are not scored on a scale"* although enormous diversity is observed depending on the region in question.

Figure 3.6. Degree of accreditation of Autonomous Regions prevention programmes (PADs)



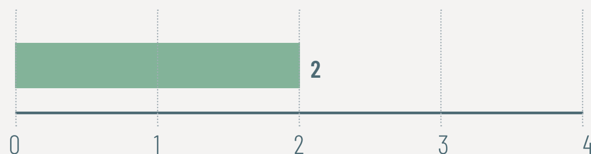
ACCREDITATION (0-4)
0: No criteriaexist.
1: Low: There are quality evaluation criteria and they are published.
2: Medium: There are instruments to rate the criteria but they are not scored on a scale.
3: High: There are instruments to rate them and they are scored on a scale.
4: Total: Programmes and services are accredited in line with quality criteria.

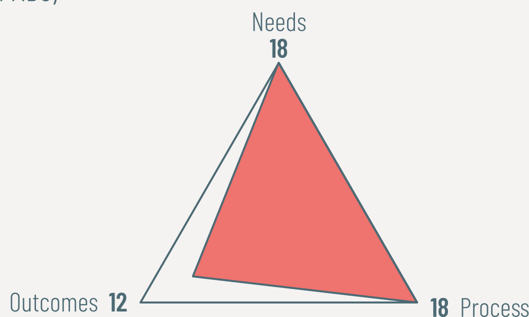
Three of the 19 PADs achieve the maximum score, whereas seven of them scored the minimum. No information has been provided by the Basque Country (País Vasco).

As far as evaluations are concerned, all of the strategies and plans rolled out to date have emphasised the question of the evaluation of programmes. That is probably what has contributed to the progress that has been made, especially when it comes to the evaluation of needs and processes, although more still needs to be done in the evaluation of outcomes.

Figure 3.7. Quality systems in the Autonomous Regions (PADs)

Level of accreditation of programmes





Nº of PADs with:

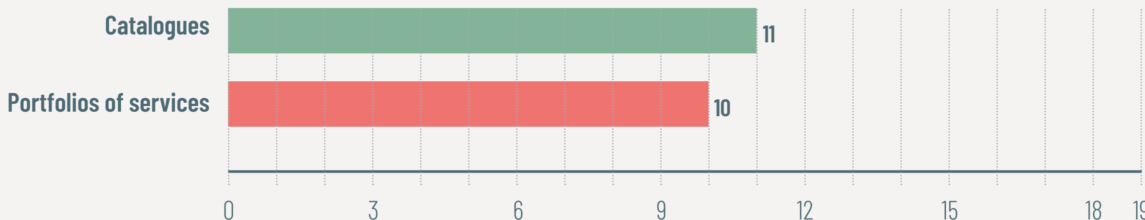
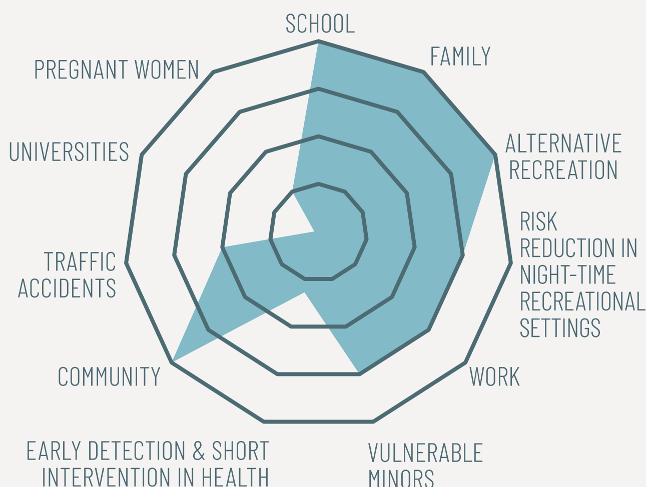
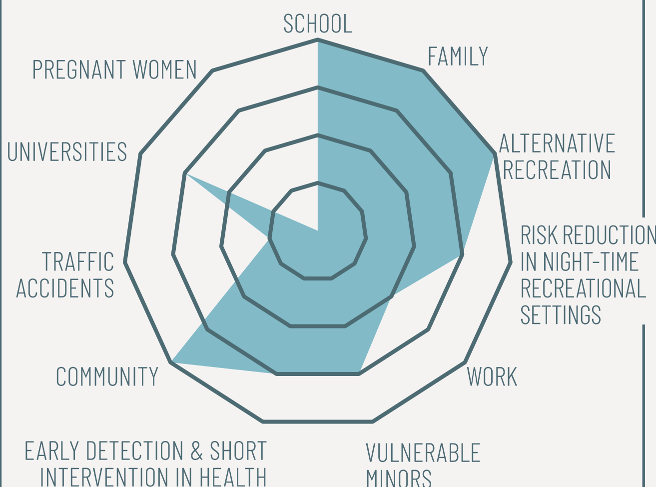


Figure 3.8. Profile of Autonomous Region prevention programmes (Source: PADs)

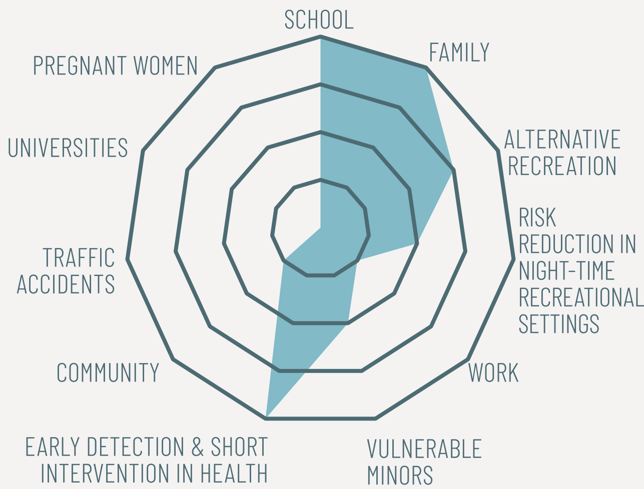
Andalusia



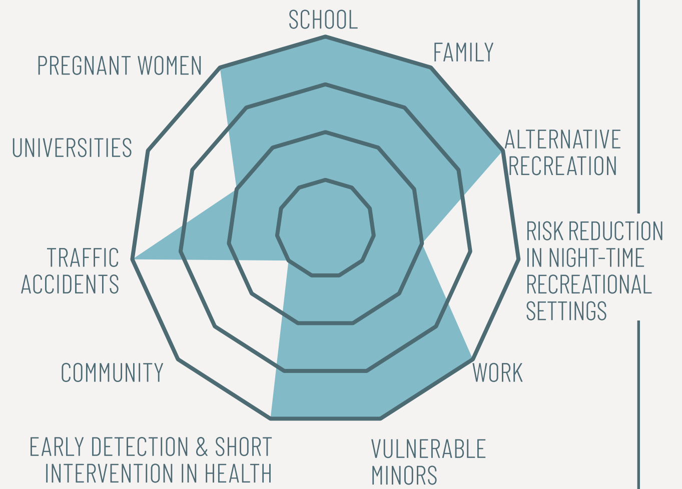
Aragon



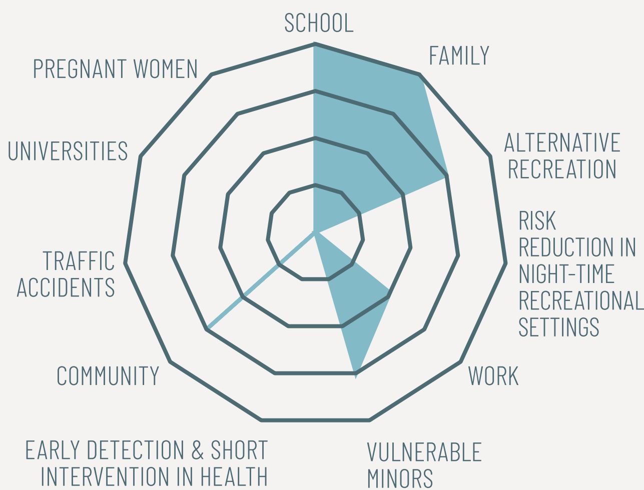
Cantabria



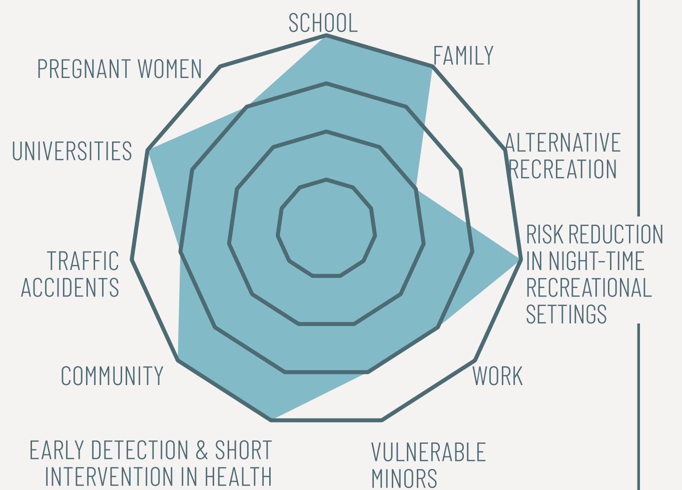
Castile and Leon



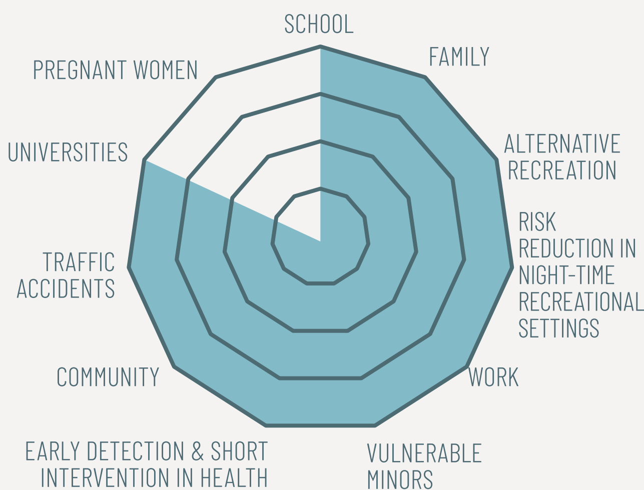
Castile La Mancha



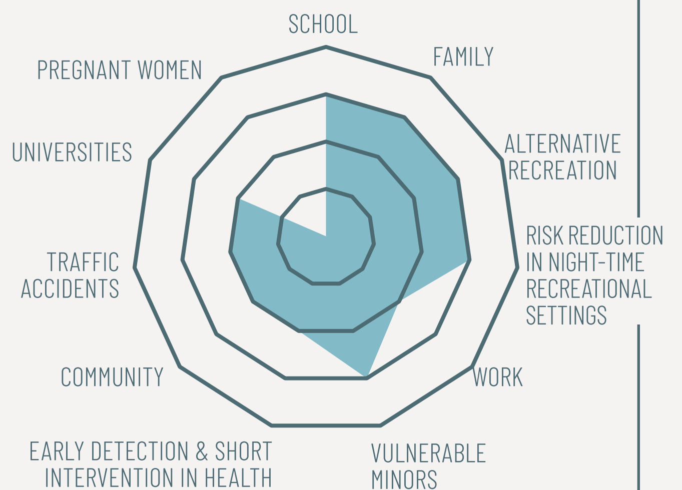
Catalonia



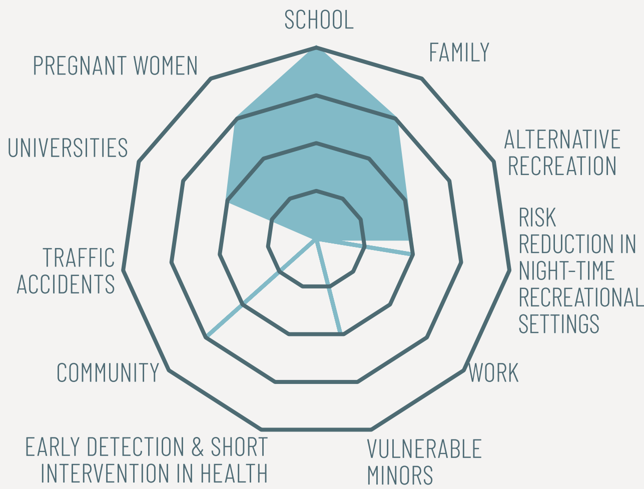
Ceuta



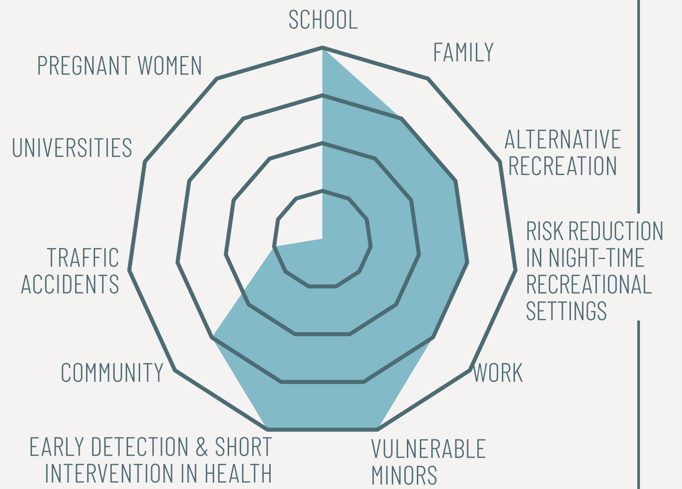
Community of Madrid



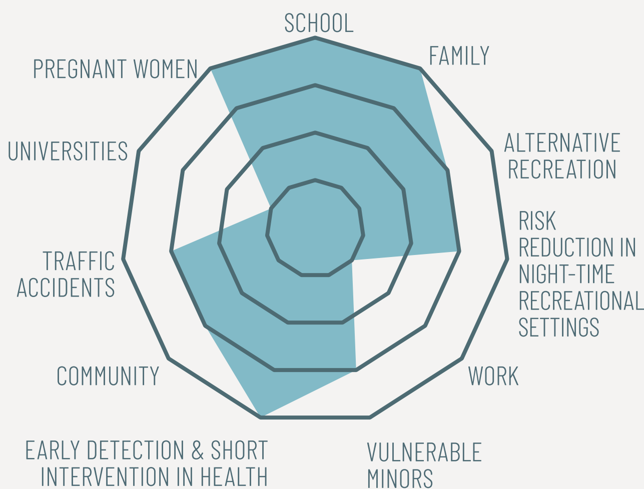
Valencian Community



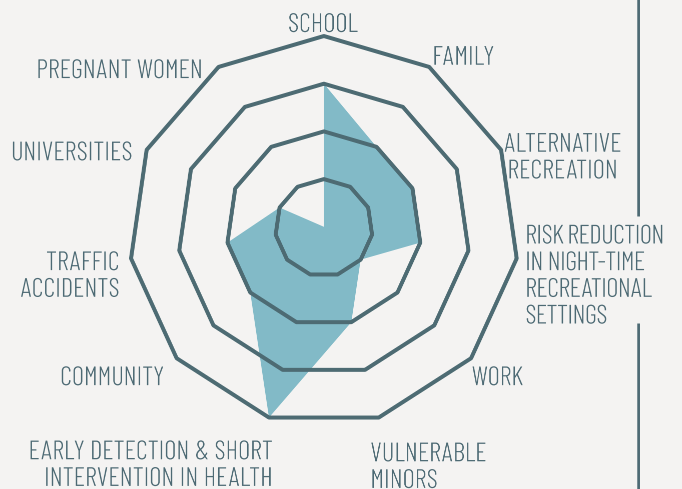
Extremadura



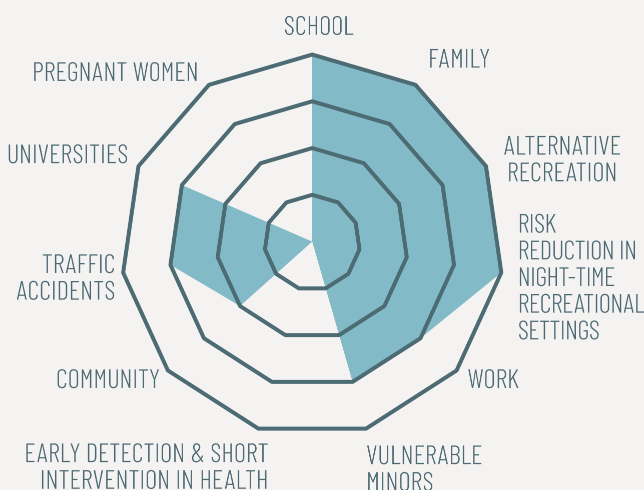
Galicia



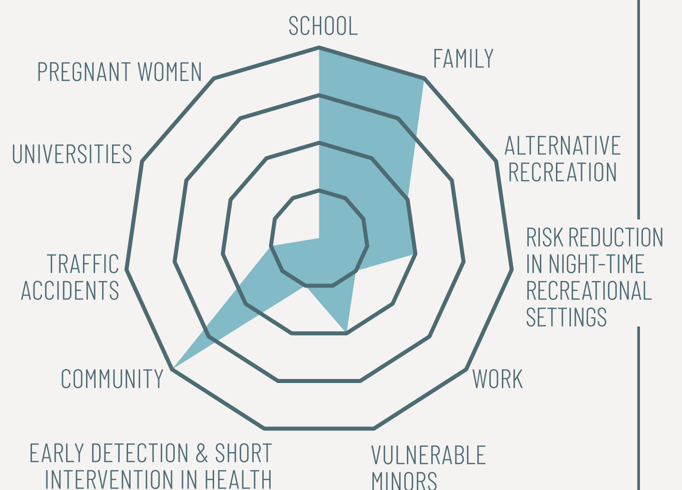
Balearic Islands



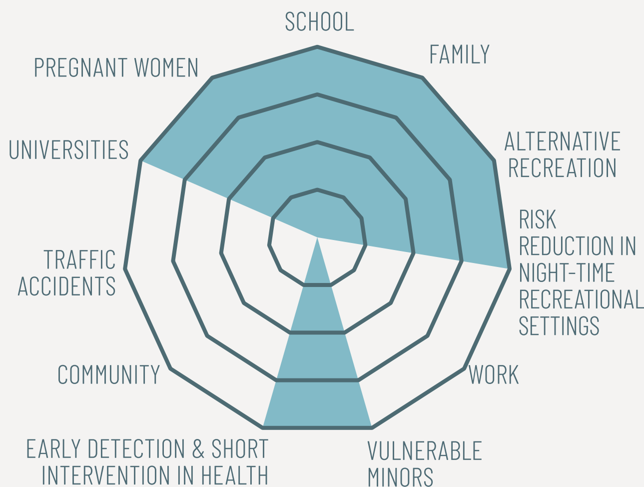
Canary Islands



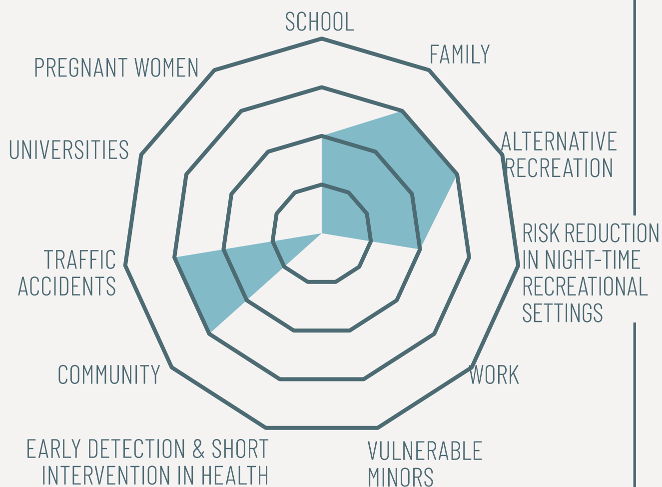
La Rioja



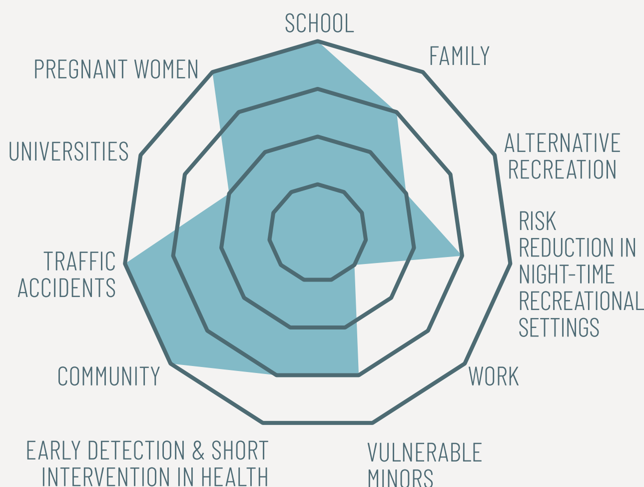
Melilla



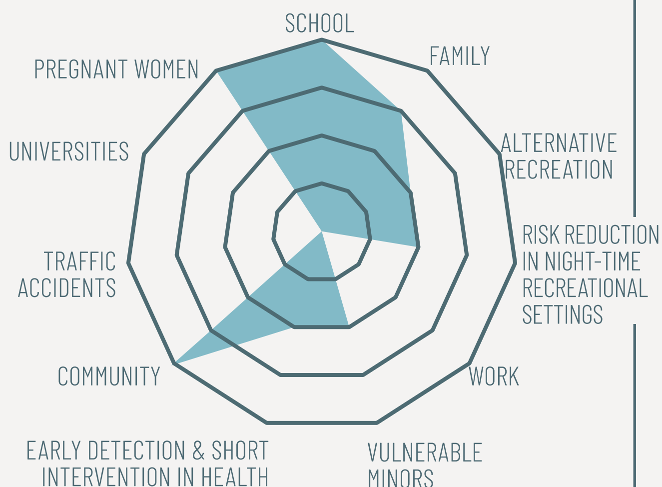
Navarre



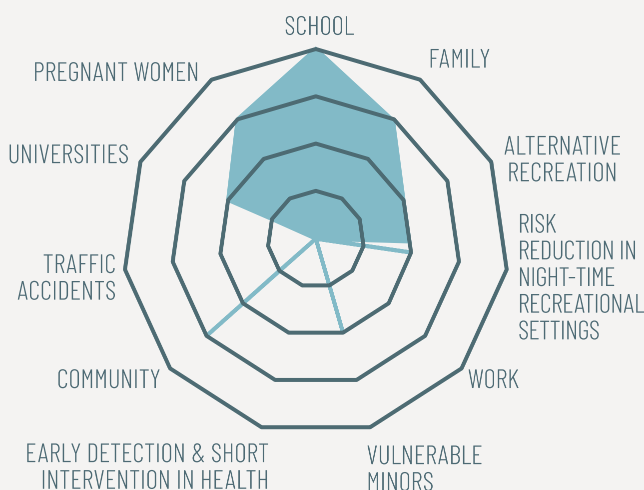
Basque Country



Principality of Asturias



Region of Murcia



CONCLUSIONS

Prevention in Spain is very broad and diverse. The priority strategy is education, especially education targeted at adolescents, with universal school prevention programmes.

During the roll-out period of the Strategy the coverage of prevention programmes has fallen slightly and the target beneficiaries have changed: the number of vulnerable minors participating in programmes has increased and participants in alternative recreation programmes have decreased.

The quality standard of prevention programmes in Spain is medium and half of the Regional Drugs Plans have prevention services portfolios.

RECOMMENDATIONS

Evidence-based interventions (family and environmental prevention) need to be reinforced and more work done in relevant but less developed sectors (health, university).

Accreditation of preventive programmes needs to be improved Quality screening must be ensured for the programmes already implemented.

More standardisation of the programmes on offer nationwide is required.

Selective prevention work with the most vulnerable population groups must continue to be reinforced.

The evidence shows that prevention is cost-efficient. Efforts must be made to guarantee the universal coverage of prevention programmes that are shown to be effective.

GENERAL OBJECTIVE 4:

DELAY THE AGE OF INITIATION

General Objective 4: Delay the age of initiation.

This is the first of the three ultimate objectives of the NDS: a great deal of the work carried out within the framework of the NDP, especially on the prevention side, is all about achieving this objective. The reason why this objective is so important is that the earlier an individual starts to use substances, the more likely it is that the person will develop substance use problems and addiction. In addition, the harms caused by drugs are much more serious when a person is still developing.

The analysis of this objective has made use of direct indicators about the degree of achievement of the objective, and indirect indicators on measurement variables identified in the literature, such as accessibility, perceived availability, the perception of normality and factors pertaining to family supervision.

According to the OEDA, a slight delay in the age of initiation in the use and consumption of tobacco, alcohol and cannabis in the case of adolescents has been achieved, with the biggest delay for tobacco (Fig. 4.1.).

Figure 4.1. Average age of initiation in drugs use in adolescents aged 14-18. (OEDA 2008-2014)

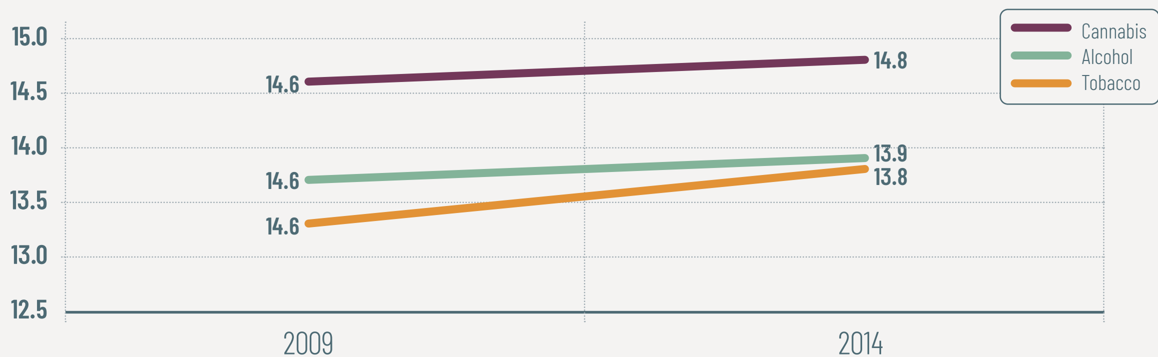
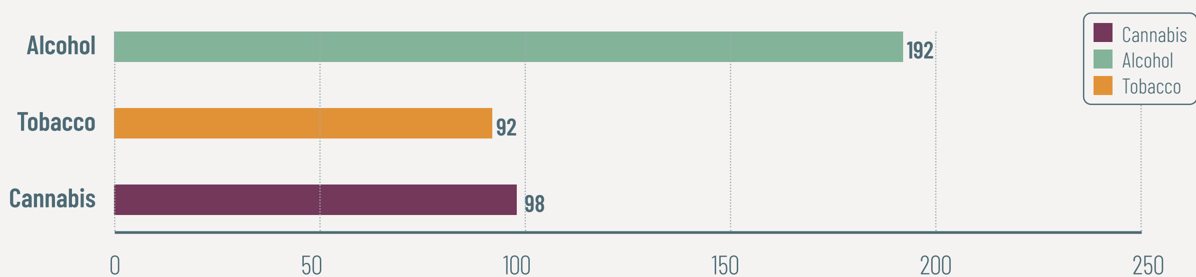


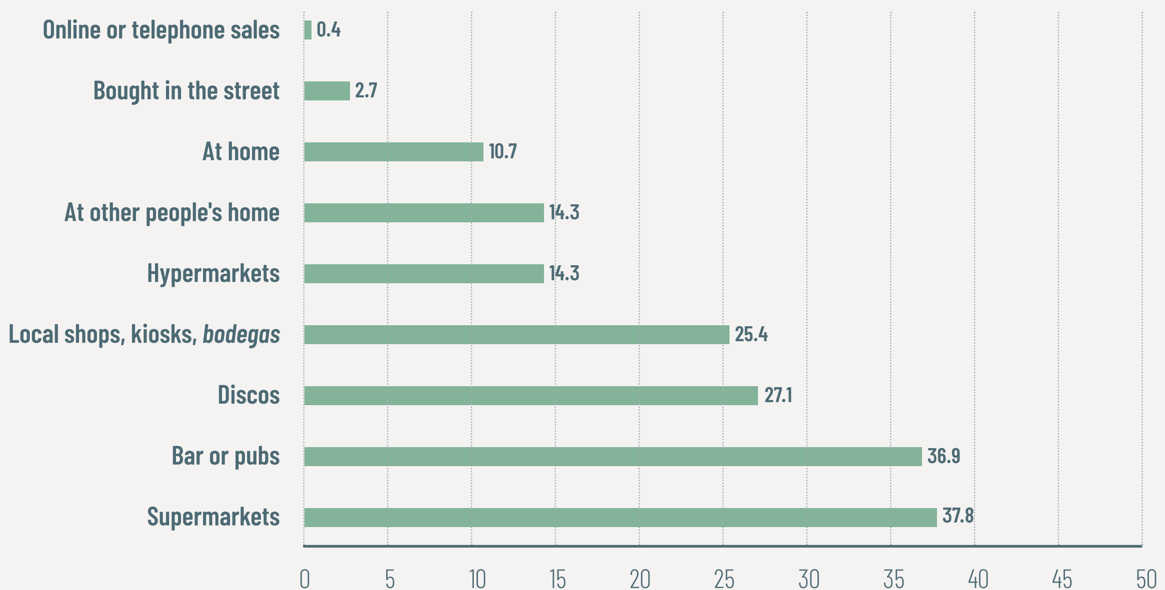
Figure 4.2. Annual incidence rate (per 1000 inhabitants) for drug use among students aged 14-18. (OEDA 2014)



As far as the measurement variables for the age of initiation in substance use are concerned, the following observations can be made:

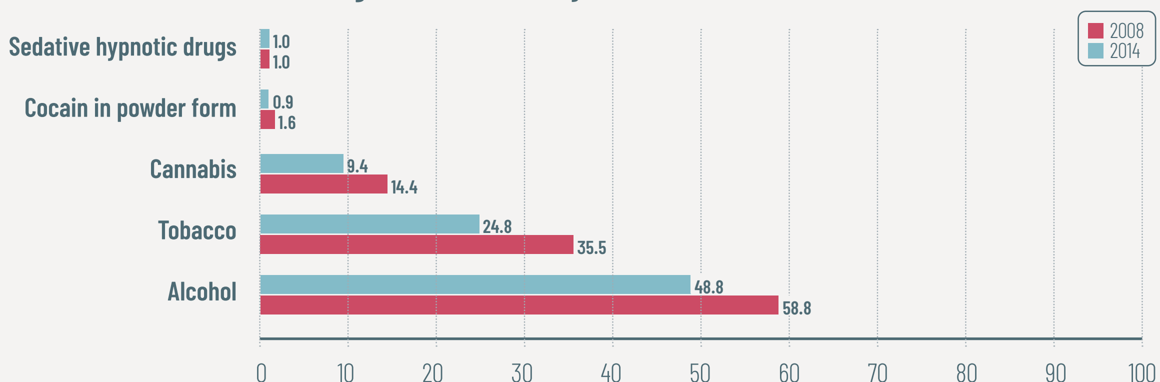
- Alcohol and cannabis are drugs perceived as highly accessible for minors. In the case of alcohol that **accessibility** is almost total, although it has fallen slightly compared to 2008. Minors can get alcohol very easily in shops and daily convenience outlets (Fig. 4.3.). What is striking is that 10% obtain alcohol in their own homes. In the case of cannabis, accessibility is lower but it is still high: adolescents perceive that they can get this drug just as easily as adults. Furthermore, this perception of easy access to cannabis is up compared to 2008 (Fig.4.6).

Figure 4.3. ACCESSIBILITY: Percentage of students aged 14-17 who obtain alcohol in the following places. 2014 (OEDA)



- Using cannabis is perceived as very **"normalised"** (Fig. 4.4.) even though this does not match up to reality as the majority of adolescents have never tried this substance (see Fig. 5.7. Ch. Reducing use).

Fig. 4.4. PERCEPTION OF NORMALITY ABOUT DRUG USE: % of students aged 14-18 believe that most of their friends have used drugs in the last 30 days (OEDA 2008-2014)



- One important fact that reflects the normalisation of cannabis use is its high **visibility** (Fig. 4.5.) both for the general population and for the school population: more than half the population frequently see joints being smoked in the street; this also happens in the case of schools (just under 20% of teachers see cannabis being smoked in the area around the school).

Some mediating factors pertaining to use and the role of parents in prevention have improved:

- Adolescents do not have so much money available for their own personal expenditure (Fig. 4.7.).
- Also, the time by which adolescents have to be home at night at the weekend (a factor particularly linked to substance use) is earlier than in 2009. That seems to indicate better parental control over the variables that are highly linked to substance use. Nevertheless, the majority of adolescents aged 14 go home after midnight. (Fig. 4.8; 4.9.)

All in all: practically all the indicators linked to the age of initiation in the use of substances have improved: adolescents are starting to use drugs later and the contextual and family risk factors have been reduced. It is difficult to know to what extent these changes can be attributed to the endeavours made in prevention or the economic crisis itself that hit during the roll-out period of Strategy and which has an impact on drug use in general.

Figure 4.5. VISIBILITY of drug use: Percentage of the population that frequently see the following types of behaviour (OEDA 2015)

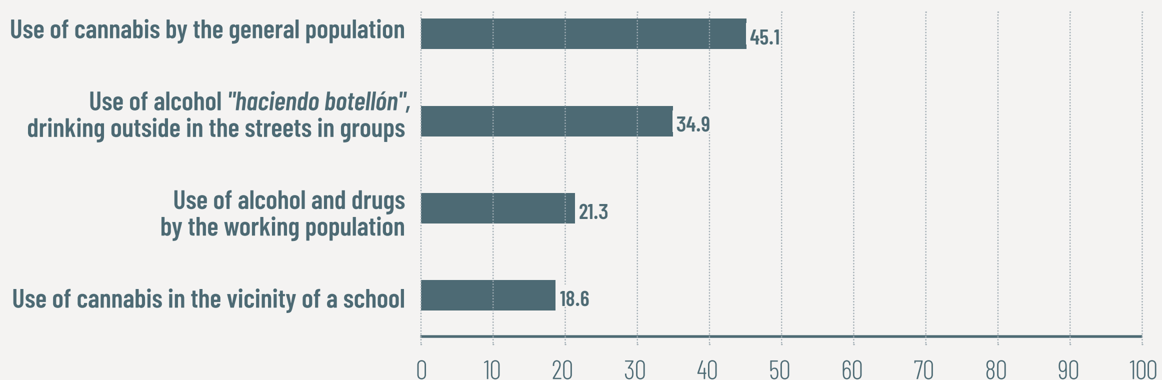


Figure 4.6. PERCEIVED AVAILABILITY: Percentage of people who think it is easy to obtain the following drugs (OEDA 2008-2014)

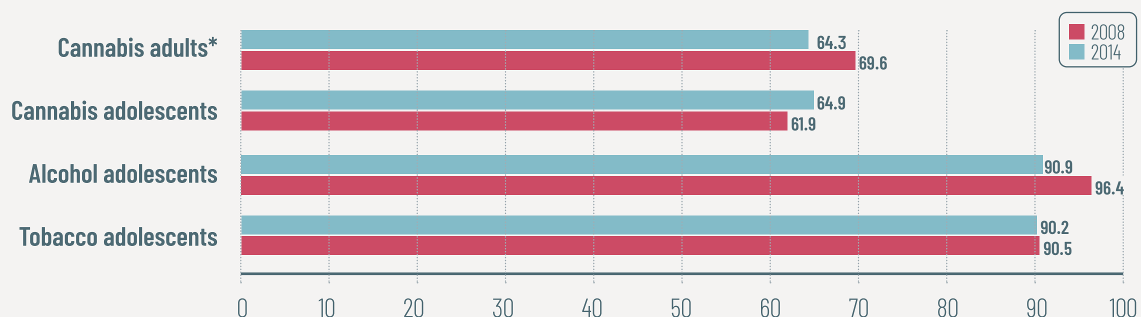


Figure 4.7. Weekly cash available for personal expenses among E.S.O. students aged 14-18 by sex and age (OEDA 2008-2014)

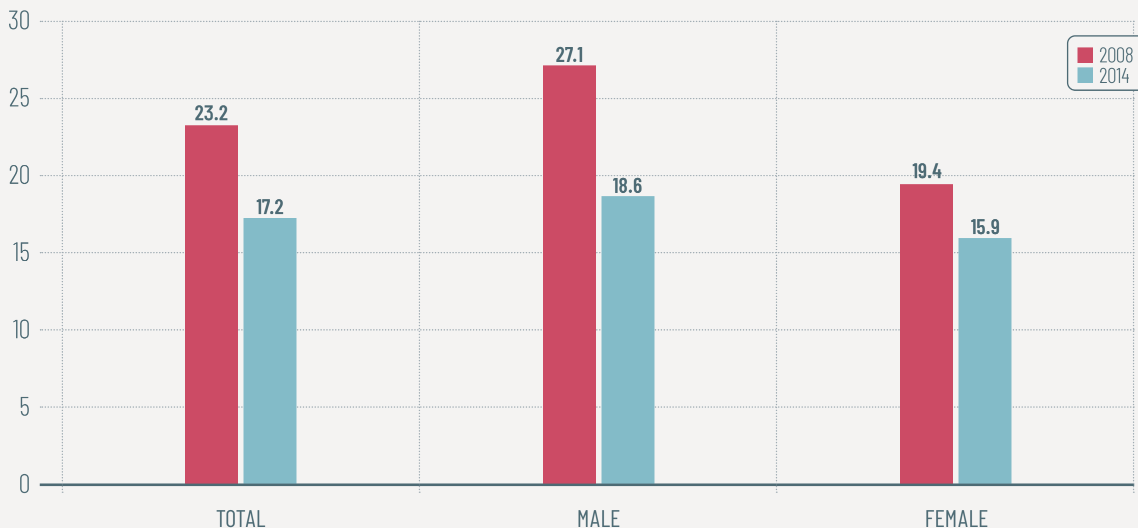


Fig. 4.8. Time 14-year-old students go home at night at the weekend (OEDA 2008-2014) (%)

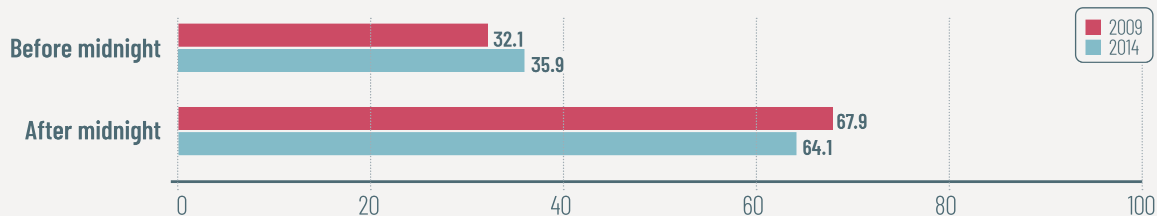
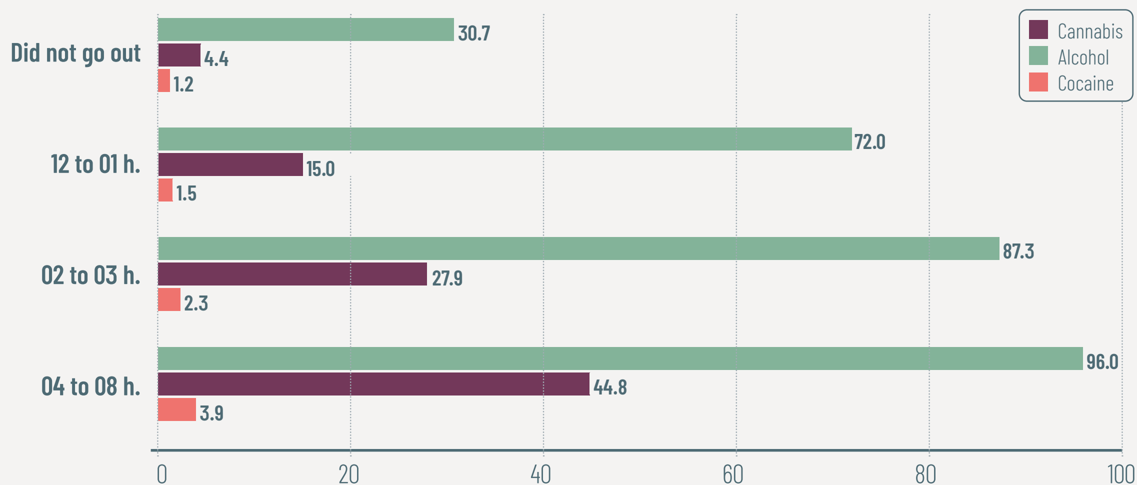


Fig 4.9. % of drug users according to the time they go home at night (OEDA 2014)



CONCLUSIONS

A slight delay in the age of initiation has been achieved. Some of the environmental risk factors have been reduced: drug use is less “normalised” and there is a lower perception of the availability of drugs, except for cannabis.

Cannabis use is perceived as “normalised”, even though this does not match up with reality; in addition, it is perceived to be a highly accessible drug, by adolescents above all.

Adolescents have relatively easy access to alcohol and they obtain it in daily convenience outlets.

Some risk factors pertaining to consumption and to the role of parents in prevention have been reduced: children go home earlier at night and the amount of money they have available to spend is more in line with their age and their real needs.

RECOMMENDATIONS

The objective of delaying the age of initiation has to be maintained because of its relevance in use patterns in life cycles and the consequences of substance use which are more serious the earlier the initiation age.

Social awareness-raising about alcohol use among adolescentes is a prerequisite for effective measures to be put in place to delay the age of initiation and limit access to alcohol by minors in line with existing evidence in environmental prevention.

Similarly, policies and programmes aiming to make cannabis less “normalised” should be continued and reinforced.

Involving adults in use prevention is crucial. Family prevention programmes should be a priority as evidence shows that those programmes are the ones that have the best results.

GENERAL OBJECTIVE 5:

REDUCE USE

General objective 5: Reduce use

This is the second of the three ultimate objectives of the NDS. What this objective seeks to do is on the one hand reduce the number of people using drugs (prevalence and incidence) and, on the other hand, reduce problematic drug use as much as possible.

The available indicators to assess the degree of achievement of this objective are as follows:

a) The development over time of the **prevalence of use and of NON use** of substances in the population at large (general population) and in adolescents.

b) **Incidence of use (number of new consumers in the last year)** in both populations.

c) The development over time of **problematic drug use** patterns in both populations.

As far as the outcomes for this objective are concerned, they are as follows:

a) The development over time of the **prevalence of use and of NON use** of substances in the general population and in adolescents.

- In the **general population, there was a slight reduction in experimental and occasional drug use.** The biggest reduction was for cocaine although in general it can be said that drugs use has stabilised (Fig. 5.1; 5.3).
- There was also a reduction in **experimental use** among **adolescents** and that reduction was significant in the case of cannabis. As regards **occasional use, it has risen significantly** for alcohol and fallen slightly for cannabis (Fig. 5.2; 5.4).

Figure 5.1. Percentage of people aged 15-64 who have used drugs at some time
(OEDA 2009-2015)

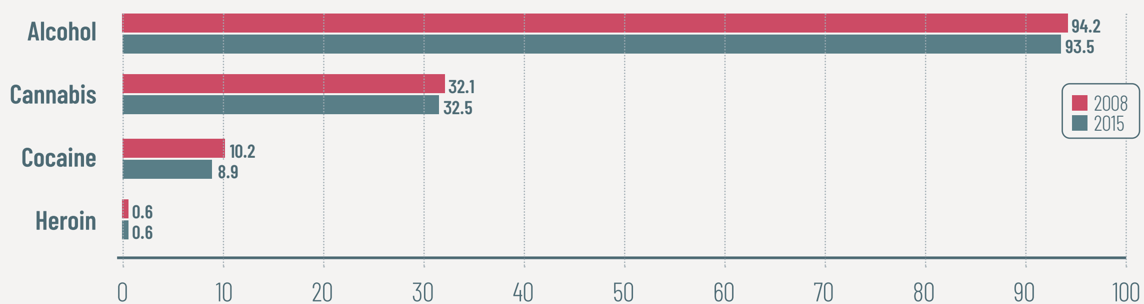


Figure 5.2. Percentage of adolescents who have used drugs at some time
(OEDA 2009-2014)

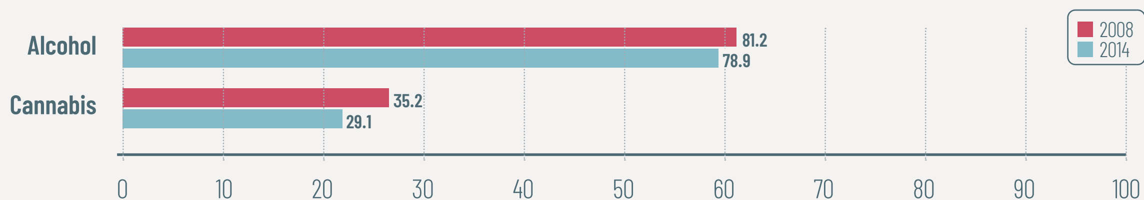


Figure 5.3. Percentage of people aged 15to 64 who have used drugs in the last 30 days (OEDA 2009-2015)

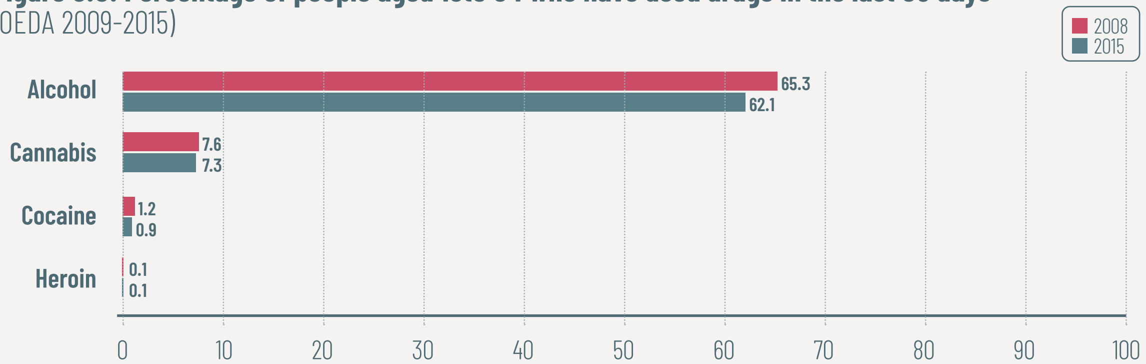
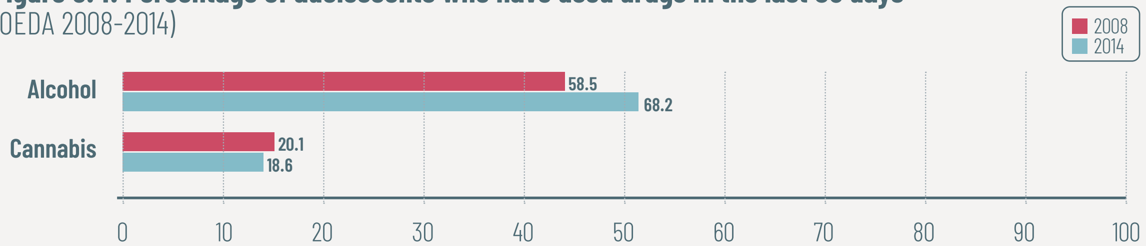


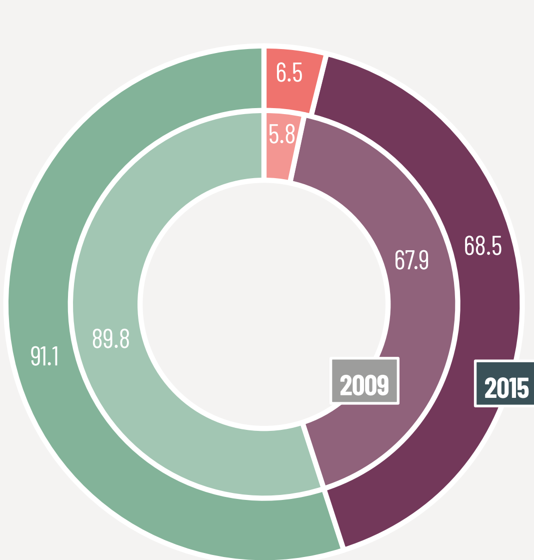
Figure 5.4. Percentage of adolescents who have used drugs in the last 30 days (OEDA 2008-2014)



- The only drug with generalised use in the population, both among adults and adolescents, is alcohol. It is also the drug that causes most harms and costs in society, precisely because of such widespread use. All of the other drugs are used by a minority of the population although their level of use such as in the case of cannabis is significantly high. It should be noted that almost 70% of the population have never tried cannabis, contrary to the perception in society of it being a drug whose use is "normalised" (Fig. 5.7; 5.8.)

Figure 5.7. Percentage of the general population and the adolescent population that do not use drugs (OEDA)

GENERAL POPULATION: NON-USERS



ADOLESCENTS: NON-USERS

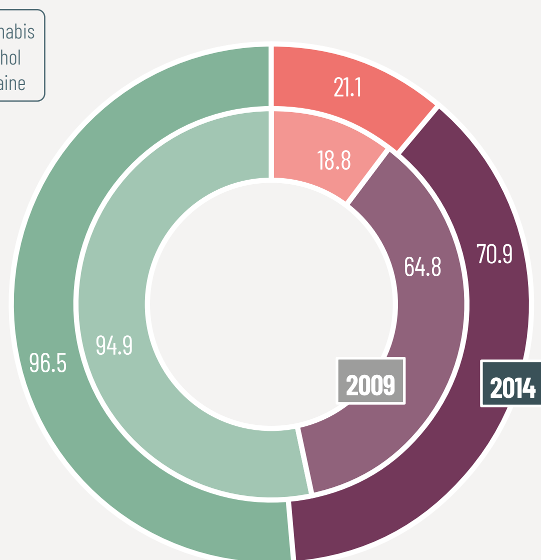
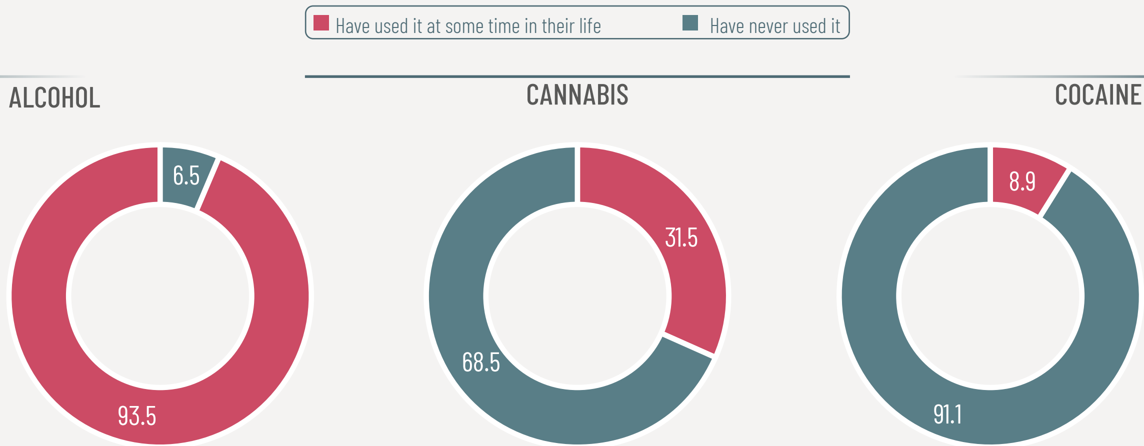


Figure 5.8. Percentage of users and non-users by drug 2015 (OEDA)



b) **Incidence of drug use (number of new consumers in the last year)** in both populations.

This is a relatively new indicator so its performance over the period studied cannot be seen. Furthermore, for alcohol only the figures for the adolescent population are included because alcohol consumption is generalised among adults.

Leaving alcohol aside, tobacco is the substance with the highest incidence of use in the general population, followed by cannabis and cocaine. This is consistent with the prevalence data for each drug (Fig. 5.9.).

As far as any gender differences are concerned, in the general population the incidence is higher in men for cannabis and cocaine with a similar incidence for tobacco (Fig. 5.11.).

Things are different in the adolescent population: for cannabis, the number of adolescents who say they have used it in the last year is very similar to the number of adults and the number of adolescents who have started to use cannabis is higher than the number of adolescents who have started to use tobacco. (Fig. 5.10). In addition, there are big differences between men and women: the incidence of tobacco and alcohol use is higher in women (Fig. 5.11.).

Fig. 5.9. No. Of people who started to use drugs in the last year. General population (OEDA 2015)

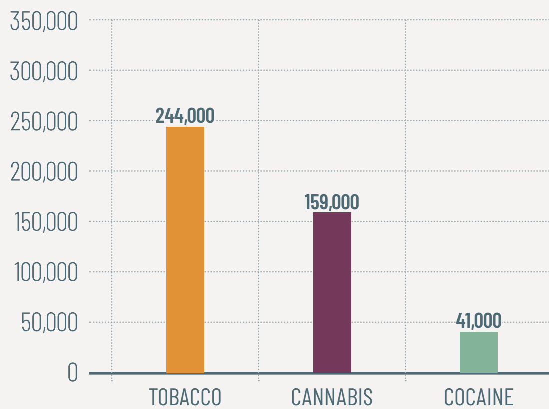


Fig. 5.10. No. of adolescents who have started to use drugs in the last year (OEDA 2014)

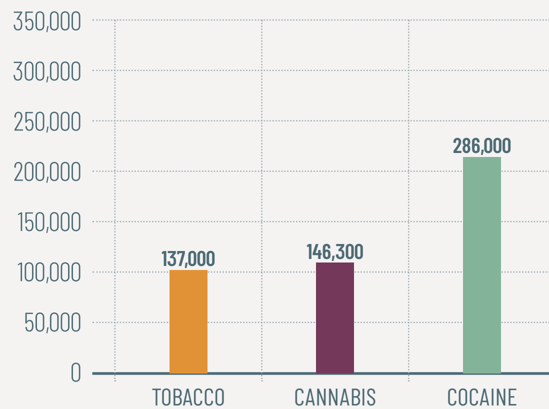


Fig. 5.11. Incidence of drug use in the general population by gender (OEDA 2015)

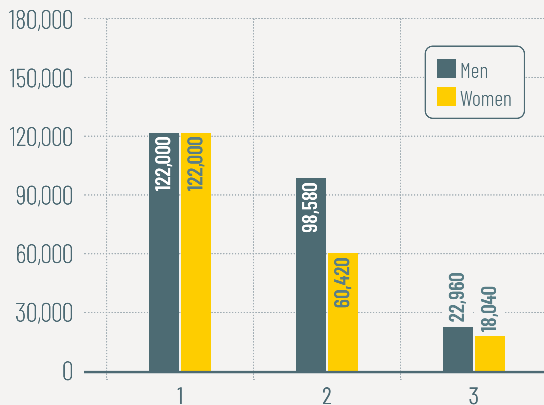
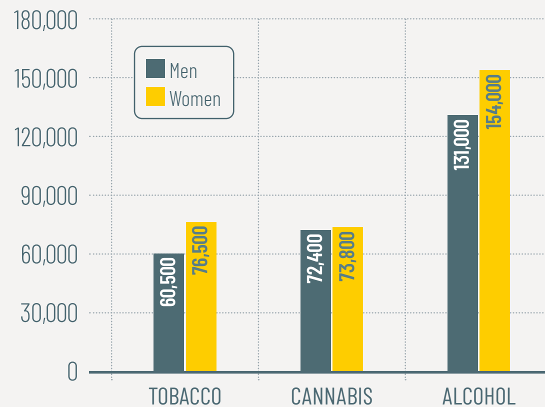


Fig. 5.12. Incidence of drug use among adolescents by gender (OEDA 2014)

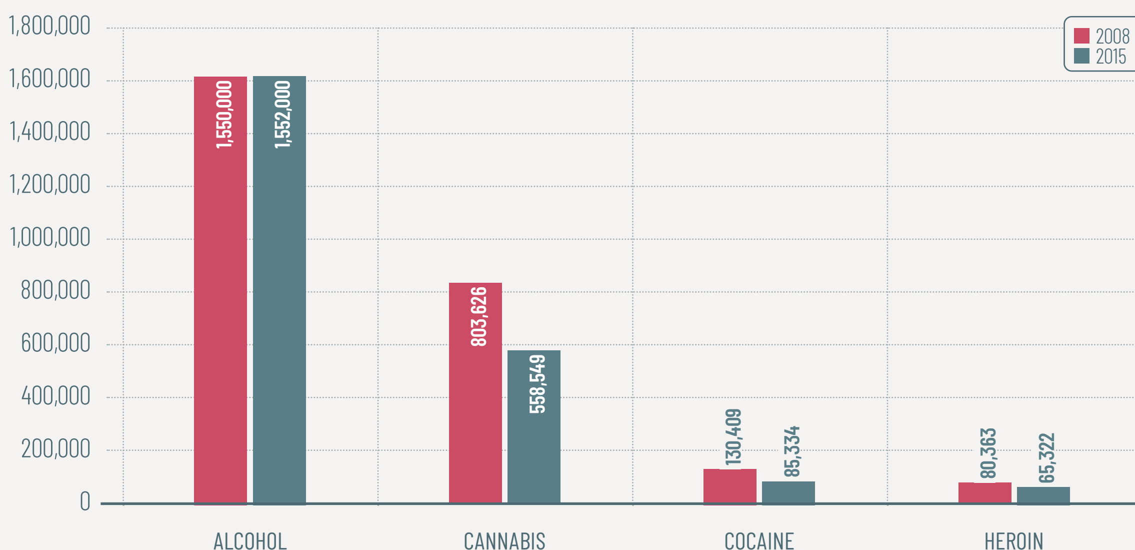


c) Development over time of **problematic use patterns in both populations.**

The problematic use of drugs in Spain has been significantly reduced in the period covered by the NDS for most drugs except alcohol, where problematic use remains the same. According to the NDP surveys, in Spain there are 1,552,000 people aged between 15 and 64 with problematic alcohol use (5% of the Spanish population in that age bracket), 558,549 with problematic cannabis use (1.8 %), 85,334 with problematic cocaine use (0.3%) and 65,322 people with problematic heroin use (0.2 %). (Fig. 5.13).

Problematic use among adolescents has also fallen significantly compared to 2009, although in spite of the improvement some of the data are still a cause for concern. One third of this population still binge-drink and one quarter get drunk at weekends. On the other hand, the figures for cannabis are very positive: the percentage of problematic adolescent users has fallen in line with the reduction in prevalence and the delay in the age of initiation (Fig. 5.15.).

Figure 5.13. Problematic users aged 15-64 2009-2015 (OEDA)



As for the population at large, almost one quarter of the occasional users of cannabis could meet the criteria to be diagnosed as cannabis-dependent, according to the data from the NDP surveys (CASTscale ≥4), as an argument against the alleged harmlessness of this drug. In the case of alcohol, the percentage is much lower, which indicates that there is a moderate usage pattern for this drug. Cocaine is in an intermediate position between the two (Fig. 5.16.).

Figure 5.14. Percentage of the population that binge drink (OEDA 2008-2014)

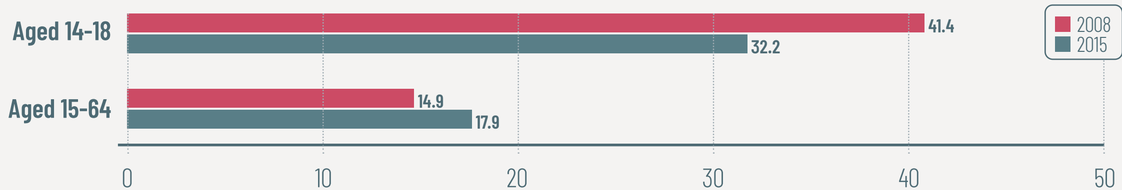


Figure 5.15. Percentage of adolescents with problematic use (OEDA 2008-2014)

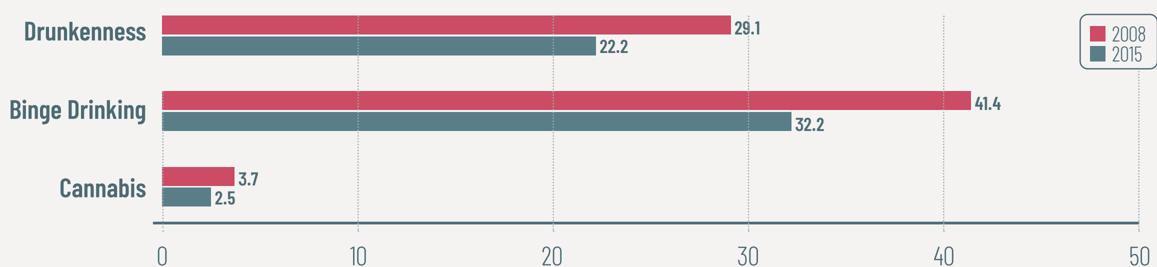
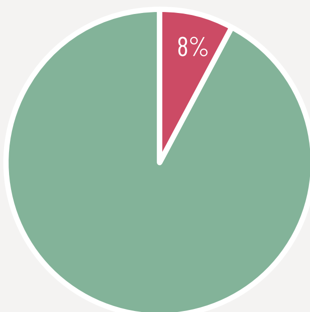
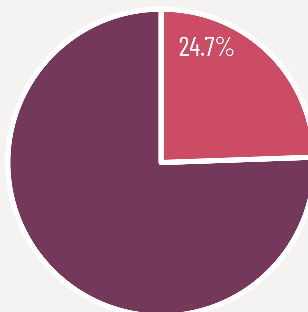


Figure 5.16. Estimated percentage of problematic users in relation to the number of occasional users in the last year 2015 (OEDA)

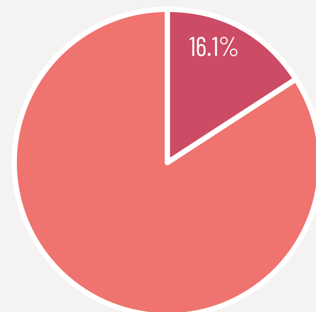
ALCOHOL



CANNABIS



COCAINE



CONCLUSIONS

In the population at large experimental and occasional use of all substances has stabilised, but problematic use has risen. The number of adolescents who drink alcohol and who have problematic use of alcohol has increased. The linkage between alcohol and adolescence is still a big problem.

The number of problematic users of each drug represents a more or less fixed percentage of the number of experimental users for each one. That is why the biggest number corresponds to alcohol, followed by cannabis, which are the most used substances.

Initiation in use is in itself a major risk factor, especially in the case of cannabis, where almost 30% of occasional users develop problematic use patterns.

RECOMMENDATIONS

More emphasis must continue to be placed on detection and early intervention of problematic users. The ideal setting for this type of programmes is the health setting but there are also others: universities or the workplace could be settings where high risk use populations can be contacted or made aware of the problem.

Social awareness-raising about alcohol use among adolescentes is a prerequisite for effective measures to be put in place to delay the age of initiation and limit access to alcohol by minors in line with existing evidence in environmental prevention.

GENERAL OBJECTIVE 6:

REDUCE ASSOCIATED HARMS

General Objective 6: Reduce associated harms

Drug use negatively affects many spheres of personal and social life: it is associated with mortality, morbidity, and impoverished and conflict-stricken lives, it affects people and their families, it causes harm to third parties and huge economic costs for society.

The information available on the costs and harms caused by drugs in our country is partial and limited. On the one hand, the indicators developed do not always have broad and representative coverage of the cases and situations they try to reflect. On the other hand, many aspects highlighted in the international literature do not fall within the system of indicators of this particular evaluation. Nevertheless, we do have sufficient information to enable us to make an approximation of the current status of the situation and to make an assessment of the degree of achievement of the objective.

The indicators that have been used in this evaluation come from a variety of sources and are as follows:

a) Drug-related deaths.

b) Hospital emergencies.

c) Morbidity (infections related to drug use: HIV; HCV).

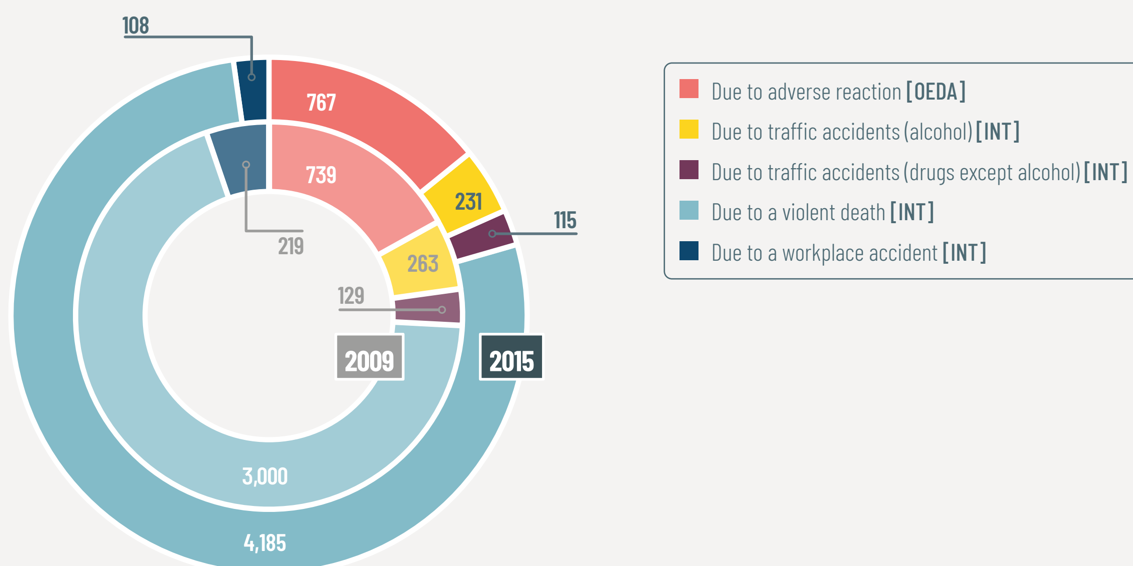
d) Crimes and offences related to drug use and driving.

The results are as follows:

a) Drug-related deaths.

- The number of deaths linked to drug use has increased by almost 1000 cases according to the data from the INT and the OEDA (Fig. 6.1.).

Figure 6.1. Nº of drug-related deaths by cause (2009- 2015)



- Two trends are observed with regard to the causes:
  - o The number of cases of violent death and death due to an adverse reaction to drugs have risen although better information systems may be the cause of that rise.
  - o The number of cases of death due to accidents either at work or driving-related have fallen.
- The higher number of drug-related deaths is linked to violence, followed a long way behind by death due to an adverse reaction.
- In the case of deaths caused by adverse reaction, the increase may be due to better information collection for this indicator. In addition to this, the drug that is still most present in toxicological analyses are opioids and then cocaine. (Fig. 6.2.).

Figure 6.2. Percentage (compared to total deaths) of deaths due to adverse reaction after using psychoactive substances, by drug detected 2009- 2014. (OEDA)

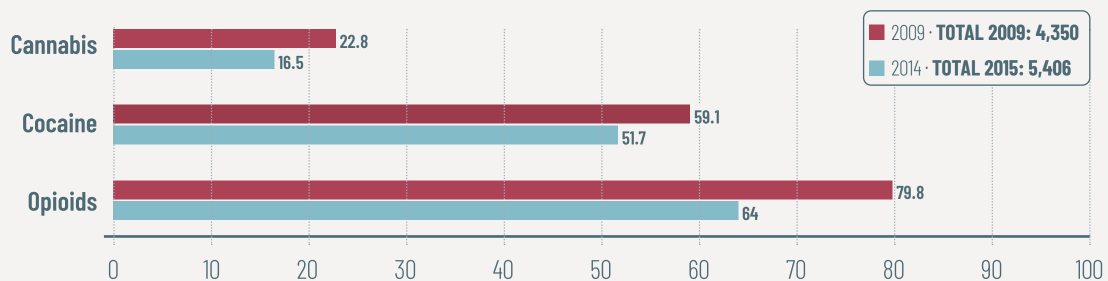


Figure 6.3. Emergency hospital admissions related to illicit drug use 2009-2015. (OEDA)

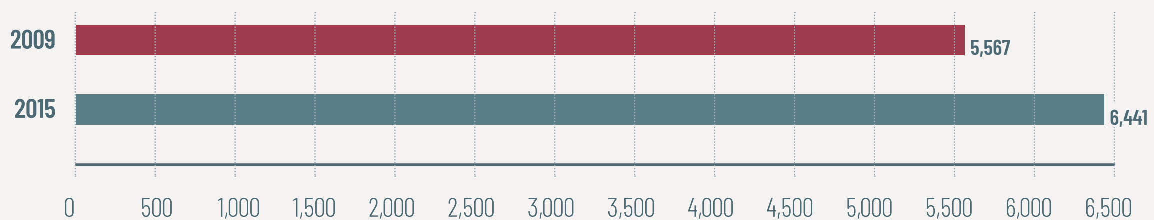
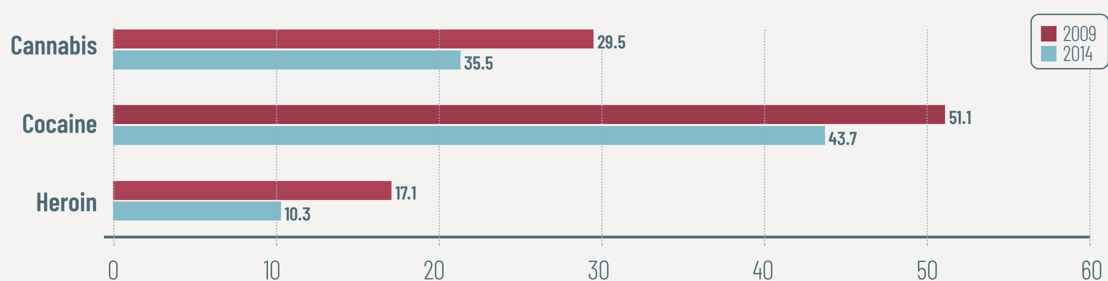


Figure 6.4. Percentage of hospital emergencies related to illicit drugs by drug detected 2009-2014. (OEDA)



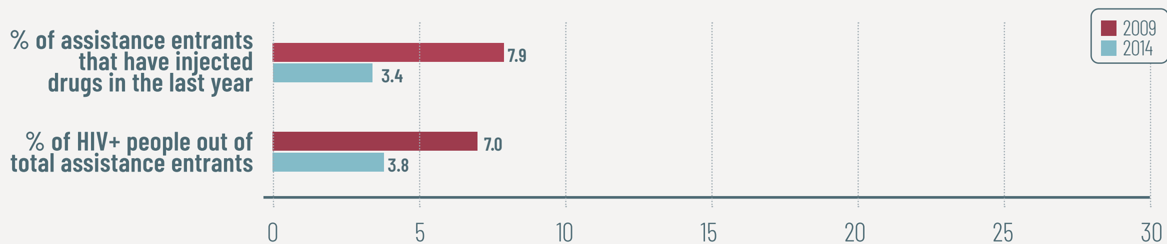
b) Hospital emergencies:

- Hospital emergencies as a result of illicit drug use have risen by almost 1000 cases (Fig. 6.3).
- Cocaine was the substance causing most emergency hospital admissions in 2009 and the situation remains the same in 2015.
- The only substance that has increased its presence in hospital emergencies is cannabis, which represents more than a third of all cases now.

c) Morbidity (infections linked to drug use: HIV; HCV).

There has been a substantial fall in the number of people who are HIV+ among assistance entrants, linked to the reduction in injecting as a form of drug use. This reduction is the result of a great deal of important and widespread work to reduce harms in Spain as we will see in General Objective 7 (Fig.6.5.)

Figure 6.5. Percentage of IDUs* and HIV+ users among assistance entrants for drug misuse or dependence 2009-2014 (OEDA)

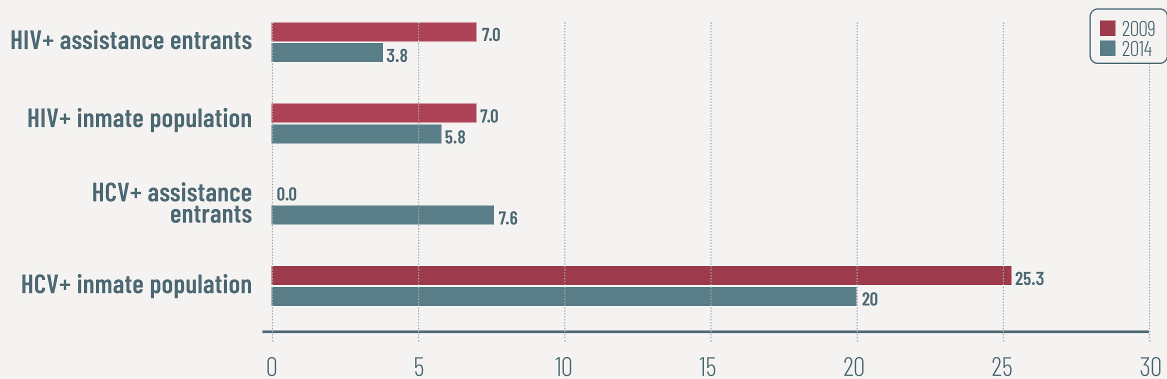


**IDUs: injecting drug users*

HCV+ infections have also decreased but they continue to be a major public health problem to which serious attention must be paid in the years to come. Above all, it is a problem that affects the most vulnerable populations: one, the prison inmate population with a higher prevalence of this illness than the population in assistance in the health network (Fig. 6.6) and, two, those IDUs that do not get in touch with the assistance networks and are more likely to share syringes than users undergoing assistance (Roncero, C. Adicciones 2017).

In addition to these, there are many other health-related harms caused by drugs, above all among long term users and older users. Taking into account the ageing and deteriorating health of a large number of the drug users in the assistance network (the average age of people in assistance for opioid use has risen by over two years in the period 2009-2014), we can assume that the need for health and social services by this population will increase in the years to come.

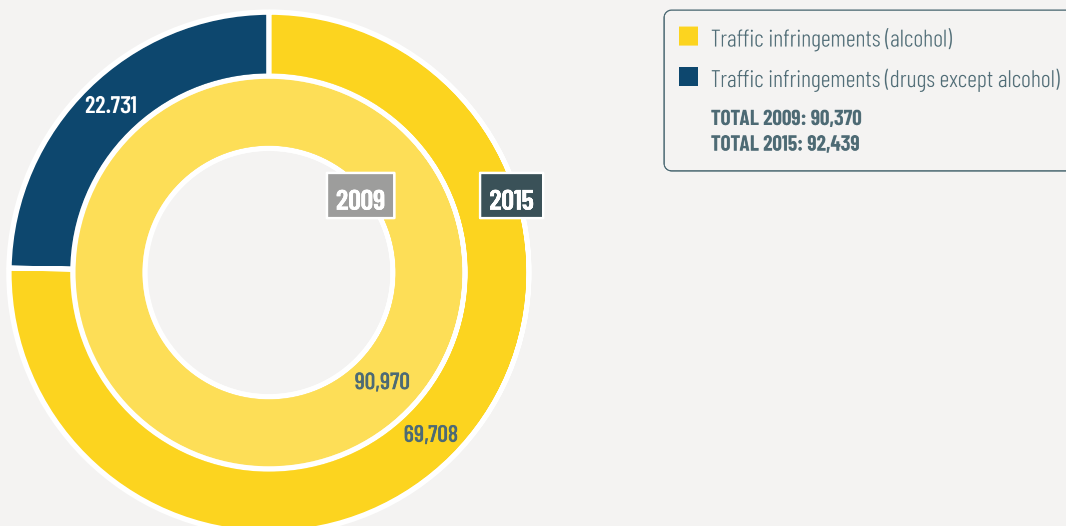
Figure 6.6. Percentage of people with drug-related health problems in prison and the in-assistance population 2009-2014 (OEDA)



d) Offences and crimes related to drug use.

The number of alcohol-related traffic infringements has been substantially reduced. However, illicit drugs are increasingly present in driving: first, road safety offences have increased five-fold and, second, for infringements, although there are no comparative data yet because these kinds of controls are more recent, there is a substantial volume of cases (Fig. 6.7.).

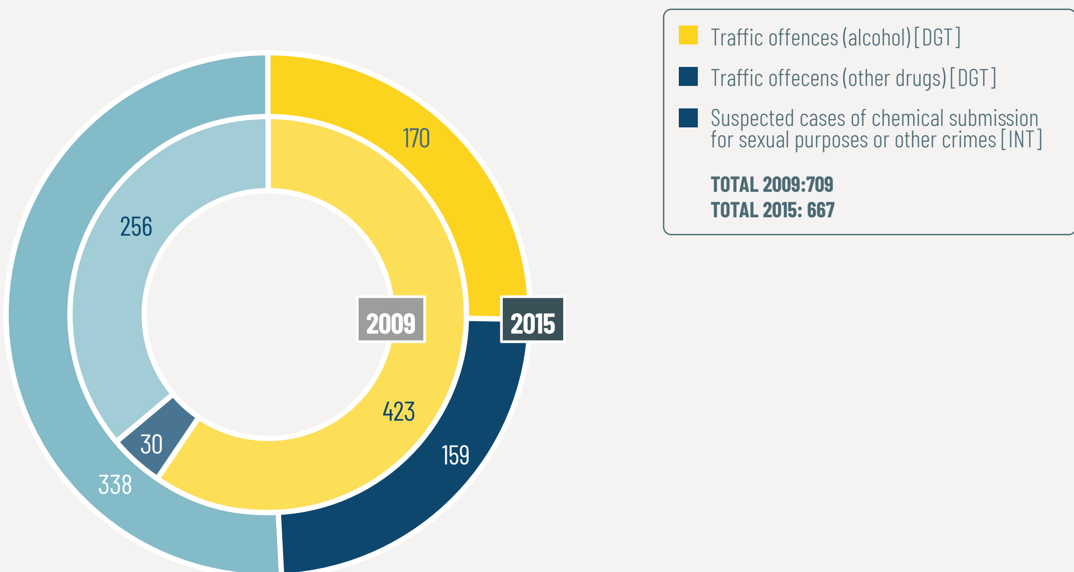
Figure 6.7. Traffic infringements due to drug use 2009-2015 (DGT)



As far as drug-related offences are concerned, according to the INT data in the last year the main cause was because of the suspicion of the use of chemical substances for sexual purposes or to commit other crimes. Moreover, these cases have increased since 2009 and deserve more attention in the future (Fig.6.8.).

All in all, despite the importance of the data above we can affirm that the risks and harms associated with drug use are underassessed. Better indicators are therefore required to provide a more accurate and complete picture of this matter and one that also takes into account the harms to the individuals themselves and to others.

Fig. 6.8. Drug-related offences (INT-DGT)



CONCLUSIONS

An increase in drugs-related deaths has been observed. Violence is the number one cause of death, followed by adverse reactions after taking drugs.

The number of emergency hospital admission cases has risen, for cannabis-related emergencies above all.

The number of traffic offences related to alcohol use has fallen but the influence of the use of other drugs in driving has been recorded since this type of controls have been made.

The harms related to drugs use are underassessed because the information systems do not collect all of the information in this regard (deaths, associated illnesses, health emergencies, school track records, performance at work …).

RECOMMENDATIONS

Harm reduction programmes should continue to play a key role in the framework of integrated assistance.

More attention needs to be paid to the harms caused to others, especially harms related to road safety (traffic) and violence.

The population must be made more aware of the risks entailed by driving under the influence of other drugs as well as alcohol.

Better information collection is required on substance use-related harms in order to have a more complete picture of the situation.

GENERAL OBJECTIVE 7:

QUALITY ASSISTANCE

General Objective 7: Quality assistance

The NDS aims to guarantee quality assistance tailored to the needs of all those people affected directly or indirectly by drug use. Spain has a broad, diversified and highly accessible network that has been adapted over time to match changes in the drugs phenomenon.

In this chapter we will include both assistance resources and programmes as well as programmes and resources designed to reduce harms.

A) ASSISTANCE PROGRAMMES

Types of programmes and their territorial coverage

In Spain there is a wide-ranging network of resources and programmes with a diversified, consolidated offering to treat drug addictions, and with highly qualified professionals. However, although there is a basic consensus about the services to offer in the different Autonomous Regions, the functioning, reporting and management, information systems, health care and referral circuits, services offered, intervention and/or evaluation resources and methodologies −especially in specific programmes and itineraries− are highly diverse. This can lead to disparities in the equity and accessibility of assistance.

According to the evaluation data, assistance is the most homogeneous area for all the Autonomous Regions although some relevant differences are observed (Fig. 7.1.):

- As in Prevention, it can be said that there is a basic portfolio with the following programmes: detoxification, withdrawal, relapse prevention and methadone programmes. These programmes exist in all the Autonomous Regions and have high coverage.
- Programmes that exist in most Autonomous Regions but not in all, with less territorial coverage at a regional level: post-discharge follow-up and buprenorphine/naloxone.
- Programmes that either do not exist in most of the Autonomous Regions or programmes with more reduced coverage than the ones above: programmes for minors, pathological gaming, social exclusion, young offenders, women's courts/police stations, in that order.

Seven Autonomous Regions have a broader than average variety of programmes and eleven have a more limited range of programmes. In the case of coverages, only three have less than average coverage and six have more than average coverage (see scale chart 4 Methodology).

Figure 7.1. Distribution of treatment programmes ARs (Source: PADs)

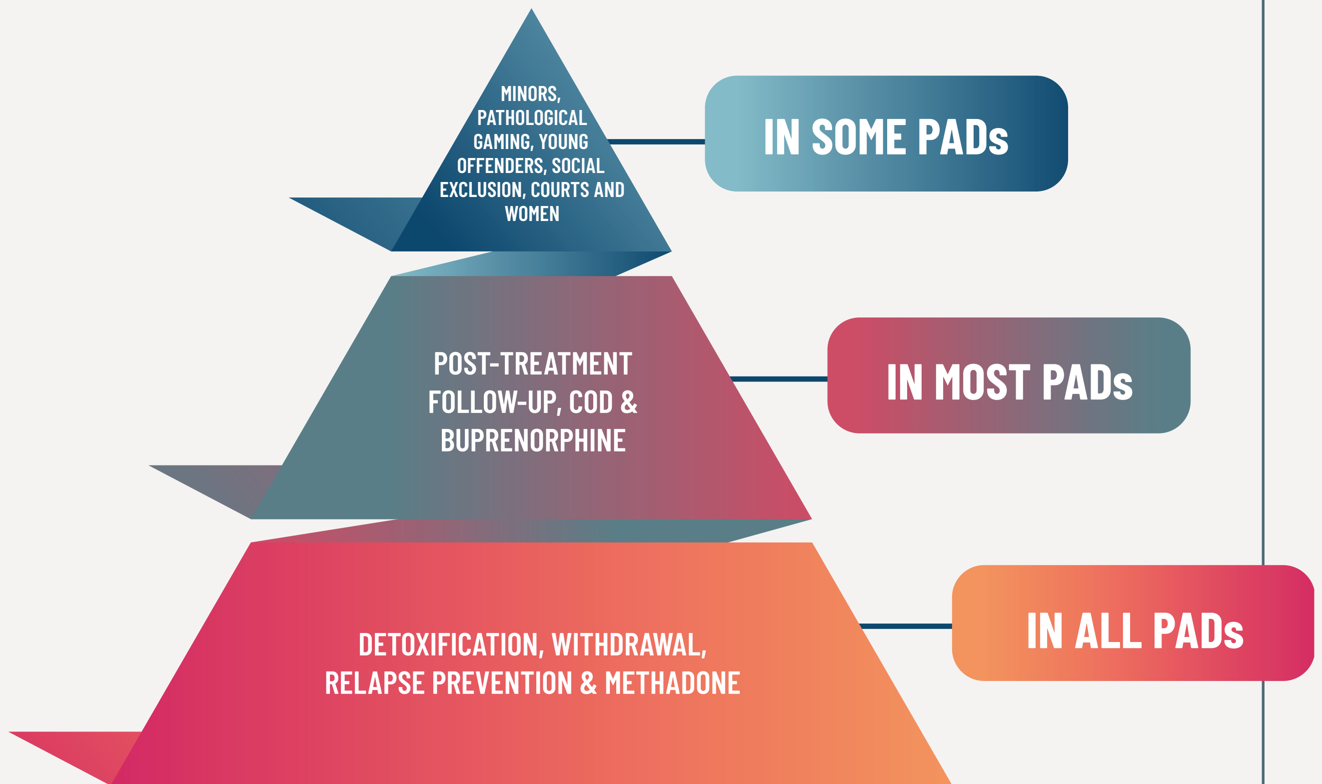


Figure 7.2. Types of treatment programmes in the ARs and their coverage (Source: PADs)

TYPES OF TREATMENT PROGRAMMES (ARS THAT HAVE THEM)

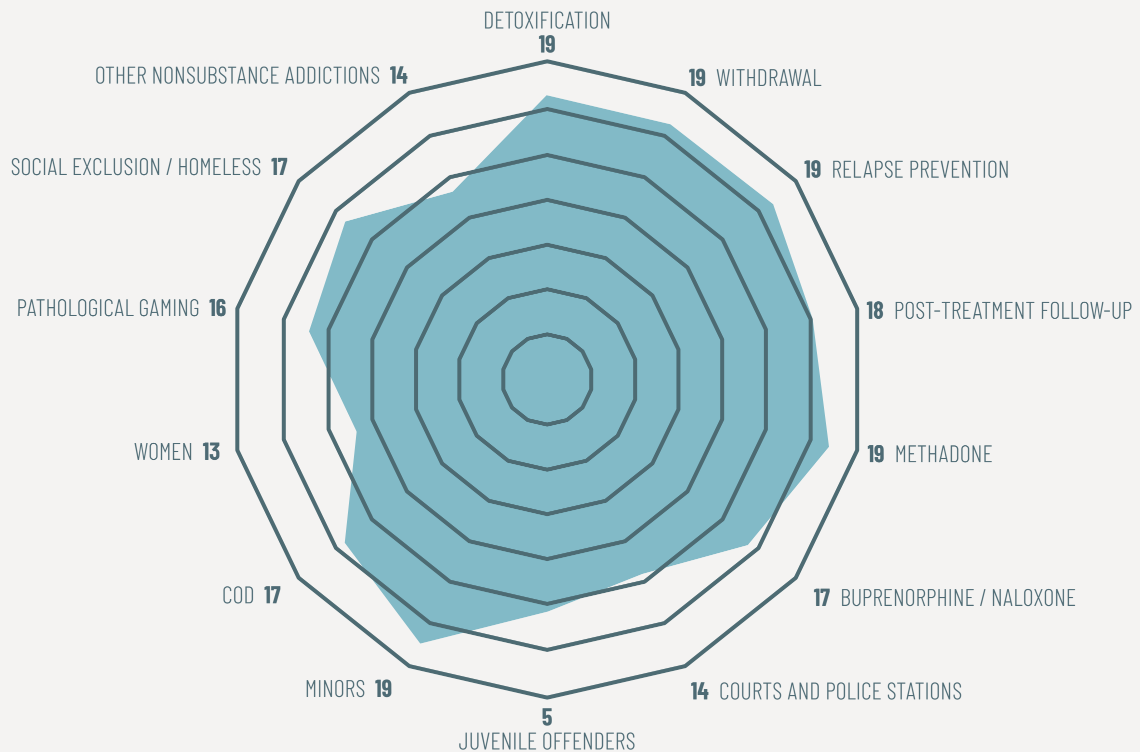


Figure 7.2. Types of treatment programmes in the ARs and their coverage (Source: PADs)

TERRITORIAL COVERAGE OF PROGRAMMES

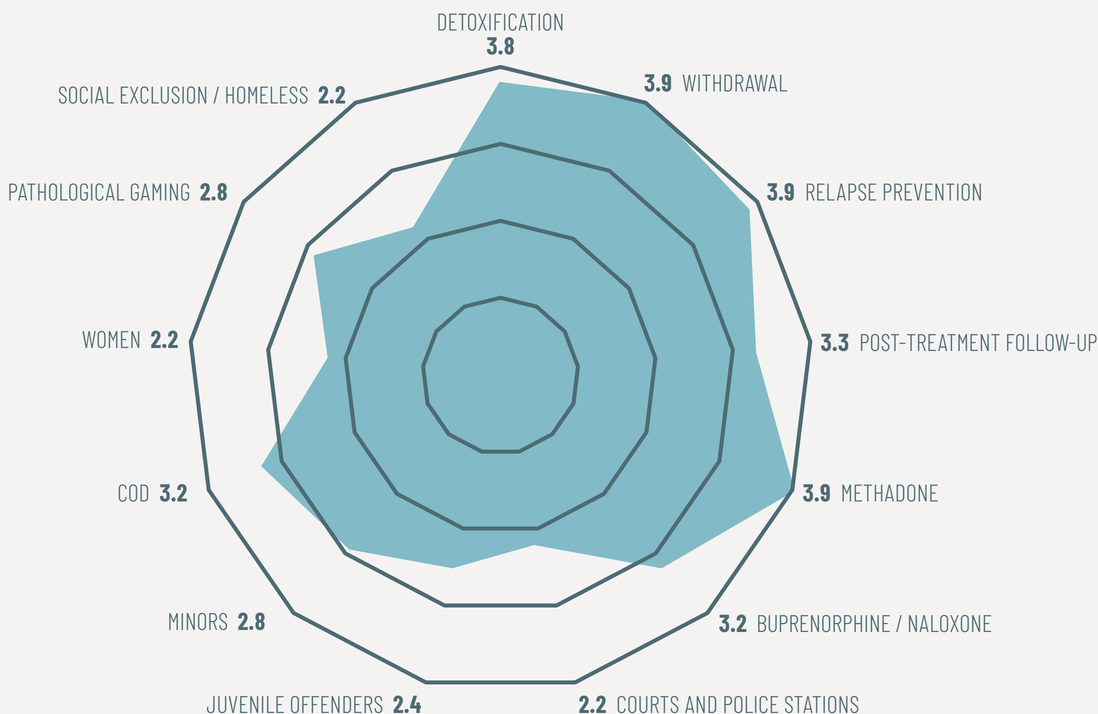
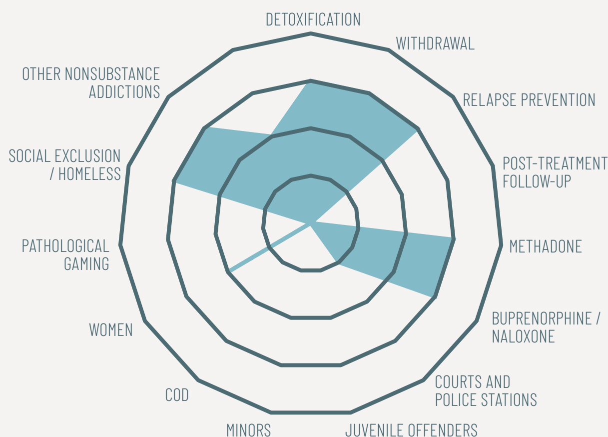
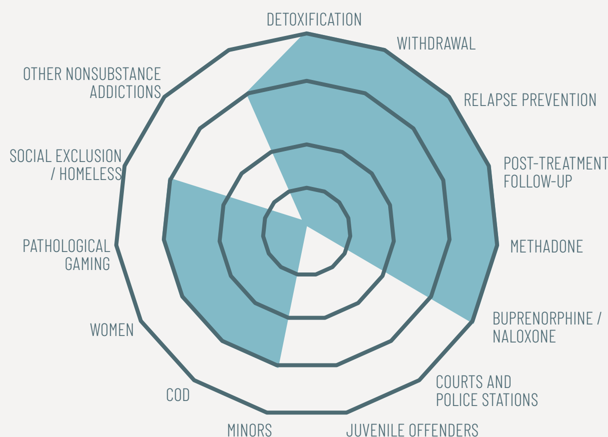


Figure 7.3. Profiles of treatment programmes in the Autonomous Regions & Cities (Source: PADs)

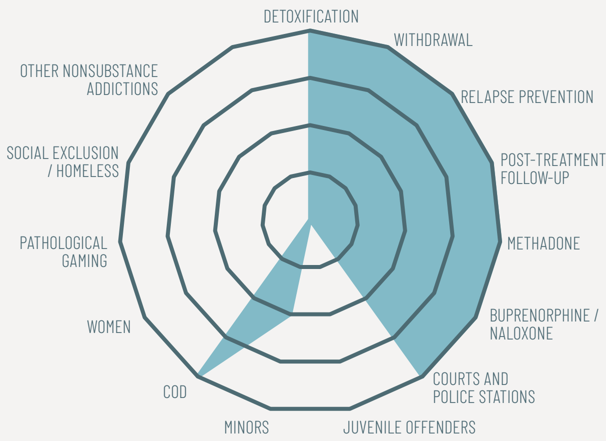
Andalusia



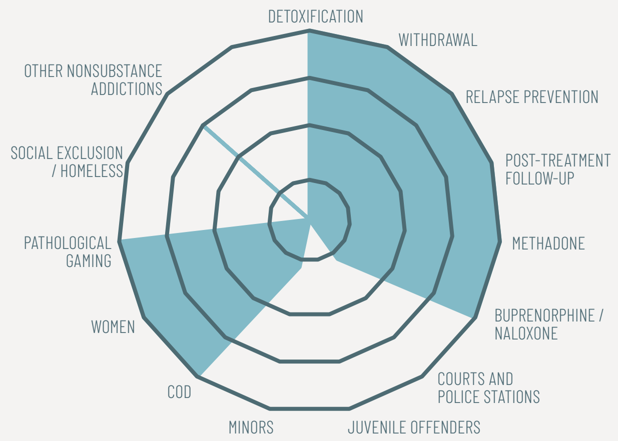
Aragon



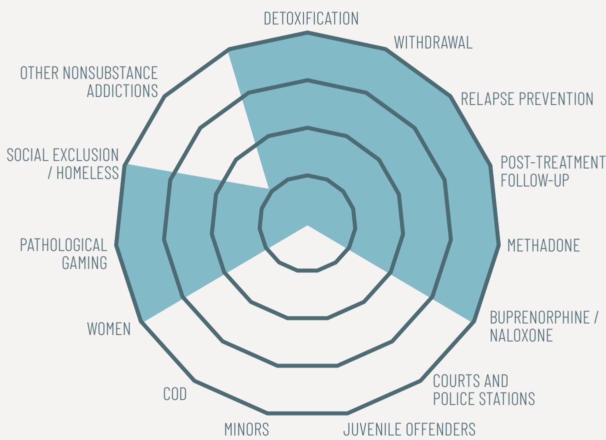
Cantabria



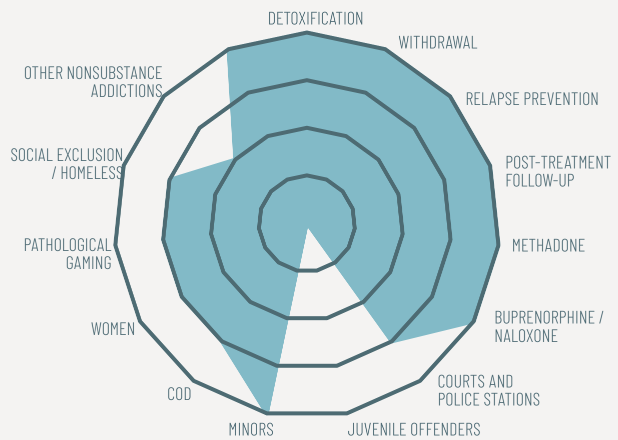
Castile and Leon



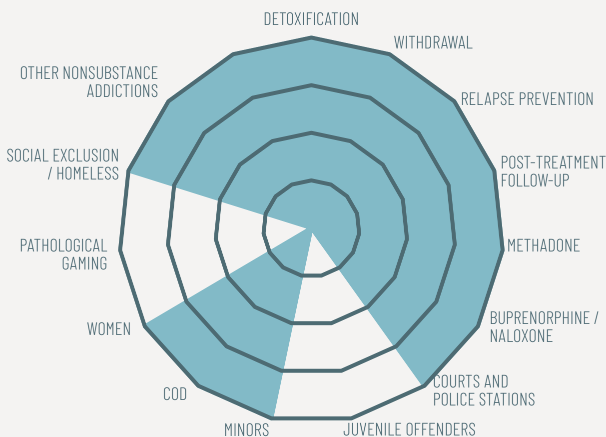
Castile La Mancha



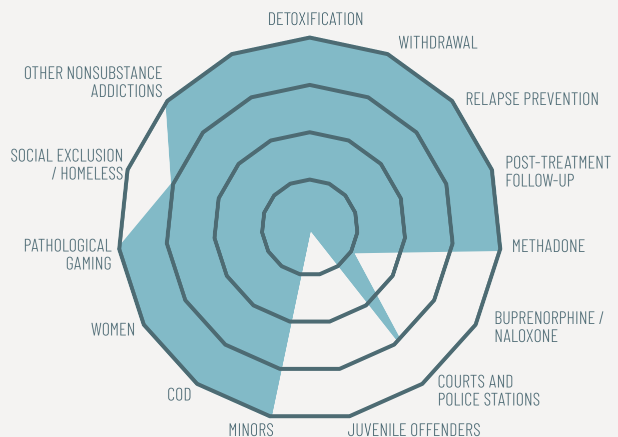
Catalonia



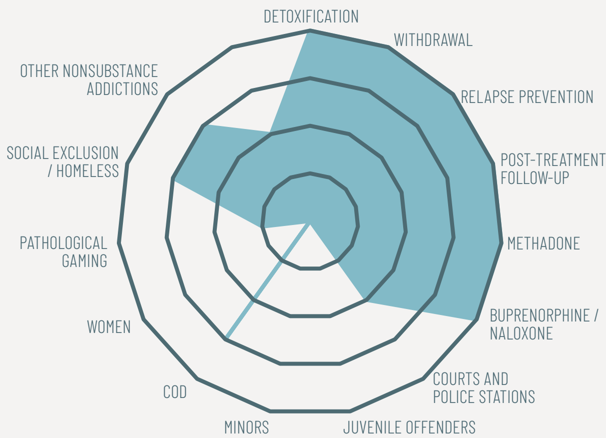
Ceuta



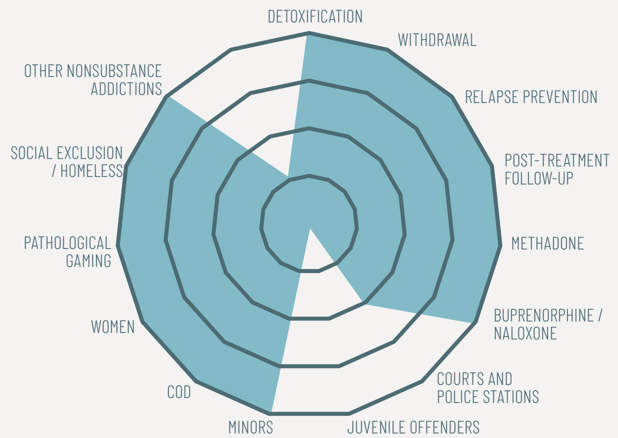
Community of Madrid



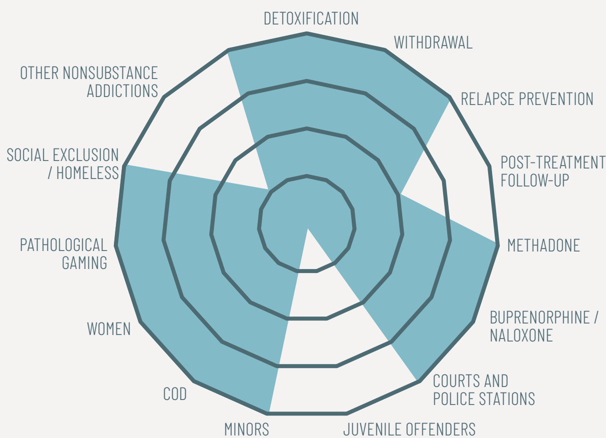
Valencian Community



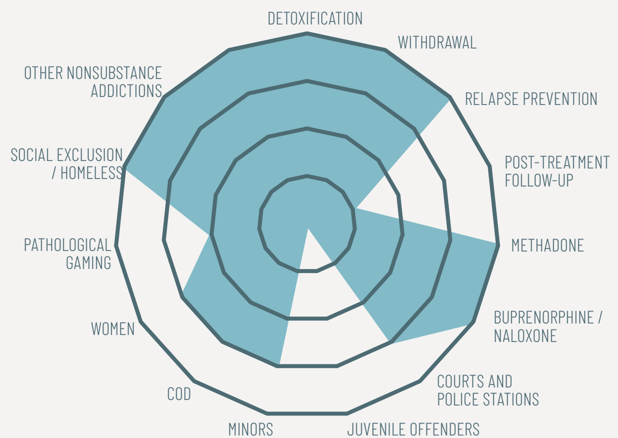
Extremadura



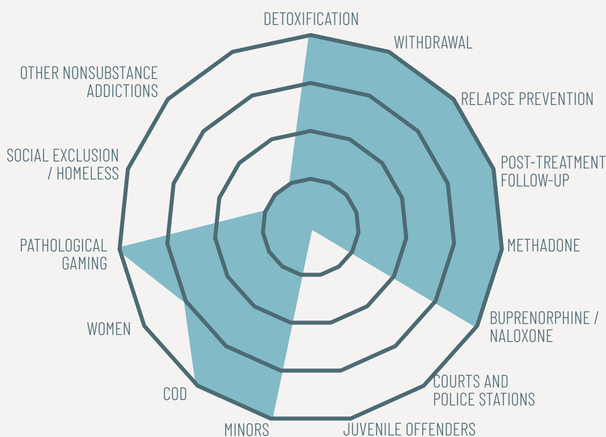
Galicia



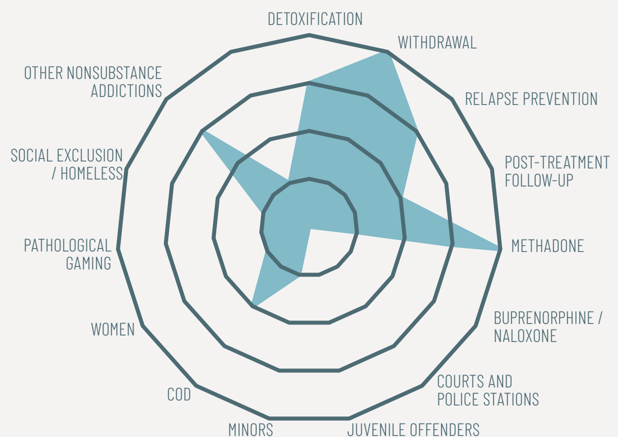
Balearic Islands



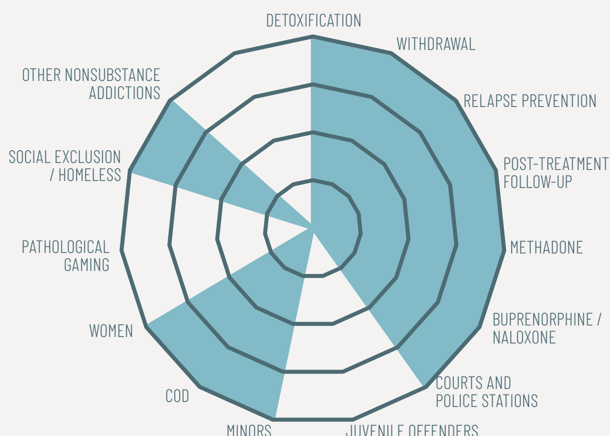
Canary Islands



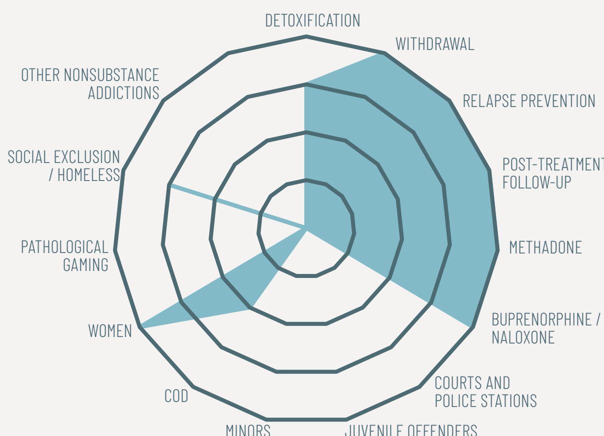
La Rioja



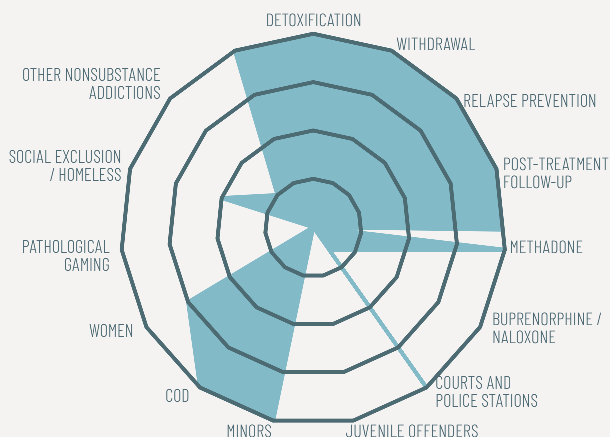
Melilla



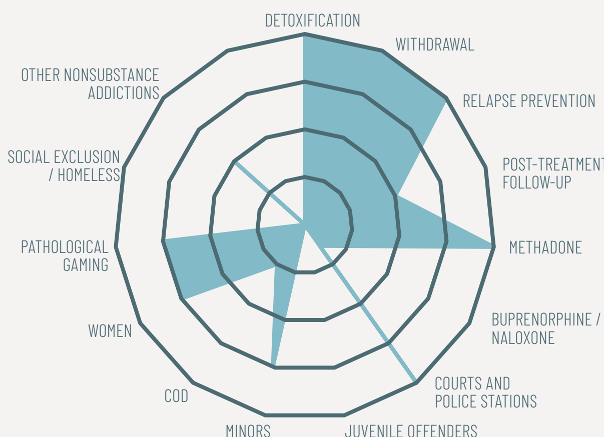
Navarre



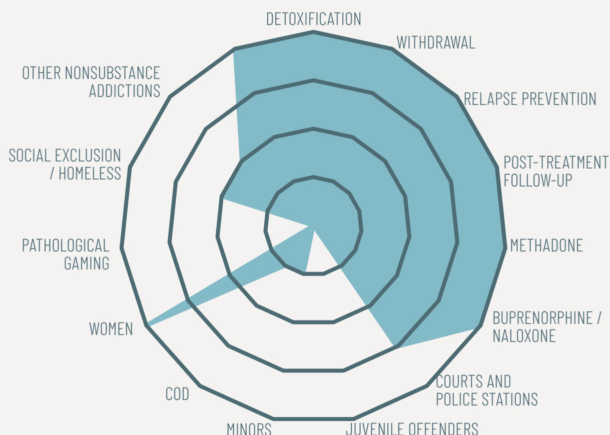
Basque Country



Principality of Asturias

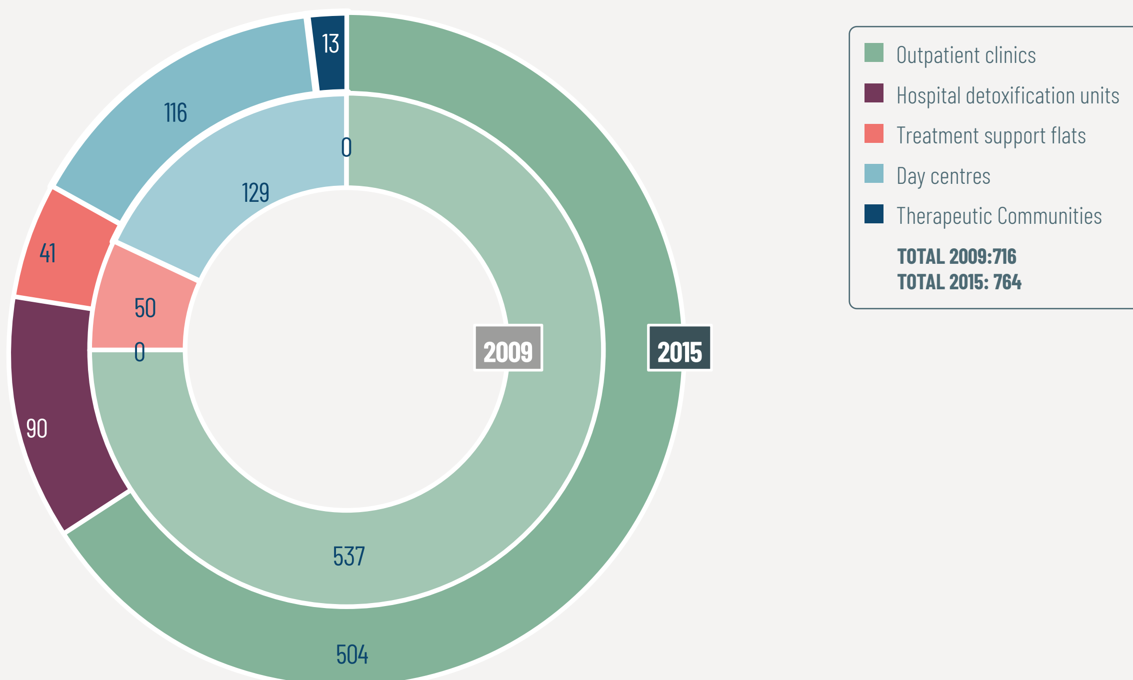


Region of Murcia



As far as the resources on offer are concerned, there is a highly varied and comprehensive range, adapted to the new needs of users of the network (Fig. 7.4.). Most are Outpatient Clinics, followed by Therapeutic Communities. An increase overall in the total number of centres is observed compared to 2009 although when the data are analysed further, we see that this increase is due to the inclusion of Day Centres and Treatment Support Housing for this last year, which is information that was not collected in 2009. The fact is that there is a significant reduction in resources of all kinds that is not reflected in the reduction in the number of users which, as we will see below, has gone up. This is a reflection of the greater efficiency of the system. The shift towards outpatient care opens up an opportunity for integration with the rest of the system, especially with primary health care, for which the experience in integration some of the regions already have may be useful.

Figure 7.4. Treatment resources in the Autonomous Regions in 2009-2015 (Source: Memoria PNSD)



Population coverage

There has been a very significant increase in the number of cases managed in the network. In general programmes this increase is 33%; in specific programmes it is 22%. (Fig. 7.5.)

It should be noted, however, that this increase is not all new cases coming to the network for assistance as the number of new cases has actually fallen. It corresponds instead to people who remain in assistance for longer periods of time. The proportion of new cases compared to the total in 2009 was 50%; in 2014, however, it was only 31%.

As far as the cases handled in specific programmes are concerned, the number has increased in Specialised Courts, Programmes for Women, Minors and Pathological Gaming, which are actually the most widely available programmes. A big drop was recorded (almost 1000 cases) in dual diagnosis disorder programmes.

Figure 7.5. No. of cases treated in treatment centres 2009-2015 (Source: Memoria PNSD)

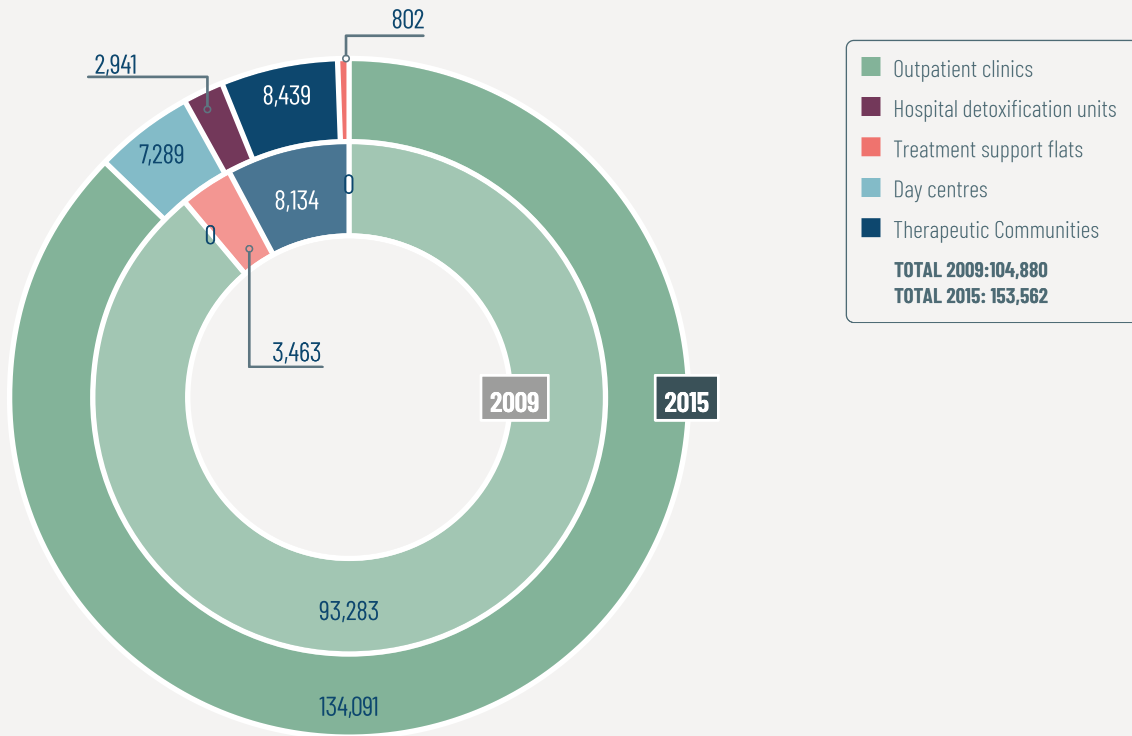
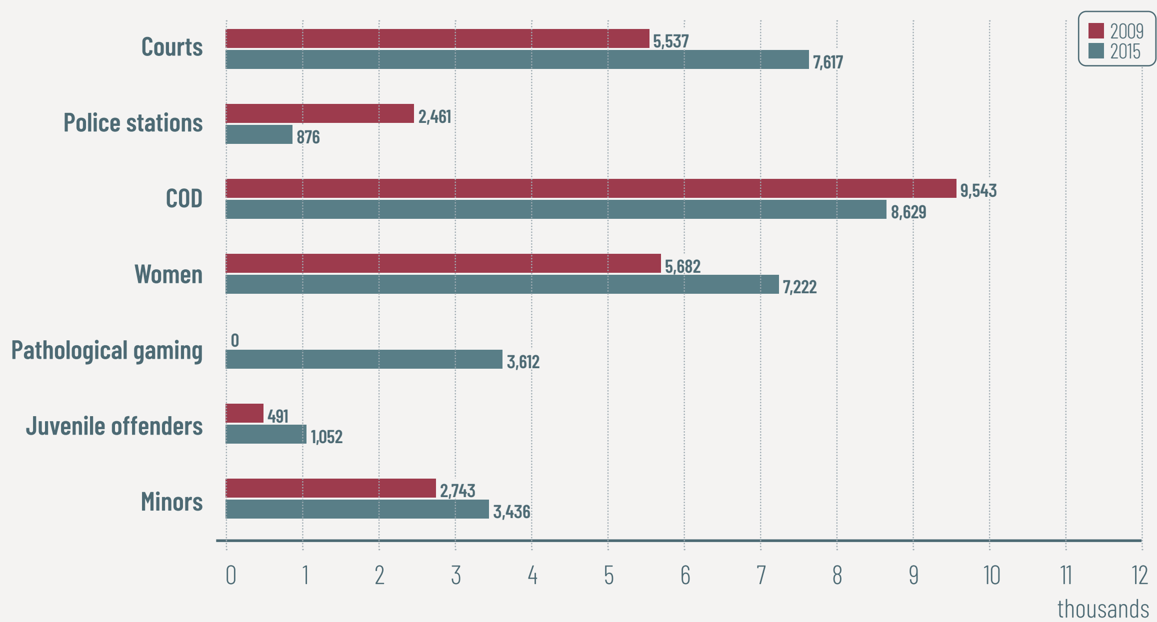
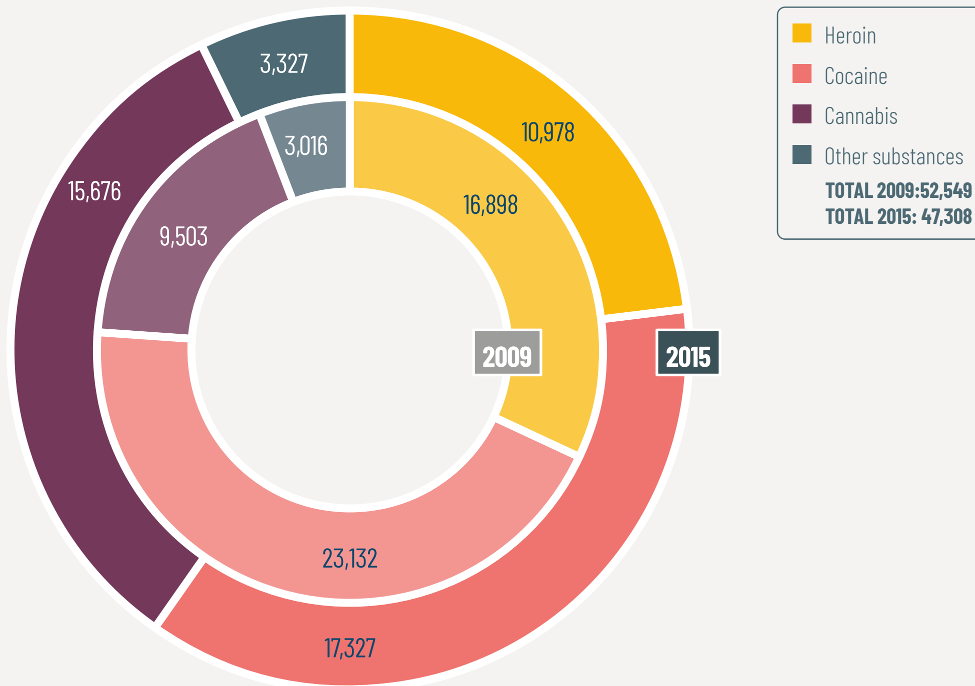


Figure 7.6. No. of cases treated in specific programmes 2009-2015 (Source: Memoria PNSD)



All of the illicit drugs that are the cause of assistance are down, except for cannabis, with a particularly relevant reduction in admissions to assistance for heroin abuse. Cocaine is still the main cause although cannabis has risen significantly compared to 2009, pushing heroin out of second place. Such a significant increase (almost double) requires special attention with a response tailored to people addicted to this drug. (Fig. 7.7.)

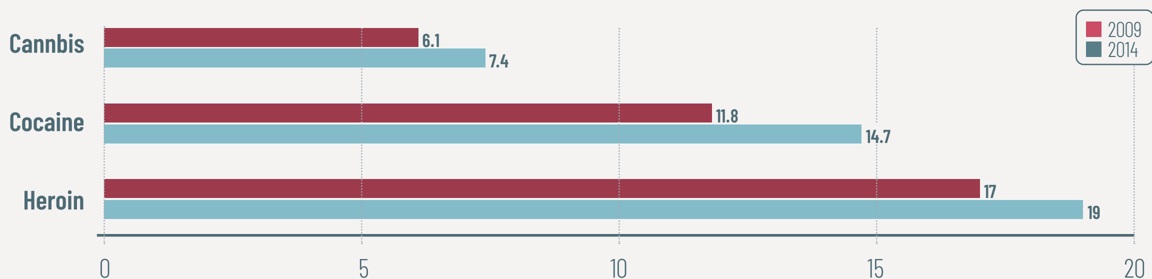
Figure 7.7 Nº of treatment entrants according to the main drug (Source: OEDA)



There has been an increase in the number of years elapsing between the start of the drug use and the start of assistance, which was already high in 2009 but has risen further in 2014 (Fig. 7.8.): three years later for cocaine, two for heroin and one and a half years later for cannabis. This gap needs to be reduced and users need to come to the system for assistance earlier so that harms can be reduced and the assistance prognosis improved.

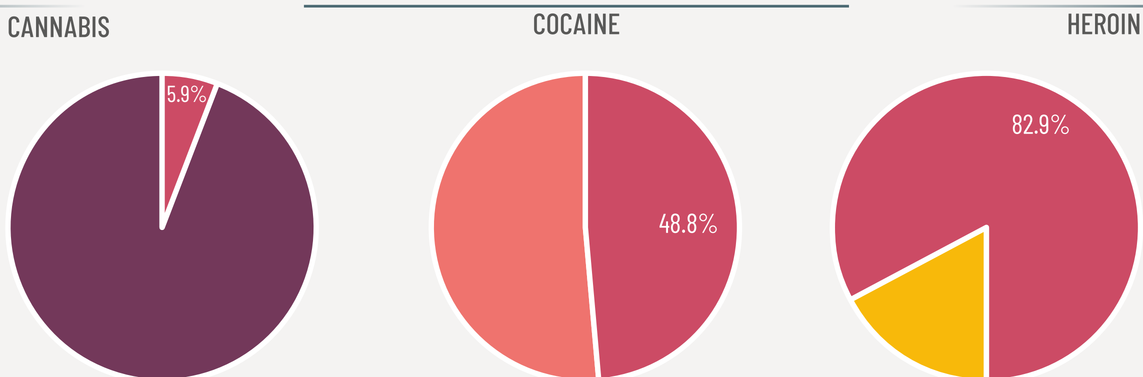
Another major gap is the proportion of problematic users who go for assistance (Fig. 7.9.). By way of an approximation to this reality we can correlate the number of problematic users in the DGPNSD surveys to the number of people who come to the network for assistance and see the differences according to the main drug used. Caution has to be exercised when interpreting the result of this comparison as the older populations with the highest level of problematic use are not represented in the surveys sample. In the case of heroin, the proportion is by far the highest: more than 80% of problematic users represented in the survey go for assistance although other estimates put the percentage at 53% (Roncero, 2017). In the case of cocaine, the figure is 50% but for cannabis the the proportion is tiny (only 6% of problematic users go for assistance).

Figure 7.8. No. of years elapsed between drug use initiation and treatment (Source: OEDA)



However, as stated above, this comparison does not take into account the population with the most problematic drug use. More efforts, therefore, need to be made on early detection and assistance motivation for these people with problematic drug use to find out more about the reasons behind this gap.

Figure 7.9. Estimated percentage of people in treatment in relation to the nº of problematic users 2015 (Source: OEDA)



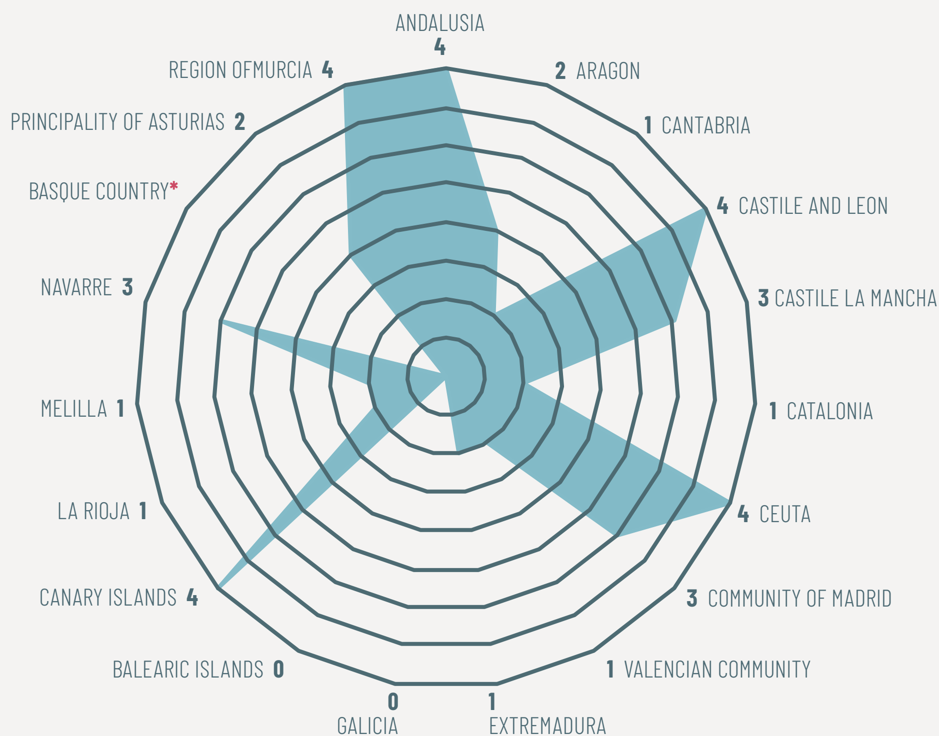
Quality

The degree of quality accreditation of programmes in the treatment area is medium (see scale in chart 4 Methodology). Eight PADs have Programme Catalogues and thirteen say they have a Services Portfolio. The treatment is highly structured through protocols both for patient care and follow-up.

Five of the 19 PADs achieve the maximum accreditation standard. Eight are rated at the minimum standard with clear room for improvement. (Fig. 7.11.)

Most PADs carry out an evaluation of needs and processes but only nine do so for treatment outcomes. Nevertheless, over the last five years ten PADs have carried out network user satisfaction surveys and twelve have made an evaluation of their programmes and services at some time.

Figure 7.10. Level of accreditation of treatment programmes in the Autonomous Regions (PADs)



** No information provided by the Basque Country (País Vasco)*

ACCREDITATION (0-4)
0: No criteriaexist.
1: Low: There are quality evaluation criteria and they are published.
2: Medium: There are instruments to rate the criteria but they are not scored on a scale.
3: High: There are instruments to rate them and they are scored on a scale.
4: Total: Programmes and services are accredited in line with quality criteria.

Figure 7.11. Standard of treatment in the ARs (PADs)

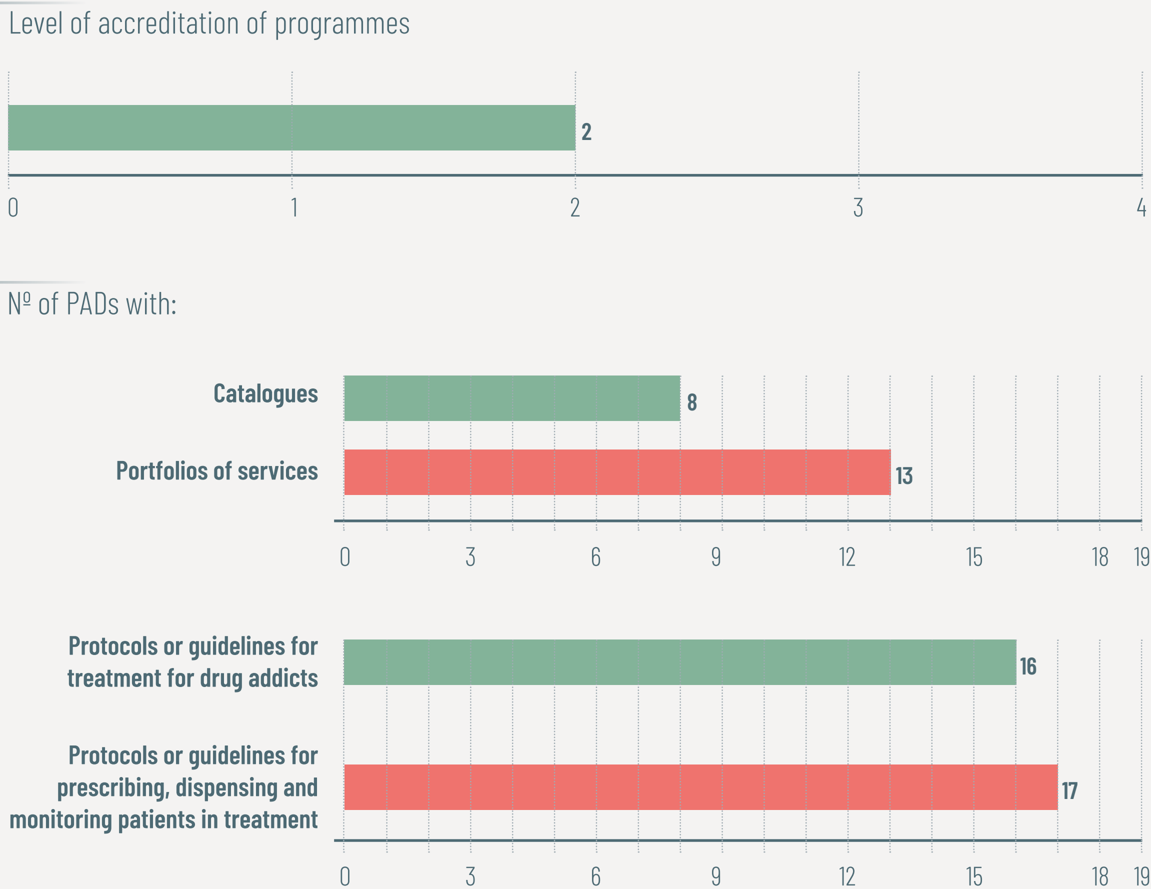
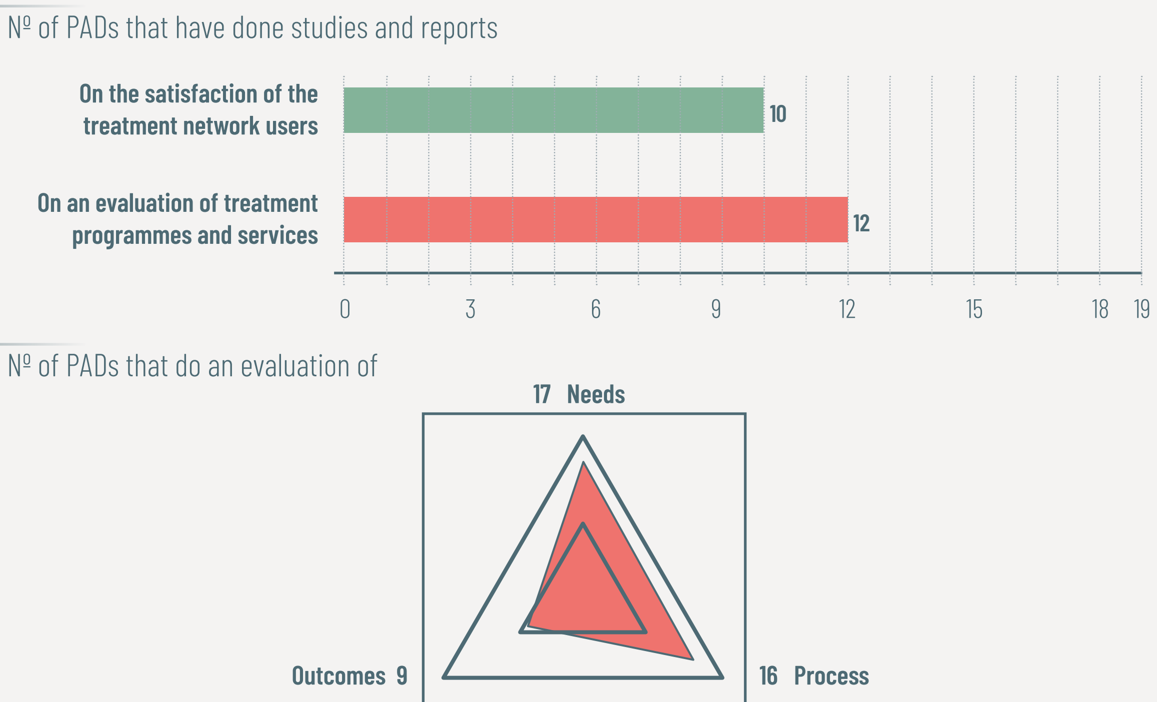


Figure 7.12. Evaluation of treatment in the ARs (PADs)



B) HARM REDUCTION PROGRAMMES

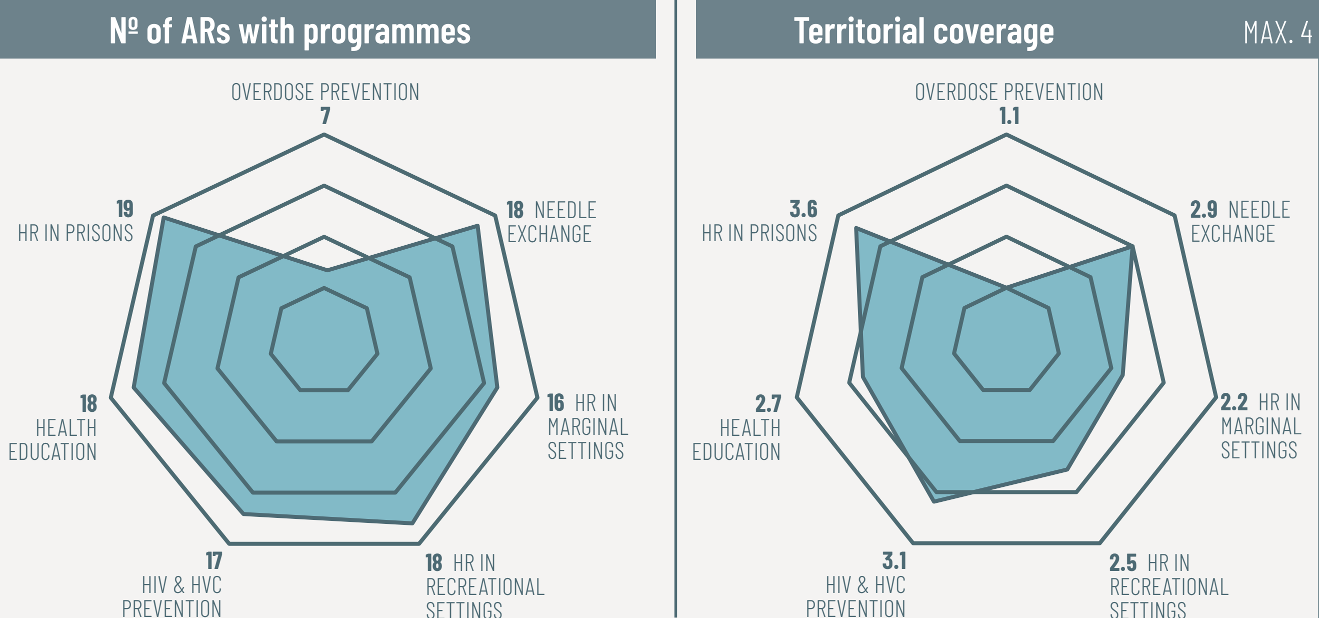
This section includes programmes and services targeted at the population with a substance dependence in order to minimise the negative consequences for health related to drug misuse. These programmes are targeted primarily at the population with the most problematic drug use, i.e. at drug addicts who are injecting drug users (IDUs) above all. The first harm reduction programmes were implemented in Spain during the 1990s to halt the HIV epidemic and since then they have become generalised and diversified all over Spain.

Types of Harm Reduction programmes and their territorial coverage

Harm reduction programmes are available generally all over Spain although their format varies according to the autonomous region where they are delivered. In practically all of them health education or needle and syringe exchange activities are offered.

Harm reduction is also generally available in Spanish prisons and there is a good level of programme implementation in marginal and recreational settings. Only the overdose prevention programmes are a limited option, on offer in only seven of the 19 autonomous regions and with less territorial coverage in the regions that deliver them (see scale chart 4. Methodology).

Figure 7. 13. Harm Reduction (HR) programmes in the Autonomous Regions (ARs) (Source: PADs)



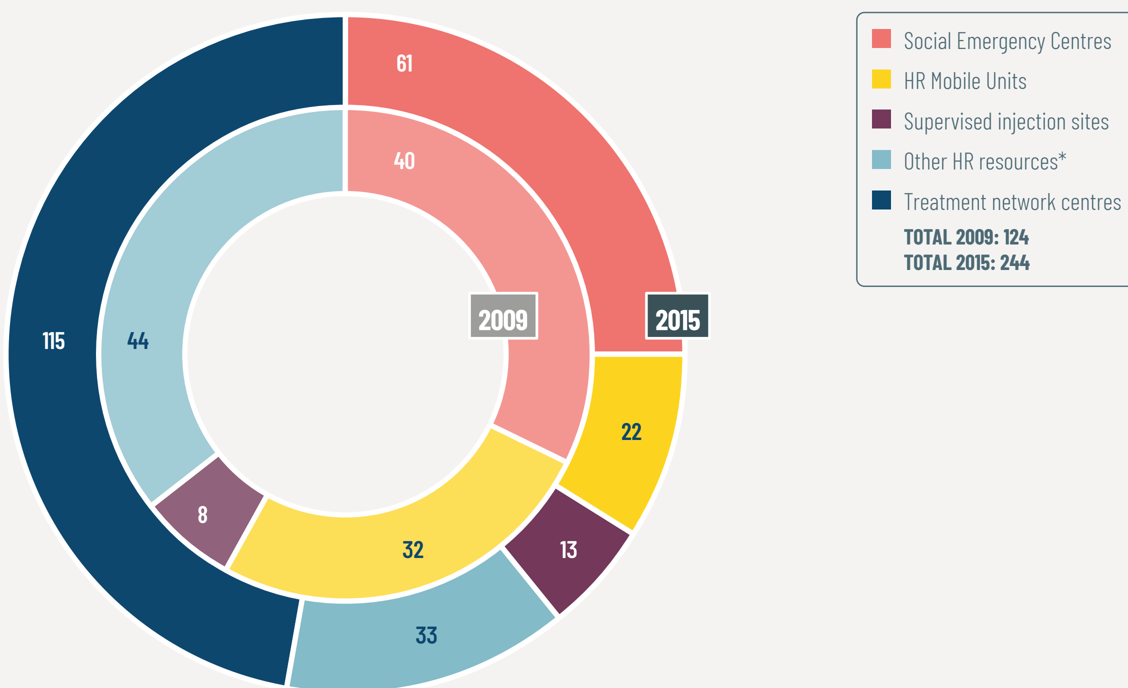
There are also major differences in the profile of the programmes offered between the different autonomous regions; eight of them implement all or most of the programmes included in this evaluation, whereas three of them have a much less varied offering than the average, with only two or three of these programmes. These differences can probably be explained by the different location of the PAD depending on whether it falls within the health system or it comes under social services.

As regards the types of **harm reduction resources**, they can be classified into three groups:

- First, the permanent facilities that users can voluntarily go to: Social Emergency Centre, assistance network centres and supervised injection sites.
- Second, the facilities that actively seek to bring in users, included under the heading "Oher harm reduction programmes", generally targeted at those difficult to reach populations who also tend to be higher risk users.
- There are also mixed facilities that take the programmes closer to the target recipients without doing any proper outreach, such as the drug consumption facilities.

The total number of harm reduction (HR) resources in the period covered by the NDS has remained stable despite the apparent increase shown by the data (Fig. 7.14). This increase is due to the inclusion in the last year of *Centros Asistenciales* assistance centres that had not been in the calculation in 2009. Nevertheless, there are changes in the type of resources available: a notable increase in Social Emergency Centres *(Centros de Emergencia Social)* and also albeit to a lesser degree in the Supervised Injection Sites *(Dispositivos de Consumo Supervisado)*; outreach programmes and Mobile Units have been reduced. This is probably something to do with the fall in the number of IDUs.

Figure 7.14. Nº of Harm Reduction resources (Source: Memoria PND)

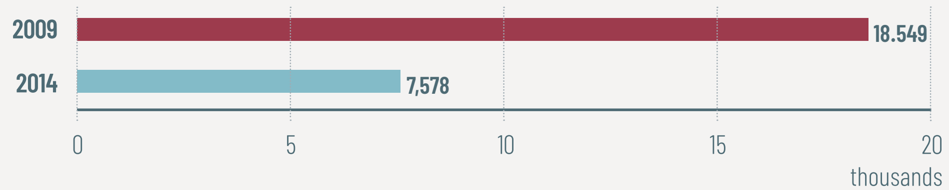


Population coverage

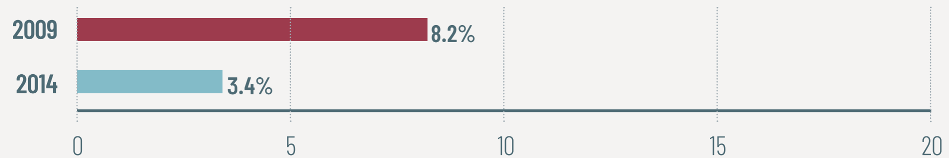
There has been a significant drop in the number of cases handled in the harm reduction programmes, essentially in the Social Emergency Centres, the Mobile Units and the Supervised Injection Sites; the lower numbers are probably linked to a fall in the number of IDUs, which has been over 60% according to OEDA data. Consequently, the number of needles and syringes distributed in the different facilities has also fallen.

Figure 7. 15. Population covered, new HIV diagnoses and needles and syringes distribution in harm reduction programmes (Source: OEDA; Memoria PND)

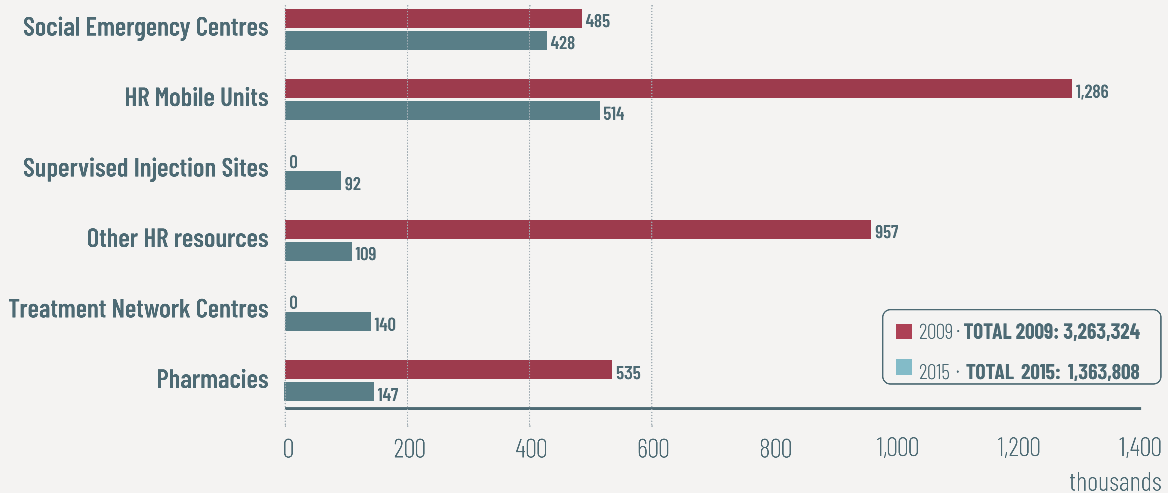
7.15.1. Nº of IDUs in the last year, 2009- 2014. Average value among the population aged 15-64 (OEDA)



7.15.2. Percentage of new HIV diagnoses with transmission via injecting drug use 2009-2014



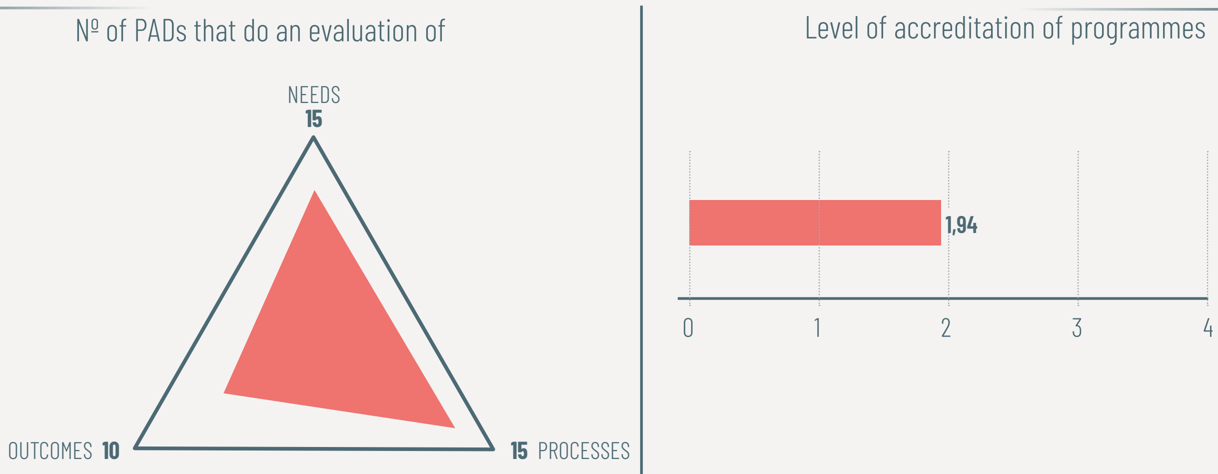
7.15.3. No. of needles and syringes distributed in harm reduction programmes 2009-2015



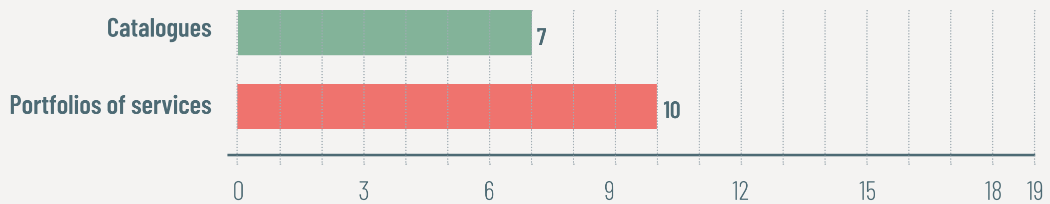
Quality

The quality of harm reduction programmes is medium, a similar standard to the quality of the rest of the assistance area. Ten of the 19 autonomous regions have service portfolios but only 7 have catalogues of programmes. As far as evaluation is concerned, just as is the case of the prevention and assistance areas, evaluations of needs and processes are more frequent than evaluations of outcomes.

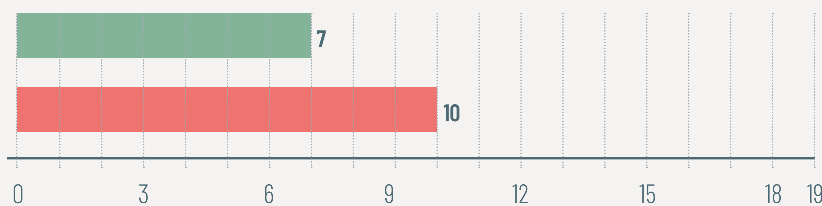
Figure 7.16. Evaluation and quality in harm reduction in the ARs (Source: PADs)



Nº of PADs that do an evaluation of



Level of accreditation of programmes



CONCLUSIONS	RECOMMENDATIONS
There is a broad, diversified and consolidated network of resources and programmes to deal with drug addictions with highly qualified professionals and with an emphasis on outpatient care.	The emphasis on outpatient assistance opens up a window of opportunity to improve integration with the rest of the health care system.
The number of resources and of cases handled in them including both general and specific programmes has gone up. In specific programmes the number of women and minors has increased and non-substance addictions are now included. Opioid substitution programmes are still very important despite the fall in the number of users.	Non-substance addictions need to be incorporated into the assistance network because of their unequal roll-out in the PADs. The gender perspective should be fully integrated in the assistance system.
There are significant variations in admissions to treatment: cannabis-related admissions have gone up for first-time treatment entrants and cocaine and heroin-related admissions have gone down.	Further research and information collection on cannabis use and its medium and long-term effects should be done. It would be advisable to find out more about the profile of new users, not only from an epidemiological standpoint but also thinking about their health care needs.
The proportion of problematic cannabis and cocaine users that get to treatment is low. In addition, the number of years elapsed between initiation in drug use and treatment is very high and has gone up for all drugs, especially for cocaine.	More efforts must be made to attract problematic users to the network and to anticipate their entry into it. In the case of cannabis, given the large number of problematic users, the possibility of delivering assistance (or at least outreach) online could be assessed.
Much has been done to implement portfolios of services and catalogues of programmes although their degree of development is uneven in the different regions. Likewise, the evaluation of needs and processes has become generalised but not so much the evaluation of treatment outcomes.	Emphasis must continue to be placed on harm reduction programmes given their effectiveness in lowering the rate of transmission of infections through injecting drug use and in the improved health of users.
The heterogeneous nature and different degree of coverage of the information systems in the ARs could affect the reliability and completeness of information about programmes.	An effort has to be made to evaluate the treatment outcomes, identify best practices and generalise them. Information, accreditation and evaluation systems need to be more homogeneous and developed further as well as being better coordinated.
There is a varied range of harm reduction programmes and resources on offer, with the exception of overdose prevention programmes that only exist in seven Autonomous Regions. The availability of harm reduction programmes in all Spanish prisons is noteworthy.	The value of extending overdose prevention programmes nationwide should be assessed on the basis of the results of the experiences in the ARs that already run this type of programmes.
The resources offering has been maintained, with an increase in the social emergency centres and the progressive incorporation of assistance network centres.	Early diagnosis and HCV infection assistance need to be improved, essentially in the prison inmate population.
The number of people covered and needles and syringes distributed have fallen. This is linked to the significant fall in injecting drug users.	
A generalised fall in the percentage of people with HIV and hepatitis C has been observed although the prevalence is still high and it is a major public health problem in prison inmates.	

GENERAL OBJECTIVE 8:

SOCIAL INCORPORATION

General Objective 8: Social Incorporation

One of the objectives of the NDS is the incorporation into society of people undergoing rehabilitation through holistic training and employment preparation and insertion programmes.

Social Incorporation (SI), i.e. social reintegration, of people with addiction problems involves a very broad array of public institutions and social organisations that manage resources and programmes. Some are specific (Outpatient centres, Day Centres, Therapeutic Communities, Housing to support incorporation), and others more generalist (Public Employment Service, Insertion Enterprises, foundations and specialised NGOs in the labour market insertion of different vulnerable groups, Information and Employment Counselling services, among others).

Types of programmes and coverage

A variety of types of SI programmes and resources exist in Spain: there is a fairly homogenous set of social incorporation programmes and resources on offer in most PADs, with variations in social or employment counselling. Almost all of the PADs offer programmes of the type that include social relations and recreation actions, training, residential and employment-related activities (Fig. 8.1.)

There is more territorial coverage in social participation and residential support programmes, and less coverage in training, work-related or employment programmes. The territorial coverage is average (see scale in the Methodology section) and there are variations within the PADs.

Figure 8.1. Types and coverage of Social Incorporation programmes in the ARs (Source: PADs)

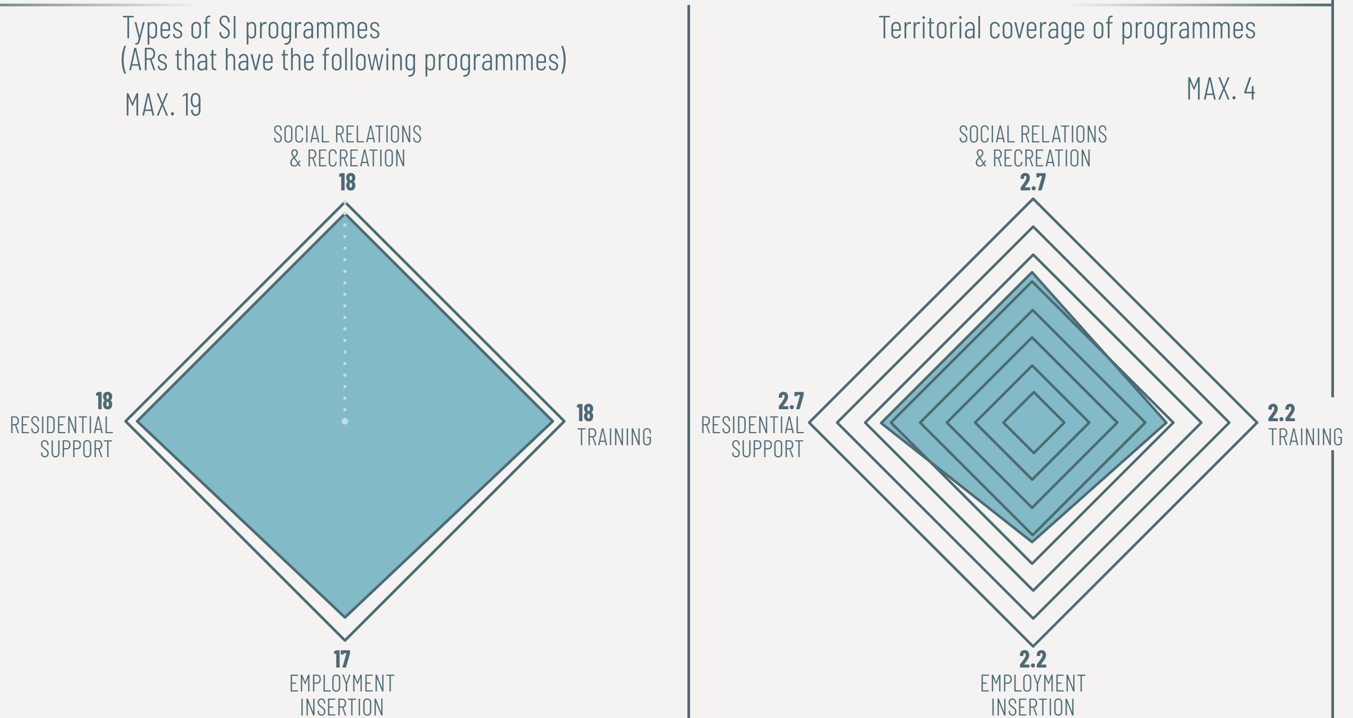
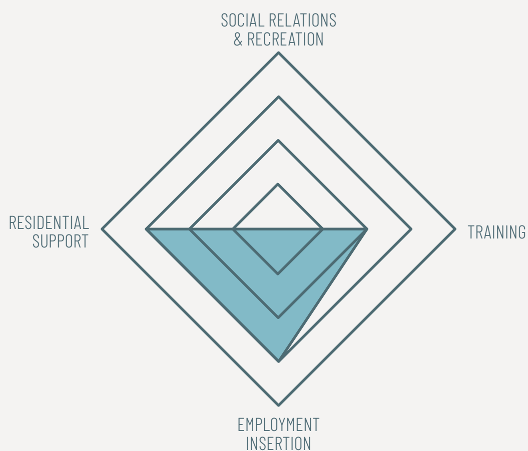
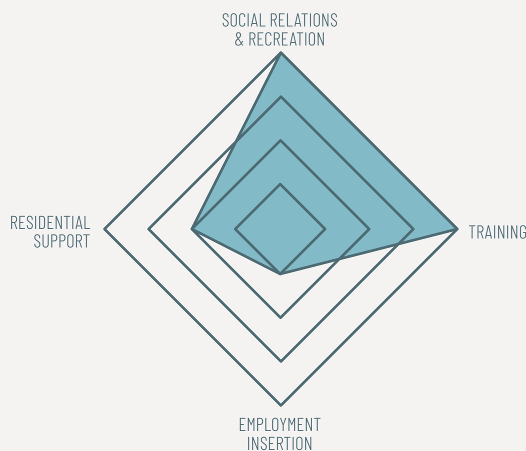


Figure 8.2. Profile of Social Incorporation programmes in the Autonomous Regions (Source: PADs)

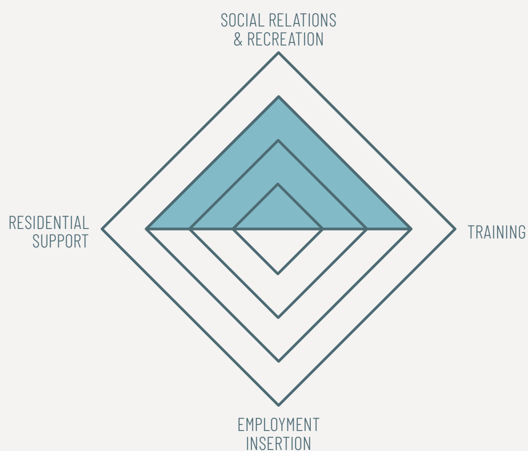
Andalusia



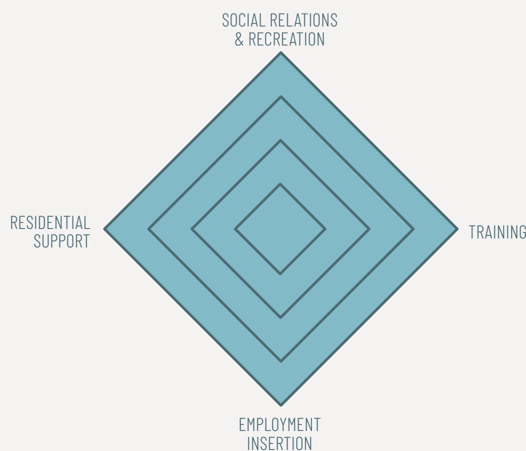
Aragon



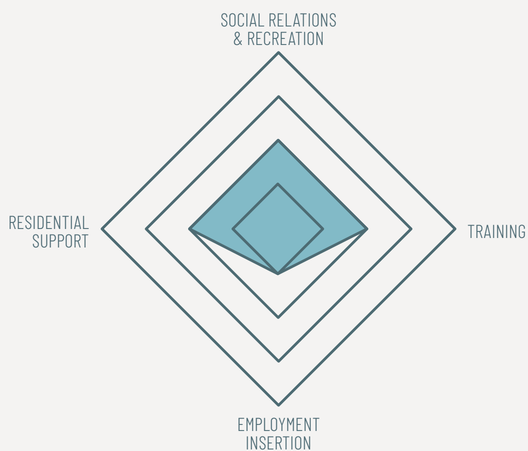
Cantabria



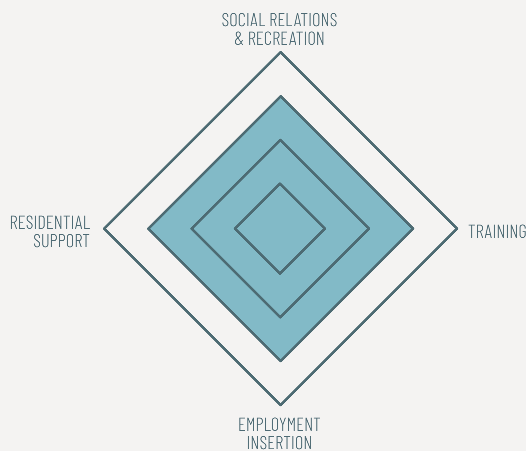
Castile and Leon



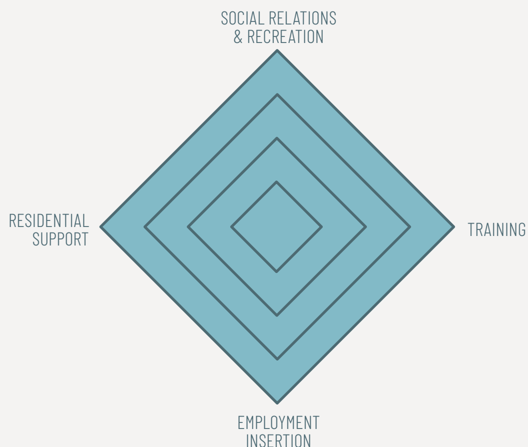
Castile La Mancha



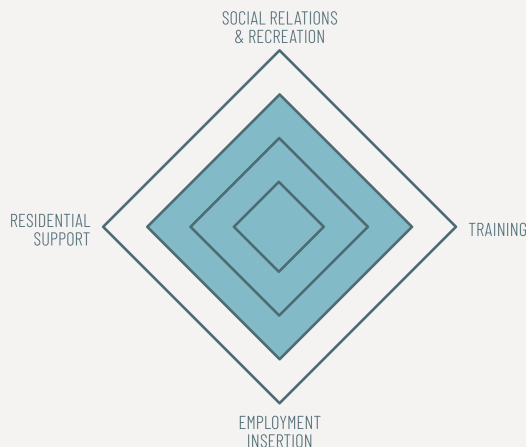
Catalonia



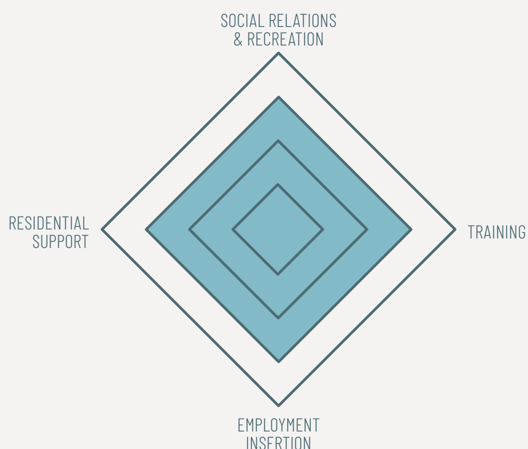
Ceuta



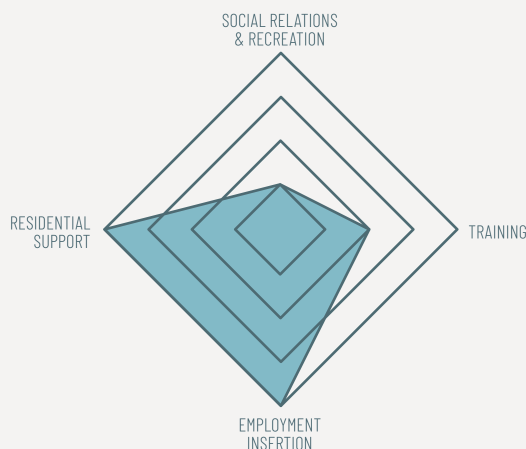
Community of Madrid



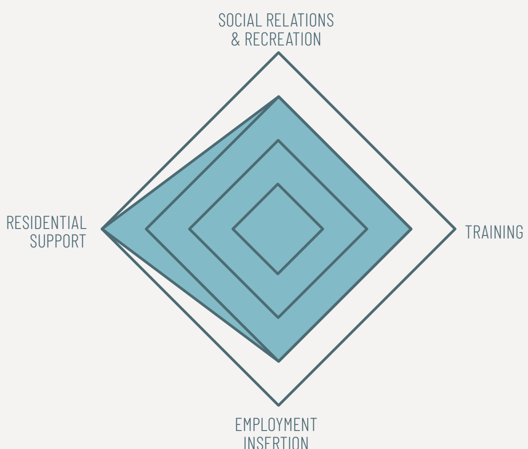
Valencian Community



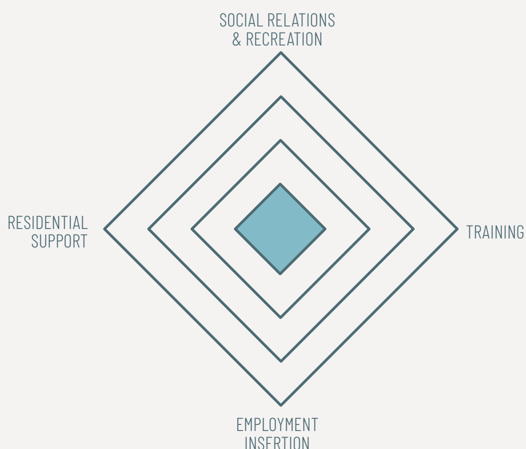
Extremadura



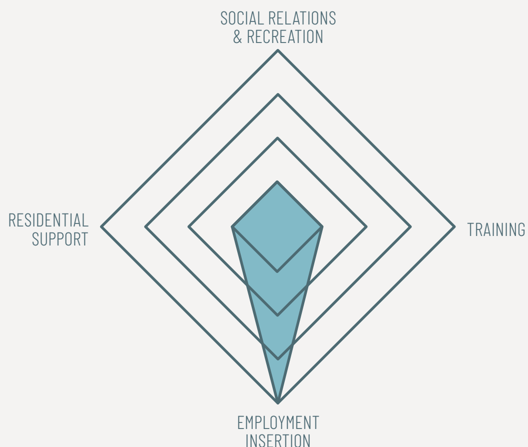
Galicia



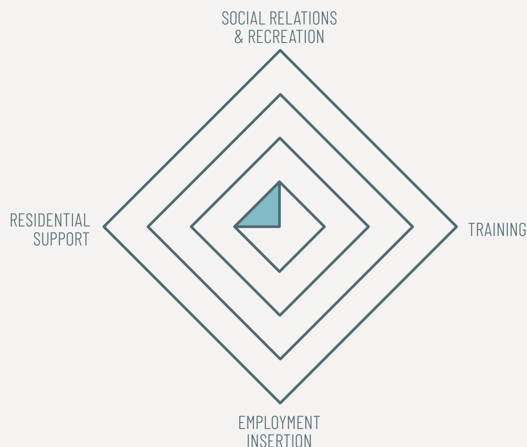
Balearic Islands



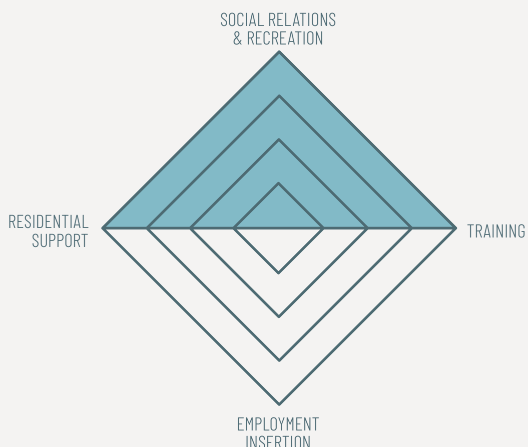
Canary Islands



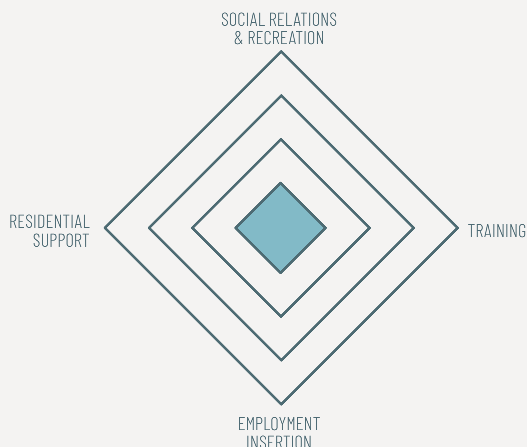
La Rioja



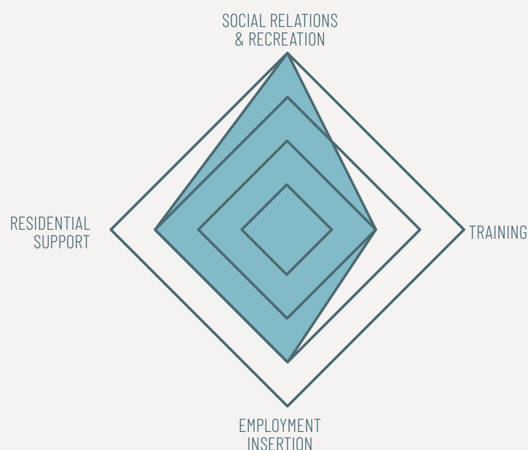
Melilla



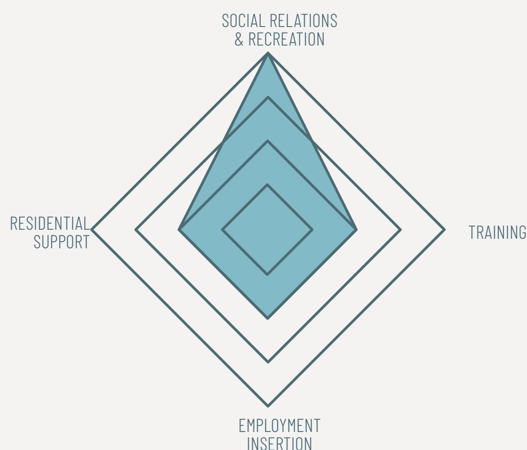
Navarre



Principality of Asturias



Region of Murcia

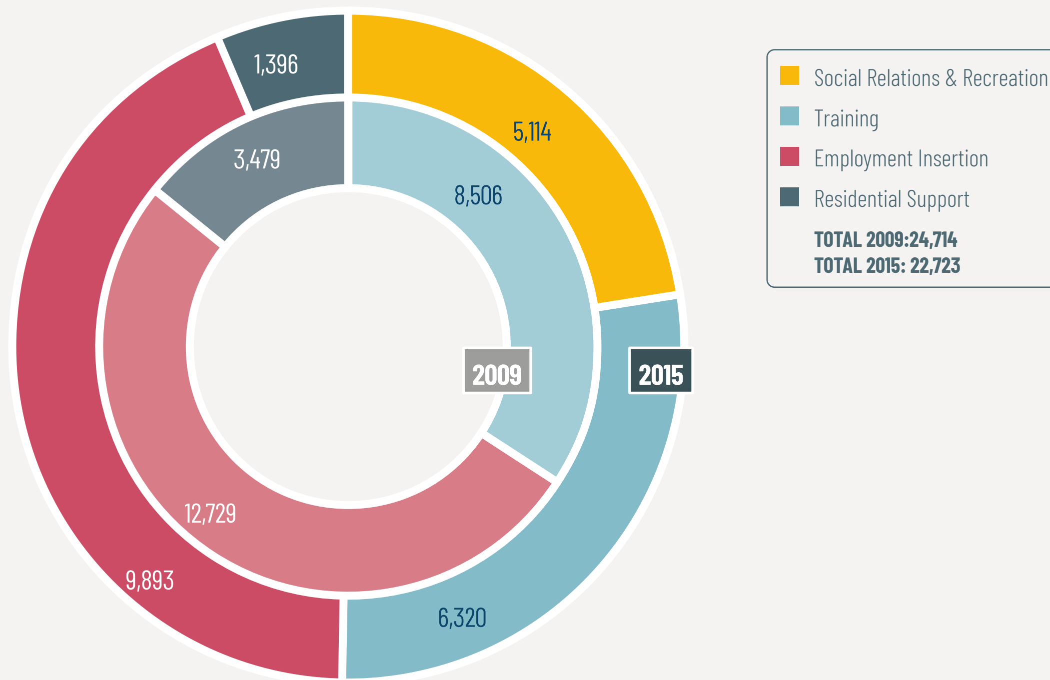


Basque Country [No information]

Population coverage

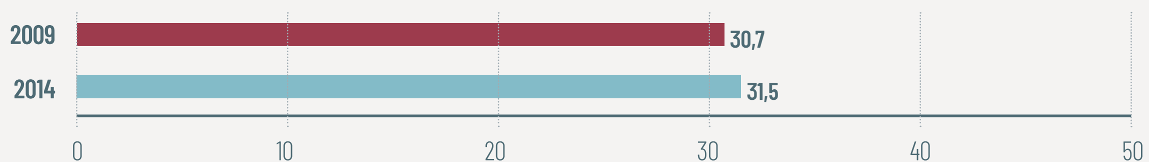
The number of cases handled in all of the social incorporation programmes in the period covered by the NDS has fallen significantly: almost 5000 fewer cases. (In 2009 figures on the number of people participating in social relations and recreation programmes were not gathered). The changing profiles and needs of the people covered by the programmes (fall in the number of heroin addicts) over recent years would at least partly explain the decline in the use of these programmes and their accessibility.

Figure 8.3. Nº of cases in Incorporation programmes (Source: Memoria PNSD)



In addition, if we compare the population coverage data of the SI (NDP reports) programmes against the admissions to assistance (OEDA), we see that the percentage of beneficiaries of SI programmes is very low as a ratio of the total number of cases dealt with in the assistance network (although it is true that not all cases require incorporation projects. Out of the total number of assistance entrants, 66.5% in 2009 and 73.4% in 2015 do not have a job). This situation, together with the decline in resources and participants suggests to us the need to prioritise SI processes in the new National Drugs Strategy.

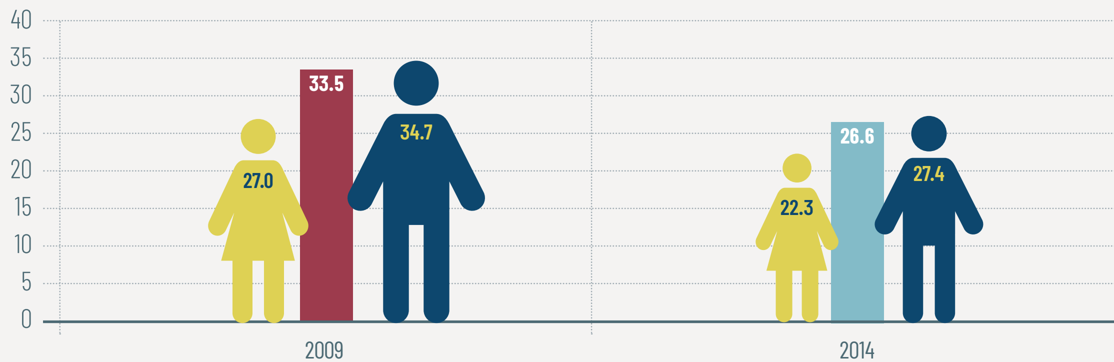
Figure 8.4. Percentage of cases in SI in relation to treatment entrants 2009-2014
(Source: OEDA; Memoria PND)



The employability and accessibility of residential support situations are worse for women than for men. Despite the progress made on gender and addictions there is still upside to improve the design of social incorporation policies and services to bring them into line with the characteristics and determining factors present in women with these problems.

Figure 8.5. Employment and accommodation among treatment entrants 2009-2014 (Source: OEDA)

Percentage of cases with employment out of treatment entrants 2009-2014



Percentage of cases in treatment living in precarious or unstable accommodation

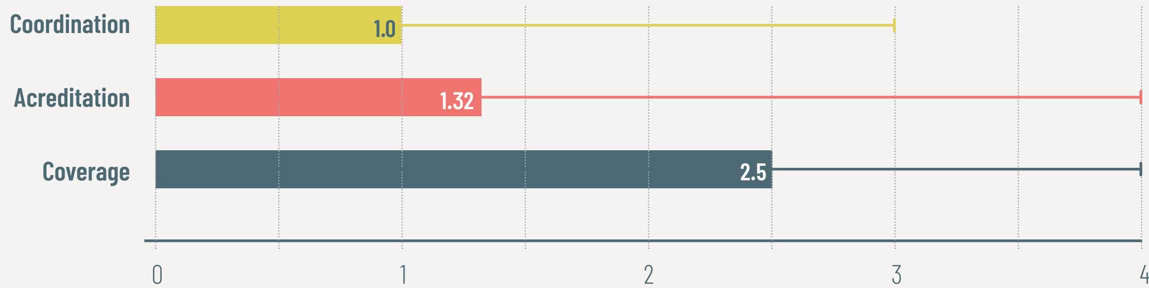
Quality

The SI area is the area recording the lowest average quality standards in comparison with the other intervention areas. Apart from other possible reasons, historically it is the area that has been allocated less budget and is less developed in terms of theory, methodology and research.

The average standard of accreditation of the programmes in this area is 1.32, which corresponds to the *Quality assessment criteria exist and are published*, but there are no instruments to evaluate them nor do any accredited programmes exist (see scale: chart 4; Methodology)

Moreover, coordination between health, social services and employment systems and networks do not attain the levels required for the effective social incorporation of people with addiction problems.

Figure 8.6. Average level of Coverage, Accreditation and Coordination of Social Incorporation programmes (Source: PADs)



Most of the Autonomous Regions have defined individualised incorporation projects. Referral protocols and accreditation criteria exist too but to a lesser extent. Fewer than half of the Autonomous Regions have defined Programme Catalogues and Services Portfolios. In line with the information supplied by the PADs for the NDP report, difficulties are also observed when it comes to knowing what human resources there are working in SI and what their situation is, as well as in information gathering for services and programme activities.

As far as the evaluation of plans and programmes is concerned, thirteen Autonomous Regions state that they carry out an evaluation of needs and processes and only seven do an evaluation of outcomes.

Figure 8.7. Quality of Social Incorporation programmes in the ARs (Source: PADs)

Nº of ARs that have:

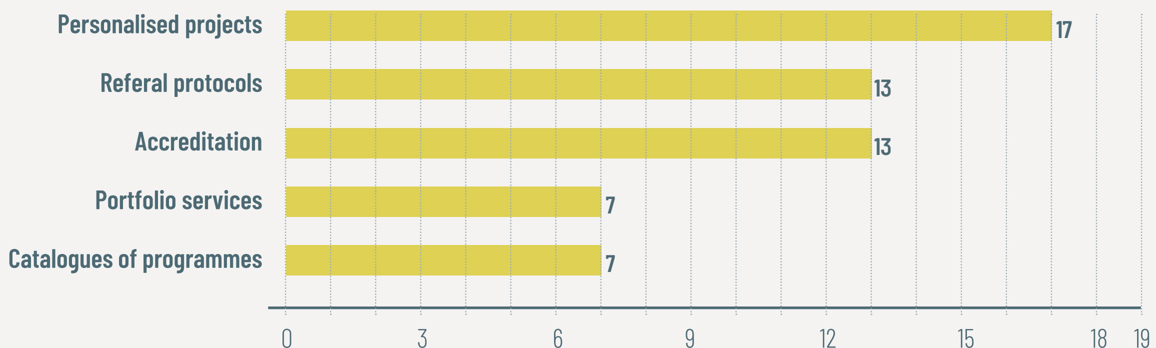
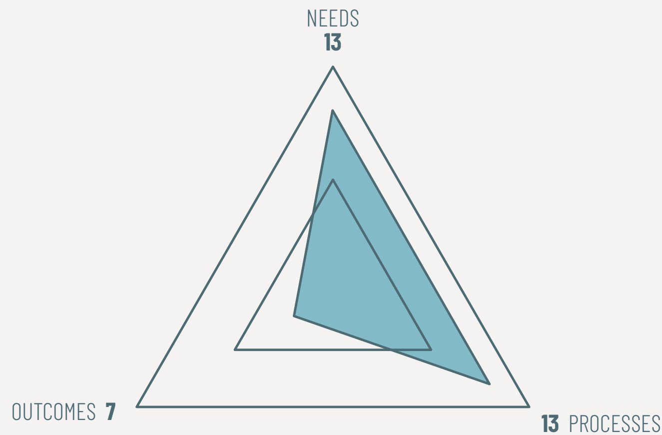


Figure 8.8. Evaluation in Social Incorporation programmes in the ARs (Source: PADs)

Nº of ARs that do evaluation



CONCLUSIONS

A fairly homogeneous set of social incorporation programmes exists with variations according to their social and/or employment orientation and with unequal territorial coverage in the Autonomous Regions.

There have been changes in the profiles of the beneficiaries and to a lesser extent in the resources and programmes.

There is a deficit in accessibility for women with addictions to employment and housing, which justifies positive discrimination in the job insertion programmes and residential support services.

Progress has been made in the management of the quality of the services and programmes although there is room for improvement in accreditation criteria, portfolios of services, catalogues of programmes, information systems and evaluation, as well as in knowledge about the available human resources.

RECOMMENDATIONS

Social Incorporation should be a priority in the new Strategy and its Action Plans. The logic model for the development of Social Incorporation (integration) policies promoted by the EMCDDA is a solid platform to achieve that goal.

Further adaptation is required to bring services and programmes into line with the new profiles and the gender differences in addictions, as well as to increase population coverage in coordination with the assistance network.

There must be further in-depth work done to identify best practices and existing evidence. In addition: implement quality criteria, define processes and itineraries, agree on catalogues of programmes, basic portfolio of services, information and evaluation systems.

GENERAL OBJECTIVE 9:

BE MORE EFFECTIVE IN CONTROLLING DRUG SUPPLY AND ILLEGAL MARKETS

General Objective 9. Be more effective in controlling drug supply and illegal markets

This objective falls within the remit of the Counter-Terrorism and Organised Crime Centre (CITCO) attached to the Ministry of Interior. The following lines of action have been developed:

PREVENTION PLAN FOR RETAIL DRUG TRAFFICKING IN SCHOOL AND RECREATIONAL ZONES

Review of actions under the plan in schools and their surrounding areas.

Instruction 7/2013 issued by the Department of the Secretary of State for Security on the *“Master Plan for Living Together and Better Safety in Schools and their Surrounding Areas”* aims ultimately to reduce the supply of drugs to younger users primarily by doing more on prevention.

The Counter-Terrorism and Organised Crime Centre (CITCO) participates in all the operational aspects of interest pertaining to retail drug trafficking and the use of drugs in areas around schools.

That plan also sets out a series of specific measures for retail drug trafficking around schools by activating four “intensification phases” a year in each one of the calendar quarters in those periods of the year when there is usually a higher risk of increased retail supply and demand for drugs.

Implementation of that instruction mentioned above has produced data on drugs corresponding to **the action period 2013-2016**, as shown below (Table 9.1)

Table 9.1. Retail trafficking prevention actions in school and recreational areas (Source: CITCO)

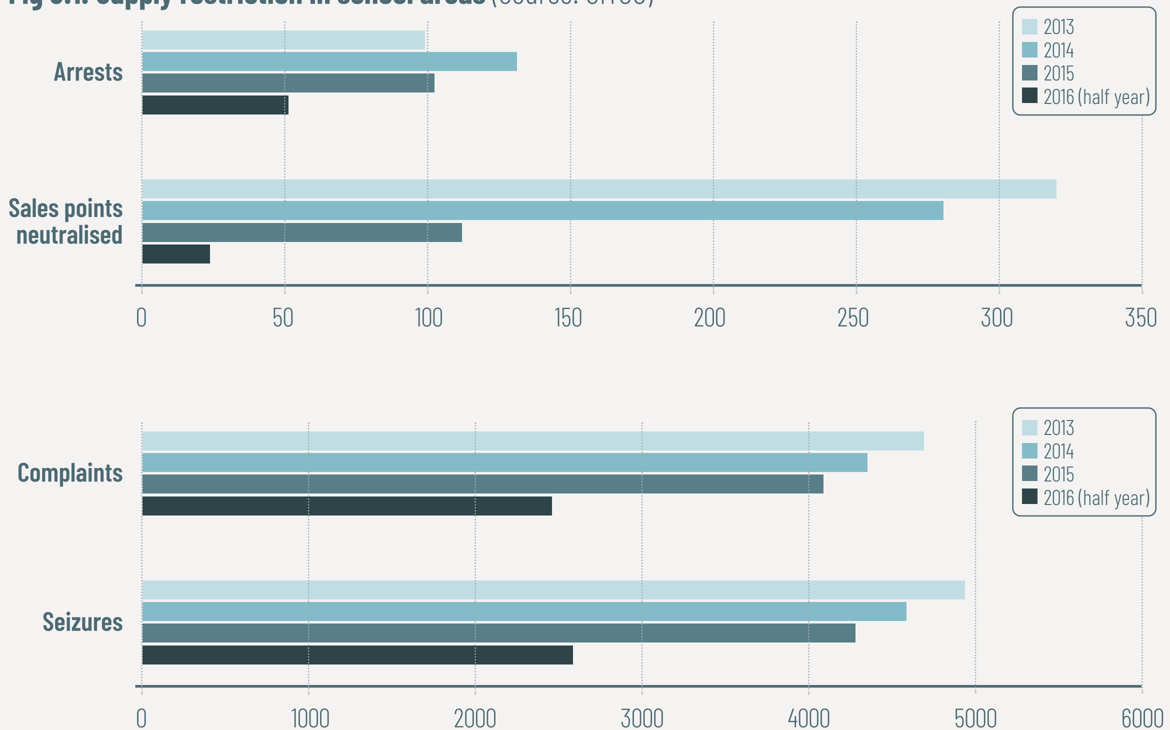
	2013	2014	2015	2016*
Arrests of Nationals	87	108	93	46
Arrests of Foreigners	11	23	9	4
Total Arrests	98	131	102	50
Complaints filed	4,721	4,367	4,108	2,468
Seizures	4,953	4,596	4,298	2,610
Sales Points Neutralised	320	281	111	23
Cocaine (g)	948	435	720	120
Cannabis resin (g)	5,765	4,960	3,070	3,916
Heroin (g)	111	71	163	15
Marihuana (g)	25,552	25,725	4,982	2,335
MDMA - ecstasy (units)	21	114	4	6
Amphetamine Sulphate (g)	553	34	30	39
Psychopharmaceutical drugs (units)	257	169	26	90

* Data from the period 1 January to 30 June 2016.

This Plan has been effective in its response to questions pertaining to the safety and security of the children and young adults in schools, irrespective of any outcomes achieved by law enforcement actions within their deterrence and prevention remit, simply because of the perception of the police presence in the immediate vicinity of schools (Fig. 9.1).

Cooperation with the educational community has made it possible to assess the problems found in schools and tailor services to their needs. This has contributed to a heightened feeling of safety and security in the school environment.

Fig 9.1. Supply restriction in school areas (Source: CITCO)



REVIEW OF ACTIONS UNDER THE PLAN IN SCHOOLS AND THEIR SURROUNDING AREAS.

Instruction 3/2011 issued by the Department of the Secretary of State on the "Strategy Plan for the Police Response to Retail Trafficking and Use of Drugs in Recreational Premises, Places and Zones", focuses on preventing and reducing the supply of drugs to users, especially to young people. It highlights the preventive nature of the actions taken by the different police forces.

The Plan is primarily focused on preventing retail sales and use of drugs in leisure and recreational areas as well as in the vicinity and access routes to them. It is an ongoing permanent plan applicable to any day or period in the year

CITCO draws up an Operational Plan every year which is implemented by the Government Delegations and Subdelegations through the Local Security and Safety Boards. It promotes coordinated activities between the different police forces as a police response to drug trafficking and use in recreational and leisure areas.

The Operational Plan is annual and includes periods in which police action is intensified with the aim of preventing and reducing drug supply. Currently the plan is divided into four intensification phases per calendar year.

Police surveillance (with uniformed or plain clothes police officers) has reduced the supply of drugs in the environments proposed in the plan in conjunction with the collaboration of local police forces and private security guards (Fig. 9.2).

Furthermore, the implementation of the Strategy Plan is highly rated by citizens and recreation businesses because it prevents public order problems and illicit or antisocial behaviour, such as thefts, affrays and vandalism of vehicles or urban furniture.

Essentially the law enforcement presence in the vicinity of schools and recreational venues acts as a deterrent and a preventive measure. Collaboration with local police forces and private security guards has managed to create a feeling of permanent police control in these areas at the same time as it has been successful in reducing the use of drugs there.

Implementation of the instruction mentioned above has produced the following data on drugs corresponding to **the 2013-2016 action period**, as set out in the table below (Table 9.2):

The goal of this Plan through the actions explained above is to restrict drug supply to users in recreational and leisure venues, premises and areas. It has obtained satisfactory results over the last few years and has managed to create a feeling of permanent ongoing police control in these areas at the same time as it has successfully reduced the use of narcotic substances there.

The police presence has also helped to reduce other public order problems and so make the areas generally safer.

Fig. 9.2. Restricting supply in recreational areas (Source: CITCO)

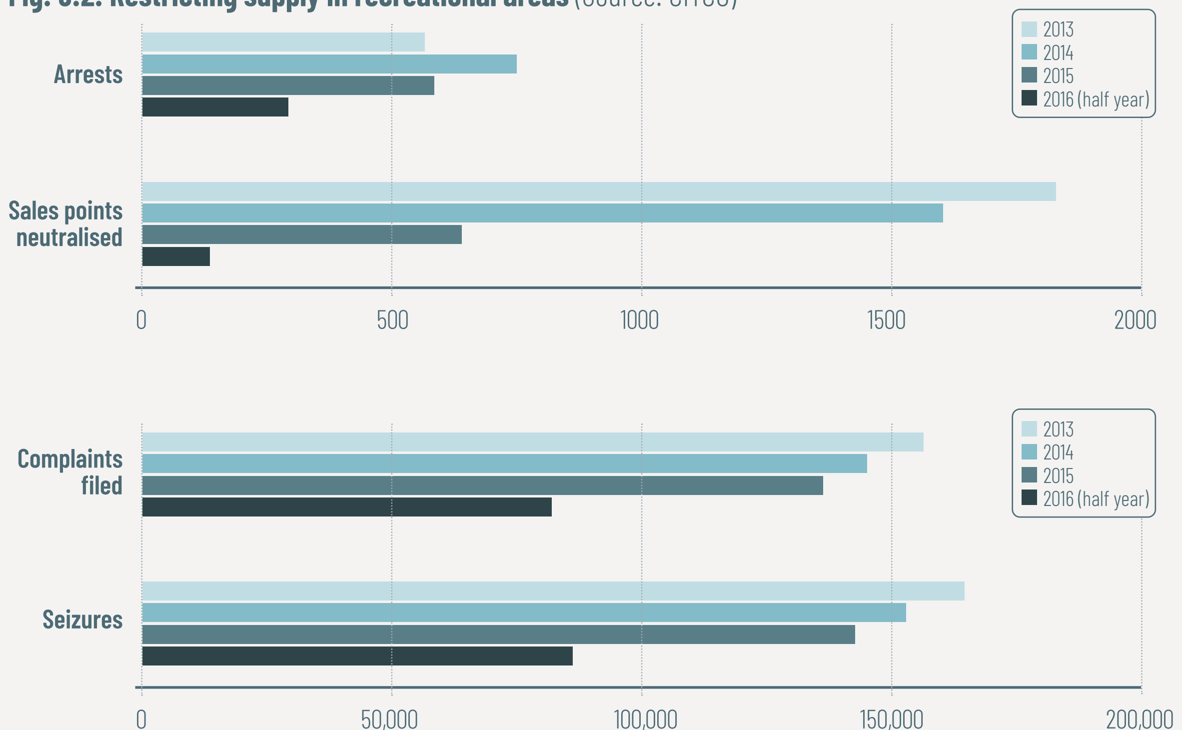


Table 9.2. Arrests, official complaints, seizures and sales points neutralised in recreational areas (Source: CITCO)

	2013	2014	2015	2016*
Arrests of Spanish Nationals	898	1.286	1.081	420
Arrests of Foreigners	440	442	405	118
Arrests	1,338	1,728	1,486 538	538
Complaints filed	138,324	146,113	134,697	45,894
Total Seizures	145,584	156,105	144,288	49,865
Sales Points Neutralised	1,197	930	553	196
Cannabis oil (gr)	185	100	40	792
Cocaine (g)	108,646	47,310	22,927	9,332
GHB (liquid ecstasy) (cc)	201	265	477	52
Cannabis resin (g)	685,423	228,274	188,949	60,243
Heroin (g)	5,028	2,580	1,740	1,630
LSD (units)	183	365	420	187
Marihuana (g)	387,116	538,539	306,364	83,608
MDMA - ecstasy (units)	10,980	10,118	9,137	747
Amphetamine sulphate (g)	5,718	5,685	21,021	3,054
Psychopharmaceutical drugs (units)	15,953	7,315	8,210	1,465

* Data corresponding to the period between 1 January and 8 May 2016 (date of the end of the second intensification phase in the Strategy Plan).

FOSTERING THE PARTICIPATION OF CITIZEN SAFETY & SECURITY UNITS IN THE FIGHT AGAINST DRUG TRAFFICKIG (MINORS AND YOUNG PEOPLE):

Organic Law 4/2015, on citizen security protection, which has been in force since 1 July 2015, covers the same offences that were in the previous Organic Law 1/92, pertaining to the use of toxic drugs, narcotics or psychotropic substances, and it adds new offences with sanctions imposed for:

- Transporting persons, in any type of vehicle, with the purpose of facilitating for them access to toxic drugs, narcotics or psychotropic substances unless it constitutes a crime.
- Illicit planting and growing of toxic drugs, narcotics or psychotropic substances in places visible to the public whenever these actions are not tantamount to a criminal offence.
- Consuming alcoholic beverages in places, thoroughfares or on public transport whenever it seriously disturbs the peace of other citizens.

The table (Table 9.3) below presents the figures compiled for the number of complaints filed by the State law enforcement and security agencies in **2013, 2014, 2015 y 2016** when implementing the provisions of this Organic Law:

Table 9.3. Official complaints filed under the Organic Law on Citizen Security (L.O 4/2015)
(Source: CITCO)

	2013	2014	2015	2016*
Total complaints	383,182	381,326	356,442	189,721
Complaints under the Citizen Security Law excluding complaints under the Recreation & Schools Plans	240,137	230,846	217,637	146,634
Complaints under the Citizen Security Law about young people aged under or up to 25	216,088	208,866	190,485	100,760

* Data corresponding to the period from 1 January to 30 June.

More than 50% of the complaints filed were about minors or young adults aged under or up to the age of 25. This is the age group to which the Citizen Safety Units pay special attention as a highly vulnerable group requiring more protection than others.

The assessment of the work done by the Citizen Safety Units to combat drug trafficking to minors and young adults is that it is effective with daily preventive services and specific services targeted at reducing drug use, drug possession or drug trafficking in public places, thoroughfares, establishments or transport.

INSPECTION PLAN FOR OPERATORS OF SUBSTANCES THAT COULD BE DIVERTED TO ILLICT CHANNELS:

In accordance with Instruction no. 16/2005, issued by the Department of the Secretary of State for Security, on *"Planning and coordination of inspections in operators of catalogued chemical substances that could be diverted for the illicit manufacturing of drugs*, the **Annual National Administrative Plans for Precursors, corresponding to each year** of the requested period have been drawn up. In these plans, checks are focused on the following groups of operators:

- Operators not registered in the General Register of Operators but for which some kind of administrative irregularity has been observed and so verification of their activities has been deemed appropriate.
- Operators that are registered but where following submission of documentation of some kind to the Precursors Area the subsequent analysis of that documentation has given rise to the assumption of irregularities being committed or that the data provided lacks consistency.
- Operators that are operating with a large quantity of catalogued substances in their commercialisation or processing activity.
- Operators that use in their activities, substances such as phenylacetic acid used in the illicit manufacturing of amphetamine type drugs subject to special monitoring because they are often diverted abroad.
- Operators recently registered in the General Register of Operators, that have not been inspected.

- Those operators that have been inspected recently but where inefficient checks have been observed in the inspection and the intention is to verify that the shortcomings have been rectified.
- Any operators that have not returned to CITCO the Annual Operations Questionnaire for previous years or where the questionnaires contain serious errors or have been returned incomplete.

According to the provisions in instruction 16/2005 cited above, the responsibility for implementing the Annual National Inspection Plan lies with the Central Inspection Unit for Operators (UCIO), a unit within CITCO, together with the specialised anti-drug trafficking units in the National Police Force and the Civil Guard.

Table 9.4 below reflects the number of inspections carried out by each one of the inspection groups mentioned in the last four years.

Table 9.4. Nº of Inspections of operators of substances that could be diverted to illicit channels (Source: CITCO)

YEAR	UCIO	POLICE	CIVIL GUARD	TOTAL
2013	37	26	26	89
2014	37	25	26	88
2015	33	29	25	87
2016	26	31	30	87

As a result of all of the inspections carried out in these last four years, the following infringements have been detected and notified to the corresponding Government Delegation (Table 9.5):

As far as the **degree of achievement of the objectives** set out in the successive annual inspection plans is concerned, the following points can be made:

- Compliance with the legislation has been ensured concerning the making available for sale of catalogued substances through the inspection of recently registered operators, by providing them with full information on the subject and by opening up a direct channel of communication for any subsequent queries.
- Likewise, the activities of other operators have been reviewed. In some of them, minor administrative errors were detected during the corresponding inspection and in each case the operator was urged to rectify the error and was informed about the most important aspects of the legislation in force.
- Communication exchanges have been streamlined as there was direct contact in the operators' own facilities not only with the agent responsible but also with the personnel in charge of the actual activities involving these substances.
- During the inspections first-hand information is given to the operator about the illicit uses of the catalogued substances which the operators' designated personnel are unaware of and

that knowledge can be of significant help in raising awareness in their collaboration with the authorities.

- In the last four years, a total of 22 infringements of different degrees of severity have been observed in the case of operators that were not ensuring proper control of the catalogued chemical substances.
- Following the opening of sanction procedures new action protocols have been set up or modified and in the main there has been a consequent improvement in the communication of data by the operators to the CITCO.

Table 9.5. Infringements by operators of substances that could be diverted to illicit channels (Source: CITCO)

YEAR	INFRINGEMENT TYPE	CATALOGUED SUBSTANCE	REGION
2013	Very serious	Potassium permanganate	Extremadura
	Very serious	Potassium permanganate	Castilla y León
	Very serious	Piperidine	Cataluña
	Very serious	Acetic anhydride	Catalonia
	Very serious	Potassium permanganate	Valencia
	Serious	Piperidine	Catalonia
	Serious	Acetic anhydride	Catalonia
2014	Very serious	Chlorhydric acid & Acetone	Catalonia
2015	Very serious	Phenylacetic acid	Andalusia
	Very serious	Potassium permanganate	Madrid
	Very serious	Potassium permanganate	Navarra
	Very serious	Potassium permanganate	Andalusia
	Serious	Potassium permanganate	Valencia
	Serious	Potassium permanganate	Catalonia
	Serious	Piperidine	Catalonia
2016[1]	Very serious	Piperonal	Catalonia
	Very serious	Potassium permanganate	Basque Country
	Very serious	Potassium permanganate	Catalonia
	Very serious	Potassium permanganate	Murcia
	Very serious	–	Madrid
	Serious	Potassium permanganate	Murcia
	Serious	–	Andalusia

1 Up to 10 December

STRENGTHENING RELATIONS WITH KEY COUNTRIES FOR SPAIN IN DRUG TRAFFICKING:

The following points can be highlighted on this subject of strengthening relations with key countries for Spain in drug trafficking involving CITCO:

- The European Union, through EUROPOL, as part of the EU 2013-2017 Policy Cycle to combat organised crime and serious international crime, is running the EMPACT (European Multidisciplinary Platform Against Criminal Threats) project which has been devised to develop actions to combat certain types of EU high priority serious crimes related to organised crime.

  EMPACT has reinforced relations on drugs in the framework of those crimes identified as high priority crimes and that include synthetic drugs, cocaine and heroin, between not only the 28 EU countries but also with other non-EU countries that are priority not only for Spain but also for the EU through the Director of CITCO, acting as the National Empact Coordinator (NEC) and all the law enforcement and security agencies involved in these actions in Spain (National Police Force, Civil Guard and Internal Revenue (Customs).

  These actions include the planning and implementation of annual operational activities in which EUROPOL coordinates the work of the participating Member States in each one of the new nine selected priorities which include these three types of drugs.

- CITCO collaborates closely with the Spanish Agency for International Development Cooperation (AECID), attached to the Ministry of Foreign Affairs, for training and information exchange in intelligence and leads on organised crime, especially drug trafficking. In this way it can build stronger relations with international bodies, counterpart centres and agencies in Ibero-America and the Caribbean.

CONTRIBUTING TO INTELLIGENCE EXCHANGE AND TO TOOLS AND PRODUCTS DESIGNED TO OPTIMISE ANTI-DRUG TRAFFICKING WORK:

The following points can be highlighted as regards the contribution made to intelligence exchange as well as tools and products designed to optimise anti-drug trafficking work involving CITCO:

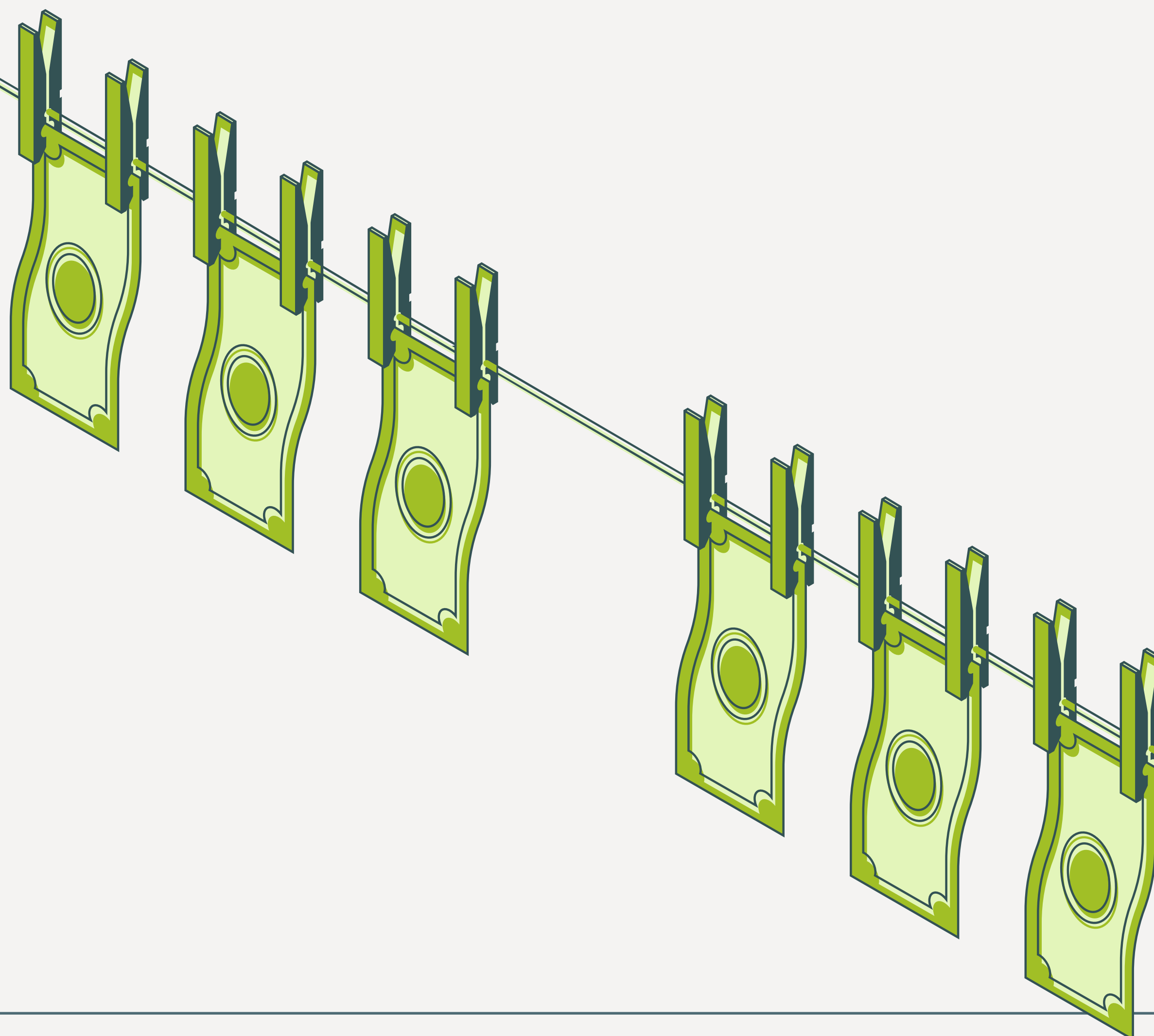
- CITCO develops, participates in and takes the lead in the Ibero-American Strategic System against Organised Crime project (SEISOCO), currently made up of eight countries (Argentina, Chile, Colombia, Ecuador, Mexico, Panama, Peru and Spain) and through which the participating countries exchange strategic information on organised crimes, with special emphasis on drug trafficking.
- CITCO is a permanent member of CLACIP *(Comunidad Latinoamericana y del Caribe de Inteligencia Policial)* and participates in its meetings for the exchange of information on transnational crime intelligence with special emphasis place on drug trafficking.
- The Bogotá Platform, set up in 2013, is a platform to exchange information on the fight against transatlantic cocaine trafficking. Led by Spain and based in Bogotá, the platform was an idea

promoted by Spain's Ministry of Interior and CITCO is directly involved in running, developing and monitoring the platform. Participating countries include some EU member states and countries in the Americas.

- CITCO runs an annual applied intelligence course on countering organised crime which among other issues examines intelligence tools and products for organised crime and drug trafficking and makes an assessment of them. The course is attended by members of the Spain's State law enforcement and security agencies, regional police forces, SEPBLAC, the armed forces and Ibero-American countries.

GENERAL OBJECTIVE 10:

ANTI-MONEY LAUNDERING (AML)



General Objective 10. Anti-money laundering (AML)

This objective falls within the remit of the Counter-Terrorism and Organised Crime Intelligence Centre (CITCO) within the Ministry of Interior. It has been developed through the following lines of action:

REINFORCING INVESTIGATIONS INTO FINANCIAL CRIME LINKED TO DRUG TRAFFICKING.

Police investigations targeting money laundering are the primary tool used to combat criminal organisations in general and narcotics trafficking in particular.

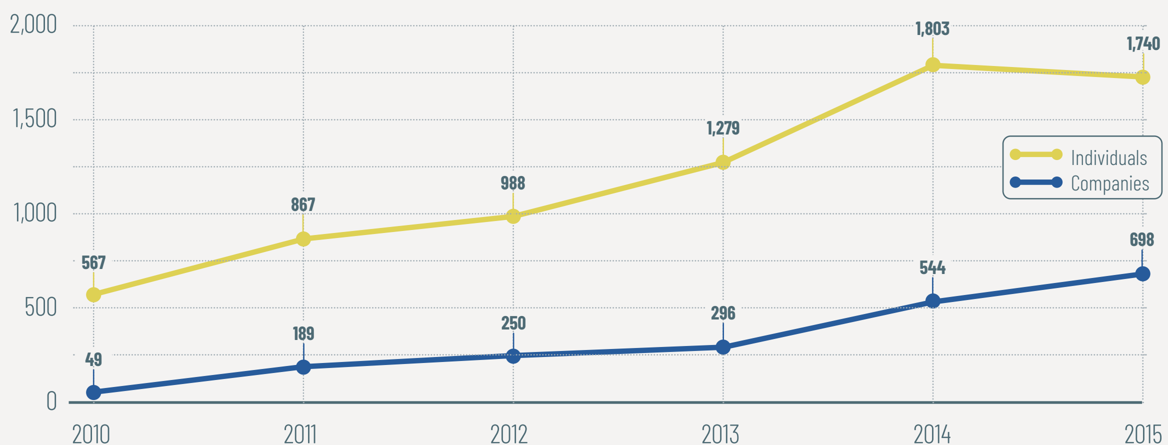
In this regard between 2013-2016 CITCO has been intensifying cooperation and specialisation initiatives in relation to investigations into the assets of these criminal organisations both in Spain and abroad.

- Spain: Five “Specialisation in police investigations into money laundering, the importance of financial wealth investigation and asset recovery” courses were held with the participation of experts from police units, prosecutors, magistrates and the Financial Intelligence Unit.
- Abroad: It has been actively involved in nine meetings of the EU ARO (Asset Recovery Office) Platform and in eight GAFILAT (Financial Action Task Force of Latin America) / RAAG meetings.

REINFORCING RELATIONS WITH KEY COUNTRIES FOR SPAIN ON MONEY LAUNDERING OF PROCEEDS OF DRUG TRAFFICKING.

The information exchanged through the two regional ARO platforms Spain belongs to has definitely gone up significantly from 1,279 individuals and 296 companies in 2013 to 1,740 individuals and 698 companies in 2015 (Fig. 10.1).

Figure 10.1. Exchange of information between Spain and other AROs: Individuals and companies investigated (Source: CITCO)



62 per cent of the information exchange requests in 2015 have been on money laundering and drug trafficking.

Although the report on 2016 has still not been finalised the figures are very similar to last year 2015.

In compliance with Council Decision 2007/845/JHA of 6 December 2007 concerning cooperation between Asset Recovery Offices of the Member States in the field of tracing and identification of proceeds from, or other property related to, crime, in 2009 CITCO became an Asset Recovery (ARO) within the Interior Ministry in order to exchange information on property and assets of persons under police investigation in any EU Member State.

Subsequently, in 2013, Spain became part of the Financial Task Force of the Latin America Asset Recovery Network (RRAG - Red de Recuperación de Activos del GAFILAT *(Grupo de Acción Financiera contra el lavado de activos en Latinoamérica)*. Joining that body means Spain can now share intelligence and information with all of the other 16 Ibero-American countries forming part of that GAFILAT Task Force (Argentina, Bolivia, Brazil, Colombia, Costa Rica, Chile, Cuba, Ecuador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru and Uruguay).

During 2015, the Asset Recovery Office and the RRAG platform have been increasingly used as international cooperation offices of this nature in the EU and Latin America respectively, continuing the trend recorded since they were set up. This indicates that they are becoming more and more consolidated as effective tools to combat organised crime whose principal purpose is financial profit.

FOSTERING EXCHANGE OF INTELLIGENCE AND OF TOOLS AND PRODUCTS SO AS TO OPTIMISE THE WORK DONE TO COMBAT DRUG-RELATED MONEY LAUNDERING.

Combatting money laundering in general and drug-related money laundering in particular is a priority in the fight against organised crime and this is reflected in Spain’s 2013 National Security Strategy where the strategic lines of action against organised crime are addressed as one of the main risks and threats to national security.

One of those strategic lines of action in the fight against organised crime in the aforementioned National Security Strategy is the need to move towards greater harmonisation of legislations on the seizure of assets of criminal organisations with Spain’s peers as well as to further and improve AML investigations with the ultimate aim of minimising their economic and financial impact.

As a result, CITCO is continuing to move forward on all kinds of questions relating to the investigation and exchange of information linked to money laundering associated with any kind of criminal activity, with drug trafficking as one of the priorities. For instance:

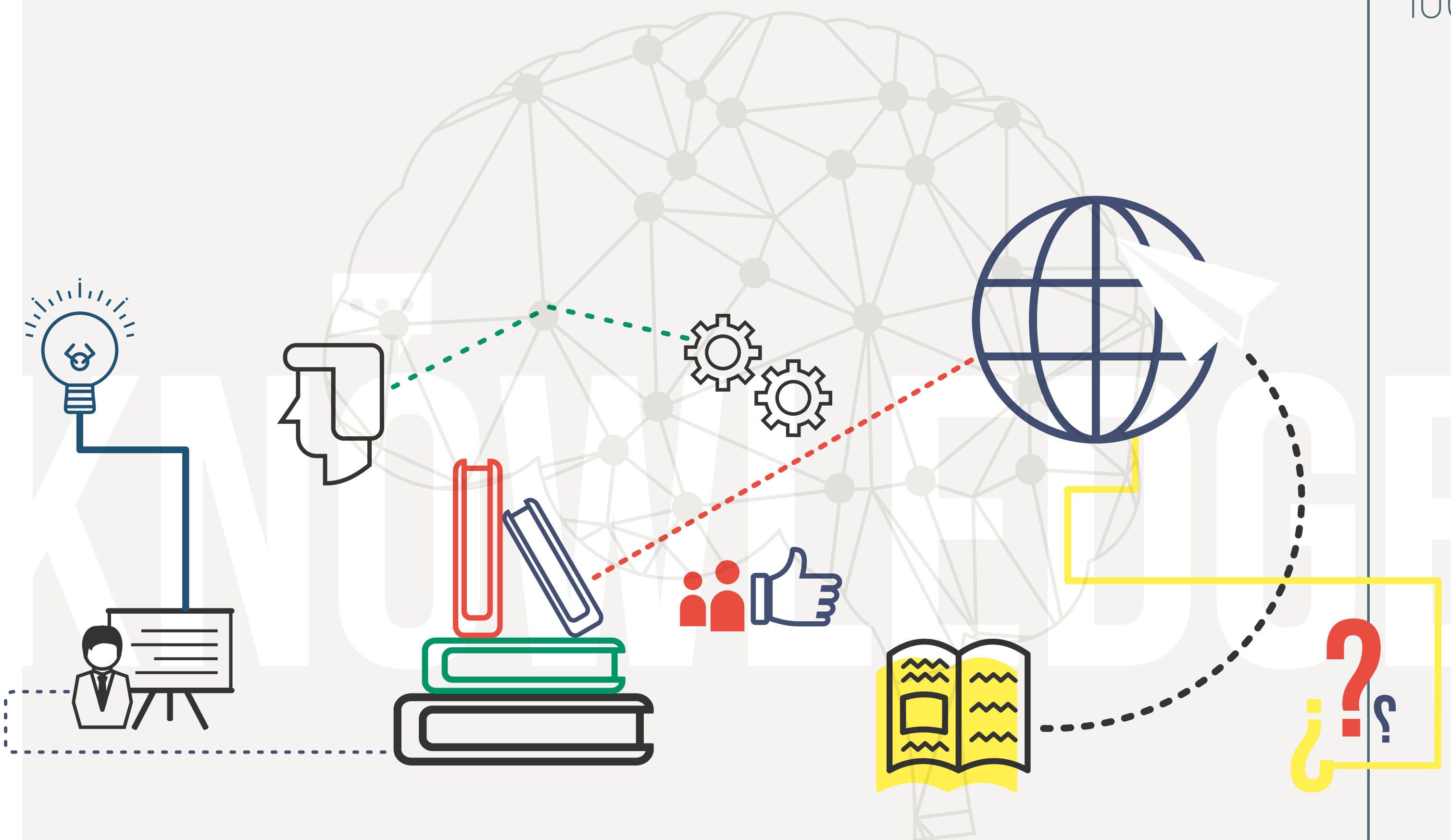
- CITCO runs an annual applied intelligence course on how to combat organised crime which covers questions including an assessment of intelligence tools and products used for organised crime and drug trafficking with special emphasis on money laundering. The course is attended by members of the State law enforcement agencies, regional police forces, SEPBLAC, the armed forces and Ibero-American countries.

- CITCO works closely with the Spanish International Development Cooperation Agency (AECID), attached to the Ministry of Foreign Affairs on training and information exchange on intelligence and leads about organised crime and especially drug trafficking and money laundering-related drug trafficking, by holding different international seminars in Ibero-America where there is an exchange of strategic information with different countries in the area on subjects including AML.

Through its organised crime data bases CITCO gathers and analyses information pertaining to money laundering by different organised criminal groups acting in our country and prepares strategic reports and exchanges information with different actors on this matter.

GENERAL OBJECTIVE 11:

DO MORE RESEARCH AND IMPROVE KNOWLEDGE



General Objective 11: Do more research and improve knowledge

One of the objectives of the 2009-2016 NDS was to increase the quantity and quality of research done to find out more about the variables related to drugs and their capacity to cause addiction, the use of drugs, their prevention and their assistance, as well as the effectiveness and efficiency of actions carried out.

Figure 11.1. Research budget DGPNSD (euros) (Source: Memoria PNSD)

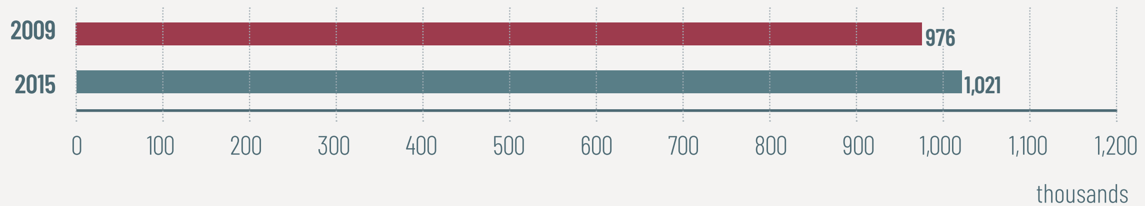
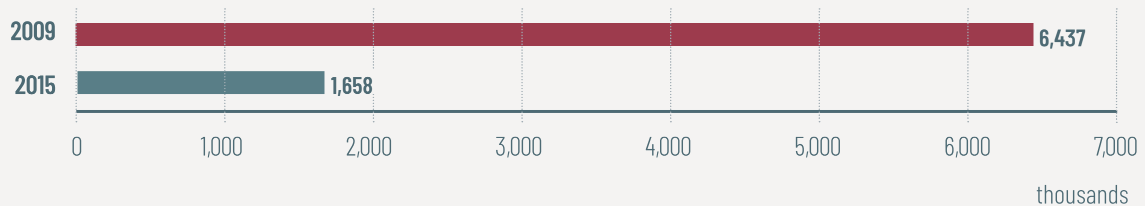


Figure 11.2. Research, documentation and publications budgets PADs (euros) (Source: Memoria PNSD)



Research is one of the areas most affected by budget cuts. Although the DGPNSD has maintained and even increased its budget for research through the contributions from the Drug Trafficking Asset Seizures Fund (Fig. 11.1), the PADs have not been able to do the same and have cut their budgets to almost a quarter. This funding cut impacts the volume of research funded which has been reduced by half in the case of the PADs (Fig. 11.2). In 2015 they funded 59 research projects, compared to the 101 funded in 2009 (Fig. 11.4). The number of projects funded by the DGPNSD, however, has risen from 15 in 2009 to 17 projects in 2016, most of which were basic research projects (Fig. 11.3). As far as the research areas are concerned, there have also been changes in the type of research funded by the PADs (Fig. 11.4): in 2009 funding was mainly for socio-health and epidemiological research projects whereas in 2015 clinical research is the area accounting for the highest number of funded research studies.

As for projects funded by the DGPNSD (Fig. 11.5), half of them focus on alcohol, a substance that started to become the centre of attention in 2009. There has been an inverse trend for cocaine: it was in the research spotlight before 2009 but the number of projects on this drug has fallen off subsequently. Cannabis is currently the number two drug with the highest number of funded research projects.

Figure 11.3. No. of DGPNSD research projects (Source: Memoria PNSD)

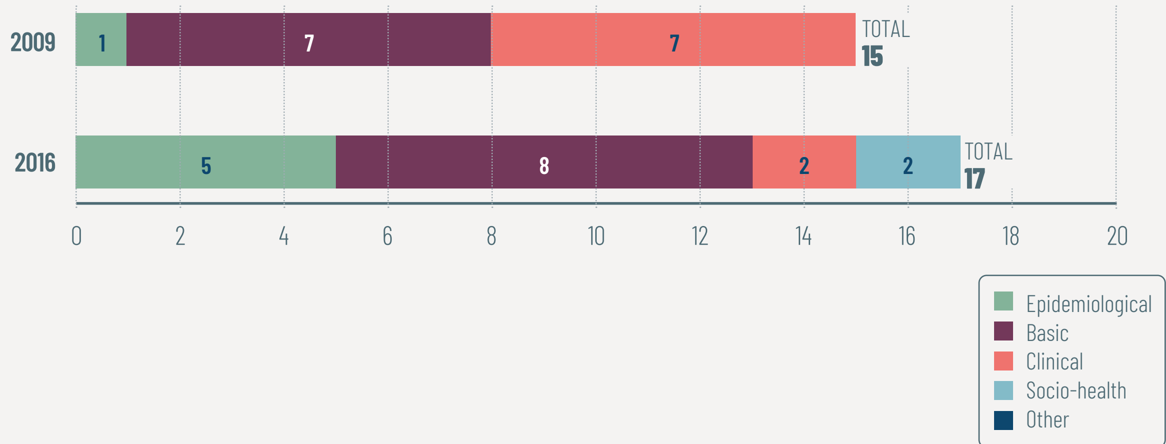


Figure 11.4. No. of PAD research projects (Source: PADs)

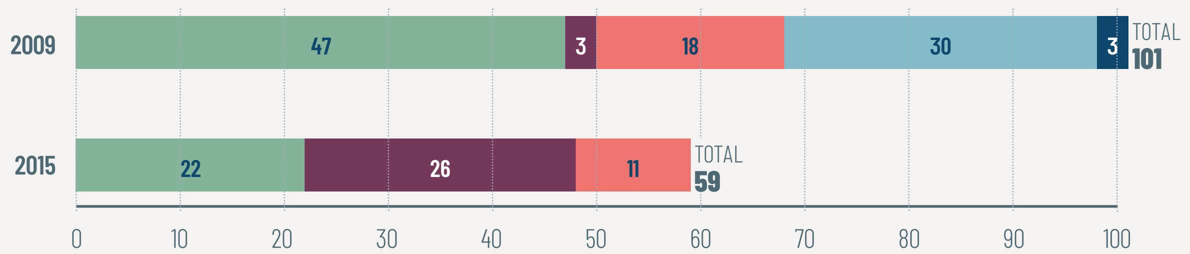
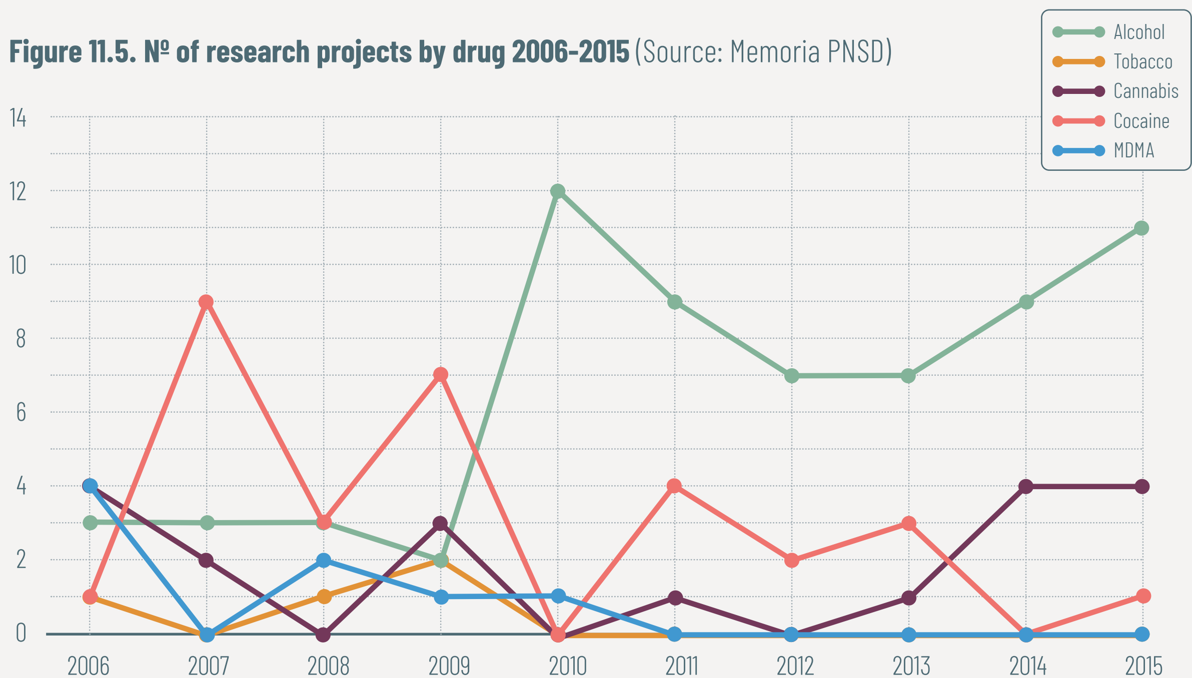


Figure 11.5. Nº of research projects by drug 2006-2015 (Source: Memoria PNSD)



Turning to the channels through which the research is made widely available, the PADs tend to use the Internet or selectively share the research with professionals (Fig. 11.7). DGPNSD-funded research is primarily made available through publications in international scientific journals and in thematic publications or books (Fig. 11.6).

Figure 11.6. Dissemination of DGPNSD-funded research: nº of projects by dissemination channel (Source: Memoria PNSD)

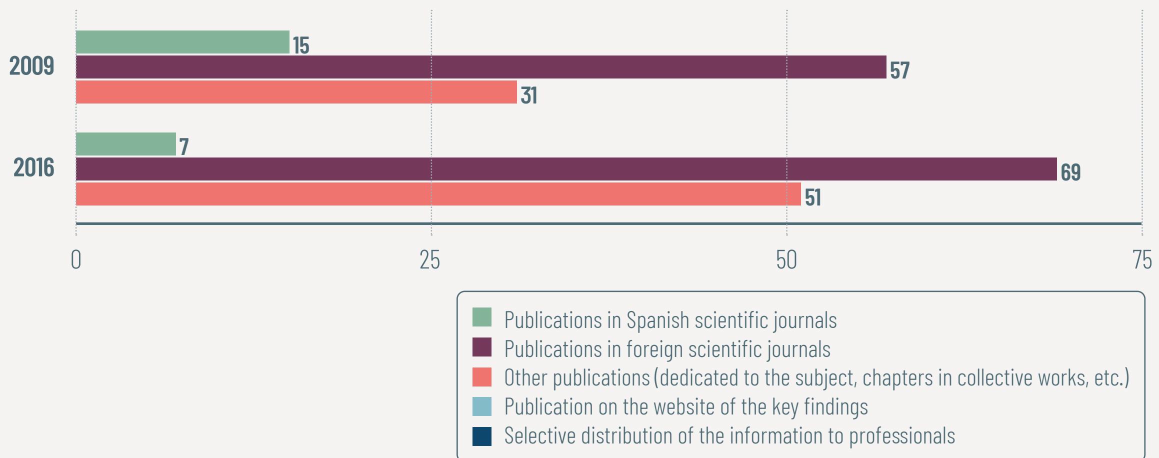
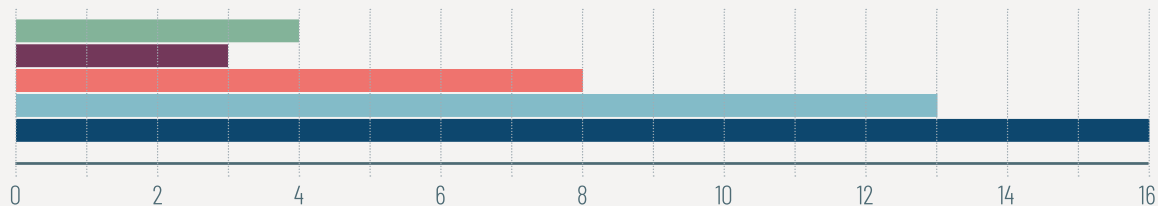


Figure 11.7. Dissemination of research ARs: No. of ARs per type of dissemination (Source: PAD, 2016)



CONCLUSIONS

The PADs mainly fund epidemiological, clinical and socio-health research projects. The DGPNSD mainly funds basic and clinical research although in 2016 it increased slightly the number of epidemiological and socio-health projects.

Research on alcohol has been one of the most funded lines of research by the DGPNSD (50% of projects), followed by cocaine, and since 2013 the number of funded projects on cannabis has also risen.

The PADs mainly disseminate their funded research through the Internet or selectively to professionals. The DGPNSD makes the research it funds available by publishing it in scientific journals and thematic publications or books.

RECOMMENDATIONS

Research on addictions funded by the Administration in Spain must be aligned with the State Plan on Scientific, Technical and Innovation Research 2017-20. More has to be done in research networks as well as multicentric groups, especially international groups.

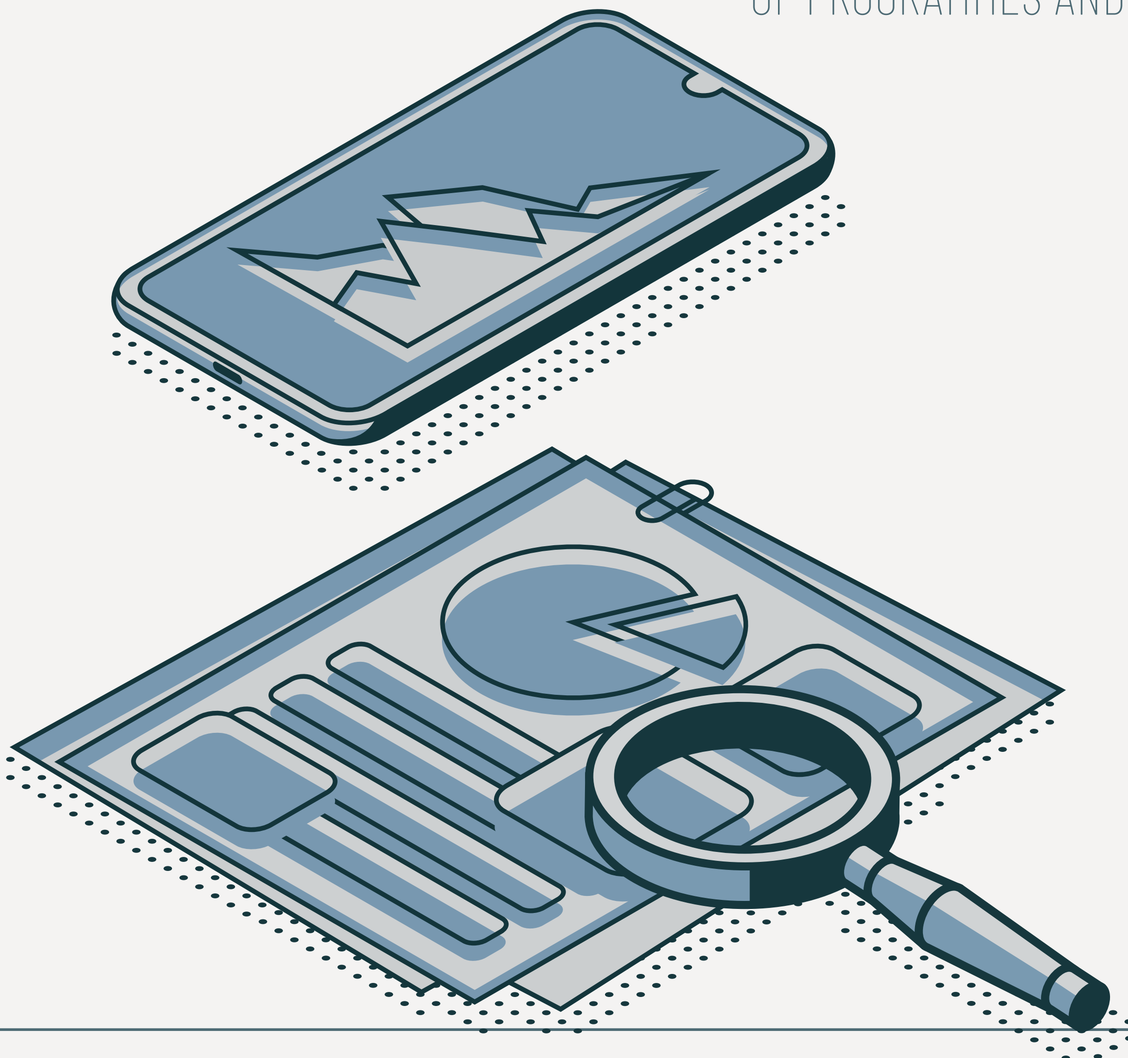
More socio-health and epidemiological research needs to be done to obtain more knowledge about the profile of new users, chronic users and older users from the standpoint of their needs.

In view of the increase in use and related problems, research and information collection about the use of cannabis and its medium and long-term effects need to be reinforced.

The findings of funded research and its applicability, both through websites and scientific publications need to be made more widely available by the PADs and the DGPNSD.

GENERAL OBJECTIVE 12:

SYSTEMATIC EVALUATION OF PROGRAMMES AND ACTIONS



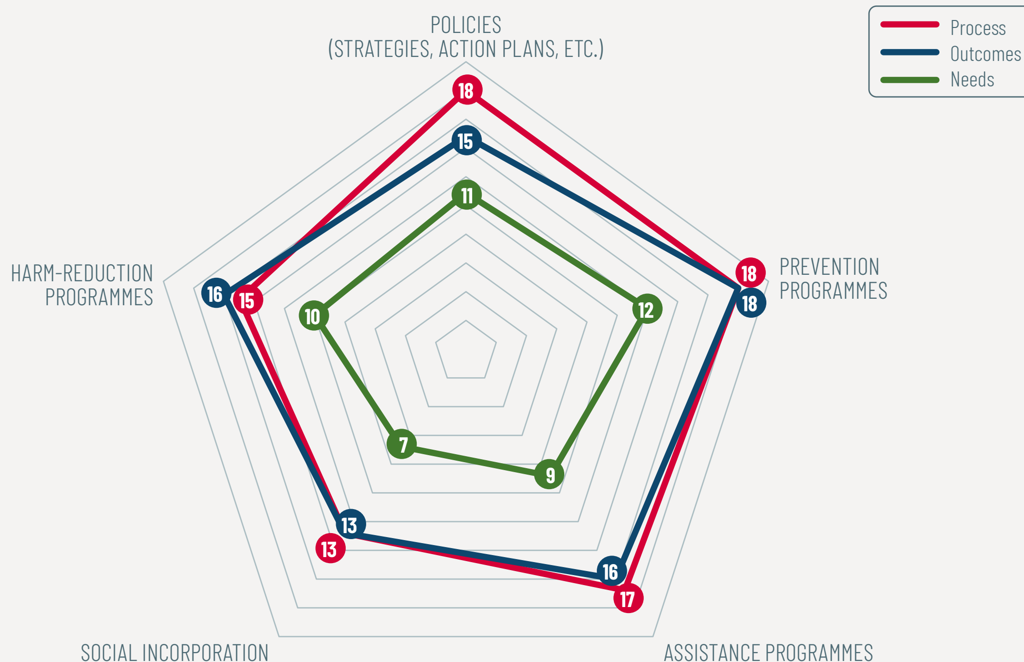
General Objective 12: Systematic evaluation of programmes and actions

One of the objectives proposed by the Strategy is “do more systematic evaluation of programmes and actions as an instrument enabling validation of the activities carried out”. To analyse the degree of achievement of this objective the PADs were consulted about the evaluations conducted in their region.

Two aspects were analysed:

- The area the evaluation was on: policies and strategies; prevention programmes, assistance programmes, social incorporation programmes or harm reduction programmes.
- The type of evaluation conducted: whether it was on needs, processes or outcomes.

Fig. 12.1. No. of PADs that carry out an evaluation of policies and programmes (max. 19)
(Source: PADs)

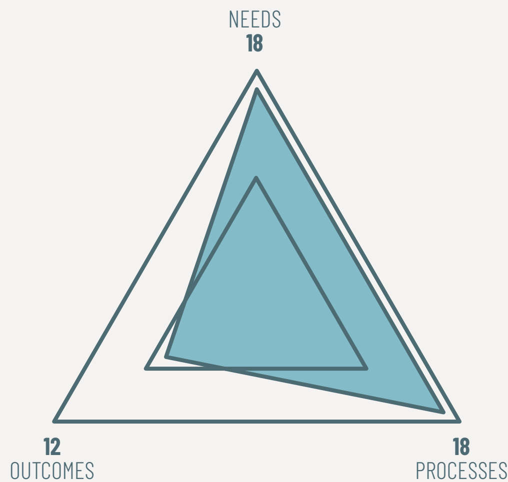


According to the data, the level of evaluation activity is good given that programme evaluations are systematically done, mainly on needs and processes and to a lesser extent on outcomes (Figs. 12.1 y 12.2). The area evaluations have been most incorporated into is prevention. In assistance there is a good level of evaluation of processes, higher than the level of needs evaluation which is also very high. In addition, over the last four years, more than half of the PADs have done evaluation reports on drug addiction programmes and services and process and outcomes evaluation reports. The opposite is the case in harm reduction where needs evaluations are more widespread than evaluations of processes.

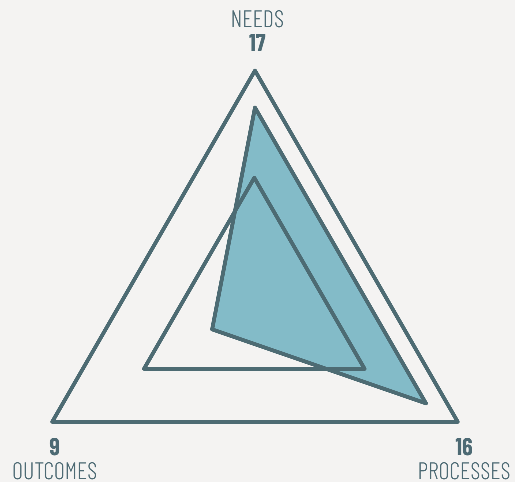
When it comes to policies, the degree of implementation of the different types of evaluation is somewhat lower because assessments of this kind have only started to be done more recently. Nevertheless, the fact that needs evaluations are not totally generalised as a basis for the design of policies and strategies is striking.

Figure 12.2. Number of PADs that carry out each type of evaluation, by intervention area. Maximum =19. (Source: PADs)

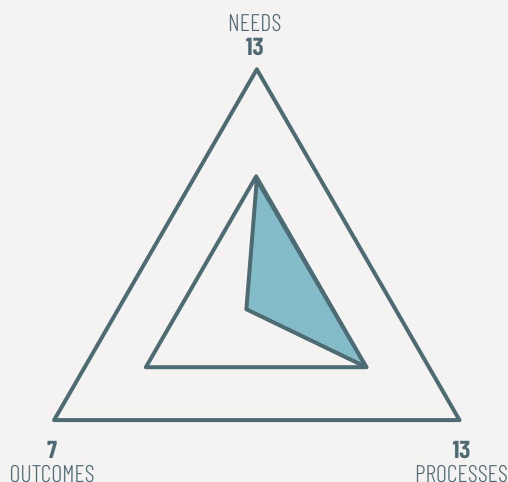
Prevention



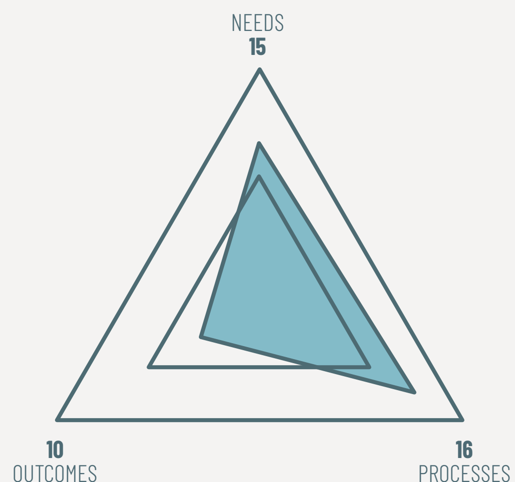
Treatment



Social incorporation

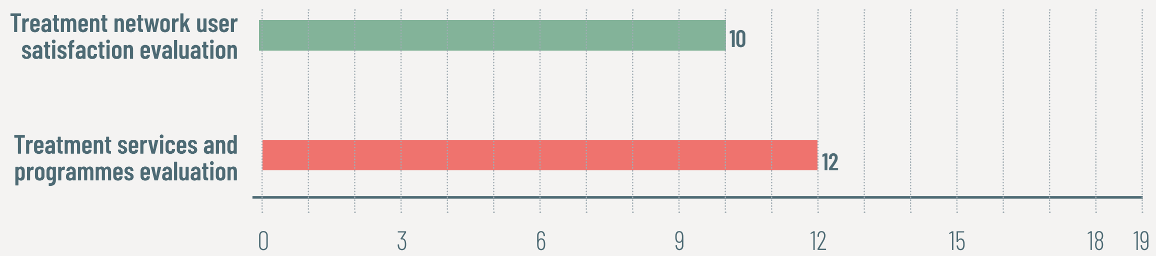


Harm reduction



Some of the PADs also carry out satisfaction rating surveys on users of drugs resources and produce evaluation reports on processes and/or outcomes of assistance services and programmes (Fig. 12.3)

Figure 12.3. No. of PADs that have done an evaluation of the treatment network (Source: PADs)



CONCLUSIONS

Programme evaluations are carried out systematically, mainly on needs and processes and to a lesser extent on outcomes.

Prevention policies and programmes are the most evaluated areas whereas social incorporation policies and programmes are the least evaluated.

Over the last four years more than half of the PADs have produced evaluation reports on processes and outcomes of programmes and services for drug addictions. Half of them have done satisfaction rating surveys on drugs network users.

RECOMMENDATIONS

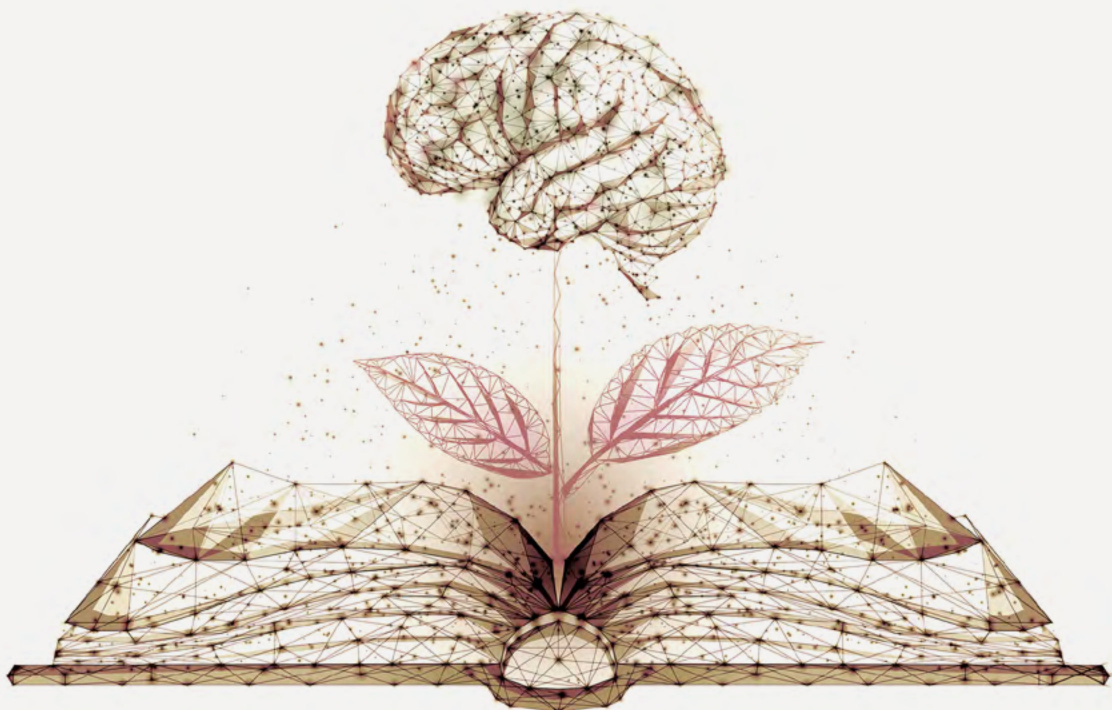
It is important to do more evaluations of outcomes as they are not as generalised as evaluations of needs and processes.

As far as the different programmes are concerned, it would be advisable to increase the number of evaluations on social incorporation programmes and keep up the level of evaluations on at least all of the other programmes.

Likewise, satisfaction rating studies on drug resource users should be generalised and more evaluation reports on processes and/or outcomes of care programmes and services should be done.

GENERAL OBJECTIVE 13:

TRAINING



General Objective 13: Training

Training for the professionals working in the drugs sector is a crucial to improving the quality of the interventions. Given the complexity of the drugs phenomenon and the multifactor approach taken to it, training is targeted at a number of different beneficiary groups.

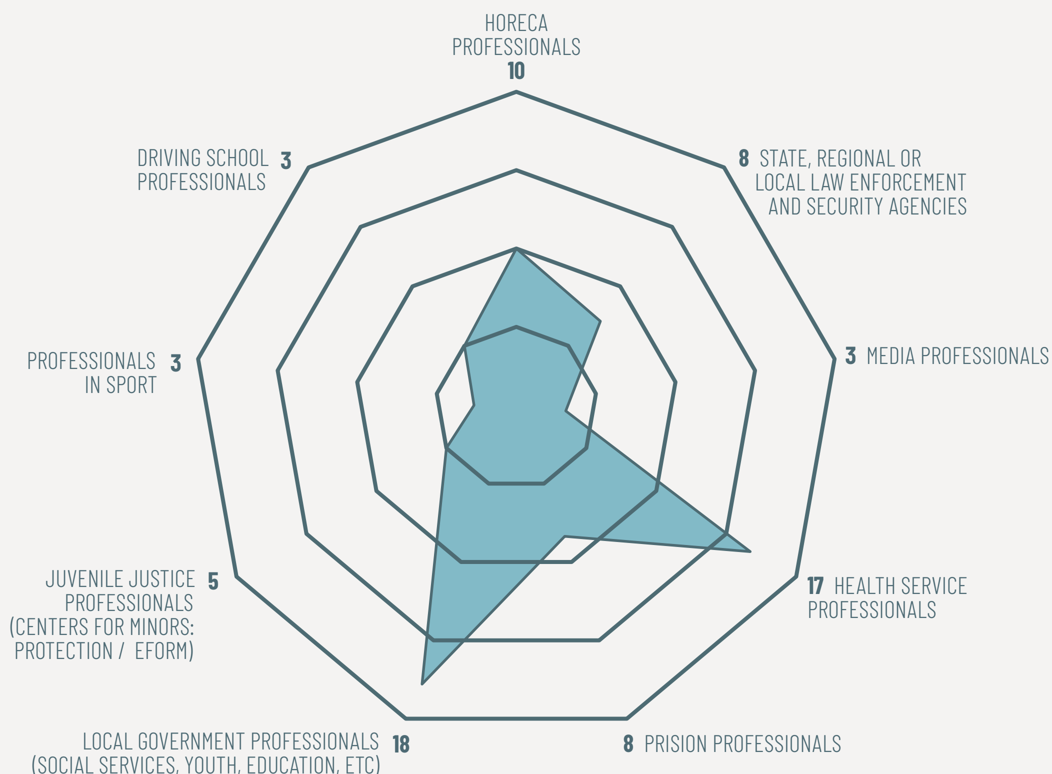
A basic distinction can be made between two categories of professionals the training is designed for:

- One, professionals in the sector who are directly involved in prevention, support, social incorporation or research.
- Two, professionals working outside the drugs network in areas with responsibilities relating to drugs.

The institutions and bodies that provide the training for these practitioners can also be divided into two types in line with the groups above:

- Institutions and bodies directly involved in the sector: PAD; DGPNSD, NGOs and scientific societies in the drugs field.
- Other central, regional and local government bodies which would include the DGT, the II.PP, FEMP and the education, health and social services departments.

Figure 13.1. Number of ARs delivering training, by type of professionals the training is designed for (Source: PADs)



We will look first at the training given by PADs and then at the training given by bodies with indirect responsibilities in this area.

The PADs focus their training activities on practitioners in the areas of health, education and social services. i.e. professionals with a more direct connection with the drugs sector. Increasingly, however, other professionals in mediation roles, such as professionals in the HORECA sector, law enforcement and security agencies, are also being included as beneficiaries of the training on offer. A minority of PADs train professionals in centres for minors, the media, driving schools or sports monitors (Fig. 13.1 and 13.2).

In addition to this basic training, five autonomous regions also have master's degrees on substance dependence and seven offer postgraduate programmes (Fig. 13.3).

Figure 13.2. Number of professionals trained by the PADs (Source: PADs)

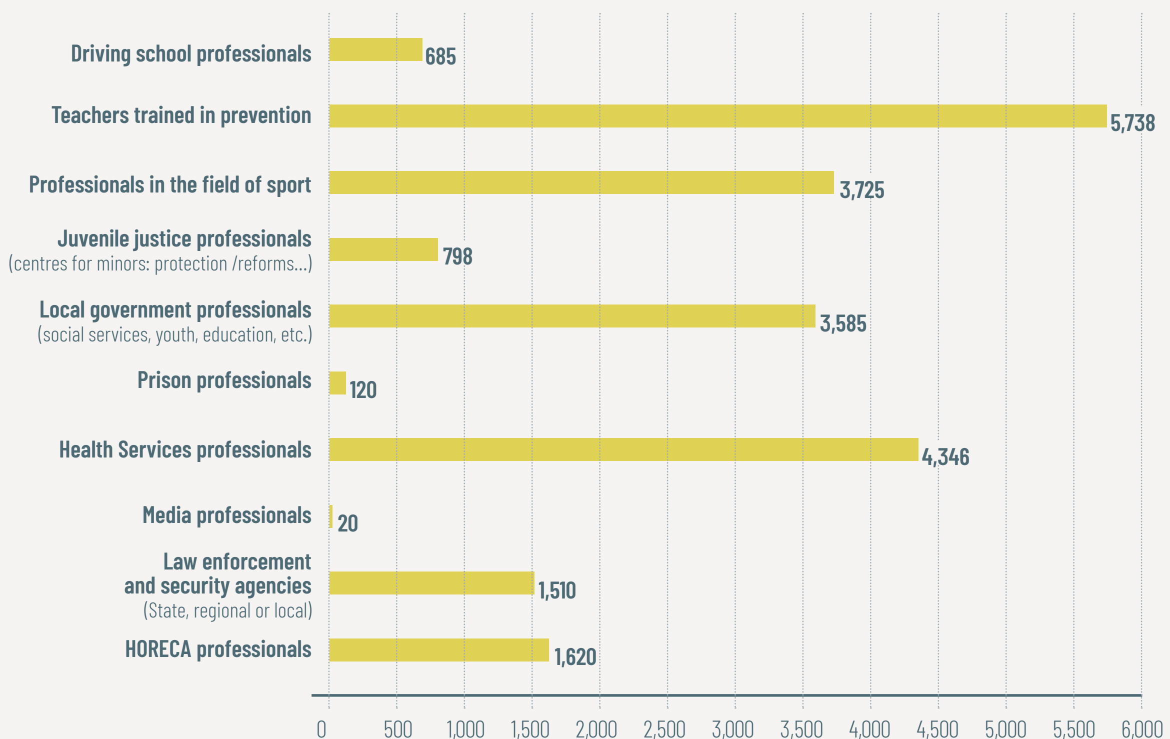
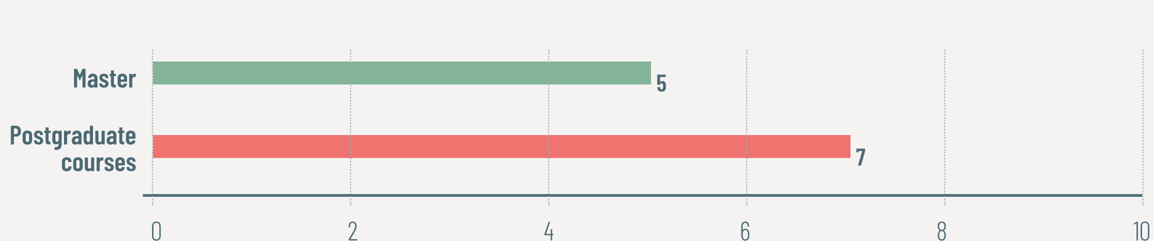
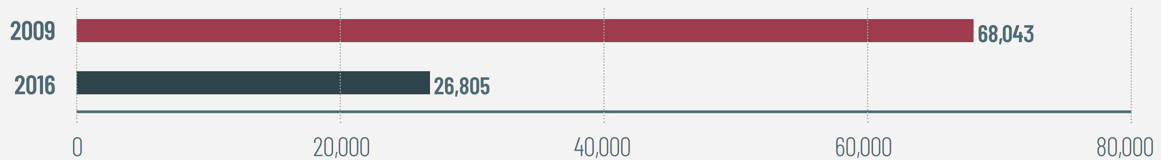


Figure 13.3. No. of ARs with Master and Postgraduate courses (Source: PAD)



Teaching staff in schools deserve a separate mention here because of their pivotal role in prevention at schools and because of the volume of professionals trained each year. Over 25,000 teachers were trained in 2016, only one third of the number who received training in 2009. This is another indicator showing the huge drop in prevention taught in schools already seen above in the analysis of G.O. 3 in this report (Fig. 13.4).

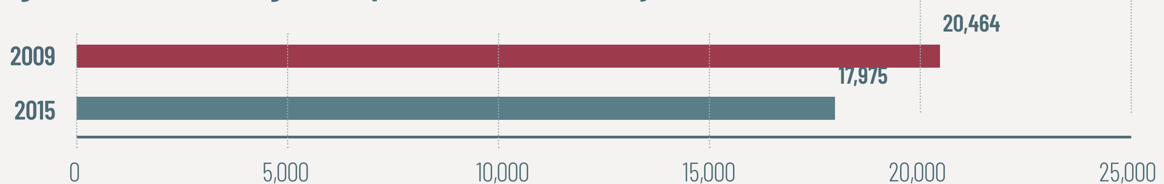
Figure 13.4. No of teachers trained in prevention by the PADs (Source: Memoria PNSD)



As well as the PADs there are **other government departments** with indirect responsibilities in this area that also offer training. This evaluation has gathered information about the activities run by the DGT, the II.PP. (prisons) Secretariat General and the education system. It includes an estimate of secondary school teacher training provided by the regional education departments themselves outside the framework of the PADs.

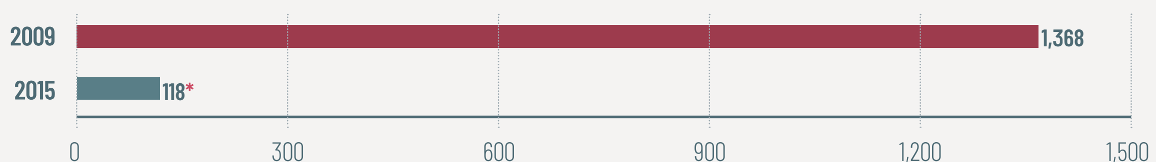
Outside of the education system, the DGT is the institution that doing the most in training. Although its training activities have been reduced compared to 2009, it still provides mass training to driving school professionals to prevent alcohol and drugs-related traffic accidents (Fig. 13.5).

Figure 13.5. Nº of driving school professionals trained by the DGT (Source: DGT)



The prisons authority (II.PP) is another body that does a great deal of training for professionals working in the prison system although over the last year that training has been concentrated on practitioners working in specific modules solely for inmates with substance dependence in assistance programmes (Fig. 13.6).

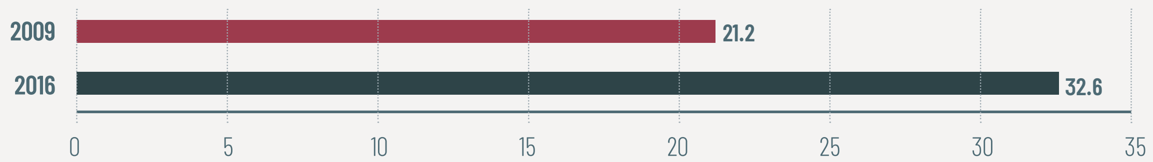
Figure 13.6. Nº of professionals trained by II.PP.



* only specific modules

Lastly, the education system also does a lot of training. According to the DGPNSD teacher survey, unlike what has happened in teacher training run by the PADs, the percentage of teachers in compulsory secondary school grades (ESO) trained has increased significantly compared to 2009. The same survey tells us that only 30% of the teachers trained in the last 5 years have received their training through the PADs (Fig. 13.7).

Fig. 13.7. Percentage of ESO grade secondary school teachers trained on drugs (Source: OEDA)



CONCLUSIONS

The complexity of the drugs phenomenon and the interdisciplinary approach taken to it makes training in this field equally complex because of the large number of groups of professionals the training is for and their different functional reporting lines.

Training on drugs is given by the sector itself and also by bodies with indirect responsibilities over drugs. In many cases this training is not done in a coordinated manner.

The groups receiving most training are school teachers, health professionals and driving school professionals. In the period covered by the NDS training activities run both by the PADs and by other government departments seem to have fallen.

RECOMMENDATIONS

There should be an agreed, certified and accredited training offering that takes into account the different groups of professionals working in the sector.

Coordination is essential with the departments and bodies with indirect responsibilities on the subject so that a joint training offering can be developed in line with the recommendation above. This would avoid any duplication of efforts and guarantee the quality of the training.

Training for professionals with direct and indirect responsibilities over drugs and other addictions should match the professional profiles of the groups trained. Their profiles and their training needs must be clearly defined for that to be possible.

GENERAL OBJECTIVE 14:

OPTIMISE INTERNATIONAL COORDINATION

General Objective 14: Optimise international cooperation

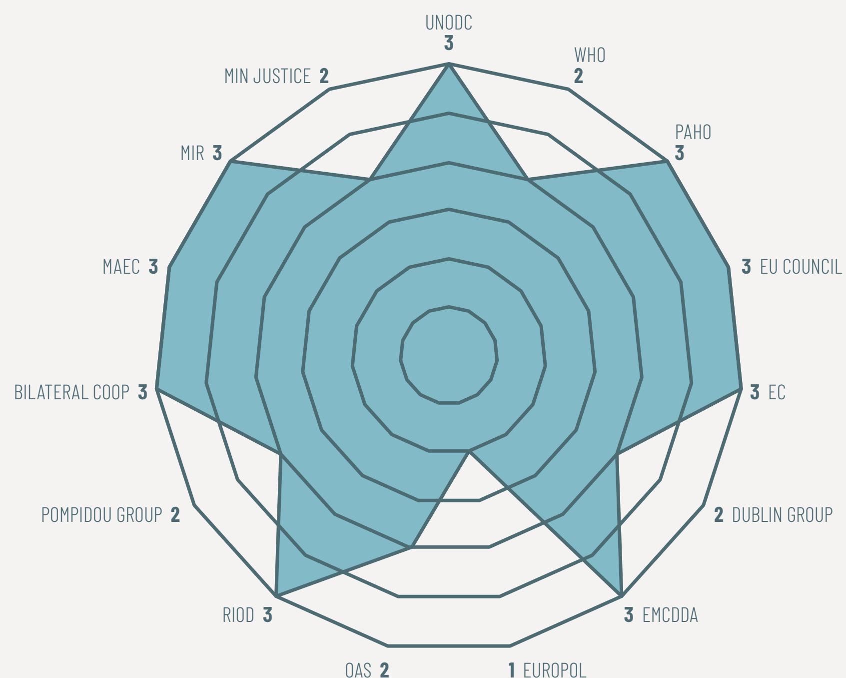
In the field of international relations, it is crucial for Spain to be represented on an ongoing basis in the different forums in which international policies and actions on drugs are developed as well as be involved in the documents that are produced in these contexts (Fig. 14.1). This is undoubtedly the most time-consuming and resource-intensive activity and given its characteristics it is one that is hard to document properly and to measure adequately in a strategy or action plan.

The DGPND's active participation in selected key, high-quality international projects is a guarantee of its involvement in the most novel and innovative work taking place in the field of addictions.

The highlights of the 2009-2016 period are listed below:

- Work done during the first semester in 2010 during Spain's presidency of the EU Council, chairing the Horizontal Group on Drugs and organising the meeting of National Drugs Coordinators.
- Design and implementation of the COPOLAD I and COPOLAD II projects funded by the European Commission and led by the Government Delegation for the National Drugs Plan.
- Preparatory work for and participation in UNGASS (UN General Assembly Special Session on global drugs problems) in 2016.
- Participation as a collaborating partner in the Joint Action on Alcohol RARHA (Reducing Alcohol-Related Harm).

Fig. 14.1 DGPNSD: Level of International Cooperation



COORDINATION (0-3)
0: No coordination.
1: Low level of coordination: ad hoc meetings.
2: Medium level of coordination: working groups to develop ad hoc projects.
3: High level of coordination: collaboration agreements; working groups to develop coordinated projects, written coordination protocols.

GUIDING PRINCIPLES: EVIDENCE, SOCIAL PARTICIPATION, INTERSECTORAL ACTION, INTEGRALITY, EQUITY, GENDER

Guiding Principles: Evidence, Social Participation, Intersectoral Action, Integrality, Equity, Gender

The following aspects listed below have been taken into consideration when evaluating this objective:

a. The inclusion of evidence in the PADs' policies and programmes.

b. The existence of accreditation systems and, where applicable, the degree of development of that system (in line with the scoring used in the evaluation (chart 4. Methodology).

c. The structuring of the programmes and services offered by the PADs (catalogues of programmes, portfolios of services).

d. Social participation: the channels put in place for participation are evaluated.

e. Equity: the accessibility of the different programmes and services is evaluated.

f. Gender: the way in which the gender perspective has been incorporated into policies and programmes is assessed.

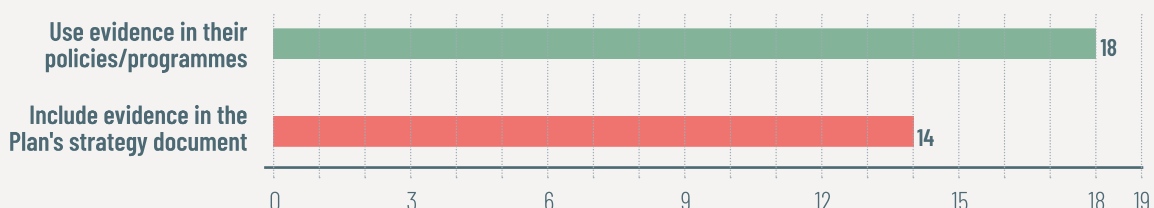
A. THE INCLUSION OF EVIDENCE IN THE PADS' POLICIES AND PROGRAMMES

Over recent years sources and catalogues of evidence and best practices in addictions have appeared. It is essential they are taken into account both in policies and programmes in order to guarantee the quality of interventions.

The PADs have evolved over time in this respect, by progressively incorporating evidence which is no longer an aspiration in most strategy documents but part of their practice. Now most PADs say they consider evidence when deciding on their strategic objectives and also when designing their programmes. A high percentage of PADs say that evidence is explicitly included in their strategic planning document (Fig. 15.1).

Despite the unquestionable progress that has been made on evidence inclusion, the need to make interventions more efficient makes this one of the crucial challenges and objectives of future strategies.

Fig. 15.1. Nº of PADs that include evidence in policies and programmes (Source: PADs)



B. EXISTENCE OF ACCREDITATION SYSTEMS

In a similar way to the appearance of evidence in the section above, and perhaps with even more intensity, a number of proposals have been made by different bodies on accreditation criteria and/or quality standards to improve programmes and services. Quality criteria are principles or rules used to implement programmes in the most appropriate way. They cover both formal aspects (structure, personnel composition…), and quality-related process aspects (intervention process, appropriateness of contents, evaluation processes….).

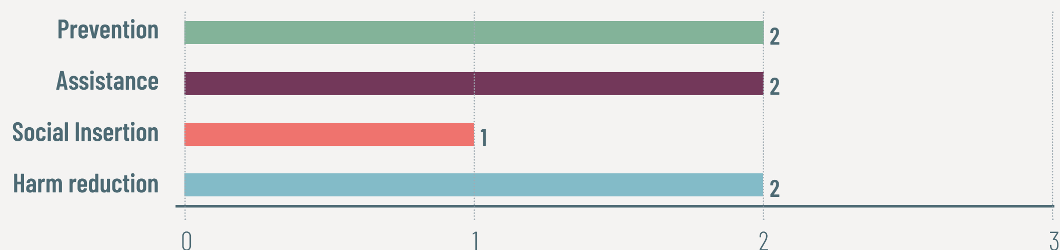
Spain has participated in international projects whose purpose is to establish a consensus on the quality criteria to be used (EQUS; EDPQS; COPOLAD). Those projects are now in the dissemination and implementation phase. In addition, in the NDS 2013-2016 Action Plan on Drugs, a task force was set up to adapt European criteria to the situation in Spain. The outcome of the work done by that task force was the approval in the Interregional Commission of a list of minimum quality criteria for the sector.
https://pnsd.sanidad.gob.es/pnsd/planAccion/plan/productos/pdf/Accion_31_Estandares_minimos.pdf

The implementation of those standards by the PADs has been evaluated in this section. A progressive scoring scale was used ranging from the non-existence of criteria (graded 0) to the full implementation of quality screening for all the programmes and services.

According to the information furnished by the PADs, the degree of accreditation of programmes in Spain is medium, with a similar level for the Prevention and Assistance areas and a slightly lower level for Harm Reduction. As is the case with other aspects of this evaluation, the Social Incorporation area is the least developed area (Fig. 15.2).

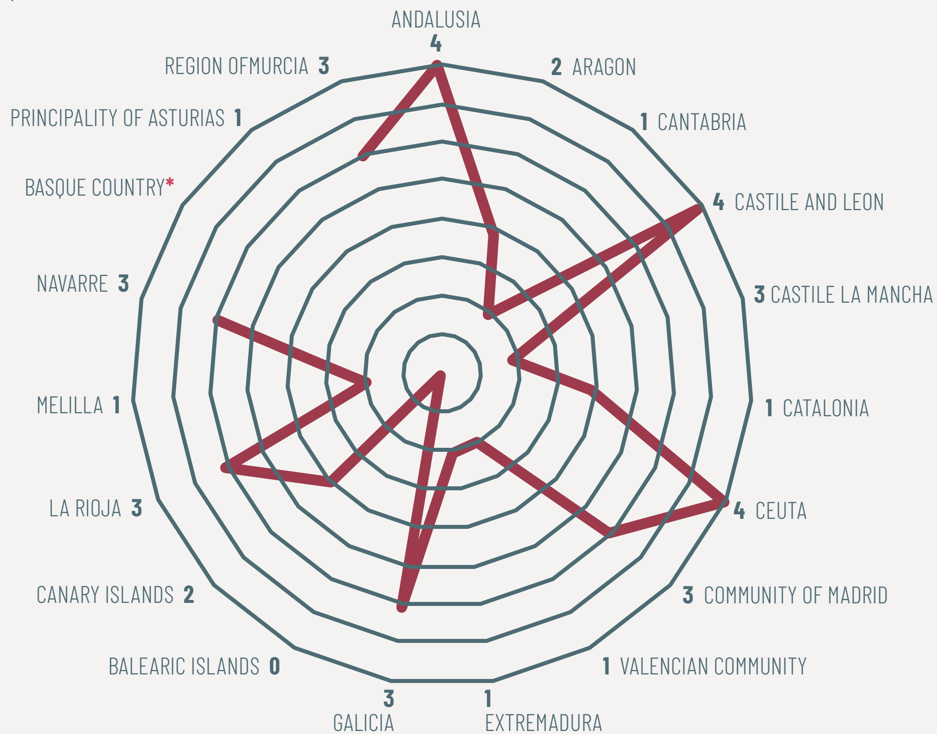
There are many differentces betwen the autonomous regions: eight of them show a good level of development in at least one of the Demand Reduction areas (Fig. 15.4). In all the others there are clear opportunities for improvement because in almost all of them although quality criteria exist their degree of implementation is uneven. By way of example, the accreditation profile in Prevention is presented below (Fig. 15.3).

Fig. 15.2. Average degree of accreditation of regional programmes (Source: PADs)



ACCREDITATION (0-4)
0: No criteria exist.
1: Low: Quality evaluation criteria exist and are published.
2: Medium: There are evaluation instruments but they are not scored on a scale.
3: High: There are evaluation instruments and they are scored on a scale.
4: Total: Programmes and services are accredited in line with quality criteria.

Fig. 15.3. Level of accreditation of prevention programmes in the Autonomous Regions (max. 4) (Source: PAD)

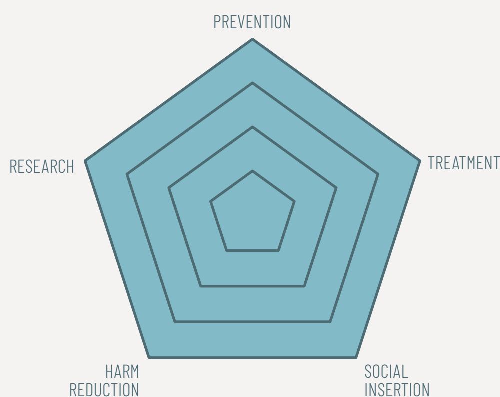


ACCREDITATION (0-4)
0: No criteriaexist.
1: Low: There are quality evaluation criteria and they are published.
2: Medium: There are instruments to rate the criteria but they are not scored on a scale.
3: High: There are instruments to rate them and they are scored on a scale.
4: Total: Programmes and services are accredited in line with quality criteria.

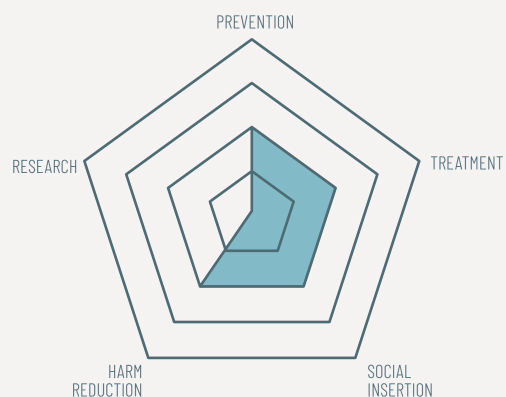
No information provided by the Basque Country (País Vasco)

Figure 15.4. Accreditation profiles of the Autonomous Regions* (Source: PAD)

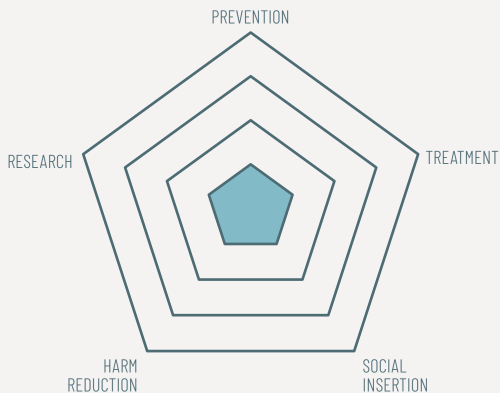
Andalusia



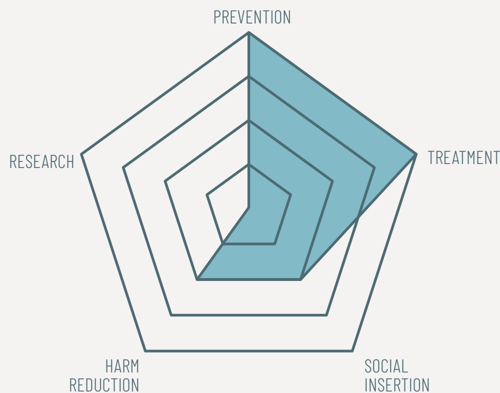
Aragon



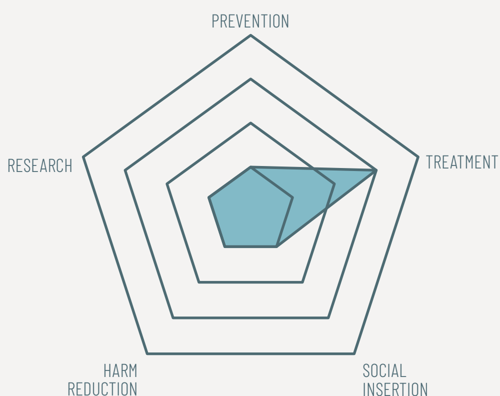
Cantabria



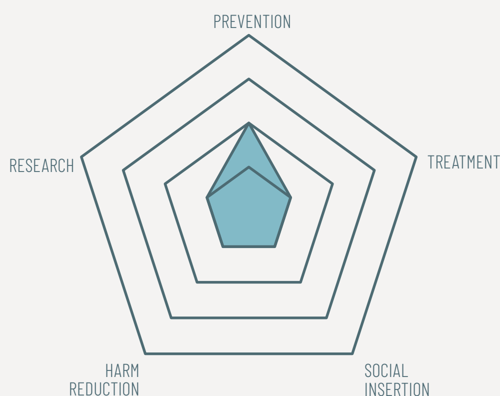
Castile and Leon



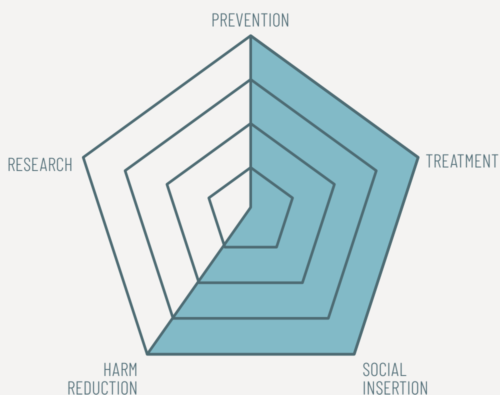
Castile La Mancha



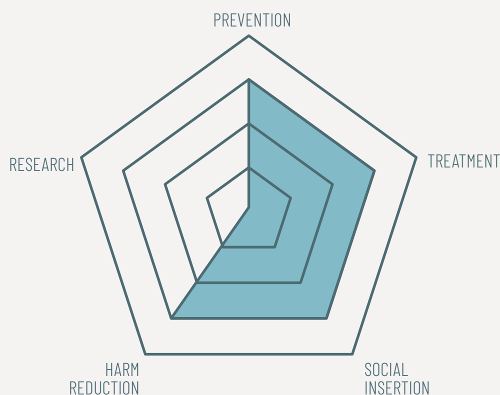
Catalonia



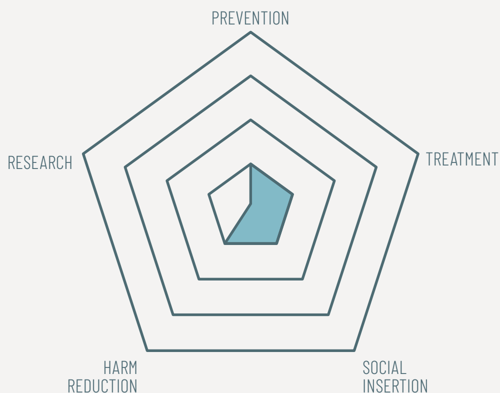
Ceuta



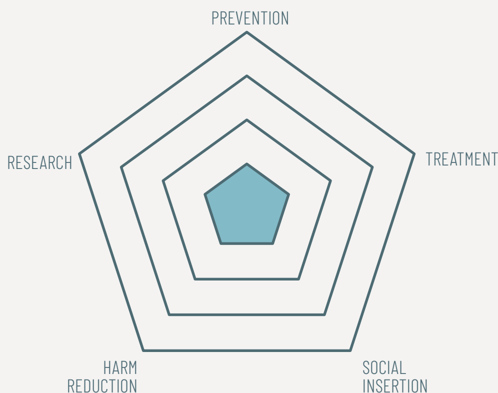
Community of Madrid



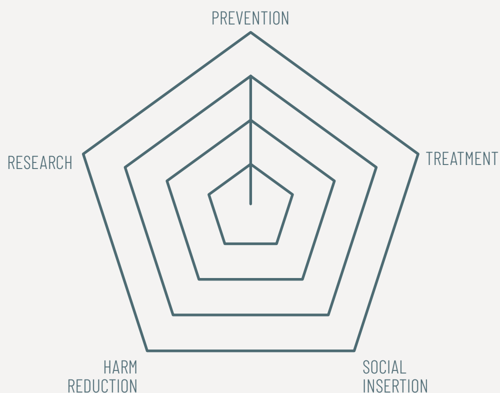
Valencian Community



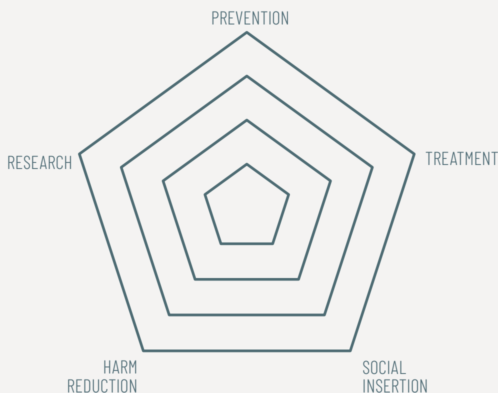
Extremadura



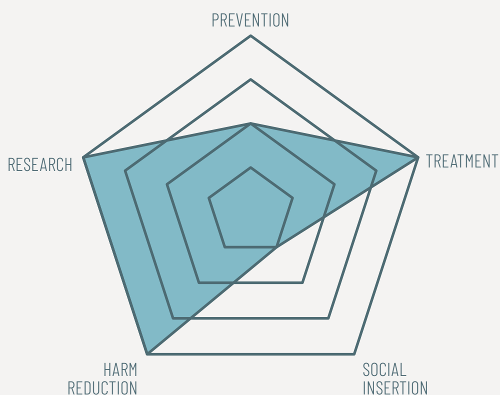
Galicia



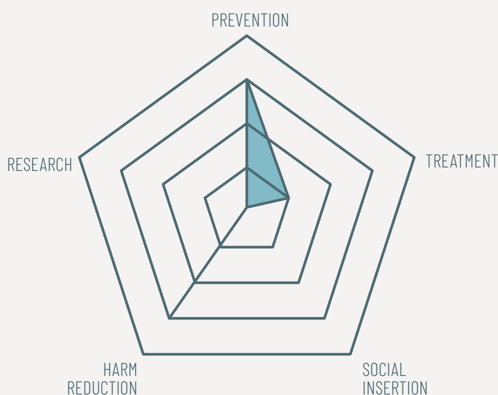
Balearic Islands



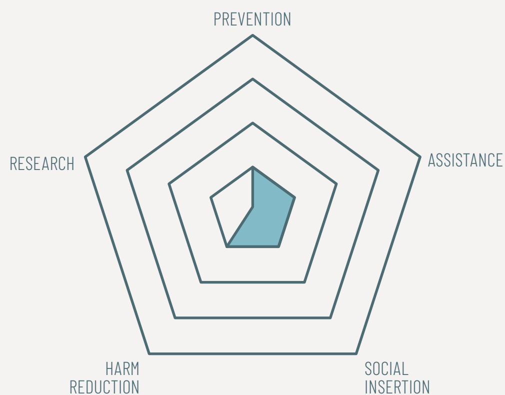
Canary Islands



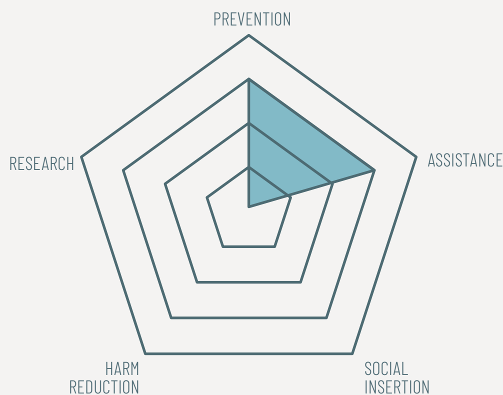
La Rioja



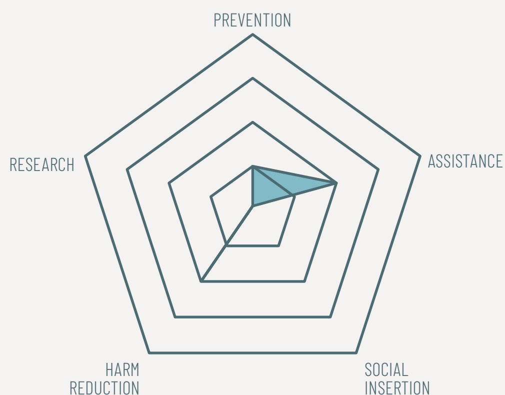
Melilla



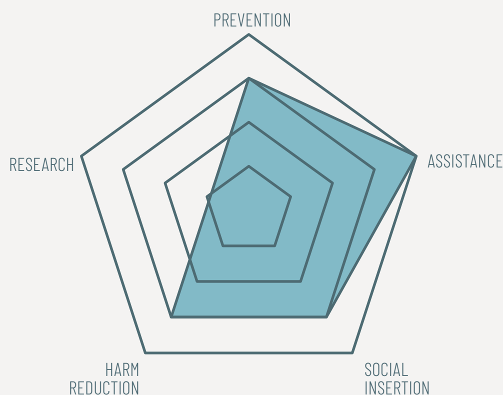
Navarre



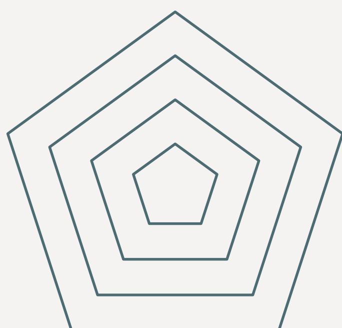
Principality of Asturias



Region of Murcia



Basque Country [No information]



C. STRUCTURE OF THE OFFERING OF PROGRAMMES AND SERVICES IN THE PADS (CATALOGUES OF PROGRAMMES, PORTFOLIOS OF SERVICES)

As seen in the evaluation of objectives 2, 3, 7 and 8, the PADs offer a broad and diversified offering of programmes and services in all areas of action. This section assesses whether this offering is organised and structured in catalogues of programmes and/or portfolios of services, according to the functional and organic reporting lines that exist in each PAD (those PADs falling within the area of health are more likely to develop portfolios whereas those that come under social services are more likely to put together catalogues of programmes).

The performance score for achievement of this objective is medium: around half of the PADs have one or more of these instruments. The assistance area is the most developed area as far as portfolios of services are concerned and, as usual, the social incorporation area is the least developed. In the case of catalogues, the prevention area is the one that stands out clearly over all the others (Fig. 15.5 and 15.6).

Fig. 15.5. Nº of ARs with Programme Catalogues
(Source: PADs)

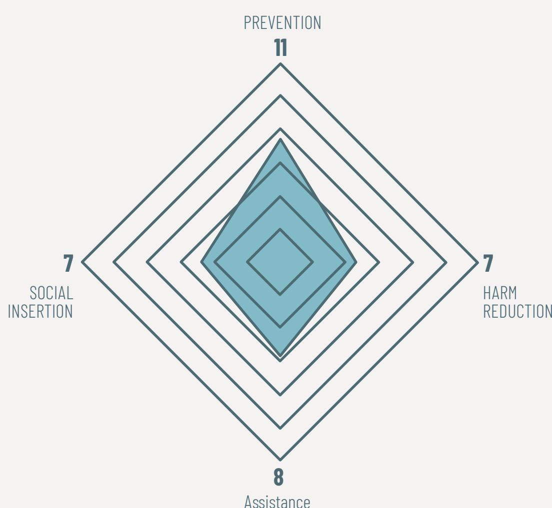
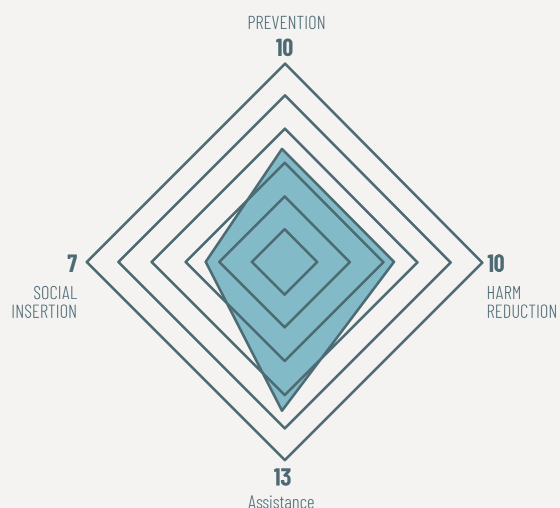
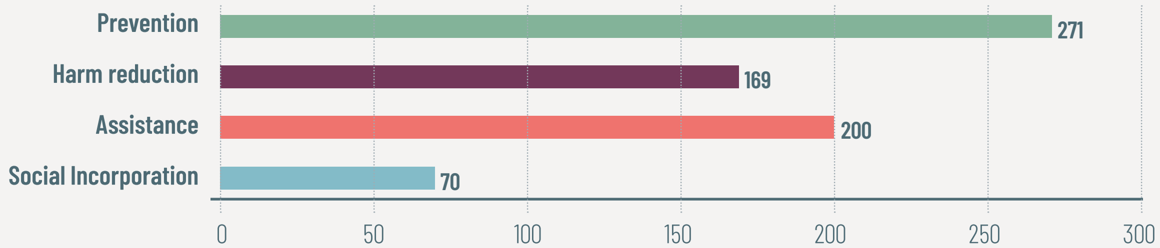


Fig. 15.6. Nº of ARs with Portfolios of Services
(Source: PADs)



The area with the most programmes is Prevention, followed by Assistance (Fig. 15.7). The average number of programmes per catalogue in the case of Prevention is 25; 25 for Assistance e too; in Harm Reduction 24 and in Social Incorporation 10. These numbers reflect a highly varied and diversified offering that should probably be made more homogeneous by selecting the evidence-based programmes.

Fig 15.7. No. of programmes included in PAD Catalogues (total) (Source: PADs)

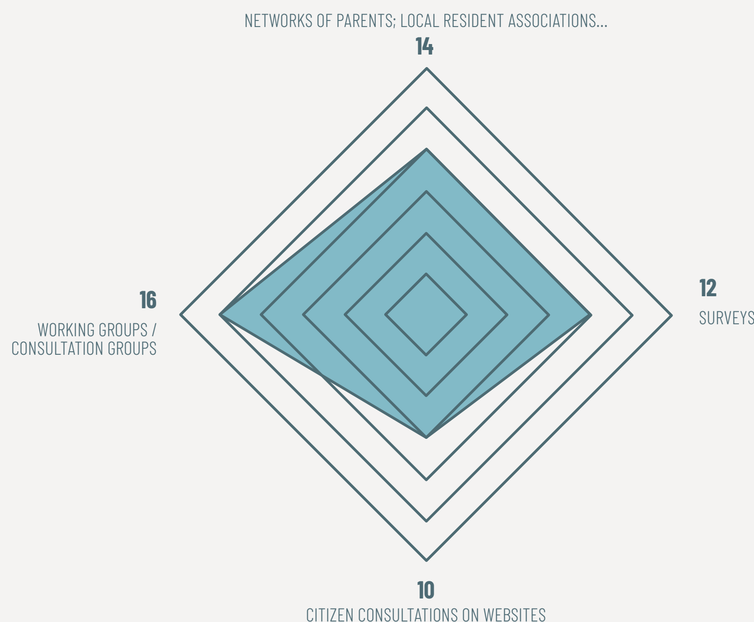


D. SOCIAL PARTICIPATION

Social participation seeks to engage the whole of society and raise awareness so that society becomes directly involved in the response to drugs. That means this objective is a good fit with GO 2 on Social awareness-raising, where we saw a high degree of activity in the sector, essentially in educational and recreational settings, health centres, websites etc. and in addition with high territorial coverage. In this section we will assess the actions whose aim is to directly engage citizens.

In most of the PADs consultation processes targeting professional groups and key information sources are usually organised through working groups but in far fewer cases these consultations are designed to interact with citizens in general. Over recent years, with the preparation of new drugs strategies or plans, half of the autonomous regions have opened public consultation sections on their websites to help establish priorities and run opinion polls. Another option used by many PADs is to rally civil society through the support to networks of parents, local resident associations and community groups (Fig. 15.8).

Fig. 15.8. No. of ARs that foster social participation (Source: PADs)



E. EQUITY

This principle seeks to guarantee effective equality when it comes to access by citizens to different programmes and services. To evaluate this principle the existence of any specific measures put in place by the PADs to reduce any access difficulties of certain social groups like people with disabilities, minors, older people aged over 65, people working in prostitution and other marginal or more vulnerable groups, was analysed (Fig. 15.10). When it comes to social groups with particular circumstances affecting their accessibility to services, we can identify three different levels according to the number of PADs that incorporate measures to make access easier for them (Fig. 15.9):

There are many differences between the autonomous regions: 15 of them offer measures for more than half of these groups (two of them with the maximum score), and only 4 would be below this level. These differences in the programmes and services on offer in the different regions, however, may lead to situations of inequality (Fig. 15.11).

Fig. 15.9. Number of ARs with measures to improve the accessibility of programmes and services
(Source: PADs)

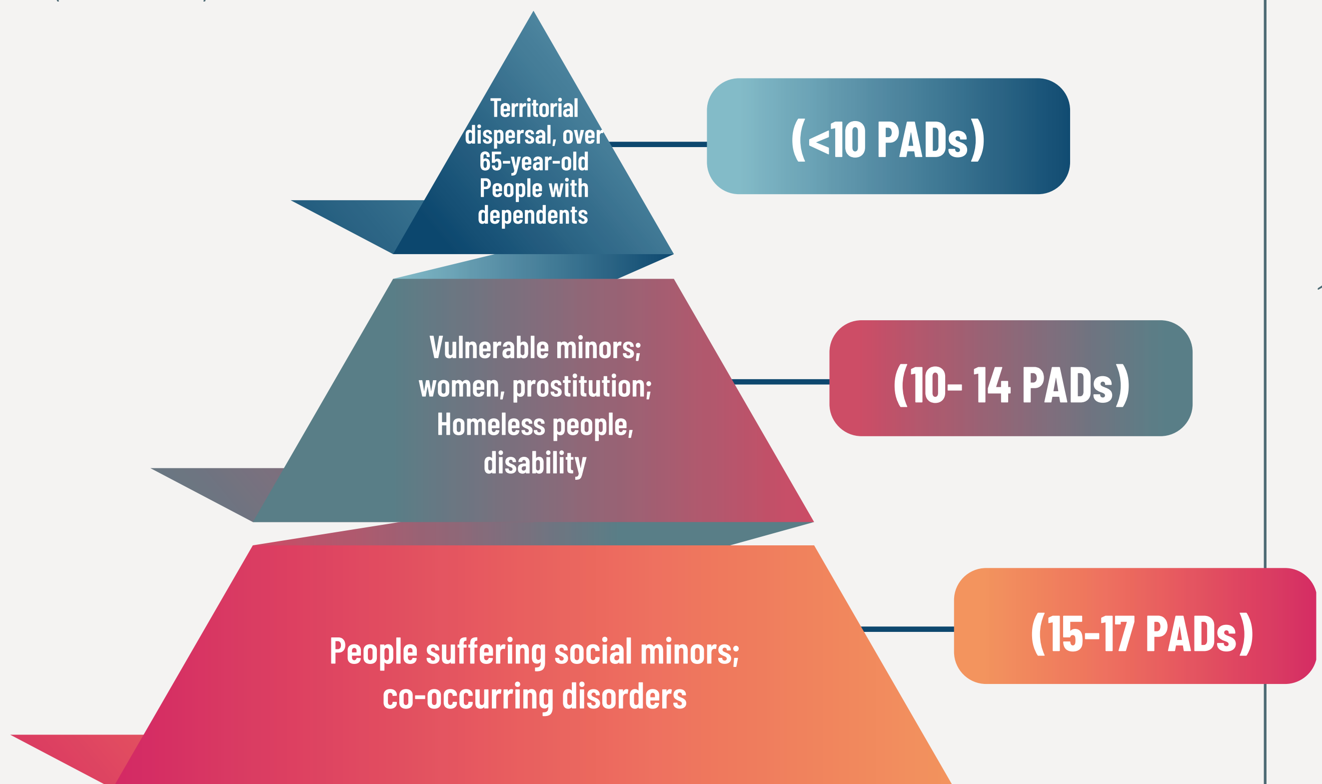


Fig. 15.10. Nº of ARs with measures to counter access difficulties (Source: PADs)

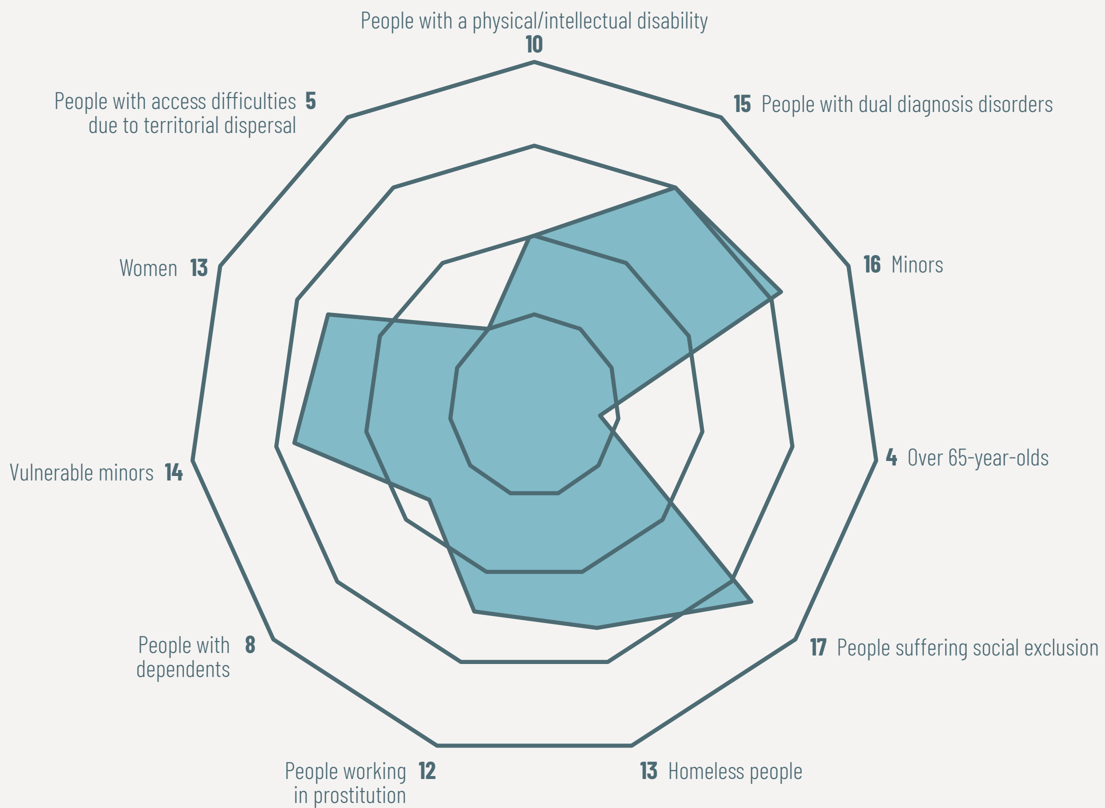
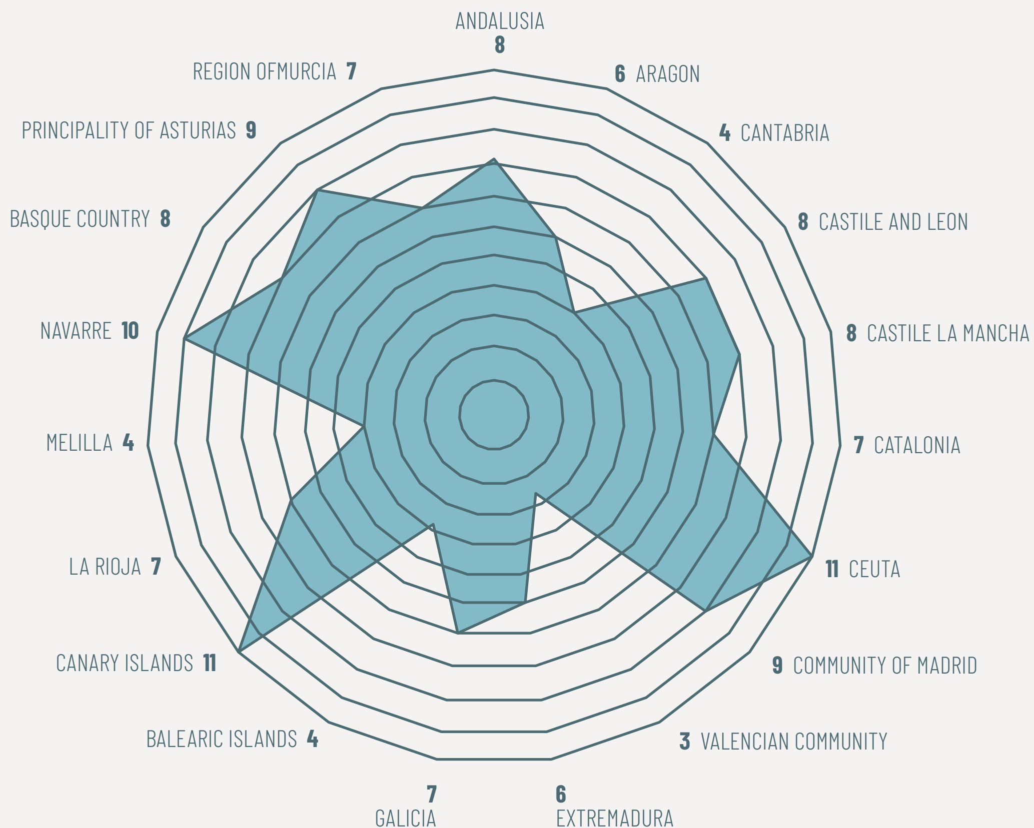


Fig. 15.11. No. of groups with facilitated access in each AR (max:11) (Source: PADs)



F. GENDER

The Strategy proposes the effective incorporation of this perspective into its objectives and actions.

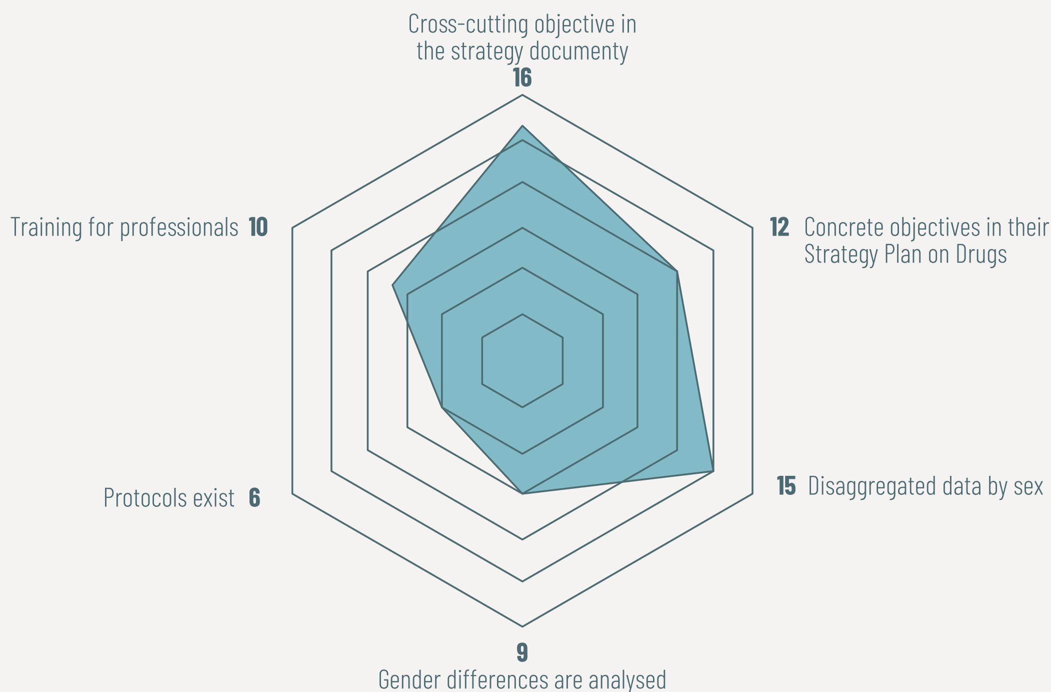
To assess that goal, the PADs were consulted about the way this perspective mainstreamed through their policies and programmes and six different and complementary ways of including the gender perspective were analysed:

- As a cross-cutting objective throughout the whole strategy document
- As specific objectives in their strategic plans.
- Through data disaggregation by sex.
- Through an analysis of the data from the gender perspective.
- With the existence of specific protocols for women.
- Through specific gender-perspective training for professionals.

The results of the analysis are shown in Figure 15.12 below where we can see that almost all the Autonomous Regions say they include the gender perspective as a cross-cutting objective but only 12 propose concrete objectives for it. The majority of them (15) also give disaggregated data by sex but only 9 analyse this information from a gender perspective. Progressive efforts are observed in training for professionals to facilitate proper inclusion of the gender perspective. Six of the PADs have protocols for women which could be used as a benchmark to be followed by the others.

These results endorse the findings of other research studies done in Spain on this question that conclude that "the necessary prior conditions exist for the gender perspective to be included in policies on addictions at state, regional and municipal level (Fundación Atenea 2015).

Fig. 15.12. No. of ARs that include the gender perspective (Max: 11) (Source: PAD)



CONCLUSIONS	RECOMMENDATIONS
Scientific evidence has gradually been incorporated into the majority of the PAD strategy documents where reference is now made to it; in some of them it is specifically covered.	More has to be done to effectively transfer the available evidence into practice and make sure that the majority of the actions are grounded in that evidence.
Progress has been made in the development of catalogues and portfolios of services, most of all in prevention. Accreditation in the sector attains a medium score for all areas except social incorporation, which has a lower level of accreditation than other areas.	A package (portfolio) of basic services should be agreed on with programmes designed on the basis of evidence and with guaranteed access for everyone in Spain. Accreditation systems need to be generalised so that the y can act as a quality screening mechanism for activity in the sector by leveraging on the experience of the PADs that have developed this area more than others.
Accessibility of services for some people with specific difficulties could be improved. In addition, the heterogeneous nature of the types of programmes available in the PADs might affect equity.	The accessibility of services –especially for people with disabilities, serious health conditions, aged over 65 and people with access difficulties due to territorial dispersion– requires improvement.
The level of social participation is good although it could be better. In addition, there is a consolidated NGO movement. Citizen consultation has been incorporated as a method of participation in the development of policies on addictions.	Scientific evidence, the gender perspective and quality should be incorporated as strategic objectives rather than action principles.
The level of incorporation of the gender perspective is medium: half of the regions propose concrete objectives for it. However, training for professionals and the existence of guidelines and protocols is limited.	The gender perspective needs to mainstreamed in all policies, programmes and activities, with key areas being training for professionals and the development and implementation of protocols, as well as the generalisation of successful experiences.

NDS IMPACT ASSESSMENT

NDS IMPACT ASSESSMENT

Impact assessment is understood as meaning an evaluation of the repercussion the NDS has had on the development and implementation of policies and programmes on drugs, both at the different levels of government and in the NGOs that work in this field.

To make the assessment a questionnaire was sent both to the levels of government in Spain with direct responsibilities (19 PADs-Annexe II. a) and with indirect responsibilities over the matter (DGT; II.PP.; FEMP- Annexe II. b), as well as to 66 national NGOs and Scientific Societies (Annexe II. c): (Spanish Society for Drug Addictions, Sociedad Española de Toxicomanías; Sociodrogalcohol and the Spanish Co-Ocurring Disorder Society, Sociedad Española de Patología Dual). Out of the 91 questionnaires sent out, 73 valid questionnaires were collected, equivalent to an 80.2 % response rate.

The questionnaire addressed the following points scored on a scale of 0-4, with 4 being the highest score.

- Degree of knowledge of the NDS, its accessibility and dissemination.
- Degree of relevance of the NDS when setting priorities in policies and programmes.
- Degree of relevance of each one of the 14 General Objectives of the NDS.
- Degree of alignment of policies with the General Objectives of the NDS.
- Additional objectives that should be included in the NDS.
- Quality of the design of the NDS on the basis of the following aspects:
    - o Its objectives are well-defined and are realistic
    - o They are suited to the needs
    - o They are concrete
    - o They can be evaluated

The results are as follows:

The degree of knowledge of the NDS by NGOs is medium and its accessibility can clearly be improved. (Figs. 16.1 and 16.2). Most of the NGOs have found out about it through the DGPNSD, but they also mention other channels that might be relevant for it to become more widely known such as a specific microsite, specific distribution to NGOs and social media.

Figure 16.1. Assessment of the degree of NGO knowledge of the NDS (%) 50 (Source: NGOs)

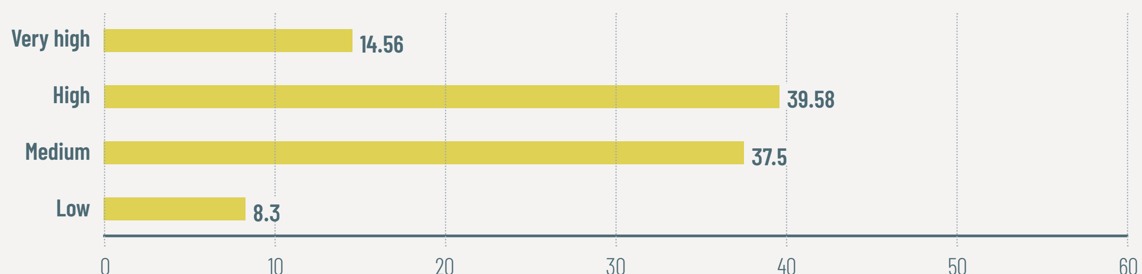
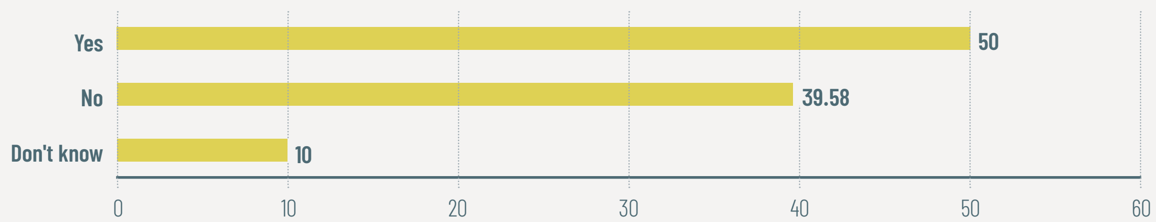


Fig 16.2. Percentage of NGOs that think the NDS is sufficiently accessible (Source: NGOs)

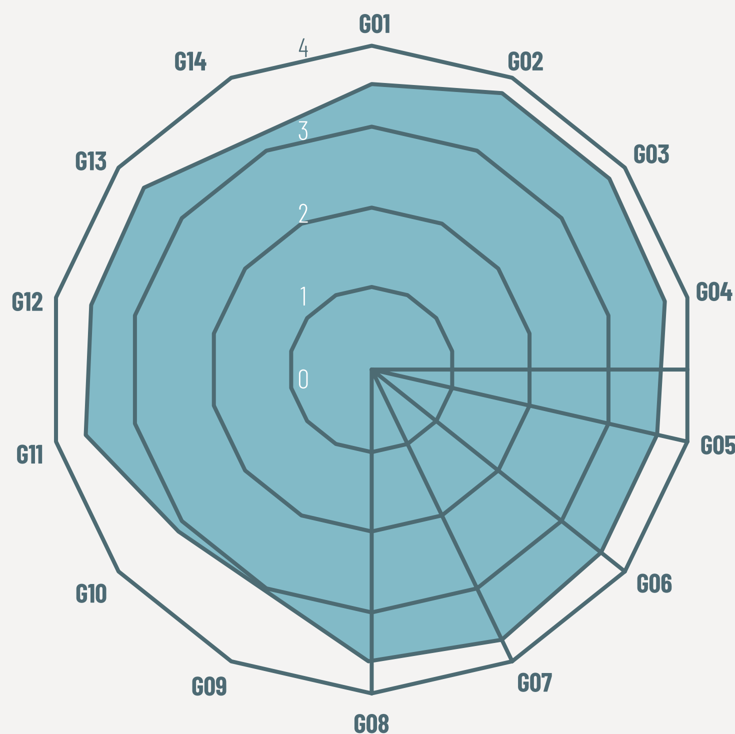


As far as the relevance of the NDS is concerned, it is clearly a reference document for the PADs to develop their addiction policies. It has been a guide when designing policies and programmes and has helped to establish priorities.

In the case of the NGOs, it is undoubtedly the basis for planning their activities concerning addictions.

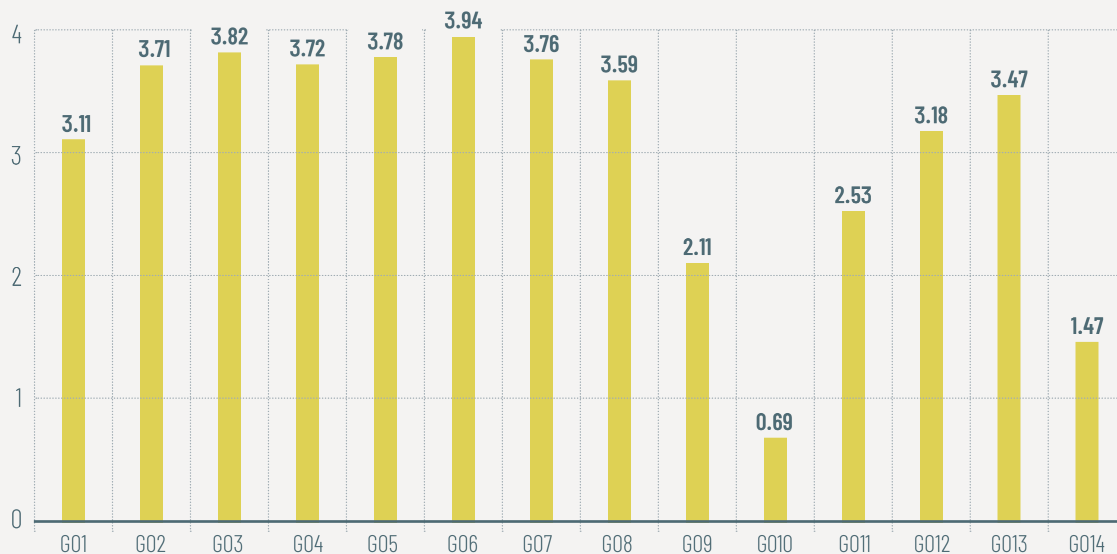
All the NDS objectives are very relevant for the NGOs, even the objectives concerning Supply Reduction, although GO 2 on social awareness-raising is the most important one for these organisations.

Figure 16.4. Degree of relevance of the NDS objectives for NGOs and Scientific Societies. (max:4) (Source: NGOs)



There is a high degree of **alignment of the objectives** in the NDS, essentially with the objectives in the PADs but also with other government departments and with the NGOs. Logically this alignment is lower for the Supply Reduction objectives (GO 9 and 10) and for the International Cooperation objective (GO 14). One objective where synergies must continue to be generated is in the research and knowledge enhancement area (GO 11). The highest degree of alignment in the PADs is in relation to GO 6 Harm Reduction, followed very closely by all of the other ultimate goals and demand reduction objectives.

Figure 16.5. Degree of alignment of the PADs objectives with the NDS (max: 4) (Source: PADs)



The PADs with the greatest alignment with the objectives are Catalonia and Canary Isles; the PADs with the least alignment are: Aragon, Balearic Isles Castilla La Mancha, Valencia and Navarra. No information has been supplied by the Basque Country *(País Vasco).*

As far as the NGOs are concerned, although coordination with them is very high as we have seen in GO 1 (Coordination), there is less alignment in objectives, making this an area with room for improvement. GO 13 (Training) particularly stands out here indicating the substantial amount of NGO activity in the training field. For Demand Reduction there is a high degree of alignment except for GO 8 Social Incorporation, where alignment is somewhat lower and so indicating the need to engage NGOs more in this objective (Fig. 16.7).

In the case of the State General Administration (Administración General del Estado (AGE), the degree of alignment depends on the different objectives but there is full alignment for objectives 5 and 6. (Use Reduction; Harm Reduction). For the other objectives, it depends on the specific remit of each body.

In general, the average degree of alignment is higher with IIPP (the prisons authority) where there are many shared objectives. In the case of the NGOs, the average score is lower because of the inclusion of Supply Reduction objectives, because this is an area where they have no remit.

Fig. 16.6. Average level of alignment of objectives in the PADs with the NDS (Max.: 4. Source: PADs)

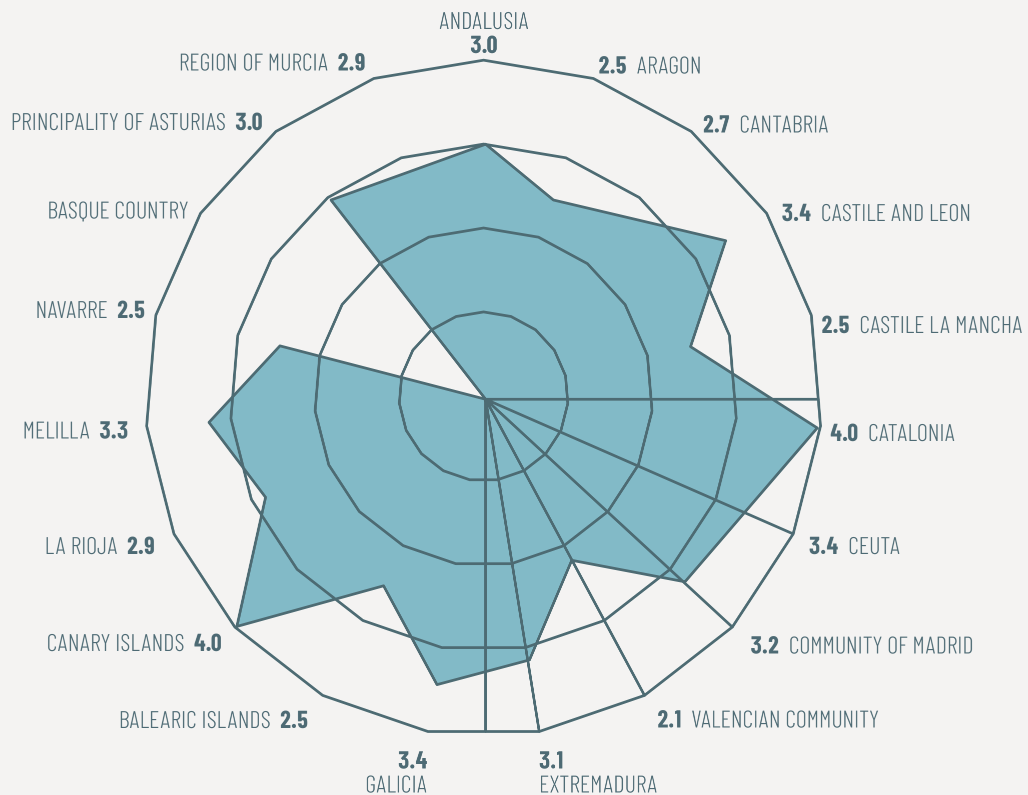
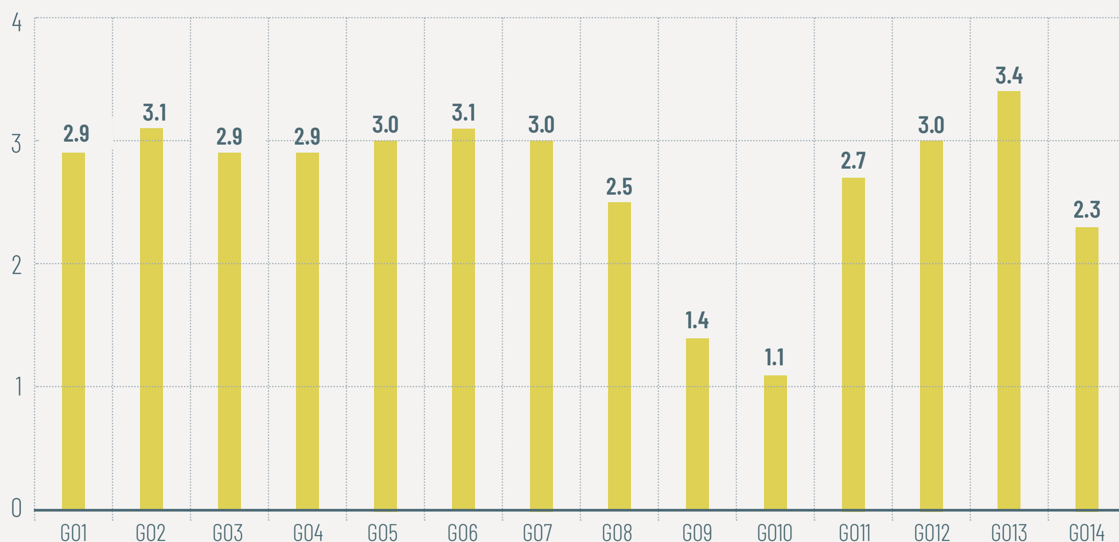


Fig. 16.7. Degree of alignment of the objectives of NGOs and Scientific Societies with the NDS objectives (Max.: 4. Source: NGOs)



As far as additional objectives to be included in future Strategies are concerned, the PADs suggest the following ones:

- Mainstream the gender perspective as a cross-cutting theme running through all the actions in order to avoid any inequality.
- Measure the impact of drugs policies and programmes through social return on investment (SROI) indicators.
- Protect children's health especially as regards the prevention of neurobehavioural disorders due to prenatal exposure to alcohol and other drugs.

The assessment made by the PADs of the NDS design quality is positive in the four aspects evaluated: good definition, suited to the needs, consistent with the measures proposed and lends itself to evaluation. Their rating of these aspects is higher than that of the NGOs (Fig. 16.10)

Fig. 16.8. Degree of alignment of DGT, IIPP, FEMP objectives with the NDS (Source: AGE-FEMP)

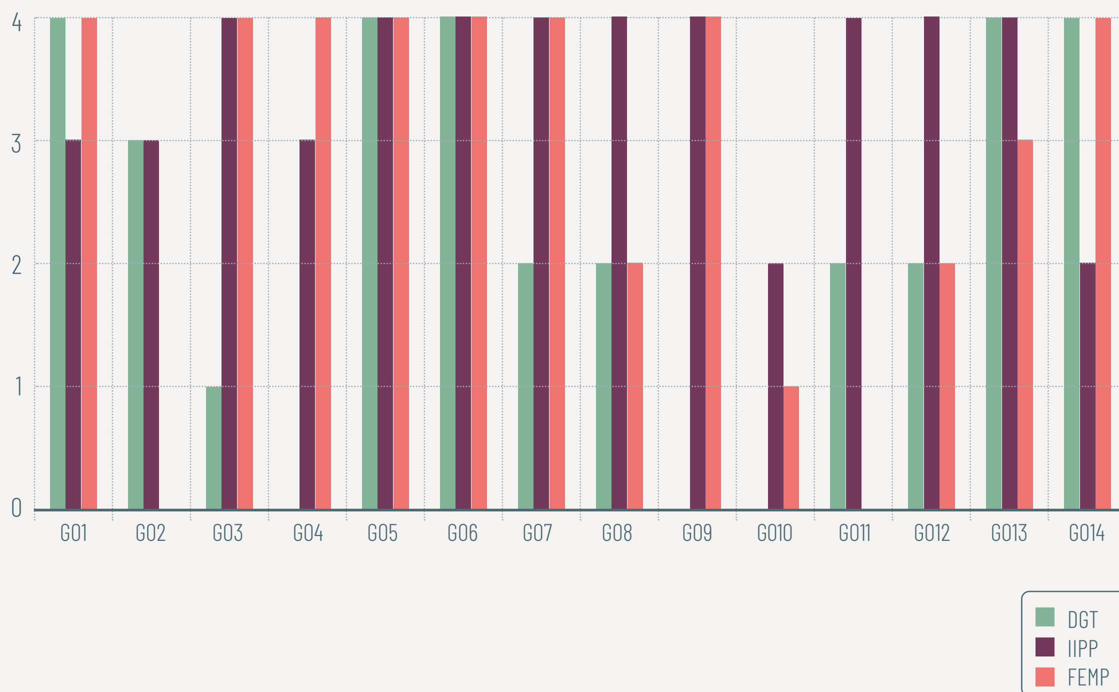


Fig. 16.9. Average degree of alignment with the NDS objectives (max:4) (Source: AGE-FEMP-NGOs)

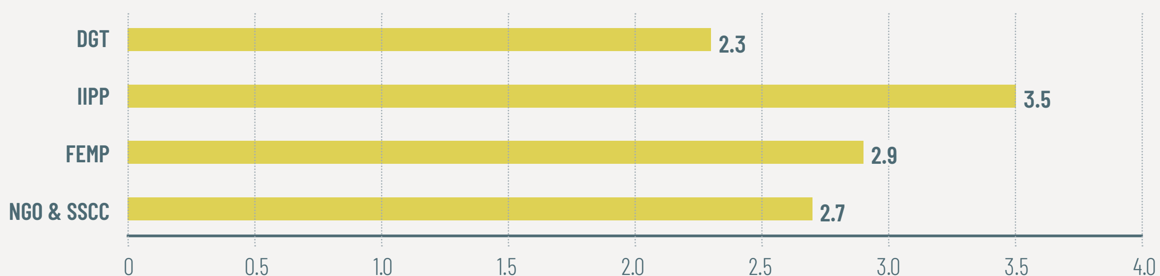
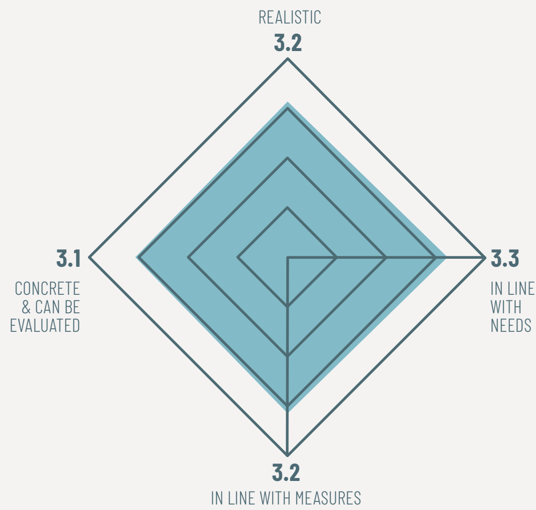
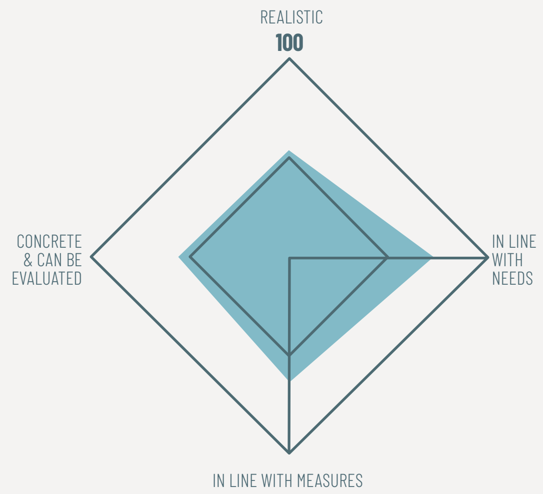


Fig. 16.10. Rating of the quality of the NDS by PADs and NGOs (Source: PADs & NGOs)

PADs Rating (scale 0-4)



NGO Rating (% agreement)

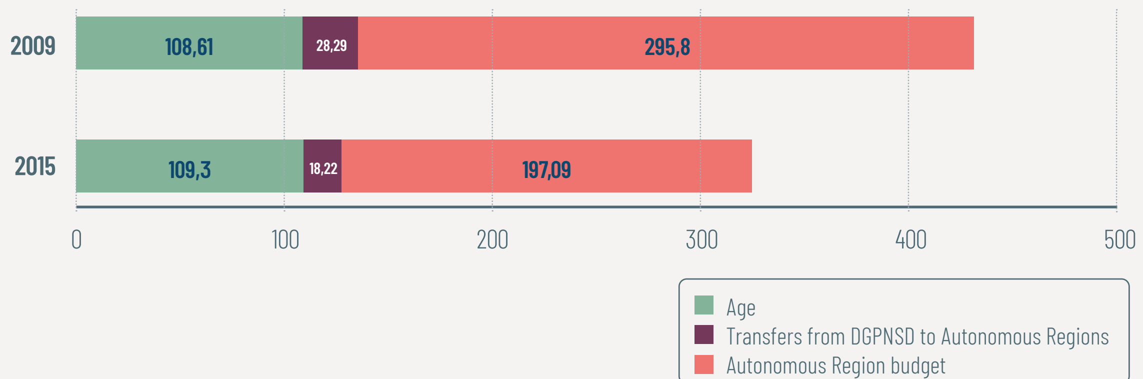


NDS BUDGETS

NDS BUDGETS

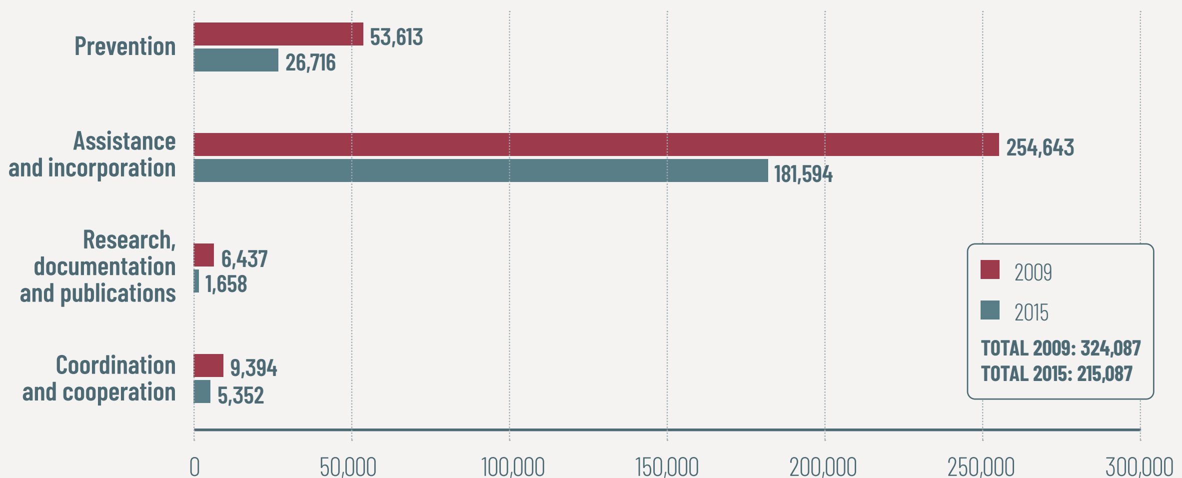
The budgets for the drugs sector in 2015 have been significantly reduced compared to 2009. This reduction is seen mainly in the budgets of the autonomous regions and to a much lesser extent in the transfers from the DGPNSD to the autonomous regions. The AGE budgets, however, have gone up slightly.

Fig 17.1. AGE and AR Budgets 2009-2015 (Memoria PNSD)



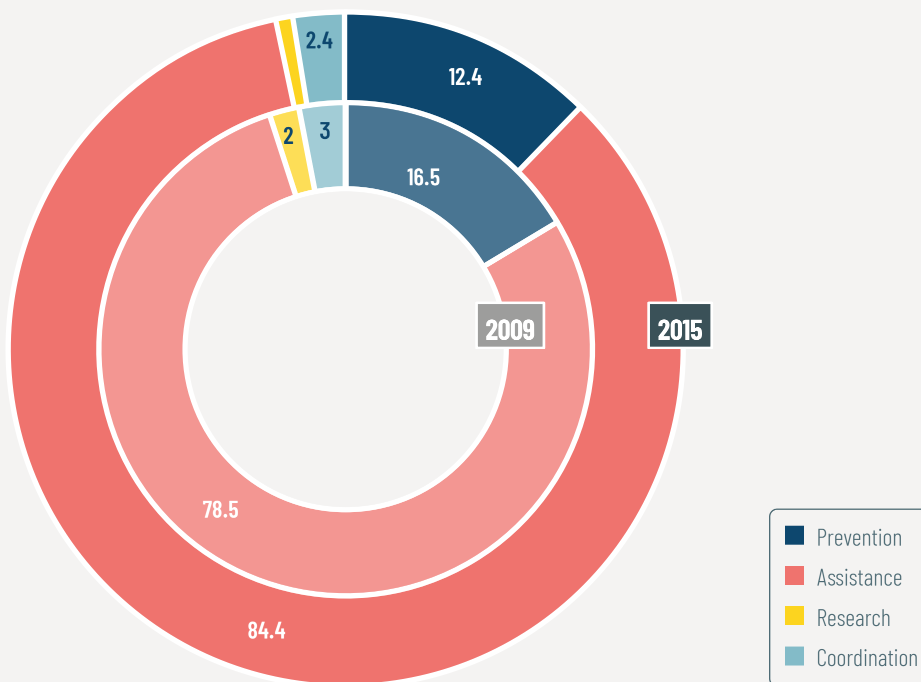
But not all the areas have suffered equally from budget cuts. Prevention, Research and Coordination have been the most affected, with the consequences already seen in the corresponding objectives (reduced coverages of prevention programmes and lower volume of research projects in the PADs) whereas Assistance has been less affected.

Fig. 17.2. AGE and AR Budgets 2009-2015 (Memoria PNSD)



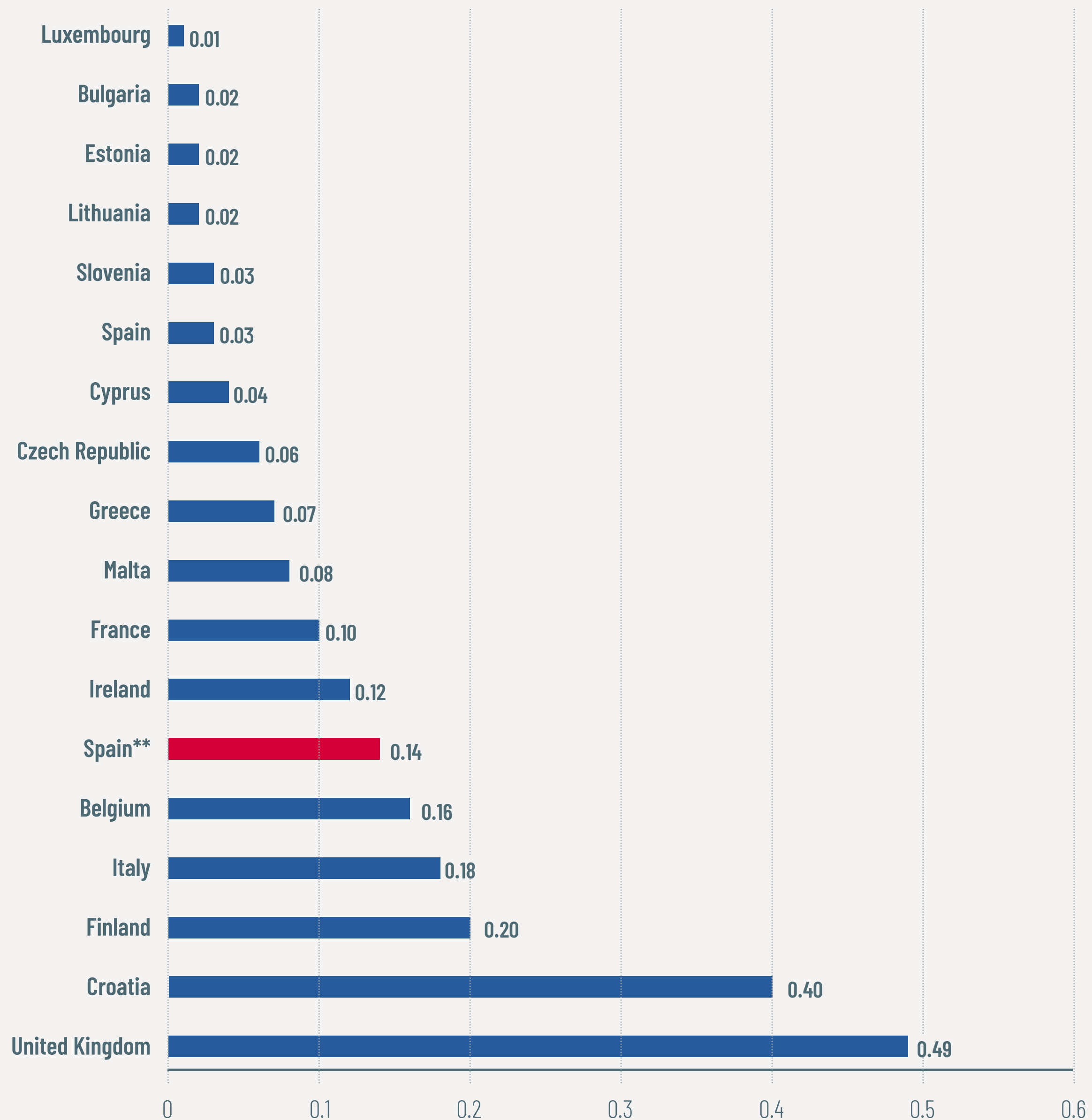
In percentage terms, the areas most affected are Research and Prevention, whereas the Assistance area accounts for a higher percentage of the budget, up from 78% to 84%. Although it is both logical and important for assistance resources to be maintained when there is a crisis, any reduction in Prevention has medium and long-term consequences so restoring the level of investment in Prevention should be a priority in forthcoming strategies (Fig. 17.3).

Fig. 17.3. AGE and AR budgets 2009-2015. % of the budget by areas. (Memoria PNSD)



According to the data provided in the mid-term assessment of the European Drugs Strategy 2009-2020, Spain would fall within the group of countries that devote the least percentage of their GDP to addressing these problems. However, in a specific study on the costs associated with the use of illicit drugs in Spain (Rivera et al; 29016) this rate is 0.14 % for 2012, putting our country in sixth place in this ranking (the study covers direct and indirect expenditure) (Fig. 17.4).

Fig. 17.4. Estimated Public Spending related to drugs. % of GDP* [Mid-term Assessment, European Drugs Strategy 2013-2020] (Source: Author's graph using data provided by the countries to the EMCDDA for the Mid-Term Assessment of the European Drugs Strategy 2013-2020).



* Only including the countries with data available from 2009.

** Estimate from the study "Costes sociales del uso de drogas ilícitas en España 2012. (Rivera et al 2016); INCLUDES INDIRECT HEALTH COSTS.

CONCLUSIONS

The NDS is a benchmark for the development of policies and programmes about drugs in Spain.

The degree of alignment of the objectives in the PADs with the NDS is very high (somewhat lower logically for the Supply Restriction objectives). The PADs view the NDS as highly relevant when they establish their own priorities.

For most NGOs there is a high degree of alignment of objectives and they rate positively the relevance of the NDS although some do not agree as much with them and say that its objectives are very generic and sometimes not very realistic.

Autonomous Region budgets (their own budgets and the funding transferred from central government) have been cut, especially in the case of prevention, research and probably social incorporation. This may have had an impact on the population coverage of the programmes.

RECOMMENDATIONS

The NDS has to continue to be a benchmark for policies on addictions in Spain. For that to happen consensus and the participation of all stakeholders must continue to be fostered. Scientific evidence, the gender perspective and quality should be incorporated as strategic objectives rather than action principles.

Non-substance addictions must be brought into the next Strategy, just as some PADs have already done.

More participation by NGOs and Scientific Societies in the setting of strategic priorities must be encouraged. The Spanish Council on Drug Dependence and other Addictions is the ideal channel to do this through.

The next NDS should have a budget to match its objectives, restored to at least pre-crisis levels and so underpinning the sustainability of its actions.

4

CONCLUSIONS AND FINAL RECOMMENDATIONS

4. GENERAL CONCLUSIONS AND RECOMMENDATIONS I

ALCOHOL & MINORS

Although the indicators for alcohol consumption and the use of other drugs have shown a modest improvement, alcohol consumption by minors and the way they consume alcohol (drinks with a high alcohol content and binge drinking) are still a priority in prevention and control strategies since this is the number one cause of health loss in this population.

EQUITY

A lack of uniformity is observed in demand reduction activities in the PADs that does not seem to be justified by differences in the problems related to drug use in the different regions. These disparities should be reduced through coordinated actions among all the institutions involved in order to guarantee equity in the programmes and services offered to the population.

QUALITY

Despite the huge progress made, continued emphasis must be placed on translating the evidence into practice, generalising accreditation systems, guaranteeing adequate training for professionals and optimising information and evaluation systems.

COORDINATION & COLLABORATIVE WORK

The working model used in the implementation of the Action Plan on Drugs 2013-2016 has proven its effectiveness in integrating all of the players in the sector and improving their coordination and synergies.

SOCIAL AWARENESS-RAISING

The use of drugs is not as widespread as the population perceives it to be and this belief that using drugs is "normal" is one of the main risk factors that must be addressed.

GENERAL CONCLUSIONS AND RECOMMENDATIONS II

THE IMPORTANCE OF PREVENTION

Prevention has improved overall: it encompasses more spheres with higher quality programmes. However, more work has to be done to expand the territorial and population coverage of programmes, especially those programmes where there is more evidence of their effectiveness, and also to incorporate the gender perspective.

ASSISTANCE NETWORK CHALLENGES

The assistance network faces a series of major challenges including how to reach problematic users, early detection of misuse, dealing with new addictions, the ageing and deteriorating health of long-term users, effective incorporation of the gender perspective and improving the quality the system.

SOCIAL INCORPORATION

There are experiences of good practices in some regions that should be used as a benchmark for improvement both in the development of programmes and in the methodological and gender perspective aspects. There has been less progress made in this area in relation to the others and so it should be a priority in the next Strategy

ASSOCIATED RISKS & HARMS

There are multiple and diverse harms linked to drug use that not only affect the drug users themselves but other people around them as well. Methods and instruments need to be improved so that more accurate information can be obtained that will allow the right decisions to be made.

EVALUATION METHODOLOGY

The evaluation design meets all of the criteria set out in the NDS 2009-16 itself: it is mixed (external-internal), participative and comprehensive (objectives + guiding principles); it is based on a continuous review of indicators and sources; the efficacy and effectiveness of the objectives are evaluated; it tries to establish causality mechanisms and contributes to decision-making.

ANNEXES

ANNEXES

I. Sources consulted and bibliography used.

II. Consultation instruments:

a. Questionnaire sent to the Autonomous Regions and Cities.

b. Questionnaires for the AGE and FEMP.

c. Questionnaire sent to NGOs and Scientific Societies.

III. List of charts and figures.

IV. PAD Demand Reduction profile graphs. COORDINATION

ANNEXE I
SOURCES CONSULTED

SOURCES CONSULTED

Alphabetical order

- Delegación del Gobierno para el Plan Nacional sobre Drogas (DGPNSD). Ministerio de Sanidad Servicios Sociales e Igualdad. (Government Delegation for the National Plan on Drugs. Ministry of Health, Social Services and Equality)
- Dirección General de Tráfico (DGT). Ministerio del Interior. (Directorate General for Traffic. Ministry of Interior)
- Federación Española de Municipios y Provincias (FEMP). (Spanish Federation of Municipalities & Provinces)
- Instituto Nacional de Toxicología (INT). Ministerio de Justicia. (National Toxicology Institute. Ministry of Justice)
- National NGOs and Scientific Societies in the drug dependence field (69).
- Planes Autonómicos sobre Drogas (PADs) (19). (Regional Drug Plans)
- Observatorio Español sobre Drogas y Adicciones de la DGPNSD (OEDA). Ministerio de Sanidad Servicios Sociales e Igualdad. (Spanish Observatory on Drugs and Addictions. Ministry of Health, Social Services and Equality)
- Secretaría General de Instituciones Penitenciarias (II.PP.). Ministerio del Interior. (Secretariat General for Prisons. Ministry of Interior)

BIBLIOGRAPHY CONSULTED

- European Union Council: Mid-Term Assessment of the EU Drugs Strategy 2013– 2020 and Final Evaluation of the Action Plan on Drugs 2013–2016. Brussels (2017).
- Delegación del Gobierno para el Plan Nacional sobre Drogas: Evaluación final del Plan de Acción sobre drogas 2009-2012. Madrid: DGPNSD (2013).
- Delegación del Gobierno para el Plan Nacional sobre Drogas. Evaluación final del Plan de Acción sobre drogas 2013-2016. Madrid: DGPNSD (2017).
- Delegación del Gobierno para el Plan Nacional sobre Drogas: Informes del Observatorio Español de las Drogas y las Adicciones. Madrid DGPNSD (2011; 2013; 2015; 2016). https://pnsd.sanidad.gob.es/profesionales/sistemasInformacion/informesEstadisticas/home.htm
- Fundación Red de Apoyo a la Integración Socio laboral: Estudio descriptivo sobre los sistemas de tratamiento a las adicciones en España. RAIS. Madrid (2015).
- Rivera *et al.*: Costes sociales del uso de drogas ilícitas en España 2012. La Coruña. (2016) (in the press).
- Roncero *et al.*: Hepatitis C crónica y usuarios con un historial de inyección de drogas en España: evaluación de la población, retos para un tratamiento efectivo. Adicciones vol. 29; nº 2; Editorial. Pp. 71-73. Barcelona (2017).

ANNEXE II
CONSULTATION INSTRUMENTS

a. Questionnaire sent to the Autonomous Regions and Cities.

b. Questionnaires for the AGE and FEMP.

c. Questionnaire sent to NGOs and Scientific Societies.

ANNEXE II A

NDS 2009-2016 FINAL EVALUATION QUESTIONNAIRE. REGIONAL DRUGS PLANS (PADs)

COORDINATION				
1. 1. Rate on a scale of 0 to 3, the **degree of coordination** of your PAD **with other departments in the Regional** Government. Select an option bearing in mind the scoring guidelines*. In the event that two or more areas are combined in the same department (e.g. Health and Social Services), mark both options.			*Scoring guidelines: **0: No coordination**. **1: Low coordination:** Ad hoc meetings; **2: Medium coordination:** Working groups to develop ad hoc projects; **3: High coordination:** Collaboration agreements. Stable working groups to develop coordinated projects, written coordination protocols.	
	1. Prevention	**2. Assistance**	**3. Social Incorporation**	**4. Harm Reduction**
Health				
Education				
Social Services				
Employment				
Consumption				
Youth				
Law enforcement and security agencies				
Justice				
Interior and Prisons				
Economy and Finance				
Equality				
Tourism				
Citizen participation				
Others (state which ones)				
1.2. Rate on a scale of 0 to 3 the **degree of coordination** of your PAD with **Civil Society**. Select an option bearing in mind the scoring guidelines*.				
NGOs and other Third Sector entities				
Business organisations				
Trade union organisations				
Parents associations				
Associations of consumers/users				
Night-time recreational sector business				
Media				
Scientific Societies				
Others (state which ones)				
1.3. Rate on a scale of 0 to 3 the **degree of coordination** of your PAD with the **Local Corporations** in your region. Select an option bearing in mind the scoring guidelines *.				
Local Corporations				

DEMAND REDUCTION		
1. Prevention		**Estimated coverage**
1.1. Which of the following **informative or awareness-raising activities** aiming to promote social awareness of drug-related harms are implemented in your PAD? Indicate their degree of approximate coverage in your Autonomous Region or City (C.A.).	YES/ NO	**4: Total:** exists in all key locations in population terms; • **3: High:** exists in most key locations but not in all; • **2: Medium:** exists in a lot of locations but not in the majority of them; • **1: Low:** exists in only some key locations; • **0: None**.
Media campaigns		
Informative activities in educational settings		
Informative activities in recreational settings		
Informative activities in the workplace		
Informative activities in health centres		
Information on drugs on your website		
Information in social networks		
Others (please specify)		
1.2. Which of the following **prevention programmes or projects**, aiming to develop personal resilience capabilities and skills to resist the drugs on offer and the determining factors of problematic behaviours are implemented in your PAD? Indicate their approximate degree of coverage in your C.A.	YES/ NO	**4: Total:** exists in all key locations in population terms; • **3: High:** exists in most key locations but not in all; • **2: Medium:** exists in a lot of locations but not in the majority of them; • **1: Low:** exists in only some key locations; • **0: None**.
School prevention programmes		
Family prevention programmes		
Environmental or structural prevention programmes		
Alternative recreation programmes		
Risk reduction in night-time recreational settings		
Work-related prevention programmes		
Socio-educational prevention programmes for vulnerable minors		
Early detection and short intervention programmes in the health field		
Community prevention programmes		
Traffic accident prevention programmes		
Prevention programmes in universities		
Prevention programmes for pregnant women or nursing mothers		
Others (please specify)		
1.3. How many primary health, specialised or emergency centres have early detection and short intervention programmes for drug addicts?		
1.4. How many prevention teams are there in your C.A.? (Total)		
Local government prevention teams		
NGO prevention teams		
Assistance centre prevention teams		
Others		

DEMAND REDUCTION		
2. Harm reduction		**Estimated coverage**
2.1. Which of the following **harm reduction programmes** for health harms caused in the case of drug users and in general for the undesirable social and health effects related to the use of drugs are implemented in your PAD? Indicate the approximate degree of coverage of them in your C.A.	YES/ NO	**4: Total:** exists in all key locations in population terms; • **3: High:** exists in most key locations but not in all; • **2: Medium:** exists in a lot of locations but not in the majority of them; • **1: Low:** exists in only some key locations; • **0: None**.
Overdose prevention programmes		
Needle and syringe programmes and distribution of preventive material		
Harm reduction programmes in recreational settings		
Early diagnosis and prevention programmes for HIV and other infectious illnesses		
Safer sex and lower risk use programmes		
Harm reduction programmes in prisons		
3. Assistance		**Estimated coverage**
3.1. Which of the following **assistance programmes** for people affected by drug misuse are run in your PAD? Indicate the degree of approximate coverage of them in your C.A.	YES/ NO	**4: Total:** exists in all key locations in population terms; • **3: High:** exists in most key locations but not in all; • **2: Medium:** exists in a lot of locations but not in the majority of them; • **1: Low:** exists in only some key locations; • **0: None**.
Detoxification programmes		
Withdrawal programmes		
Relapse and reuse prevention programmes		
Post-assistance monitoring programmes		
Methadone substitution assistance		
Assistance programmes with buprenorphine/naloxone		
Specific programmes		
Programmes in courts and police stations		
Programmes for young offenders		
Specific programmes for minors with drug problems		
Dual diagnosis assistance programmes		
Intervention programmes for women		
Intervention programmes for pathological gambling/gaming		
Intervention programmes for other non-substance addictions		
Intervention programmes for people at risk of social exclusion/ homeless people		
Early detection and short intervention programmes in health settings		
Others (please specify)		
3.2 Do you have any protocols or guidelines in your PAD for assistance for drug addicts?		
3.3. And for prescribing, dispensing and monitoring patients in opioid substation therapy (OSR)?		
3.4. Is there any opioid substitution therapy offered in your PAD that does not use either methadoneor buprenorphine/ naloxone?		

DEMAND REDUCTION		
4. Social Incorporation programmes		**Estimated coverage**
4.1. Which of the following social incorporation programmes aimed at people in rehabilitation are implemented in your PAD? Indicate the degree of approximate coverage of them in your C.A.	YES/ NO	• **4 Total:** exists in all key locations in population terms; • **3: High:** exists in most key locations but not in all; • **2: Medium:** exists in a lot of locations but not in the majority of them; • **1: Low:** exists in only some key locations; • **0: None**.
PARTICIPATION (in cultural, free time, sports activities etc.)		
TRAINING (official, unofficial, Public Employment Service, Programmes)		
RESIDENTIAL SUPPORT (houses, flats, shelters, hostels, etc.)		
EMPLOYMENT INSERTION (information/guidance, job search)		
4.2. Do the social incorporation programmes in your PAD	YES/ NO	
have referral protocols with the assistance network?		
design personalised social incorporation projects?		
mainly come under general services (social, employment, cultural, sports, free time)?		
get implemented in specific services for drug addictions (out-patient centres, day centres, therapeutic communities, etc.)?		

IMPROVING KNOWLEDGE			
1. Indicate if your PAD conducts any kind of evaluation in the following fields.	Needs Evaluation	Process Evaluation	Outcomes Evaluation
Evaluation of policies (Strategies, Actions Plans, etc.)			
Evaluation of prevention programmes			
Evaluation of assistance programmes			
Evaluation of social incorporation programmes			
Evaluation of harm reduction programme			
2. Has your PAD made any assessment of the satisfaction of users of the drugs network resources in the last 4 years?			
3. Has your PAD produced any process and/or outcomes evaluation report on drug addiction intervention services and programmes in the last 4 years?			
4. Indicate how the findings of the research carried out in your Autonomous Region or City have been made widely available in the last year.	YES/NO		
Publications in Spanish scientific journals			
Publications in foreign journals			
Other publications (thematic works, chapters in joint authorship books etc.)			
Publication of the main findings on the website			
Selective distribution of information to professionals			

TRAINING			
1. Do you have any official university training programmes on drug addictions in your PAD? How many courses?	YES/NO	No.	
Master			
Post-graduate			
2. Indicate which **categories of professionals** the training is designed for and if it is accredited or not. Indicate the approximate number of professionals trained annually.	Training is given	Accredited training	No of people trained annually
HORECA professionals			
Law enforcement and security agencies (state, regional or local).			
Media professionals			
Driving school professionals			
Health Services professionals			
Local government professionals (social services, youth services, education, etc.)			
Juvenile justice professionals			
Professionals working in sport			

EVIDENCE				
1. Scientific evidence	YES/NO			
1.1. Are the intervention strategies proposed in your Regional Drugs Plan (PAD) based on scientific evidence?				
1.2. If the answer is Yes: is that evidence included in the Plan's strategy document?				
1.3. Are the proposed intervention strategies based on professional consensus?				
1.4. If the answer is Yes: is that professional consensus included in the Plan's strategy document?				
2. Accreditation				
2.1. Are there any quality control criteria and/or systems for the programmes and activities promoted or funded by your Regional Drugs Plan (PAD)?	**0:** None; **1:** Quality assessment criteria exist and are published (in tender notices, regulatory terms and conditions…); **2:** There are instruments to assess the quality criteria but they are not scored on a scale; **3:** There are instruments to assess the quality criteria and the assessment criteria are scored on a scale; **4:** The programmes and services are accredited in line with quality criteria.			
Prevention				
Assistance				
Social incorporation				
Harm reduction				
Research				
Training				
2.2. Do you have any services catalogues or portfolios for different action areas in your PAD? If the answer is Yes, indicate the number of programmes included. If possible, indicate the number of professionals working in each area.				
Prevention				
Assistance				
Social incorporation				
Harm reduction				
Research				
Training				
2.2. Do you have any services catalogues or portfolios for different action areas in your PAD? If the answer is Yes, indicate the number of programmes included. If possible, indicate the number of professionals working in each area.	YES/NO	YES/NO	YES/NO	YES/NO
	Catalogues	Services portfolios	No. of programmes included	No. of professionals working in each area
Prevention				
Harm reduction				
Assistance				
Social incorporation				

SOCIAL PARTICIPATION	
1. Do any channels exist to promote **social participation** in the definition of policies and in the delivery of responses to the problem?	
2. Which of the channels below?	YES/NO
Parents associations; local residents associations…	
Surveys	
Online citizen consultation	
Others (please specify)	
GENDER	
1. How has the **gender** perspective been addressed in your PAD's Strategy?	YES/NO
The gender perspective is a crosscutting objective in your PAD's strategy document	
Concrete objectives are proposed in your Strategy Document to bring in the gender perspective	
Data is disaggregated by sex	
Gender differences are analysed	
Action guidelines and/or protocols exist for interventions with a gender perspective	
Training is provided to professionals on how to handle the gender perspective	
EQUITY	
1. Do resources/programmes/measures exist to counter the **access difficulties** of the following groups that are in a particularly vulnerable situation?	YES/NO
People with a physical/mental disability	
People with a co-occurring disorder	
Minors	
People aged over 65	
People suffering social exclusion	
Homeless people	
People working as prostitutes	
People with dependents (minors, disabled dependents, ill or elderly relatives) with no family/social support	
Vulnerable minors	
Women	
People with access difficulties due to territorial dispersion	

IMPACT	
1. Rate on a scale of 0 to 4 the **degree of alignment** of the objectives of your PAD with the NDS 2009-2016 objectives where 0: no alignment and 4: total alignment	
G.O. No.1: Optimise coordination and cooperation in the framework of the Spanish State.	
G.O. No.2: Raise social awareness about the importance of drug-related personal and social problems, harms, and costs, about the real possibility of avoiding them and about the importance of society as a whole playing an active part in their solution.	
G.O. No. 3: Develop personal resilience capabilities and skills to resist the drugs on offer and the determining factors in problematic behaviours related to them.	
G.O. No. 4: Delay the age of initiation for contact with drugs.	
G.O. No. 5: Reduce the use of licit and illicit drugs.	
G.O. No. 6: Reduce or limit health harms in people who use drugs and in general the undesirable social and health effects related to their use.	
G.O. No. 7: Guarantee quality assistance tailored to the needs of drug users. *Normalise health assistance* for drug addicts on the basis of scientific evidence through the development of protocols, guidelines and intervention catalogues.	
G.O. No. 8: Facilitate social incorporation into society of people undergoing rehabilitation through integrated training and social and employment preparation and insertion.	
G.O. No. 9: Be more effective in the measures aiming to control the supply and illicit markets of psychoactive substances.	
G.O. No. 10: Increase AML mechanisms.	
G.O. No. 11: Increase and improve research with the aim of gaining more knowledge of the different variables related to drugs and their use, as well as their prevention and assistance.	
G.O. No. 12: Do more systematic evaluation of programmes and actions as an instrument enabling validation of the activities carried out.	
G.O. No. 13: Improve and expand training for professionals who work in this field as well as the training aimed at people who collaborate in the field as volunteers.	
G.O. No. 14: Optimise coordination and cooperation in the European and international framework in general.	
2. Is there any general objective included in the current Strategy Document in your CA that is not included in the 2009-2016 National Strategy?	
2.1. Indicate which one(s):	
3. How relevant has the 2009-2016 NDS been for the development of policies and programmes? *(4: Crucial: i t has laid down the guidelines for policies in this sphere; 3: Important: it has been a guide for priority-setting. 2 Medium: it has been a help when developing the Regional Drugs Plan; 1: Low, it has not been taken into account to set objectives or priorities in drug-related policies or programmes; 0: don't know /no relevance)*	
4. Indicate your level of agreement with the following assertions about the 2009-2016 NDS, where 0: do not agree - 4 very high level of agreement.	
Its objectives are well defined: they are clear and realistic	
Its objectives are appropriate and match the needs of the sector	
The objectives are in line with the measures proposed	
The objectives are concrete and can be evaluated	

ANNEXE II B

DIRECCIÓN GENERAL DE TRÁFICO. MINISTERIO DEL INTERIOR (TRAFFIC AUTHORITY, MINISTRY OF THE INTERIOR)

Impact evaluation questionnaire for the 2009-2016 National Drugs Strategy (NDS)

The general objectives of the 2009-2016 NDS are listed below. Please select those objectives coinciding with your strategy or action plan and rate them on a scale of 0 to 4 for their degree of alignment, where "0" is the lowest score (no alignment) and "4" the highest (total alignment). Indicate too if the DGT is implementing or promoting any programme or project related to any of these objectives. If it is, please include the name of the programme or project.

GENERAL OBJECTIVE	Degree of alignment	Name of the programme or project related to the General Objective
1: Optimise coordination and cooperation in the framework of the Spanish State.		
2: Raise social awareness about the importance of drug-related personal and social problems, harms, and costs, about the real possibility of avoiding them and about the importance of society as a whole playing an active part in their solution.		
3: Develop personal resilience capabilities and skills to resist the drugs on offer and the determining factors in problematic behaviours related to them.		
4: Delay the initiation age of contact with drugs.		
5: Reduce the use of licit and illicit drugs.		
6: Reduce or limit health harms in people who use drugs and in general the undesirable social and health effects related to their use.		
7: Guarantee quality assistance tailored to the needs of drug users. *Normalise health assistance* for drug addicts on the basis of scientific evidence through the development of protocols, guidelines and intervention catalogues.		
8: Facilitate social incorporation into society of people undergoing rehabilitation through integrated training and social and employment preparation and insertion.		
9. Be more effective in the measures aiming to control the supply and illicit markets of psychoactive substances.		
10. Increase AML mechanisms.		
11. Increase and improve research with the aim of gaining more knowledge of the different variables related to drugs and their use, as well as their prevention and assistance.		
12: Do more systematic evaluation of programmes and actions as an instrument enabling validation of the activities carried out.		
13: Improve and expand training for professionals who work in this field as well as the training aimed at people who collaborate in the field as volunteers.		
14: Optimise cooperation and coordination in the European and international framework in general.		

1. Do you think that there is enough collaboration between the DGT and the Government Delegation for the National Drugs Plan (DGPND)?
2. Which aspects of that collaboration should be improved?
3. How could the collaboration be improved?
4. Is there any DGT document that you think is important and should be taken into account when the new National Drugs Strategy is developed?
5. Please list the guidelines, manuals, protocols, consensus documents, etc… prepared by the DGT for the prevention of alcohol and drugs use when driving (we have included the ones we have information about)

REMARKS: Add any remarks, suggestions or proposals you think are appropriate to complete your opinion on the subjects proposed.

2009-2016 NDS FINAL EVALUATION INDICATORS

We have listed below a series of indicators that will be used to evaluate the outcomes of the NDS 2009-2016. If you have no information on any of them please say so in the corresponding box.

DGT AWARENESS-RAISING ACTIVITIES	2009	2016*
No. of **drink driving** campaigns funded by the DGT		
Budget earmarked for drink driving campaigns		
Campaigns on **drugs and driving** funded by the DGT		
Budget earmarked for campaigns on drugs and driving		
ACTIVITIES TO CONTROL DRUG USE AND DRIVING (1)		
No. of alcohol breathalyser tests carried out		
% of positive alcohol breathalyser tests		
No. of drugs driving tests carried out		
% of positive drugs driving tests		
HARM CAUSED BY ALCOHOL AND DRUGS USE AND DRIVING (2)		
No. of traffic accident fatalities linked to alcohol.		
No. of traffic accident fatalities linked to drugs.		
EDUCATIONAL PREVENTION PROGRAMMES		
No. of Autonomous Regions running alcohol and drugs use and driving prevention programs in collaboration with the DGT		
No. of municipalities running alcohol and drugs use and driving prevention programmes in collaboration with the DGT		
TRAINING		
No. of driving school professionals trained in the prevention of traffic accidents due to alcohol or drugs use		

* Use the latest data available and indicate which year they correspond to

INSTITUTO NACIONAL DE TOXICOLOGÍA. MINISTERIO DE JUSTICIA (NATIONAL TOXICOLOGY INSTITUTE, MINISTRY OF JUSTICE)

2009-2016 NATIONAL DRUGS STRATEGY (NDS) EVALUATION INDICATORS

2009-2016 NATIONAL DRUGS STRATEGY (NDS) EVALUATION INDICATORS DRUG-RELATED DEATHS AND OFFENCES	2009	2015/16*
No. of deaths due to an adverse drug reaction		
No. of deaths in traffic accidents (alcohol)		
No. of deaths in traffic accidents (drugs except alcohol)		
No. of road safety traffic offences (alcohol)		
No. of road safety traffic offences (drugs except alcohol)		
No. of violent deaths		
No. of work-related accident deaths		
No. of minors admitted to hospital due to suspected intoxication		
No. of cases of suspected chemical submission with sexual intent or other criminal intent		

SECRETARIA GENERAL DE INSTITUCIONES PENITENCIARIAS. MINISTERIO DEL INTERIOR (PRISONS AUTHORITY, MINISTRY OF INTERIOR)

Impact evaluation questionnaire for the 2009-2016 National Drugs Strategy (NDS)

The general objectives of the 2009-2016 NDS are listed below. Please select those objectives that coincide with your strategy or action plan and rate them on a scale of 0 to 4 for their degree of alignment, where "0" is the lowest score (no alignment) and "4" the highest (total alignment). Indicate too if your department is implementing or promoting any programme or project related to any of these objectives. If it is, please include the name of the programme or project.

GENERAL OBJECTIVE	Degree of alignment	Name of the programme or project related to the General Objective
1: Optimise coordination and cooperation in the framework of the Spanish State.		
2: Raise social awareness about the importance of drug-related personal and social problems, harms, and costs, about the real possibility of avoiding them and about the importance of society as a whole playing an active part in their solution.		
3: Develop personal resilience capabilities and skills to resist the drugs on offer and the determining factors in problematic behaviours related to them.		
4: Delay the initiation age of contact with drugs.		
5: Reduce the use of licit and illicit drugs.		
6: Reduce or limit health harms in people who use drugs and in general the undesirable social and health effects related to their use.		
7: Guarantee quality assistance tailored to the needs of drug users. *Normalise health assistance* for drug addicts on the basis of scientific evidence through the development of protocols, guidelines and intervention catalogues.		
8: Facilitate social incorporation into society of people undergoing rehabilitation through integrated training and social and employment preparation and insertion.		
9. Be more effective in the measures aiming to control the supply and illicit markets of psychoactive substances.		
10. Increase AML mechanisms.		
11. Increase and improve research with the aim of gaining more knowledge of the different variables related to drugs and their use, as well as their prevention and assistance.		
12: Do more systematic evaluation of programmes and actions as an instrument enabling validation of the activities carried out.		
13: Improve and expand training for professionals who work in this field as well as the training aimed at people who collaborate in the field as volunteers.		
14: Optimise cooperation and coordination in the European and international framework in general.		

Do you think that there is enough collaboration between your department and the Government Delegation for the National Drugs Plan (DGPND)?

1. Which aspects of that collaboration should be improved?

2. How could the collaboration be improved?

3. Is there any document in your department that you think is important and should be taken into account when the new National Drugs Strategy is written?

4. Please list the guidelines, manuals, protocols, consensus documents etc. prepared for the prevention, assistance and social incorporation of inmates affected by drug use in prisons (we have included the ones we have information about)

   - Personalised insertion protocol for drug addicts undergoing rehabilitation who are prison inmates (action 15, Drugs Action Plan 2013-16)
   - Intervention programme for drug addicts with alternative measures (action 14, Drugs Action Plan 2013-16).
   - Coordination protocol for drug addicts with alternative measures (action 14, Drugs Action Plan 2013-16).
   - Guide to Resources for drug addicts with alternative measures (action 14, Drugs Action Plan 2013-16).
   - Evaluation of the Pilot Project for the Rollout of the Awareness-raising Programme on Drug addiction for offenders sentenced to community service (action 14, Drugs Action Plan 2013-16).

REMARKS: Add any remarks, suggestions or proposals you think are appropriate to complete your opinion on the subjects proposed.

2009-2016 NDS FINAL EVALUATION INDICATORS

We have listed below a series of indicators that will be used to evaluate the outcomes of the 2009-2016 NDS. If you do not have any information about any of them, please say so in the corresponding box.

Objective 5: Reduce use	2009	2016 *
% of prison inmates with drug use		
No. of prisons implementing prevention programmes		
No. of inmates participating in prevention programmes		
Objective 6: Reduce harms		
No. of prisons implementing harm reduction programmes (NSP, HIV prevention…)		
No. of deaths of inmates due to drug overdose		
No. of inmates participating in harm reduction programmes		
No. of syringes/needles distributed in prisons		
Objective 7: Guarantee quality assistance		
No. of drug addicts serving alternative prison sentences		
No. of prisons offering assistance to drug addicts		
No. of drug addicts in assistance in prisons		
No. of prisons with specific modules for drug addicts		
No. of inmates in assistance in the specific modules		
Objective 8: Promote social incorporation		
No. of prisons offering social incorporation programmes for drug addicts		
% of drug addicts participating in social incorporation programmes in prisons		
Objective 13: Training		
No. of prison professionals trained in drug addictions		

* Use the latest available data and indicate the year they correspond to (some figures this Delegation has for 2009 are included here. Please correct them if they are wrong).

FEDERACIÓN ESPAÑOLA DE MUNICIPIOS Y PROVINCIAS (SPANISH FEDERATION OF MUNICIPALITIES AND PROVINCES)

2009-2016 National Drugs Strategy (NDS) final impact evaluation questionnaire

The general objectives of the 2009-2016 NDS are listed below. Please select those objectives that coincide with your strategy or action plan and rate them on a scale of 0 to 4 for their degree of alignment, where "0" is the lowest score (no alignment) and "4" the highest (total alignment). Indicate too if your department is implementing or promoting any programme or project relating to any of these objectives. If it is, please include the name of the programme or project.

GENERAL OBJECTIVE	Degree of alignment	Name of the programme or project related to the General Objective
1. Optimise coordination and cooperation in the framework of the Spanish State.		
2. Raise social awareness about the importance of drug-related personal and social problems, harms, and costs, about the real possibility of avoiding them and about the importance of society as a whole playing an active part in their solution.		
3. Develop personal resilience capabilities and skills to resist the drugs on offer and the determining factors in problematic behaviours related to them.		
4. Delay the initiation age of contact with drugs.		
5. Reduce the use of licit and illicit drugs		
6. Reduce or limit health harms in people who use drugs and in general the undesirable social and health effects related to their use.		
7.Guarantee quality assistance tailored to the needs of drug users. *Normalise health assistance* for drug addicts on the basis of scientific evidence through the development of protocols, guidelines and intervention catalogues		
8: Faciliate social incorporation into society of people undergoing rehabilitation through integrated training and social and employment preparation and insertion.		
9. Be more effective in the measures aiming to control the supply and illicit markets of psychoactive substances.		
10. Increase AML mechanisms.		
11. Increase and improve research with the aim of gaining more knowledge of the different variables related to drugs and their use, as well as their prevention and assistance.		
12.Do more systematic evaluation of programmes and actions as an instrument enabling validation of the activities carried out.		
13. Improve and expand training for professionals who work in this field as well as the training aimed at people who collaborate in the field as volunteers.		
14. Optimise cooperation and coordination in the European and international framework in general.		

Do you think that there is enough collaboration between your department and the Government Delegation for the National Drugs Plan (DGPND)?

1. On which aspects should that collaboration be improved?

2. How could the collaboration be improved?

3. Is there any document in your department that you think is important and should be taken into account when the new National Drugs Strategy is developed?

4. Please list the guidelines, manuals, protocols, consensus documents etc. prepared for the prevention, assistance, social incorporation of drug addicts at the local level.

REMARKS: Add any remarks, suggestions or proposals you think are appropriate to complete your opinion on the subjects proposed.

2009-2016 NDS FINAL EVALUATION INDICATORS

We have listed below a series of indicators that will be used to evaluate the outcomes of the 2009-2016 NDS. If you do not have any information about any of them, please say so in the corresponding box.

	2009*	2016 **
Approximate no. of municipalities implementing drugs programmes		
No. of existing Municipal Drugs Plans		
Approximate % those plans represent out of the total number of municipalities with more than 20,000 inhabitants		
No. of local police officers trained in prevention		
No. of programmes that have won an award in the FEMP Best Practices Competition		

*Data from 2008 or 2009 can be used. Please give the exact year the data refer to

** Data from 2015 or 2016 can be used. Please give the exact year the data refer to

ANNEXE II C

NATIONAL DRUGS STRATEGY 2009-2016 IMPACT EVALUATION QUESTIONNAIRE FOR NGOS AND SCIENTIFIC SOCIETIES

ENTITY:	
CONTACT PERSON:	
CONTACT DETAILS: (Tel.; email)	

This questionnaire is one of the instruments developed for the 2009-2016 National Drugs Strategy Evaluation.

It consists of 10 questions grouped under the following headings:

1. Degree of knowledge of the 2009-2016 NDS in order to establish whether the strategy has been sufficiently disseminated and made known.

2. Impact on the development of public policies and programmes: to find out its relevance for the setting of common objectives for everyone working on the drugs problem.

3. Quality of the NDS: to assess the degree of definition of the strategy; the clarity of the objecti-ves; internal consistency; whether it is suited to the problem it deals with.

1. DEGREE OF KNOWLEDGE OF THE NDS 2009-2016

1.1. Rate on a scale of 0 to 4 your d**egree of knowledge*** of the 2009-2016 NDS document.

	Score*
Degree of knowledge	

* 4: Very high, I know it in detail; 3: High, I know the general objectives it sets out; 2 Medium, I partly know its approaches; 1: Low, I only know of its existence and the odd proposal; 0: I don't know anything about it.

1.2. As far as its **dissemination** is concerned:

1.2.1. Do you think the NDS is sufficiently accessible and has been sufficiently dissemina-ted?

	yes		no		DON'T KNOW	

1.2.2. Through which of these channels did you find out about the 2013-2016 National Drugs Strategy:

The Government Delegation for the National Drugs Plan website	
Other websites	
Conferences, Seminars, Events…	
I have received it by post or email	
I have been involved in the development/ implementation process	
Through a colleague	
Others	

1.2.3. Have the dissemination channels been the right ones?

	yes		no		DON'T KNOW	

1.2.4. Which of these channels do you think would have been useful to disseminate it?

The Government Delegation for the National Drugs Plan website	
Other websites	
National Drugs Plan documentation centre distribution lists	
Conferences, Seminars, Events…	
Sending by post or email	
Involvement in the development/implementation process	
Social media	
Media	
Journals about addictions	
Others (please specify)	

2. IMPACT ON THE DEVELOPMENT OF PUBLIC POLICIES AND PROGRAMMES

2. 1. What do you think has been the relevance of the NDS in the development of policy* and your entity's programmes on the subject? Indicate the most suitable option.

	Score*
Relevance of the NDS	

**4: Crucial: it has laid down the guidelines for the entity's policy in this sphere; 3: Important: it has been a guide for the entity to set priorities in this sphere; 2: Medium: it has been helpful for the entity to develop programmes; 1: Low, it has not been taken into account when setting objectives or priorities in policies or programmes; 0: No relevance.*

Make any comments you feel are appropriate:

2.2. Rate on a scale of 0 to 4, the **degree of alignment** between the Objectives of your Organisation and the Objectives of the 2009-2016 NDS (0: no alignment at all-4: Total alignment).:

2.3. Rate the relevance each one of the objectives in the Strategy has in your view from 0 to 4, where 0 is not relevant at all and 4 very relevant.

	2.2. Alignment	**2.3. Relevance**
G.O. No.1: Optimise coordination and cooperation in the framework of the Spanish State.		
G.O. No.2: Raise social awareness about the importance of drug-related personal and social problems, harms, and costs, about the real possibility of avoiding them and about the importance of society as a whole playing an active part in their solution.		
G.O. No.3: Develop personal resilience capabilities and skills to resist the drugs on offer and the determining factors in problematic behaviours related to them.		
G.O. No.4: Delay the age of initiation for contact with drugs.		
G.O. No.5: Reduce the use of licit and illicit drugs.		
G.O. No.6: Reduce or limit health harms in people who use drugs and in general the undesirable social and health effects related to their use.		
G.O. No.7: Guarantee quality assistance tailored to the needs of drug users. *Normalise health assistance* for drug addicts on the basis of scientific evidence through the development of protocols, guidelines and intervention catalogues.		
G.O. No.8: Facilitate social incorporation into society of people undergoing rehabilitation through integrated training and social and employment preparation and insertion.		
G.O. No.9: Be more effective in the measures aiming to control the supply and illicit markets of psychoactive substances.		
G.O. No.10: Increase AML mechanisms.		
G.O. No.11: Increase and improve research with the aim of gaining more knowledge of the different variables related to drugs and their use, as well as their prevention and assistance.		

G.O. No. 12: Do more systematic evaluation of programmes and actions as an instrument enabling validation of the activities carried out.		
G.O. No. 13: Improve and expand training for professionals who work in this field as well as the training aimed at people who collaborate in the field as volunteers.		
G.O. No. 14: Optimise coordination and cooperation in the European and international framework in general.		

3. QUALITY OF THE NATIONAL STRATEGY ON DRUGS:

3.1. Indicate your level of agreement with the following assertions about the 2009-2016 NDS. Score from 0 (no agreement) to 4 (high level of agreement):

Its objectives are well defined and they are clear	
Its objectives are well defined and they are realistic	
The objectives are appropriate and match the needs of the sector	
The objectives are aligned with the measures proposed	
Its objectives are concrete	
Its objectives can be evaluated	

3.2. Indicate which aspects in your view would have improved the quality of the Strategy

ANNEXE III

LIST OF CHARTS AND FIGURES

LIST OF CHARTS AND FIGURES

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6. Chart 6: Analysis diagram of the NDS 2009-2016 evaluation indicators (source: the author).

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GENERAL OBJECTIVE 2.

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GENERAL OBJECTIVE 3.

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22. Figure 3.2. Distribution of Autonomous Regions prevention programmes. (Source: PADs).

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24. Figure 3.4. Main beneficiaries of prevention programmes in Spain 2009- 2015 (Source: Memoria PNSD).

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26. Figure 3.6. Degree of accreditation of Autonomous Regions prevention programmes (Source: PADs)

27. Figure 3.7. Quality systems in the Autonomous Regions (Source: PADs).

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    - No. of PADs with catalogues and portfolios of prevention services.
    - No. of PADs that do evaluations in prevention.

28. Figure 3.8. Profile of Autonomous Regions prevention programmes (Source: PADs).

GENERAL OBJECTIVE 4:

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32. Figure 4.4. Perception of normality about drug use: Percentage of students aged 14-18 who believe that most of their friends have used drugs in the last 30 days (Source: OEDA).

33. Figure 4.5. Visibility of drugs use: Percentage of the population that frequently see the following behaviours 2015 (Source OEDA).

34. Figure 4.6. Perceived availability: Percentage of people who think it is easy to obtain the

following drugs (Source: OEDA).

35. Figure 4.7. Weekly available cash for personal expenses among E.S.O. students aged 14-18 by sex and age (Source: OEDA).
36. Figure 4.8. The time 14-year-old students go home at night at weekends. (Source: OEDA).
37. Figure 4.9. Percentage of drugs users according to the time they go home at night (Source: OEDA).

GENERAL OBJECTIVE 5:

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39. Figure 5.2. Percentage of adolescents who have used drugs at some time (Source: OEDA).
40. Figure 5.3. Percentage of people aged 15 to 64 who have used drugs in the last 30 days (Source: OEDA).
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42. Figure 5.7. Percentage of the general population and the adolescent population that do not use drugs 2009-2015 (Source: OEDA).
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47. Figure 5.12. Incidence of use in adolescents according to gender (Source: OEDA).
48. Figure 5. 13. Problematic users aged 15-64 2009-2015 (Source: OEDA).
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GENERAL OBJECTIVE 6.

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56. Figure 6.5. Percentage of IDUs*and HIV+ among assistance entrants for drug misuse or dependence 2009-2014 (Source: OEDA).
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GENERAL OBJECTIVE 7.

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66. Figure 7.7. No. of assistance entrants according to the main drug 2009-2014 (Source: OEDA).
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69. Figure 7.10. Level of accreditation of assistance programmes in the Autonomous Regions (Source: PADs).
70. Figure 7.11. Standard of assistance in the Autonomous Regions (Source: PADs).
71. Figure 7. 12. Evaluation of assistance in the Autonomous Regions (Source: PADs).
72. Figure 7. 13. Harm reduction programmes in the Autonomous Regions (Source: PADs).
73. Figure 7. 14. No. of Harm Reduction resources (Source: Memoria PND).

74. Figure 7. 15. Population covered, new HIV diagnoses and needles and syringes distribution in harm reduction programmes (Source: OEDA).

75. 7.15.1. No. of IDUs in the last year, 2009-2014. Average value among the population aged 15-64 (Source OEDA).

76. 7.15.2. Percentage of new HIV diagnoses transmitted via injecting drug use 2009-2014 (Source: OEDA).

77. 7.15.3. No. of needles and syringes distributed in harm reduction programmes 2009-2015 (Source: Memoria PND).

78. Figure 7. 16. Evaluation and quality in harm reduction in the Autonomous Regions (Source: PADs).

GENERAL OBJECTIVE 8.

79. Figure 8.1. Types and coverage of social incorporation programmes in the Autonomous Regions (Source: PADs).

80. Figure 8.2. Profile of social incorporation programmes in the Autonomous Regions (Source: PADs).

81. Figure 8.3. No. of cases in incorporation programmes (Source: Memoria PNSD).

82. Figure 8.4. Percentage of cases in social incorporation in relation to assistance entrants 2009-2014 (Sources: OEDA-Memoria PNSD).

83. Figure 8.5. Employment and accommodation among assistance entrants 2009-2014 (Source: OEDA)

84. Figure 8.6. Average level of Coverage, Accreditation and Coordination of Social Incorporation programmes (Source: PADs).

85. Figure 8.7. Quality of Social Incorporation programmes in the Autonomous Regions (Source: PADs).

86. Figure 8.8. Evaluation in Social Incorporation programmes in the Autonomous Regions (Source: PADs).

GENERAL OBJECTIVE 9.

87. Table 9.1. Retail trafficking prevention actions in school and recreational areas (Source: CITCO).

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90. Table 9.2. Arrests, official complaints filed, seizures and sales points neutralised in recreational areas (Source: CITCO).

91. Table 9.3. Official complaints filed under the Organic Law on Citizens Security (L.O 4/2015) (Source: CITCO).

92. Table 9.4. No. of inspections of operators of substances that might be diverted to illicit channels (Source: CITCO).

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GENERAL OBJECTIVE 10.

94. Figure 10.1. Exchange of information from Spain with other AROs. Natural and legal persons investigated (Source: CITCO).

GENERAL OBJECTIVE 11.

95. Figure 11.1. Research budget DGPNSD (Source: Memoria PNSD).

96. Figure 11.2. Research, documentation and publications budgets PADs (Source: Memoria PNSD).

97. Figure 11.3. No. of DGPNSD research projects. (Source: Memoria PNSD).

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99. Figure 11.5. No. of research projects by drug 2006-2015 (Source: Memoria PNSD).

100. Figure 11.6 Dissemination DGPNSD-funded research projects: no. of projects carried out (Source: Memoria PNSD).

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GENERAL OBJECTIVE 12.

102. Figure 12.1. No. of PADs that do evaluations of policies and programmes (max. 19) (Source: PADs).

103. Figure 12.2. No. of PADs that carry out each type of evaluation, by intervention area. (Source: PADs).

104. Figure 12.3. No. of PADs that have done an evaluation of the assistance network (Source: PADs).

GENERAL OBJECTIVE 13.

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106. Figure 13.2. Number of professionals trained by the PADs (Source: PADs).

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