

# NATIONAL STRATEGY ON ADDICTIONS 2017-2024



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DELEGACIÓN DEL GOBIERNO  
PARA EL PLAN NACIONAL  
SOBRE DROGAS

# NATIONAL STRATEGY ON ADDICTIONS 2017-2024

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# 1. INTRODUCTION

Spain's National Strategy on Addictions 2017-2024 is a document that has been prepared with the participation and consensus of relevant stakeholders, including all the Public Administrations, non-governmental organisations (NGOs) in the sector, scientific societies, research centres and all public and private bodies involved with any involvement in the National Plan on Drugs.

As planning documents, national strategies have become the primary means used to establish and support the different responses offered at local and/or regional level through the creation of a coordination tool for all stakeholders involved in implementing drugs policies.

Approximately one third of the 30 countries (28 EU members plus Turkey and Norway) monitored by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) currently include legal substances and other addictions within the scope of their strategies on addictions. In fact, in numerical terms, there are more users of legal addictive substances such as alcohol, tobacco and certain pharmaceutical drugs than any other substance.

Since the National Plan on Drugs [*Plan Nacional sobre Drogas*, PNSD] was created in Spain back in July 1985 there have been two strategies designed to establish the framework for actions to be taken to implement policies on drugs and drug addictions and to lay down the general lines for policy implementation.

In both cases the impetus to draw up the two strategy documents came from the Government Delegation for the National Plan on Drugs [*Delegación del Gobierno para el Plan Nacional sobre Drogas*, DGPNSD] as the institution responsible for leading, driving forward and undertaking the general coordination and supervision of the services whose remit is to update and implement the National Plan on Drugs in Spain. There was also considerable participation in the preparation of both strategies from the departments and units in the State General Administration and their counterparts in the autonomic administration, local corporations and other institutions also involved in the National Plan on Drugs.

This current National Strategy on Addictions 2017-2024 [*Estrategia Nacional sobre Adicciones*, ENA 2017-2024] builds on and is informed by the two previous strategies (National Drugs Strategy 2000-2008 and the National Drugs Strategy 2009-2016), as well as by the three Action Plans developed under those two Strategies (the National Action Plan on Drugs 2005-2008, under the 2000-2008 Strategy, and the Action Plans on Drugs covering 2009-2012 and 2013-2016 respectively, which were developed under the second National Drugs Strategy 2009-2016).

Moreover, this document is informed by the findings of the evaluation of the two earlier Strategies and of the Actions Plans mentioned above as well as by the analysis made on the situation in Spain with regard to drugs and drug addictions in the period 2009-2015. The National Strategy on Addictions 2017-2024 also draws on the EU Drugs Strategy (2013-2020), on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Strategy 2025 as well as on other national strategies developed by other countries (such as Germany, UK, Italy, France, Sweden and Australia) with a similar context.

Likewise, the different current strategies and action plans put in place in the autonomous communities and cities in Spain have also been analysed in order to take into account the goals, approaches and intervention areas in them.

Lastly, the available scientific evidence on addictions has been reviewed, particularly the evidence concerning the role of new technologies as facilitators of access and drivers of behavioural addictions.

The National Strategy on Addictions 2017-2024 was developed following an initial internal consultation process within the Government Delegation for the National Plan on Drugs. It also benefited from collaborative input given by all the institutions and stakeholders forming part of the National Plan on Drugs through a specific questionnaire and a number of successive rounds of consultations in which the authorities/departments responsible for drugs at the autonomous communities and cities [*Planes Autonómicos de Drogas*, PADs] played a notable part. In addition, numerous departments in the State General Administration, the Spanish Federation of Municipalities and Provinces [*Federación Española de Municipios y Provincias*, FEMP] participated in the process together with a great many social entities, scientific societies, universities and experts in different disciplines (epidemiology, clinical studies, prevention, holistic or integrated intervention, legislation and law enforcement, social sciences, gender, etc.) as well as working groups in the Spanish Council for Drug Addiction and other Addictions [*Consejo Español de Drogodependencias y otras Adicciones*].

The outcome is a multi-stakeholder consensus-based document that provides a policy action framework for the development of policies on addictions to be implemented within the Spanish State as a whole, the autonomous communities and cities and the local corporations, and it is used as a reference document by NGOs for any activities they too may carry out in this area.

The structure of Spain's National Strategy on Addictions 2017-2024 has been aligned as far as possible with the EU Drugs Strategy 2013-2020, albeit with the appropriate modifications and adaptations required to reflect the situation as it is in Spain. Consequently, the National Strategy on Addictions 2017-2024 is designed around two overarching goals with a number of different strategic objectives grouped within several policy action areas. These areas are supported in turn by six cross-cutting themes. The two goals are: a) "To achieve" a **healthier and better-informed society** through a reduction in the demand for drugs and in the prevalence of addictions in general, and b) "To have" a **more secure** by reducing the supply of drugs and controlling any activities that might lead to addictions.

The cross-cutting themes are: a) coordination, b) knowledge management (information systems, research and training), c) legislation, d) international cooperation, e) communication and dissemination, and f) evaluation and quality.

The Strategy will be rolled out through two consecutive **Action Plans**, each one covering a period of four years: 2017 to 2020 and 2021 to 2024. These two plans will include a list of specific actions to be implemented together with the bodies, entities or administrative units responsible for their implementation as well as the indicators and instruments for those actions to undergo evaluation.

## 2. CURRENT OVERVIEW OF ADDICTIONS IN SPAIN

### 2.1. Information systems

Spain relies on a number of reliable sources of information and information systems as well as many different research studies that furnish data on a variety of aspects linked to drugs and drug addictions: drug use prevalence and user profiles; attitudes and perceptions in different social sectors; number and characteristics of people in treatment or who have been treated by emergency services; morbidity and mortality rates linked to drug use; prevention, support and social incorporation actions, as well as any other actions related to judicial and law enforcement intervention in drug supply control.

The autonomous communities and cities represent the most important source of information. Others include, data provided by different ministries and government departments and bodies, state law enforcement and security agencies, autonomous communities police forces and the special anti-drugs prosecutor. Increasingly, local corporations and the Spanish Federation of Municipalities and Provinces have also been providing valuable information on the work they do in this field.

Since 1987 Spain has been using indicators to compile annual information on admissions to treatment due to the use of psychoactive substances, on emergency hospital episodes due to psychoactive substance use and on mortality due to an acute reaction to psychoactive substances. Additional indicators have also been available since 2006 such as problem drug use/high-risk drug use indicator and drug related infectious disease among drug users, for which a number of different information sources are available.

Moreover, two types of surveys have been carried out regularly by the Government Delegation for the National Plan on Drugs since the mid-1990s: the Household Survey on Alcohol and Drugs in Spain [*Encuesta Domiciliaria sobre Alcohol y Drogas en España*, EDADES], and the State Survey on the Use of Drugs in Secondary Schools [*Encuesta Estatal sobre Uso de Drogas en Enseñanzas Secundarias*, ESTUDES]. Other surveys are conducted periodically, such as a Survey on the use of Psychoactive Substances in the Workplace in Spain [*Encuesta sobre Consumo de Sustancias en el Ámbito Laboral*], which is carried out every 7 years (the first one was in 2007) on the resident working population in Spain aged between 16 and 64, and the Survey on Health and Drug Use in Inmates in Penitentiary Institutions in Spain [*Encuesta sobre Salud y Uso de Drogas en Instituciones Penitenciarias*], conducted on a five year cycle since 2006. Other surveys include a Survey of Secondary School Teachers on Drugs and other Addictions in Spain [*Encuesta a Profesores de Enseñanzas Secundarias sobre Drogas y otras Adicciones en España*, 2014, EPAD] and a State survey on People entering Heroin or Cocaine Addiction Treatment 2003-2004.

Likewise, Spain uses information systems such as the Statistical Analysis and Evaluation System on Organised Crime and Drugs [*Sistema Estadístico de Análisis y Evaluación sobre Crimen Organizado y Drogas*, SENDA) which periodically gathers joint law enforcement and judicial information on seizures of the main substances and their characteristics, arrests for drug trafficking and official complaints filed about infringements of Organic Law 4/2015 of 30



March on the Protection of Citizen Safety on matters pertaining to drugs, judicial proceedings initiated, etc., based on the data sent in regularly by the National Police and Civil Guard Corps and the Department of Customs and Excise duties as well as the data reported on an annual basis by the autonomous communities police forces. The information obtained is used to produce and disseminate the **Annual Statistics on Drug Trafficking**, which publishes details of the development of the key global supply control indicators (most recent report dated on 2016). The purpose of the statistics is to provide guidance and support in the efforts to combat illegal drug trafficking as well as to highlight how this phenomenon is developing geographically and over time in Spain.

This statistical and epidemiological information is used by a number of national public bodies and private entities when preparing their own studies and reports. Much of the data and indicators described above use internationally comparable methodology and that means not only can trends be tracked over time nationally but also Spanish data can be analysed and benchmarked against data from other countries. In fact these data and indicators are already used by the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA), EUROPOL, INTERPOL, United Nations Office on Drugs and Crime (UNODC), International Narcotics Control Board (INCB), and other international bodies as documentary support when publishing their own reports.

## 2.2. Developments in drug use and behavioural addictions

As far as drug demand is concerned, **illegal drug use** in Spain continues to be one of the most persistent threats to the health and welfare of society and is a problem that directly and indirectly affects the lives of millions of people in our country.

In general terms, one third of the Spanish population have used some form of illicit drugs at least once in their lifetime and that percentage has remained relatively stable over recent years. Nevertheless, a modest rise in the use of legally sold psychoactive substances—especially alcohol and hypnotic drugs—is now being recorded whereas the prevalence of tobacco use has remained at the same level it fell to following the enactment of specific legislation in 2005 and 2010.

According to data from the Household Survey on Alcohol and Drugs, EDADES 2015-16, **the drugs with the highest prevalence of use in Spain** (in the 12 months prior to the survey) in the population aged between 15 and 64 **are legal substances**: alcohol (77.6%; 9.3% daily) and tobacco (40.2%; 30.8% daily) followed by hypnotic drugs, obtained with and without a prescription (12%; 6% daily).

**The illegal drugs** most used in Spain in the last year are cannabis (9.5%; 2.1% daily) and cocaine (2%). Both of them have a higher usage prevalence compared to other EU countries, especially among adolescents and adults up to middle age where drug use is mainly concentrated (young adults aged between 15 and 34). The trend in heroin use remains stable at very low levels. Only 0.1% of the people surveyed had used heroin in the last year and in the last month. The majority user profile is a male aged over 35. As far as MDMA, amphetamines, hallucinogens and inhalants (volatile substances) are concerned, the falling trend that started in 2001 for all uses in men and women has been consolidated. The lowest figures ever since surveys started have been recorded in the substance use indicator over the last 12 months for MDMA (0.6%), amphetamines (0.5%) and inhalants (0.1%). The use of hallucinogens has increased compared to the previous survey but still remains at very low rates (0.6%). On the other hand, 3.5% of the population aged 15 to 64 have tried

a new psychoactive substance (NPS) at least once in their lives. This pattern of use is experimental and mainly seen among males aged 25 to 34.

**The mean age of first use** remains stable, with an earlier onset age recorded for legal substances: tobacco (16.4 years) and alcohol (16.6 years). Cannabis is first used at the age of 18.3; the latest age of first use is for hypnotic sedative drugs (35 years). With the exception of hypnotic sedatives, the prevalence of use of all drugs is higher in the 15 to 34 years old age group and among males. However, the pattern of polydrug use is very widespread and often (90%) includes high-risk consumption of alcohol and cannabis.

**About 9.8 million Spaniards aged 15 to 64 have used cannabis at least once in their lifetime whereas 2.6 million people have tried cocaine and 1.08 million have used a New Psychoactive Substance (NPS). Furthermore, 65,322 adults are high-risk opioid users.**

## CANNABIS

According to data from the EDADES 2015-16 survey, cannabis is the most used illicit drug; in addition it is the only drug use recording a rise in consumption compared to all other drug uses (at least once in lifetime use, last year, last month, daily).

The profile for the onset of cannabis use corresponds to a male aged under 25 in 77% of all cases. One fact that should be highlighted is that the percentage of cannabis users aged between 15 and 17 (12.6%) is higher than the percentage of users among adults aged over 35 (5.5%).

In parallel to the increased use of the substance, the percentage of the population who consider cannabis use to be a risk behaviour has dropped from 82.4 to 79.8%. Although there is still a higher percentage of the population who believe that the legalisation of cannabis would not contribute to solving the problem the number of respondents who now believe that it would has risen from 33.1% to 37.4%. This percentage is concentrated in cannabis users – especially problem users. (*The profile of a problem cannabis user corresponds to a male aged under 25 who smokes 3 marijuana joints a day; 19% of the population aged 15-64 who have used cannabis in the last 12 months is problem users*).

## DRIVING AND DRUGS

Driving after using a psychoactive substance is unfortunately something that happens frequently in Spain: 12% of Spaniards with a car have used an illicit substance and/or alcohol before driving at some time. This is the general percentage finding from the study on the prevalence of psychoactive substance use carried out in 2015 by the DGT, the National Traffic Authority in Spain (EDAP, 2015 and DGT, 2016). The drugs most used by motorists continue to be cannabis (7.5%), followed by cocaine (4.7%). Some 4% of drivers have used more than one substance before driving. After falling off following the 2008 peak, the trend in drug use is now rising again although it has not yet attained 2008 levels.



## OVERVIEW OF ADDICTIONS IN SPAIN FROM THE GENDER PERSPECTIVE

**Women and hypnosedative drugs:** This is the only drug use in which the prevalence of women is greater than men; in fact it is almost double. This drug use is hidden use, not because of any stigma attached to it, but because of ignorance about it and the view that this type of drug use is “normal”, especially in women. On top of that is the fact that there are no generalised prevention and awareness-raising campaigns focusing on this type of substance use as there are for other substances.

- 3,732,000 people used hypnosedative drugs in 2015 (last 12 months). 65% of those users are women and 57% of them are aged between 45 and 64.
- Of the total number of people aged 15-64 who used hypnosedative drugs over the last year, 544,000 started to use them in 2015. Of this figure for new users 67% are women and 89% are men or women aged over 25. The highest onset rate is recorded among women aged 45 to 54.
- 2.5% of the general population aged 15 to 64 and 21% of the population aged 15 to 64 who have used hypnosedative drugs in the last 12 months are problematic users (775,762 people). The highest problem use of hypnosedative drugs is recorded among women (3%) in the 45 to 64 year old age bracket (no data are available beyond this age).

**Women and alcohol:** excessive alcohol consumption is the number one public health problem in Spain and one that causes serious harm to society and other people not only the consumer.

- The World Health Organisation (2010) has identified alcohol abuse as one of the risk factors in violence perpetrated against a partner and sexual violence. A significant percentage of perpetrators misuse alcohol or are alcohol dependent. Moreover, it is estimated that around 20% of men who participate in drug use reduction intervention programmes and who live with their partners have assaulted them at least once during the year prior to entering treatment for their addiction.

In fact it is common to find participants in drug addict intervention programmes who have a restraining order issued against them or who have been reported to the police for abuse. In addition, it seems that there is a stronger linkage between alcohol and aggression among men who abuse their partner than among men in the general population and it is thought that the risk consumption of alcohol increases the likelihood of the assaults being more serious. Likewise, the continued use of substances has been deemed a predictor of future assaults by that person against their partner.

- Furthermore, women who have been victims of violence perpetrated by their partner are almost twice as likely to suffer alcohol-related problems; the sexual violence they have suffered may lead in turn to an increase in their own alcohol consumption.

Women, therefore suffer twice over as victims of excessive alcohol consumption. Firstly, they are the victims of violence perpetrated against them by a partner with harmful alcohol consumption and secondly, by suffering themselves from harmful consumption problems as a consequence of that violence.

## OTHER BEHAVIOURAL ADDICTIONS

**Gambling** is a disorder that has been recognised by the American Psychiatric Association since 1980 (DSM-5; APA, 2013) and by the World Health Organisation (WHO), which included gambling in its International Classification of Diseases in 1992. From an etiological standpoint, pathological gambling is a disorder with multiple causes involving environmental risk factors (gender, age, socioeconomic background, education, availability and supply of gambling, etc.), psychological factors (impulse control and the search for sensations, shortcomings in strategies for dealing with and solving conflicts, co-morbidity, neuropsychological shortcomings and alterations) and biological factors.

In 2016 a **Study on the prevalence, behaviour and characteristics of gamblers in Spain** [*Estudio sobre prevalencia, comportamiento y características de los usuarios de juegos de azar en España*] <http://www.ordenacionjuego.es/es/estudio-prevalencia> was published. The research work was coordinated by the Directorate General for the Regulation of Gambling (DGOJ) and was based on a questionnaire for the resident population in Spain aged over 18 with additional face-to-face questionnaires for the resident population aged 15 to 17. The findings showed a 0.9% prevalence rate for people classified as pathological gamblers, 1% in people classified as gamblers with problems and 4.4% for gamblers with some kind of risk. These values fell to 0.3%, 0.6%, and 2.6% respectively if the findings linked to gambling in the last year are taken. Moreover, 76% of the people surveyed stated that they had gambled in the last year.

Some 69.6% of pathological gamblers in Spain are male. The age groups most affected are the 25-34 and the 55-64 age groups. The majority of these pathological gamblers are people in work (although as the problem severity increases so does unemployment), earning between €601-1,500, who gamble on their own and are aware of their situation (8 out of 10). The percentage of single, divorced or separated gamblers goes up as gambling problems extent and severity increase. A relationship can be observed between the degree of problem gambling and psychological problems in 45.5% of all gamblers.

**The mean age of onset** in gambling (gamblers with problems) is 19, with fruit/slot machines being the main form of initiation to gambling and the main source of problems. A high percentage of people acknowledge having gambled before the age of 18 (44.8% of people who have a gambling-related problem).

Offline gambling is the most used method (gambling at home/betting houses, slot machines/fruit machines, gambling in casinos, contests, racetrack betting and card games played for money), although there has been an upturn in online gambling. In addition, as the gambling problems extent and severity rise, the expenditure on online gambling is higher.

In this respect, according to the findings of the research study analysing the **Profile of Online Gamblers** (2015) also conducted by the Spanish Directorate General for the Regulation of Gambling (DGOJ), an across the board increase in the key indicators compared to 2014 can be observed, with growth in all the **online gambling** segments: the total number of active gamblers, 985,333 people (up 19.6%); the mean number of monthly active gamblers, 379,883 (up 16.2%), the mean participation €8,614 (up 10.9%, mainly in women), and the average expenditure per gambler, €293 (up 20.6%).

Fixed-odds sports betting is the online gambling option most in demand although an increase is observed compared to 2014 in the number of gamblers in the betting (34.4%), bingo (37.6%) and casinos (80.4%) segments, with the latter driven to a great extent by marketing of gaming machines. The majority of online gamblers are men (83%), although a significant increase in women has been recorded (up 53% compared to 2014). 87% are aged between 18 and 45. The most representative gambler profile by volume of participation in betting, casinos and poker continues to be a male aged between 26 and 35 whereas in bingo the representative profile is a woman aged between 36 and 45. Men gamble on average 34% more money than women (€8,992 men, €6,734 women) and spend more than double women do (€322 men and €146 women). Participation per gambler rises with age. Gamblers aged between 36 and 45 spend the most (€500), with gamblers aged between 18 and 25 spending the least (99€).

There is a broad consensus in the scientific and professional community about the fact that gambling can be considered an addiction on the basis of clinical data and the neurobiological phenomena present in the patient. For other behaviours that are frequently identified today as possible addictions (Internet, digital screens, ICTs, etc.) more information and definition are required about for a scientific consensus to be reached considering, however, that current knowledge indicates that the latter show analogies to addictions to substances and to pathological gambling.

According to the data in the ESTUDES - State Survey on the Use of Drugs in Secondary Schools (2014-15), 18% of the population of adolescents and young people aged between 14 and 18 misuse information and communication technologies (ICTs). Even though this use will probably return to normal levels with age, within this percentage of the population the school dropout rate tends to be higher and drug use is more prevalent.

### 2.3. Problems related to substance use and behavioural addictions and their social impact

The human and social cost of addictions is very high; added to this is the cost for the public health system (prevention, health care and treatment), public safety and security, the environment and labour productivity.

The latest data report that the use of all substances—especially the problematic use of cocaine—has stabilised or recorded a slight decrease when measured on the basis of usage frequency criteria and scales in the different surveys, with the exception of cannabis use and binge drinking. Although the number of people who have never used substances among both adolescents and the general population is rising, worrying levels of usage persist, above all in minors where it is the first cause of health loss in this population. According to the 2015 EDADES survey, problem cannabis users are more likely to have risk sexual relations, traffic accidents, family problems, financial, psychological, employment problems, problems with the police and with friends and other types of problems than the general population. The prevalence of drunkenness and binge drinking among problem users of cannabis is much higher than in the general population and they also have more polydrug use of three or more drugs.

In addition, indicators assessing health consequences associated with substance use have highlighted on the one hand, a decline in the impact of cocaine which was at maximum levels 2-3 years ago, and on the other hand, a striking increase in the presence of cannabis, which in 2012 surpassed cocaine as the most frequent cause of first time treatment demand and also surpassed heroin in terms of a proportion of the total number of admissions to treatment for psychoactive substances in Spain. Similarly the presence of cannabis continues to increase in the hospital emergencies indicator relating to non-medical use of drugs and in the toxicological analysis of fatalities due to acute reaction to psychoactive substances.

Heroin users complete the full picture of illegal drugs in Spain and despite the progressive decline observed in the number of heroin users and in the use of injection as the main route of administration by first time treatment seekers (who represented only 4% in 2013 of the figure they represented in 1991), they make up a subpopulation of users who account for the greatest socio-health impact of drug use in Spain (social exclusion, HIV, HVC etc.) and who continue to demand a very considerable proportion of the available resources in this area. In addition this is now an ageing population with the consequent appearance of ageing-related co-morbidities.

One positive aspect is the reduced prevalence of infectious diseases, which in general has fallen substantially since 2009, in parallel with the decrease in injected drug use.

There has been an increase in drug-related deaths since 2009—especially violent deaths. At least 767 people died of a fatal drug overdose in Spain in 2015 (739 in 2009).

## DRIVING AND DRUGS

In its 2016 report on the analysis of traffic accident fatalities in 2015, the National Toxicology and Forensic Sciences Institute in Spain [*Instituto Nacional de Toxicología y Ciencias Forenses INTCF*] reported a total of 900 deaths in traffic accidents. A psychoactive substance was present in 43% of **driver fatalities** and 91.6% of these were **men**. Alcohol was present in 28.8% of the driver fatalities, illicit drugs in 13.6% and psychoactive drugs in 11.4%. In the positive illegal drug tests, the most frequently found substance was cocaine followed by cannabis. Among pedestrians, 46.4% of fatalities showed positive results in blood tests for drugs and/or psychoactive drugs and/or alcohol, and 73.5% of them were men. The percentage evolution compared to the total number of drivers analysed each year indicates a rise in the proportion of driver fatalities in traffic accidents where there was a presence of psychoactive substances (especially alcohol), which had fallen over the previous three years.

As far as the results of alcohol tests on drivers involved in accidents with fatalities on interurban roads are concerned, it can be observed that 9% of the injured admitted to hospital, 7% of the injured not admitted to hospital as well as 4% of the drivers involved who did not require medical treatment all tested positive for alcohol.

Despite the stabilisation and/or slight drop in problem use of some substances (cannabis, cocaine, heroin) in the general population, there has been an increase in the harm caused by drugs: medical emergencies, drug-induced deaths and some related crimes, with harm caused to third parties on the rise. Nonetheless, there is still insufficient social awareness of the risks, harms and costs associated with drugs.

## 2.4. The drugs market and gambling: related aspects

The illicit drugs market is the most dynamic criminal market. According to data from EMCDDA and EUROPOL, it is estimated that EU citizens spend more than 24.000 million euros every year on illicit drugs.

### DRUGS SEIZURES

The trend with regard to drugs seizures in Spain varies depending on the type of drug concerned. Significantly there has been an almost 250% increase in MDMA seizures by the state law enforcement agencies in the last year (2016), pointing to a clear upturn in trafficking (and therefore in the use) of this substance.

AMOUNTS SEIZED	2015	2016	% CHANGE 2015-2016
Cocaine (kg)	21,621	15,629	-27.71
Cannabis resin-hashish (kg)	380,361	324,379	-14.72
Herbal cannabis (kg)	15,915	21,138	32.82
Heroin (kg)	256	253	-1.17
MDMA-ecstasy (units)	134,063	346,848	158.72
Amphetamine powder-speed (kg)	209	355	69.86
Cannabis plants (units)	379,846	724,611	90.76

Source: Ministerio del Interior (Spanish Interior Ministry)

### COCAINE

Spain reports more and larger cocaine seizures than any other European country, thus making our country a true retaining wall keeping drugs out of the European Union.

The cocaine trafficking routes bringing cocaine into Spain that are still active are the “northern or sailboat route” (vessels sailing north of Madeira or the Azores heading for northern European countries and the Iberian peninsula), the “central route or freighter and fishing vessel route” (whose destination is the area around Cape Verde and the Canary Isles), the “African route” and the “Mediterranean Sea route”.

Cocaine seizures have been falling over the last four years, with 27.7% less cocaine seized in 2016 compared to 2015.

In 2016, ports were once again the primary entry point for cocaine brought into Spain with more cocaine seized in 2016 on container ships (more than half) than the cocaine seized on vessels at sea (both in Spain’s territorial waters and in international waters). In 2015, however, the amounts seized on container ships were similar to the seizures on vessels at sea. More cocaine was seized on

container ships than in 2015 but in a fewer number of container ships, which means the amount of cocaine in each shipment is increasing.

Cocaine seizures in Spanish airports through “human mules” have dropped 14% compared to 2015 as the falling trend of recent years continues.

## CANNABIS RESIN

Cannabis resin-hashish trafficking in Europe has remained very high primarily because of its proximity to Morocco where most of the cannabis resin used in Europe comes from. As in the case of cocaine, Spain has been playing a crucial role in preventing this substance entering Europe and every year seizes more than 75% of all the cannabis resin confiscated in the EU and half of the cannabis resin seized in the world.

There are two major trafficking routes into Europe for this drug: “the Gibraltar Strait route” in which Spain is used as the main entry and transit point for the rest of the continent and the “Eastern Mediterranean route”, starting mainly in Morocco and transporting the drug across the Mediterranean to other countries with a Mediterranean coast.

Cannabis resin seizures fell by 14.72% in 2016 compared to 2015, bringing the upward trend recorded since in 2014 to an end. More than half of the cannabis resin confiscated has been seized as traffickers were trying to bring the drug into Spain in international waters. This is a new trend compared to 2015 when a similar amount was seized in international waters and in Spanish ports.

## HERBAL CANNABIS

The herbal cannabis produced in Europe is normally used in Europe. Historically Spain was never part of the two origin or transit areas in Europe for this drug but in recent years there have been evident signs of the professionalisation of herbal cannabis production and trafficking in Spain whereby cannabis is grown not only for local consumption but also for export. This fact is supported by the seizures in France of herbal cannabis originating in Spain.

Seizures of this substance have recorded an upward trend with a significant 30% increase in the last year.

## CANNABIS PLANTS

Over recent years cannabis plant growing has increased all over Europe including both small-scale production for personal use and for large-scale trafficking through large outdoor and indoor cannabis plantations.

This increase in production together with the increasingly higher concentration of THC may be prompting a partial substitution of imported cannabis resin.

Over recent years, the number of plants seized in Spain has risen exponentially by more than 300% in this three-year period (2013-2016). In the last year alone (2016) seizures were up by 90%.



## HEROIN

The bulk of the heroin used in Europe is produced using opium from Afghanistan that is trafficked along three routes: the “Balkan route, the “Southern route”, and the “Northern route”.

The largest amounts seized have been the result of police investigations or during transportation of the heroin between different areas in Spain or in transit from other EU countries. Seizures of heroin in “human mules” accounted for 13% of the total.

## MDMA-ECSTASY

Most of the MDMA production takes place in illegal laboratories located in Netherlands and Belgium.

In 2016 the amount of MDMA-ecstasy seized in Spain rose by more than 250% compared to the previous year. Although peaks can be seen in previous years they were due to the seizure in a single operation in 2014, which impacted the general statistics for that year.

As regards where exactly the drug is seized, the largest quantity was located not at border points but rather mainly in households as a result of investigations conducted by law enforcement agencies.

## ARRESTS AND COMPLAINTS FILED

**Arrests** recorded for drug trafficking in 2016 were up (4.26%) compared to 2015, bringing the falling trend of recent years to an end.

By drug families, the group of substances for which most arrests were made is the cannabis family (52.82%), followed by cocaine substance related arrests (27.95%).

The number of **police reports** filed about the use and possession of drugs and other serious connected offences increased in 2016 (392,900) compared to 2015 (390,843), in contrast with the downward trend recorded since 2013. The age group with most police reports filed against them is the 19 to 25 year old age group, which accounted for 41.35% of the total. Men accounted for 94.29% of the people who were reported.

In a breakdown by drug families, the leading groups for reports filed were cannabis-related—accounting for 84.37% of the total—and those related to cocaine substances, which account for 10.44%.

## NEW PSYCHOACTIVE SUBSTANCES

In the last four years, **new psychoactive substances** (NPS) have become increasingly available in the open market and/or on the Internet and this availability is becoming a serious health threat. According to the European Drugs Report 2016, through the EU Early Warning System in 2015 a total of 98 NPS were reported for the first time, bringing the number of new substances to more than 560, 70% of which have been detected in the last five years.

A production and distribution system for NPS has been created which is based on either a minimal modification of conventional drug molecules or on the design of new substances that simulate

the effects of conventional drugs but with unknown medium and long-term effects for health. NPS pose a clear challenge for all levels of government when trying to lay down regulations and legislate on drugs.

The main pattern that has been identified for the NPS coming into Spain is usually air transport routes. As for channels through which NPS are sold, although some “grow-shops/smart shops” have been detected and put out of business, NPS seem to be mainly sold through websites; their distribution is through packages sent through the post.

## THE GAMBLING MARKET IN SPAIN

The national gambling market in Spain is run through a segment for lotteries, which are a reserved business activity, and other additional offline and online gambling segments. The nationwide lotteries under this reserved business activity heading are run by two operators: Sociedad Estatal de Loterías y Apuestas del Estado S.M.E., S.A., (SELAE), which is the State Lotteries and Betting Company and the Organización Nacional de Ciegos Españoles (ONCE), the National Organisation for the Blind. The rest of the online gambling market is mainly organised around betting, casinos, bingos, gaming and gambling parlours and type “B” machines. In the online market authorised operators can offer all the different legally permitted gaming options. This picture of the gambling market in Spain is completed with the different gambling activities run under the jurisdiction of the autonomous regions and autonomous cities. The data presented below therefore come from the aggregation of a number of sources (DGOJ, SELAE, ONCE, and autonomous communities essentially) and are estimates for the key variables of each type of gambling.

2016 was another growth year for regulated gambling with an estimated **gambling margin** (profit) of almost € 8,399.71 million, 3.03% up on the previous year, 49.1% of that profit figure corresponding to gambling in lotteries (€ 4,127.40 million), 30% to fruit/slot machines (€ 2,519.20 million), 7.6% to betting (€ 640.74 million), 7% to bingo (€ 586.68 million), 4.8% to casinos (€ 409.30 million) and 1.4% to other forms of gambling (€116.39 million). The rise in betting activity and other gambling is primarily due to online gambling machines.

Within the offline sector regulated by the DGOJ, the performance of lottery ticket sales by the state-run lottery and betting company (SELAE) and the National Organisation for the Blind (ONCE) are to be highlighted. Their combined sales in 2016 totalled € 10,593.30 million and they achieved a margin of € 4,131.42 million reflecting a 1.15% increase in turnover compared to the previous year.

The **breakdown of the margin by channel** between the **offline and online** channels is similar to the split recorded in previous years, with the offline channel accounting for 93.9% and the online channel 6.1%.

**Regulated online gambling** in Spain is structured in three branches: state online gambling, regulated by Law 13/2011 and subject to the control of the DGOJ, online gambling taking place within each autonomous communities’ jurisdiction, and online gambling run by entities authorised to sell lottery tickets.

During 2016 an increase was recorded in the **amount of money gambled** in practically all types of online gambling with the exception of poker. As far as the state online segment is concerned, the

gambling margin figures totalled € 429,274,246, (34.3% more than in 2015). The **gambling margin in the online gambling channel** accounted for 3.94% of the total amount of money gambled in 2016 (in 2015 it was 3.7%; in 2014 3.88%). The importance in the overall figures of fixed-odds betting (accounting for 53.7% in 2016) should be highlighted here; together with poker, online fruit/slot machines and roulette combined accounted for 90.09% of the overall margin.

## 2.5. Actions carried out in the field of demand and supply reduction

The findings of the **Evaluation of the National Drugs Strategy 2009-16** show a positive development for the actions taken in the area of demand and supply reduction although there is still room for improvement.

According to the Evaluation of the National Drugs Strategy 2009-16, a highly varied and structured array of **prevention programmes** is on offer in Spain. However, the coverages of these programmes have been declining since 2009 and the offering is highly focused on education. More action is required on the social conditions that drive drug use (promotion, accessibility, social normalisation) through environmental prevention programmes and in order to guarantee universal coverage of evidence-based programmes that meet the quality criteria approved by the autonomous communities and cities.

On the other hand, the intervening or mediator variables related to the role of families in prevention (coming home time, disposable income) have improved although they still need to be taken more into account as they are the principal protection factor to prevent drug use by minors (in 2014 more than 60% of all 14-year olds were coming home after midnight at weekends).

Early detection and prevention when it comes to the most vulnerable members of society should be a priority and here the education system and the health system have a crucial role to play. Drug use is very much linked to academic failure at school and early behavioural problems.

As regards health care and treatment, Spain offers **integrated assistance** to people with problems of substance addiction. There is a broad, consolidated, diversified and accessible network to provide help and treatment to people with a drugs problem. Notably over recent years a highly significant increase in the number of people who have received help in the network has been observed (a 33% rise in cases in general programmes and 22% in specific programmes). Another salient point is the ageing population with long-term drug use and chronic physical and mental health problems (the mean age of people in treatment has risen by 2 years). In addition, there are a high percentage of problematic cannabis users who are not receiving help and the time elapsing between the onset of use and the start of treatment has lengthened.

The **harm reduction** programmes have been very successful in reducing HIV and HCV infection. Over recent years there has been evidence of a substantial reduction in injected drug use and of HIV+ and HCV+ cases. Spain is one of the EU countries that has achieved the most positive results in its targets for harm reduction in higher risk users (according to the evaluation of the European Drugs Strategy) thanks to the variety and coverage of the programmes it has rolled out (high coverage of syringe programmes, outreach, focus on marginal and recreational settings

and full coverage of harm reduction in prisons). Nevertheless injected drug use is still one of the most relevant health problems in the prison inmate and marginalised populations. Furthermore the need for more overdose prevention programmes—currently only existing in seven autonomous communities and cities—needs to be stressed.

**Social integration** programmes are generally available in all the autonomous communities and cities but their coverage varies considerably and overall the programmes targeted more at integration in the labour market are less developed. Inclusion of the gender perspective has to be reinforced in programmes to take into account the special needs of women (lower employability, family responsibilities, housing problems).

**Coordination** is a key pillar that needs to be strengthened, especially coordination between the autonomous communities and cities. Although the standard of coordination in this sector is already high, more concrete coordination mechanisms (stable working groups, written agreements, etc.) are still needed. Coordination is of particular importance in areas like integrated health care and treatment (to establish protocols for patient itineraries and therapeutic processes) and prevention, and to ensure universal coverage of programmes.

**Budgets** have been cut (particularly in the autonomous communities and cities) with the resulting reduction in resources, programmes and coverages. The areas most affected are research and prevention. Health care has been less affected and so treatment programmes have been able to maintain their coverage.

There are still opportunities for improvement in the overall **quality** of the addictions sector. Substantial progress has been made but the challenge today continues to be how to transfer evidence into practice, make the certification and quality control systems for programmes and services more generalised, ensure the provision of more training and the optimisation of information and evaluation systems.

**Gender and equity** are still major challenges.

As far as the gender perspective is concerned, better mainstreaming of the specific needs of women through all the prevention and care programmes is vital. In this regard it is important for gender violence to be integrated as one of the elements to be taken into account when addressing addictions.

As far as **equity** is concerned more work is needed to continue to improve the accessibility of services and treatments and to extend best practices. The diversity that currently exists in services and programmes on offer in the autonomous communities and cities is not something that can be explained by any differences in the problems associated with drug use in the different territories and may give rise to situations of inequality. Moreover, the implementation of standardised accreditation processes, good practices and catalogues of services (methodology, minimum services provision, etc.) requiring the cooperation and consensus of all the autonomic drugs plans should be furthered.

When it comes to reducing the supply of drugs Spain sets the benchmark for efforts to **combat drug trafficking and money laundering**.

**Police work** has increased safety and security around **schools and recreational areas**. The Spanish Ministry of Interior's prevention plan for schools and their surrounding areas has enabled an assessment to be made of the problems found in schools and this has resulted in an increased

feeling of safety in and around them. The “tutor officer” scheme, promoted by the Government Delegation for the National Plan on Drugs (DGPNSD) and the FEMP since 2012 and implemented by the local police force has helped to achieve the goals in this area. The prevention plan for recreational areas has reduced the supplying of drugs in the areas envisaged in it and its implementation has prevented law and order problems and illegal or antisocial behaviour such as thefts, brawls and vandalism to vehicles and urban furniture.

With regard to the actions carried out in the field of **other behavioural addictions** such as **gambling**, **Law 13/2011 of 27 May on the regulation of gambling** oversees the correct functioning of gambling activities within the jurisdiction of the state, especially any gambling activities sold online. The law also addresses the issue of protection of vulnerable groups, particularly children, by developing and promoting actions and programmes to prevent the development of gambling addictions. There is also another piece of relevant legislation, the **General Law 7/2010 of 31 March on Audiovisual Communication** and also a **Code of conduct on commercial communications relating to gambling activities**, which sets out the principles of self-regulation for commercial communications in audiovisual broadcasting. As well as compliance with the applicable legal provisions for commercial communications and self-promotion contained in the law, the broadcasting time slot for commercial communications and promotional material on gambling activity is specifically addressed by the code.

In 2012, the Directorate General for the Regulation of Gambling (DGOJ) with input from the Government Delegation for the National Plan on Drugs launched an initiative to try to establish a common **responsible gambling** strategy with the participation of the gambling industry, associations working with people suffering from gambling addictions, treatment centres and gambling addiction experts, the relevant authorities in the autonomous communities and cities and in the State Administration. Under that plan the Responsible Gambling Advisory Board was created in 2013.

Lastly, the aim of **gambling access controls** is to protect vulnerable groups, particularly minors and people registered in the General Register of Gambling Access Bans [*Registro General de Interdicciones de Acceso al Juego*, RGIAJ]. As these two groups are not allowed to have access to gambling either because of a legal ruling or because of public health issues or because they have taken the decision individually to be banned from gambling, when anyone wants to have access to an online game operators are required by law to carry out a mandatory player identification check and to use secure accreditation mechanisms. The DGOJ facilitates completion of both checks electronically online by gambling operators. At 31 December 2016 there were 37,749 people registered with the RGIAJ, 7.4% more than were listed on the access ban register at the end of the previous year. The majority of the new registrations have been men (80.52%) in the 26 to 35 and the 36 to 45 age brackets, although there is a growing percentage of under 26 year olds.

Nevertheless, the regulatory framework applicable to gambling within the scope of the State’s jurisdiction needs to be the subject of continued ongoing analysis and, if so required, adaptation. The regulatory framework should strive to strike the right balance between the aims and interests of the gambling market in Spain and the essential protection of public health, minors and the prevention of addictive and fraudulent behaviour online. It also needs to ensure unauthorised fraudulent online gambling activities that do not have the relevant licence are eradicated.

## 2.6. Challenges

### **SOCIAL AND DEMOGRAPHIC CHANGES**

The economic situation, unemployment and precarious working conditions, the curtailment of opportunities in life for many young people because of the crisis; the rise in the number of single person households and loneliness, difficulties to achieve work-life balance; dysfunctional families and broken homes and the rise in single parent families; increased consumer pressure on adolescents and the cultivation of the desire to find satisfaction and/or immediate answers are all factors that may contribute to substance abuse and to other behaviours with the potential to become addictive such as the misuse of new technologies. Significantly in this regard, an increase in the prescription of medicines with addictive potential (benzodiazepines and hypnotic drugs) has been observed.

Moreover, despite all the efforts made, getting people with disorders due to substance use into the labour market is still proving to be a difficult task.

The emergence today of a highly influential view point openly expressing the idea that the use of certain substances is a personal option (consumer clubs) and so demands new regulatory arrangements on their use (especially cannabis) requires a reaction from the authorities and the scientific community. It is their job to try to educate citizens and give them information on the real risks of using these substances.

The ageing of the general population and of substance users entails a challenge in all areas from prevention to health care, risk and harm reduction, training of practitioners, etc.

### **NEW FORMS OF ADDICTION AND CONSUMER BEHAVIOUR PATTERNS**

We live in societies today that are more and more dynamic and subject to change and where addressing the issue of new technologies is crucial. There is growing concern about the rise in the misuse of the Internet, digital media and social media, as well as about the role of new technologies as facilitators of access to and drivers of other behavioural addictions. A prime example of this is gambling (specially betting) and online gaming among adolescents, which are highly influenced by the intervening factor of aggressive advertising.

On the Internet today you can find a market where substances can be bought and sold and chat forums used to exchange “information” and instructions on drug use, but there are also certain apps (Wapo, Tinder, Grinder, etc) that are behind the appearance and spreading of new patterns of behaviour linking the use of drugs with sexual practices: chemsex and slamming or slamsex — a practice combining sex and injecting drugs to make people feel less inhibited and the “sessions” last longer.

On the other hand, digital media could also be seen as potential tools to help in the prevention and treatment of addictions.



## TRENDS

A slight increase in the high-risk consumption of alcohol and other substances and in young people particularly has been observed lately, together with a low risk perception and the social “normalisation” of the recreational use of substances (alcohol, cannabis, cocaine, new psychoactive substances, and others). Outdoor consumption of these substances contributes to this normalisation and trivialisation of the phenomenon and despite the fact that under-age access to gambling (bars, gambling parlours with no access control, online, —gambling, etc.) is an issue on which the competent regulatory authorities and all of the other administrative units involved in control and inspection devote major efforts to minimise its incidence, there are factors—both regulatory and social—that require attention if the presence of minors in gambling is to be totally eliminated.

The broad range of (video)games on offer and heavy advertising in the media and in sports venues as well as aggressive marketing strategies—primarily targeted at the very young—for sports betting and online betting have contributed to an increase in the number of people with gaming and gambling addiction problems and to a change in the profile of gamers and gamblers. In particular, the profile for online gamblers (younger, with a higher education level and, surprisingly, more younger women with Internet betting game problems) has changed.

As well as this focus on the younger segments of the population, more attention needs to be paid to people in the older age bracket as a risk group. There are insufficient data available on these age groups but what we do know is that they take prescription drugs (including psychoactive drugs) more frequently than the rest of the population.

Polydrug use has a strong presence (especially in adolescents and young people) and new easily accessible psychoactive substances (NPS) are continually appearing on the market.

Consequently, it is now necessary to analyse new substance use systems that might incite or initiate drug addiction or entail an added risk (new instruments, different administration routes, etc.).

Similarly, more knowledge is definitely needed about the types and ways of using substances and the associated problems in the over 64 year-old age group for which no data is readily available.

## GENDER

As far as gender is concerned, it is essential:

- a) To effectively incorporate the gender perspective as an analytical tool into all programmes, research and intervention and prevention.
- b) To develop greater awareness of the gender perspective.
- c) To raise awareness in society as a whole in order to foster aspects that are protection factors in women (prudence, solidarity, etc.) and so encourage men to adopt them too.
- d) To promote the prevention and early detection of gender violence in women who are addicted to psychoactive substances and in environments where these substances are used.
- e) To drive forward programmes that focus on the needs of women (e.g. their dependence on psychoactive drugs: hypnotosedatives, opiate-derived pain relievers, etc.) by analysing all the aspects linked to their use and developing non-pharmacological treatment alternatives.

- f) To address the differences and specificities of men and women in each one of the following challenges:
- Social change: how does it affect men? And how does it affect women?
  - New forms of addiction. Differences in the use of new technologies, the incidence of gambling among men and women, differences in the way of using psychoactive substances and of gambling...
  - New usage patterns and trends: different ways to access and obtain psychoactive substances between men and women, different settings for substance use, explaining the differences between men and women from the standpoint of gender constraints.

## HEALTH CARE FIELD

Psychoactive substances users' progressive ageing and how to address consequent increased chronicity, including everything to do with associated cognitive impairment, is one of the main challenges facing the health care system today.

Social and health care for dual pathology, which is present in almost half of all the people with addiction problems in Spain, is another health care challenge that must be tackled by the new National Strategy on Addictions 2017- 2024.

Likewise, more tailored health care and treatment to deal with the specific needs of women is necessary as is access to health care for the most vulnerable groups in society, including the homeless and heroin users in precarious living conditions.

## SUPPLY REDUCTION

On the supply reduction side, more needs to be done in the following areas:

- a) Early detection of NPS and new supply sales channels.
- b) Control of offences linked to the production and trafficking of illegal substances that increase the financial proceeds of organised crime.
- c) Monitoring of any movements of significant amounts of money made from illegal substance trafficking that requires laundering.
- d) Control of the entry, distribution and sale (especially retail) points..
- e) Monitoring of domestic cultivation of cannabis plants increasing trend as the rise in the number of seizures of these plants seems to indicate.

### 3. INSTITUTIONAL FRAMEWORK

The institutional framework of Spain's National Strategy on Addictions 2017-2024 was set up following the creation of the first National Drugs Plan in 1985, the Government Delegation for the National Plan on Drugs and the implementing legislation to develop that National Plan on Drugs.

The institutional framework comprises, inter alia, the Autonomous Communities and Cities Drugs Plans, the departments and bodies in or attached to the General State Administration with competences for drugs and addictions in general, local entities, the Spanish Federation of Municipalities and Provinces (FEMP), non-governmental organisations, scientific societies and other social entities and groups with activities under the aegis of the National Drugs Plan.

Moreover, on 16 September 2014 (art. 20.1 of Law 15/2014) the Spanish Council for Drug Addiction and other Addictions was set up *for the general purpose of improving the technical standard in the definition and implementation of state policies and actions to control the supply of and reduce the demand for drugs as well as for other addictions such as gambling and their harmful effects on people's lives and on society, that may be promoted, coordinated and implemented by the Government Delegation for the National Plan on Drugs, within its remit.* Taking into account its composition, structure and particular rules of procedure, the Council was also attributed a number of the basic functions that had been performed until then by the two bodies (the interministerial group for the National Plan on Drugs and the advisory board of the Spanish Monitoring Centre on Drugs and Drug Addiction) that were abolished by the same Law 15/2014 under which it was set up. The aim in doing this was to avoid any possible impairment of the effectiveness of that specific structure and to allow those functions to be performed in a more coordinated, effective, efficient and agile way by the newly created body. The Council is structured, operates and achieves its aims through a) a plenary and b) specialised working groups.

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### 4. MISSION

To provide a reference framework with an integrated, balanced and evidence-based approach for: firstly, all the Public Administrations, authorities at all levels of government engaged in the National Plan on Drugs and any other entities concerned, so that with all the flexibility required they can put in practice plans and programmes related to addictions that fall within the scope of their competences, harnessing any synergies that might be created through coordination and collaboration between all stakeholders; and secondly, for any actions that might be undertaken by the National Plan on Drugs in the international context (European Strategy, UN Political Declaration, UNGASS, Conventions, etc.).

## 5. GENERAL OBJECTIVES

- Reduce the harm associated with the use of substances with addictive potential and behavioural addictions.
- Reduce the presence of and use of substances with addictive potential and behavioural addictions.
- Delay the onset age of addictions.

## 6. VISION

By 2024, the harm associated with the use of substances with addictive potential in Spain and the harm caused by behavioural addictions will have been reduced through the implementation of policies on drugs and addictions designed to lessen their presence and use, with actions targeted at people and their setting, families, the community and society as a whole, thus contributing to building a healthier, better informed and more secure society.

## 7. VALUES

Spain's National Strategy on Addictions 2017-2024 maintains the unswerving commitment of the National Plan on Drugs to guarantee that all the aspects of demand and supply reduction and related measures and international cooperation will be addressed in full compliance with the goals of the **United Nations Charter**, **International Law** and the **Universal Declaration of Human Rights**, as well as the recent agreements reach by the UN (UNGASS 2016) and the EU.

## **A HOLISTIC PUBLIC HEALTH APPROACH, INCLUDING THE PERSON, THEIR FAMILY AND SOCIAL ENVIRONMENT AND THE COMMUNITY AS A WHOLE**

Public health always takes a community-based approach with actions targeting the individual directly affected by the addiction, but taking into account at the same time that any individual action also has an impact on the community as a whole (in terms of safety and security, economic and health terms, etc.); it places the priority on people in order to raise the standard of collective health overall because the use of drugs has a spillover effect that goes beyond the individual drug user to society as a whole and because everyone is potentially a target for substance misuse during their lifetime. It is an approach that does not neglect actions to improve the state of health lost by a person through substance use by means of the necessary rehabilitation-reintegration processes, but encompassing too all the people around an addict who are affected as well.

### **UNIVERSALITY**

Free, universal coverage under the framework established by the Royal Decree on the Basic Portfolio of National Health System Services and any other state and autonomous and cities legislation relating to health care and treatment for addictions, with (global/universal) actions of proportional intensity to needs and solidarity, with priority given to the protection of the most vulnerable groups in society.

### **COHERENCE AND COLLABORATION BETWEEN THE PUBLIC ADMINISTRATIONS**

The aim is to make policies uniform by integrating laws and previously accepted agreements and by avoiding contradictions and diverging views. To achieve this, the Public Administrations should foster collaboration and cooperation in order to optimise the cross-cutting approach potential offered by the different levels of government.

### **RESPONDING TO DIVERSITY**

This means taking the necessary steps to facilitate access and care and treatment for people with diverse identities so that a tailored response to their individual needs can be given and their integration into society can be promoted in parallel.

### **SOCIAL CO-RESPONSIBILITY AND PUBLIC RESPONSIBILITY**

Active intervention of all the social agents and institutions both in the planning process and in the rollout of the planned actions. This in turn involves creating the right conditions for participation in order to make it possible for the planned measures to be the outcome of a consensus reached between all the social and institutional stakeholders involved.

## 8. GUIDING PRINCIPLES

### EQUITY

Ensuring free access in equal conditions and with no discrimination for the whole population to prevention, health care and social integration services, as and when needed and paying special attention to the most vulnerable social groups or groups with the severest difficulties when it comes to gaining access to and making use of services and resources, all this within the framework established by the Royal Decree on the Basic Portfolio of National Health System Services and any other state and autonomic legislation concerning the treatment of addictions.

### GENDER PERSPECTIVE

Organic Law 3/2007 of 22 March for the effective equality of women and men (art.20) lays down the obligation to incorporate the gender perspective as the framework for analysis and to develop the necessary tools that enable the different way addictions are presented in and affect women to be made visible, analysed and addressed. As a result it will be possible to make a better diagnosis of the real situation and to incorporate the needs and situation of women in all strategic actions and interventions.

### TRANSPARENCY

Law 19/2013 of 9 December states that transparency, access to public information, and good governance standards should underpin any political action taken. In this regard, the National Strategy on Addictions 2017-2024 will contribute to better publicity and dissemination of: data, findings of data analysis, research into and evaluation and the results and of the impact of interventions. The aim is to gain a better understanding of all the aspects of the phenomenon of addictions by promoting the use of general, robust and empirically contrasted data underpinning the measures and actions.

### SCIENTIFIC EVIDENCE

Any actions devised to prevent and lessen the presence of addictions and its associated harm must be empirically contrasted, have scientific grounds and be efficient, seeking realistic and measurable results that can be evaluated and so promote **good practices**. In addition, the fact that evidence is constantly evolving must be taken into account and therefore the priorities and effective responses will be established on the basis of that evolution during the time span of the National Strategy on Addictions 2017-2024. Whenever evidence is not available, is limited or is insufficient, effective policies should be applied to broaden the knowledge base.



## PARTICIPATION

Through advocacy and awareness-raising work with society as a whole in order to engage it directly in this issue. Special attention will be paid to the identification, motivation and active involvement of the most vulnerable groups in society. Citizens everywhere must be actively engaged in dealing with the phenomenon of the use of drugs and gambling, through the definition of objectives, actions and stakeholders in the participative structures and networks for work in each area and at each territorial level so that society overall is an active part of the solution.

## AN INTERSECTORIAL AND INTERDISCIPLINARY APPROACH

Offer a multifactorial, intresectorial and multidisciplinary approach of addressing the question and seek to optimise efforts and resources through coordination and cooperation between the different stakeholders.

## QUALITY

Guarantee that actions taken are preventive, health-care oriented and devised to reduce risks and harms and also adapted to the needs of society and of all the people directly or indirectly affected by addictions. Quality is likewise endorsed by scientific evidence, another guiding principle already described above. This principle will underpin every single action stemming from this National Strategy on Addictions.

## EFFICIENCY AND SUSTAINABILITY

Make a commitment to the efficient management of resources that can guarantee the effectiveness and sustainability of the system and its evaluation; and that enables the implementation of the agreed policies through the corresponding budget allocation.

## 9. SCOPE

The scope of Spain's National Strategy on Addictions 2017-2024 covers four key headings:

- **Legal drugs (tobacco, alcohol).**
- **Prescription drugs and other substances with addictive potential.**
- **Illegal drugs, including new psychoactive substances.**
- **Non-substance addictions or behavioural addictions**, with particular emphasis on betting (offline and online), as well as videogames and other addictions through new technologies.

## 10. GOALS, ACTION AREAS AND STRATEGIC OBJECTIVES

### GOAL 1: TOWARDS A HEALTHIER AND BETTER INFORMED SOCIETY

Drug use and its consequences are a major direct cause of avoidable morbidity and mortality in Spain. Indirectly drug use is also associated with other social and health problems and so entails greater political challenges in these areas. The heroin use epidemic that affected Spain in the past has left in its wake an ageing cohort of problematic drug users with considerable health care needs.

Although alcohol consumption has remained stable it is still the drug with the highest prevalence of use in Spain and excessive alcohol consumption is the number one public health problem that causes serious social damage and harm to third parties. In addition, the high level of alcohol consumption by under-age drinkers, the way they consume alcohol (drinks with a high alcohol content, binge drinking, a high percentage of intoxications and drunkenness episodes) make prevention and control strategies a continued priority given that alcohol abuse is the number one cause of health loss in this population.

As far as the use of illicit drugs is concerned, in general opioids still account for the largest proportion of health-related costs although this situation is now changing somewhat. The reason for this change is the fact that contemporary drug problems are more dynamic and complex than in the past. For some years now in Spain cannabis has been the reason for the higher number of admissions for treatment for substance abuse, followed by cocaine and heroin. Hospital emergencies related to cannabis use are still on the rise as is its presence in the toxicological analyses of deaths caused by acute reactions to psychoactive substances. Furthermore, both acute and chronic problems are currently linked to the use of multiple substances (polydrug use, including alcohol and medicines). These changes are reflected in and partly driven by a more dynamic and globalised drugs market.

Over the last couple of decades there has been a growing understanding of the addictions phenomenon and greater acceptance of the principle that investments should only be made in approaches that have been proven as effective. Also, we are now entering a new phase in which it is likely that a broader variety of approaches to addressing substance abuse problems may become available. Developments in fundamental sciences are giving rise to new pharmacological treatments; applied research is providing us with new techniques for surveillance, prevention, treatment and harm reduction. Furthermore, a greater realisation of the importance of implementing scientific developments is improving our understanding of how to translate evidence from research into policies and programmes that can be successful in the different real world environments in which they will have to be applied.

The multifaceted nature of the problems related to addictions and their interaction with other social and health-related changes are affecting the political approaches adopted to reduce the negative effects of the use of drugs in society. There is no common model but generally there is a growing interest in issues such as the treatment of the recreational misuse of substances

and a broader perspective on public health; exploration of different regulatory approaches; the importance of addressing environmental factors; and the development of policy models that are consistent and mutually supportive in the different political spheres. Drug use can thus become an important issue for policy considerations in areas like housing, employment, crime prevention and even safety and security.

In this regard, there is a need to address the subject of the harmful use of alcohol by taking into account data on gender violence and alcohol consumption. That is why it is necessary to build up strategies aiming not only to lower levels of alcohol consumption but also for early detection of those women who might be at risk because of their partners' misuse of alcohol. Special attention should also be paid to the early detection of the harmful use of alcohol in women who are victims of gender violence.

Turning to other addictions, the annual increase in people entering treatment because of pathological gambling and the latest scientific evidence that points to a major presence of behavioural addictions linked to the use of ICTs at young ages highlight the need to include the so-called “non-substance addictions” within the scope of action of this strategy.

Overall these changes pose a challenge for the National Strategy on Addictions 2017-2024. Epidemiological surveillance tools that are fit for purpose have to be made available to be used in relation with the current and future patterns of use of substances and new addictions and the associated health and social problems we will no doubt face. In addition, innovative, timely and specific communication and information channels would need to go hand in hand with these tools so that these findings can be better and more quickly incorporated into policies and actions.

Likewise, we should keep a record of the new research findings that are changing our understanding of how substance use problems develop and that help us to identify and adopt new intervention options for both established and emerging problems. Incorporation of the new findings into practice needs to be furthered. This has to go hand in hand with an understanding of the most important factors to ensure successful implementation in the different contexts, systems and environments all over Spain.

## AREAS FOR ACTION

### 10.1. Prevention and risk reduction

The aim of **preventive interventions** is to reduce risk factors and to increase protection factors when tackling drug use and other behaviours that are likely to lead to addiction. This aim is achieved through different strategies implemented in different fields. Prevention-oriented interventions are classified in three levels depending on the target population: universal interventions for the whole population; selective interventions, targeted at vulnerable groups; and indicated interventions designed for individuals with higher risk profiles. It is essential for these actions targeting people to be supplemented with others designed to modify the risk factors of the social contexts or settings in which such behaviours take place, which are called environmental prevention interventions and act on a social level by modifying social rules and market regulations.

However, the ultimate aim of interventions for **risk reduction** in the field of addictions is to lessen the negative effects of the substance use. This can be done for instance by avoiding experimental use and sporadic use turning into continued use and preventing the appearance of risk and/or problematic uses like binge-drinking, by reducing the negative consequences that their use may have in other areas, or by avoiding any driving under the influence of alcohol or other drugs in order to prevent traffic accidents.

According to the evaluation of the National Drugs Strategy 2009-2016, in Spain today prevention is essentially people-centred and this approach has to be counterbalanced with other strategies designed to reduce the risk factors and promote protection in the different settings. In addition to that, the coverage of prevention programmes needs to be increased so that universal coverage of those evidence-based programmes is guaranteed.

Today prevention is facing new challenges: new forms of non-substance addiction, especially pathological gambling, the perception of normality in alcohol consumption and cannabis use by under 18 year olds, lobbying for cannabis legalisation or the constant appearance of new psychoactive substances in the drugs markets are aspects that require new responses. Moreover, preventive responses should be adapted to the new contexts and new types of relationships where substances use takes places—especially social media—and take advantage of the opportunities that those contexts offer for prevention.

## STRATEGIC OBJECTIVES

- 10.1.1 Reduce the presence and promotion of drugs and of other behaviours likely to generate addiction.
- 10.1.2 Limit the accessibility to drugs and to other addiction prone behaviours for minors.
- 10.1.3 Raise social awareness about the risks and harm caused by drugs and addictions, increase the perception of risk associated with their use and with certain behavioural addictions (gambling, ICTs) and encourage citizen participation in this endeavour.
- 10.1.4 Reduce the unjustified perception in society and especially among young users that drug use—essentially cannabis and alcohol—is “normal”.
- 10.1.5 Develop personal skills and capabilities that reduce vulnerability when it comes to drug use and other behaviours likely to cause addiction.
- 10.1.6 Promote healthy living and habits, healthy use of new technologies and healthy leisure alternatives that are incompatible with substance abuse and other behavioural addictions.
- 10.1.7 Detect problems early and prevent the highest risk uses (use by minors or pregnant women, substance use when driving, etc.).

**Contexts for action:** prevention interventions can be developed in different fields such as the educational community, families, the workplace, the media, the health system (mainly primary health care), the armed forces, the hospitality and restaurants industry, recreational settings and the community in general. Likewise, regulation and legislation on drugs and on other behavioural addictions play a crucial role in the prevention of risk behaviours and the promotion of healthy habits.

Environmental prevention should be incorporated mainly into community recreational and leisure settings (local festivities) and music and dance contexts (music festivals, large-scale public or private parties) without forgetting other contexts for action as and where appropriate. Furthermore, this kind of prevention needs to be supplemented with community preventive measures at a local level in order to reduce problems associated with alcohol consumption—especially in under-age users.

**Target population:** minors and young people, women (especially women of reproductive age and during pregnancy), the adult population in those age groups where greater use is observed, the prison inmate population and professionals in the hospitality industry.

**Selective and/or indicated prevention** will be aimed particularly at the most vulnerable groups, incorporating the target populations into the definition of policies, strategies and prevention programmes.

## 10.2. Integrated and multidisciplinary care and treatment

Treatment for addictions not only reduces the social harm and the damaging effect on health associated with the use of substances and certain behavioural addictions but also brings down levels of use and their associated costs. Scientific research and clinical practice demonstrate the value of a continued, integrated and multidisciplinary approach in the treatment of the addiction where integrated means an approach that simultaneously addresses the biological, psychological and social aspects of the addiction.

Treatment for the addiction should help people to stop using drugs or to avoid the addictive behaviour and at least reduce the harm associated with that use or behaviour and get people to function productively in the family, at work and in society.

Just as with previous strategies, the goal of the National Strategy on Addictions 2017-2024 is to guarantee needs-tailored quality care for all of those people directly or indirectly affected by a behavioural addiction, with standardisation of the care approach on the basis of scientific evidence through intervention protocols, guidelines and catalogues.

The transfer of competences to the Autonomous Communities and Cities over the integrated care and treatment of people with addiction problems has meant that the therapeutic itineraries and dedicated resources in each one of the Autonomic Drugs Plans have developed differently over time. This diversity contributes to the richness of the Spanish health care model. Nonetheless, although a basic consensus does exist about the services to offer, in some cases this diversity may lead to some unevenness in the availability of and accessibility to treatment when the systems function differently with different reporting structures and management, information systems, health care and referral circuits, resources and intervention methodologies, or different service offerings. On the other hand, the need to provide assistance to groups with a higher risk of marginalisation such as immigrants and ethnic minorities or to provide specific care such as in the case of women, children and young people or people with a dual pathology, requires organisational and resource flexibility that can ensure these people get access to the most suitable treatment for them.

Moreover, the annual increase in numbers of people entering treatment for pathological gambling and the most recent scientific evidence pointing to a major presence of behavioural addictions at an early age linked to the use of new ICTs signal a need to bring the so-called “non-substance” addictions within the scope of integrated or comprehensive care and treatment of addictions.

Lastly, the health care and treatment network should include gender violence as an aspect with a close linkage to addictions; it should not be treated as a factor with a causal relationship but rather as a factor to be taken into account given that in cases of substance abuse gender violence rates are triple the figures for the rest of the population. Gender violence is a social problem that is multiplied in the case of addictions. Work on gender violence needs to be integrated into interventions with both men and women; women should be treated as possible victims and men as possible perpetrators of gender violence.



## STRATEGIC OBJECTIVES

10.2.1. Guarantee quality integrated care and treatment through:

- 10.2.1.1. Coordination of the addiction treatment network with the rest of the social services and health services system.
- 10.2.1.2. Better treatment and follow-up in health and social services of people with chronic addictions and more elderly addicts.
- 10.2.1.3. Integration into community health plans of an approach to address addictions.
- 10.2.1.4. An evaluation of all actions.

10.2.2. Consolidate the incorporation into the care and treatment network of new addictions (substance or non-substance addictions).

10.2.3. Foster an integrated, comprehensive health care approach through personalised itineraries designed to match the characteristics of each patient (e.g. chronic patients, patients with a dual pathology, patients who are homeless, etc.).

- 10.2.3.1. Design protocols for action with other institutions, organisations and resources to implement measures targeting the vulnerable population to ensure comprehensive care and treatment and to facilitate access to resources.
- 10.2.3.2. Implement resources and programmes for intervention in the area of dual pathology.

10.2.4. Guarantee the quality of all actions and their basis on evidence.

10.2.5. Include the gender perspective through all levels of the treatment and care process.

- 10.2.5.1. Foster an integrated approach to care by incorporating gender constraints into the analyses explaining drug use and abuse and other addictions as well as the consequences of those factors in women and men with problematic use in the case of women (less visible substance use, greater stigma attached and feelings of guilt and less support and understanding, harsher judgement reinforced by the fact that they are mothers and the consequences there are for their children). Family responsibilities (and the fact that women are the ones who have to cope with the immense majority of them) need to be taken into account as a possible impediment to women getting access to the health care network and to the rehabilitation and social integration process. For men there is more social justification for violent attitudes as well as a higher regard for the values associated with masculinity that reinforce high risk substance use and attitudes.
- 10.2.5.2. Promote women-centred treatments focusing on them and their type of substance use on the basis of comprehensive interventions; in the case of psycho-pharmaceuticals the interventions should build in aspects linked to their prescription by the health system and the development of non-pharmacological treatment alternatives.
- 10.2.5.3. Foster integrated health care and treatment and the coordination of resources for women who suffer gender violence, and for their children, in order to avoid institutional victimisation.

**Contexts for action:** social and health care field, prisons, workplaces...

**Target population:** the population for which a therapeutic indication exists within the following groups: adolescents and young people, women, people with chronic addictions and/or co-morbidities, the more elderly population (especially over 64 year-olds), prison inmates, ethnic minorities ...

### 10.3. Harm reduction

The harm reduction intervention model includes all of the policies, strategies and programmes whose ultimate aim is to lessen the negative effects of substance use (without necessarily aiming to achieve a reduction in their use) either at an individual level, in families, in their setting or as regards other third parties, both in the area of treatment and in prevention and social incorporation.

Harm reduction strategies foster safer behaviour, reduce the preventable risk factors and can contribute to reducing social and health inequalities among specific population groups.

The objective of these interventions is to reduce or limit the harm caused to the health and lives of people who use drugs and in general the social, health care and economic effects related to their use. Another objective is to bring the user into contact with the standardised health care and treatment network because as a general rule the people who join harm reduction programmes tend to lead lives in environments where access to standardised resources is difficult.

In Spain these activities and programmes have been extensively developed for a number of years now. The activities that should be maintained moving forward and those that will have to be improved within the framework of this strategy differ depending on whether they relate both to the risks and to the harm caused by legal drugs, medicines and substances that are readily available and may end up being addictive, or whether they refer to the use of illegal drugs.

Marginalisation and social vulnerability are associated with increased harm as a result of substance use and pose greater risks. A complex interplay of factors including physical and mental health, social constraints and discrimination have an influence on the vulnerability of an individual or a group in substance abuse.

Alternatives to prison sentences and assistance mechanisms for people who have been arrested for drug use also have to be framed within this harm reduction vision from a social assistance standpoint.

In addition, harm reduction should also include protection for the health and safety of children and other members of the family in environments affected by drug use. There is significant proof that the misuse of substances by a person may have an impact on the lives of the people around that person, and especially on their family. A strong linkage has been observed between domestic violence and substance abuse, particularly in high-risk alcohol consumption. Nevertheless, the impact depends on a series of factors including the type and frequency of the substance used and the social environment.

Lastly, with the inclusion of non-substance addictions within the scope of this strategy there is now an obligation to review the programmes and activities that have been run in the past and, if appropriate, to design new ones that will include actions focusing on reducing risks and harm in this type of behavioural addictions.

## STRATEGIC OBJECTIVES

- 10.3.1. Maintain harm reduction programmes, broaden their coverage and adapt them to new usage profiles.
- 10.3.1.1. Broaden the availability of opioid substitute medication by improving access in the Spanish NHS to other opioid agonists/antagonists for people for whom methadone treatment has not worked.
  - 10.3.1.2. Broaden the availability and coverage of overdose prevention programmes (e.g. with the inclusion of the prescription and provision of naloxone to users of opioids and patients in substitution treatment) in different fields.
  - 10.3.1.3. Improve needle and syringe programmes (NSPs) and broaden their coverage in primary health care.
  - 10.3.1.4. Work on the social integration of people excluded with addictions to bring them into harm reduction programmes.
  - 10.3.1.5. Reinforce harm reduction in places where drugs are trafficked and used.
  - 10.3.1.6. Extend this methodology to use in young people and adolescents.
  - 10.3.1.7. Maintain alternative measures to prison in patients with addiction problems.
- 10.3.2. Improve and broaden the early diagnosis of transmissible infections (HIV, HCV, and others) and access to treatment for drug users.
- 10.3.3. Mainstream the harm reduction methodology through the health care and treatment networks.
- 10.3.4. Improve coordination with primary health care and mental health care for mental disorder detection and early intervention.
- 10.3.5. Include the harm reduction model in the approach taken to the treatment of other behavioural addictions (in which avoidance is practically impossible or unsuitable, such as behavioural addictions involving ICTs).

**Contexts for action:** in the family setting, in prisons, in the social and health care environment, in places where drugs are used, recreational settings, etc.

**Target population:** injecting drug users, prison inmates, groups in a position of vulnerability, women, adolescents and young people, people with dual pathology.

## 10.4. Social incorporation, with special emphasis on labour market integration

Social incorporation means the personalised and flexible socialisation process comprising actions and interventions that aim to actively engage people, make them take responsibility for, promote and facilitate their self-sufficiency, development, social welfare, participation and critical ability to deal with their environment. As such it includes different fields or domains (personal, family, work and employment, etc.) where the work and employment aspect is important but it is neither the only factor of importance nor the main one. Although there is currently no valid or sufficiently comprehensive definition backed by a consensus of the most relevant institutions that work in this area in Spain, *social incorporation* is the term that has been most used traditionally to make a distinction with the terms *insertion or integration*, which refer more specifically to actions or methodologies (insertion techniques facilitate the process of incorporation).

Different sources (EMCDDA, COPOLAD) point to the shortage of evidence about what works when it comes to social incorporation interventions for different reasons: conceptualisation difficulties; the absence of standardised evaluations; the diversity of criteria and political/institutional guidelines; the multiplicity of actors participating in the design, implementation and evaluation of the programmes.

It is generally accepted that therapeutic treatment on its own does not seem to be sufficient for the effective recovery of people who have addiction problems. The social incorporation of these people requires an integrated, comprehensive intervention that can make an impact on all spheres of their lives (not just the employment aspect): personal, relationships, leisure and recreation, family, education, health, training, work, residential, judicial, etc.

This integrated intervention should be implemented in accordance with the typology of the people demanding (they do not all have the same characteristics and needs), the contexts and resources in which it will take place (specific, generalist) and the processes and itineraries that are established (continuity of care and treatment, individually tailored itineraries).

According to the evaluation of the previous National Drugs Strategy (2009-2016), the social incorporation programmes on offer in Spain are fairly homogenous albeit with variations depending on their social and/or employment orientation and with unequal territorial coverage in the autonomous communities. Much has been done to improve the quality of the interventions.

However, social incorporation has not been developed to the same extent as other areas of intervention either as regards the budget allocated or the resources made available for it and should therefore be a priority now:

- A logical model for actions needs to be defined and agreed on.
- Further alignment of services and programmes to match the new profiles and gender differences in addictions is essential as is greater population coverage in coordination with the health care, treatment and assistance network.
- More in-depth work should be done on the identification of best practices and of existing evidence. In addition, quality criteria need to be implemented in programmes and processes and itineraries defined as well as a consensus reached on catalogues of programmes, a basic portfolio of services and an information and evaluation system.

## STRATEGIC OBJECTIVES

- 10.4.1. Define a common model for social incorporation actions, both as regards conceptual aspects and when establishing treatment and care continuity processes and individually designed itineraries for programme beneficiaries.
- 10.4.2. Broaden the array of services and programmes—occupational services and especially labour market reinsertion services—and bring them into line with the new profiles of the people who receive health care, treatment and assistance (including non-substance addictions), with the different impact of addictions on women and men and with the differential needs of drug addicts in older age brackets.
- 10.4.3. Increase population coverage in coordination with the health care, treatment and assistance network.
- 10.4.4. Improve the quality of the actions by encouraging research and the quest for evidence, the evaluation of programmes and interventions, the development of catalogues of programmes and the setting up of an information and evaluation system on social incorporation.
- 10.4.5. Improve interinstitutional coordination between departments with real involvement in this area: health, social services, employment, education and interior (home affairs).
- 10.4.6. Increase the support provided by the Government Delegation for the National Plan on Drugs and the Autonomic Drugs Plans to local corporations and NGOs in their own social incorporation programmes.
- 10.4.7. Foster the participation of local corporations in employment and social insertion programmes.
- 10.4.8. Foster the participation of private, nonprofit entities in the development of social and labour market insertion programmes through personalised itineraries.

**Contexts for action:** centres and services attached to local corporations, integrated health care and treatment network centres; health services; prisons; the public employment service, community social services; NGOs working in this area; companies.

**Intervention spheres:** personal; relationships, leisure and recreational; family; educational; health; training-work; residential; judicial.

**Target population:** women, people with chronic addictions and/or co-morbidities, people in older age brackets, ethnic minorities.

## GOAL 2: TOWARDS A MORE SECURE SOCIETY

As far as safety and security are concerned, Spain's new National Strategy on Addictions 2017-2024 must address the same fundamental challenges that are posed in the sphere of health. In other words, it must address the need to adapt to the pace of a more changing and dynamic situation, to respond better and effectively to new threats and to provide support for the political and operational responses.

Improving the quality of monitoring tools on the supply side must continue to be a priority in order to achieve significant progress in the endeavours to raise the standard of existing measures and make them more comparable.

Furthermore, the new Strategy for 2017-2024 is committed to providing effective responses to several blind spots with regard to areas in which the safety and security implications of drugs markets can be described. That is the reason why the approaches to monitoring in this area need to go further and deeper in order to understand the key drivers of change and keep up with pace of innovation. Some examples of areas that are still relatively undeveloped and areas in which progress needs to pick up speed include the sale of medicines and other substances online, innovation in production processes and the utilisation of commercial delivery and transport services, and a fast evolving NPS market that is challenging public health and policies on drugs.

The faster pace of change in globalisation and technology is making its presence felt in the drugs market too. The illegal drugs market is also being impacted by the development of ICTs in the same way as they affect the licit basic products markets. Criminal groups identify and quickly take advantage of the opportunities offered by easy access to information, the use of the Internet as a social and economic resource and the growth of international trade, which moves large volumes of goods very rapidly across borders and through multiple real and virtual transit points. The huge availability of new substances (sold as "legal highs" and dietary supplements) through websites and physical outlets as well cannot be ignored, nor can the ability of anonymous markets on the dark web to act as a major supply route for these new substances and other illegal substances.

An important point to underscore here is that any information gathered should be analysed within a broader geographical and geopolitical context in recognition of the interaction between the drugs market in Spain and the (wider) European and world markets. It is therefore vital to identify and understand major events outside Spain in order to anticipate the future drugs-linked security threats and to develop measures to deal with them.

Drug-related crime is also a key issue in the security pillar. The consequences of crime and its development are still not sufficiently understood. However, what is evident is that they have a considerable impact on society and that there are growing concerns in some areas, for instance, about the interaction between drug trafficking and other serious security threats like terrorism, people trafficking and illicit financial flows.

## AREAS FOR ACTION

### 10.5. Supply reduction and control

According to the European Drugs Strategy (2013-2020) the overall objective in drug supply reduction is to contribute to a measurable reduction of the availability of illicit drugs. This has to be achieved through prevention, deterrence and the disruption of drug-related crime, in particular organised crime, through judicial and law enforcement cooperation, confiscation of criminal assets, investigations and border management.

In this field, the actions to be developed are different depending on whether we are talking about illegal drugs or legally available drugs and medicines.

In the case of illegal drugs, the state law enforcement and security agencies, the autonomous communities' police forces, the tax authority/customs surveillance agency, judicial bodies and the anti-drugs special prosecutor intervene in four major vulnerable areas of criminal organisations:

- a) The drug production process using raw materials and precursors, to which the cultivation of substances like cannabis has been added in recent years.
- b) The wholesale distribution process for substances, including international trafficking and domestic trafficking in each country.
- c) The retail distribution process, i.e. distribution of the substance to the end consumer.
- d) The process of transformation of the proceeds obtained into financially measurable assets.

Currently Spain is not a country where illegal substances tend to be manufactured using cultivated raw materials or chemical processes that transform the active ingredients into substances ready to be used by the people who demand them. Nevertheless, due attention has to be paid to the possibility of laboratories that manufacture all kinds of drugs (especially cocaine, heroin and synthetic drugs) being transferred to Spain at some point as well as the increase in the number of marijuana plantations all over the country according to the higher number of seizures now being made by Spanish law enforcement agencies.

Moreover, as everyone knows, because of its geographical position and as a transit country used to bring cannabis resin and cocaine hydrochloride into Europe, Spain is still required to act as a retaining wall keeping the substances out of Europe. This is corroborated by the fact that for years now it has been the leading European country for amounts of these substances seized and is also high up in the world ranking for country seizures.

The achievements in drugs supply reduction during the life span of the previous National Drugs Strategy 2009-2016, together with the conclusions and recommendations that came out of the evaluation of that strategy, have determined the strategic objectives to be pursued in the area of actions to reduce the supply of drugs in this new 2017-2024 Strategy.



## STRATEGIC OBJECTIVES

- 10.5.1. Combat the cultivation, production, importing, distribution and sale of illegal drugs and the facilitation of these activities including by digital means (the Internet, dark web/ deep web, etc.).
- 10.5.2. Strengthen the tools to investigate money laundering and capabilities in this area with particular emphasis on the recovery of illicitly gained assets.
- 10.5.3. Maintain policing around educational centres and leisure/recreational centres.
  - 10.5.3.1. Reinforce the position of law enforcement officers as social agents and key figures in prevention (“tutor officer”).
- 10.5.4. Strengthen specialised anti-drug trafficking police units.
- 10.5.5. Increase the control of retail points of sale for drugs.
- 10.5.6. Study and propose changes in legislation that would allow new psychoactive substances to be controlled by chemical groups or “families” instead of by each chemical substance individually in order to make their control more operative and effective.

## 10.6. Revision of legislation

In any drugs and addictions policy increasing individual responsibility as a protection factor is certainly important but shifting the burden of reducing supply onto the individual, however, is something that should be avoided. That is why it is crucial to achieve a broad consensus among the different stakeholders in society around the dangers linked to the consumption of addictive substances or participation in behavioural addictions. Legislation is therefore also important when it comes to promoting healthy behaviour. When a person can become ill or their life can be endangered as a result of the health-threatening behaviour of others, legislation (just like legislation protecting non-smokers) is essential.

The State is responsible for ensuring children and adolescents are protected through legal rules whenever other measures are insufficient to provide effective protection. Legal measures must come up with adequate responses to new challenges. If the challenge is new substances, for instance, we are faced with the problem of only being able to ban “ingredients” and substances that have been specifically cited by name during a legislative process that takes a long time. However, these interdictions can easily be circumvented by synthesising new “ingredients” or by making a slight alteration to the chemical composition of existing substances. There are international loopholes for “evasion”; crossborder distribution through the Internet is fairly effortless. Given the combination of these factors, ways and means must now be found to ensure fast and effective protection of the population from these substances.

## STRATEGIC OBJECTIVES

- 10.6.1. Revise current legislation concerning the sale, promotion, prescription and use of legal drugs (particularly the legislation designed to protect minors).
- 10.6.2. Improve regulations on money laundering related to drugs trafficking as an activity that generates huge proceeds.
- 10.6.3. Contribute to improving regulations on the inclusion of new psychoactive substances on controlled substances lists, especially the speed with which they can be added to those lists. These substances are not on the UN Convention controlled substances lists and therefore until they are banned by governments their position is “no ban” or “not illegal”.
- 10.6.4. Revise the international control legislation on precursors likely to be diverted into drugs production.
- 10.6.5. Revise the gambling and betting (online) rules and regulations with regard to their accessibility and promotion (advertising), particularly the rules and regulations designed to protect minors.

## 10.7. National and international judicial and law enforcement cooperation

The problems created by illegal drugs go beyond our national borders in Spain as they do in Europe and internationally. Drug production, trafficking and related crimes, as well as drug use, are on a worldwide scale unconstrained by any geographical borders.

Policies and operational responses to the security challenges posed by drugs markets nationally and internationally must be supported. All the knowledge gained and experience acquired over recent decades on drugs markets and their consequences must be harnessed and put to good use. The supplying of objective, viable and reliable information and analyses will support the creation of capability in Spain and beyond its borders; it will help the decision-makers and policy-makers to come up with responses to the new threats related to drugs; and it will establish reference data that will underpin the assessment of supply-side interventions.

## STRATEGIC OBJECTIVES

- 10.7.1. Increase and enhance internal cooperation between law enforcement and security agencies as well as with the autonomous police forces through suitable mechanisms in the interests of better international cooperation.
- 10.7.2. Improve mechanisms for information exchange and to facilitate cooperation in joint operations and investigations nationally and internationally by envisaging the use of special investigation techniques including Joint Investigation Teams (JITs).
- 10.7.3. Strengthen collaboration with financial entities to detect movements of large amounts of money.

- 10.7.4. Strengthen police interventions coordinated by law enforcement agencies with regard to criminal organisations and small and large-scale distribution networks.
- 10.7.5. Reinforce the sale of alcohol to minors control through all the different levels of government and agencies involved (state law enforcement agencies, autonomous police forces, local corporations, autonomous governments).

# 11. CROSS-CUTTING AREAS

## 11.1. Coordination

Coordination is a way of ensuring actions and policies are as reasonable and efficient as possible; it provides a framework for action that will avoid any duplication, harness and pool efforts, reduce timelines (for people to receive care and treatment, for people to be incorporated into the system), save on and maximise the use of resources (financial and human resources) and foster the necessary participation of every single one of the organisations forming part of the National Drugs Plan.

### STRATEGIC OBJECTIVES

- 11.1.1. Guarantee synergies, consistency and effective practices between all levels of the Public Administrations, different institutions and initiatives and so avoid any duplication of efforts and guarantee effective information exchange, so making efficient use of resources and ensuring the continuity of actions taken.
- 11.1.2. Foster and encourage active and meaningful participation and engagement of civil society (scientific and professional associations, NGOs, social partners, neighbourhood associations, and others).
- 11.1.3. Foster coordination within and between the Autonomous Communities and Cities and with local corporations that have their own addiction plans in order to ensure continuity of actions.
- 11.1.4. Guarantee coordination with social and health strategies and plans rolled out by the national government that have an impact on the social groups covered by the National Strategy on Addictions 2017-2024 (population at risk of social exclusion, adolescents, women, immigrants, prison inmates).

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## 11.2. Knowledge management

Although Spain already has a number of different reliable information sources and systems what it needs is a more integrated and flexible system that can adapt to the dynamic and changing reality of the substance market and substance use and to the appearance of new behavioural addictions or addictions facilitated through different means today like new technologies.

Much more needs to be done in this regard to improve the quality and integration of data from other information sources, e.g. by making better use of resources that already exist such as the pharmaceutical information systems used in the different Autonomous Communities. These databases could be a useful source of information in the analysis of substances such as hypnotics or pharmacological opioids for which a medical prescription is a key driver in their use. Likewise, further standardisation of information systems on drugs at different levels of government in Spain would be of help.

One additional problem is the data we currently compile and its constraints, including the age bracket limitation in the surveys conducted (and other sources) and a shortage of data on non-substance addictions.

Moreover, the Spanish Early Warning System, which does provide extremely useful information, needs to be allocated more resources to ensure further development.

As far as government-funded research is concerned, this should be brought into line with the general R&D framework set out in the State Plans and with the needs of society as they change in line with the evolution of the drugs phenomenon.

Training for practitioners working with addictions and other groups of professionals is an essential tool to improve quality and disseminate best practices in each area of action; for this new National Strategy specific training on non-substance or behavioural addictions needs to be boosted.

## STRATEGIC OBJECTIVES

### INFORMATION SYSTEMS

11.2.1. Develop and reinforce information systems and epidemiological surveillance tools to obtain and analyse the most up-to-date data on addictions as a phenomenon, including their patterns and trends and their impact on public health and the safety and security of citizens. The underlying aim is firstly to improve decision-making and provide guidance for addiction policies and secondly to evaluate those policies and improve the response to this phenomenon.

- 11.2.1.1 Develop the *Spanish Early Warning System (Sistema Español de Alerta Temprana, SEAT)*.
- 11.2.1.2 Integrate drugs information systems into social and health services information systems.
- 11.2.1.3 Incorporate indicators on drug use and associated problems in other areas (traffic, law enforcement, etc.) and revise and adapt established indicators to new circumstances.

### RESEARCH

11.2.2. Research on addictions funded by the Public Administrations should be in alignment with the strategy defined in the State Scientific and Technical Research and Innovation Plan 2017-2020 and with the Strategic Health Action covered within the framework of that Plan. The development and use of networks of researchers and institutions—particularly multicentric groups—should be boosted, as should Spain's presence in international research groups with the aim of making more efficient use of available resources and gaining visibility.

11.2.3. Promote research activity in complementary areas of interest to the addictions phenomenon, particularly in the social, health care and epidemiological field, such as gender differences; the profile of new users; chronic users and users in the older age bracket from the standpoint of their treatment and care needs in order to adapt existing services accordingly. Likewise, support research work on the effects of substance use on driving and the prevention of traffic accident injuries and fatalities linked to the use of psychoactive substances, as well as in the workplace.

## TRAINING

11.2.4. Modernise training programmes designed for practitioners working in prevention and treatment and care for drug addicts and addictions and for other social agents involved, including specific training on behavioural addictions; the training should make use of the latest training tools (online training) adapted to the current situation.

11.2.5. Improve and extend training for practitioners working on addictions as well as for the volunteers who help out in this field, both on the demand reduction and the drug supply reduction side, encouraging specialisation in “addictions” by these practitioners.

11.2.6. Improve knowledge and capacity building for different groups of professionals (e.g. in the areas of education, health, road traffic, social services, prison services, justice, armed forces, law enforcement agencies) involved in prevention [of addictions] and in the provision of integrated treatment and care for people with addictions, both on the demand side and on the supply reduction side.

11.2.7. Improve and develop effectively gender perspective training at all levels within the Public Administrations, civil society, the academic community, as one of the key pillars in training on addictions.

## 11.3. Legislation

Now that the scope of this new Strategy has been expanded compared to the earlier one, legislation should now be developed accordingly so that those fields of addictions that are not sufficiently legislated (advertising) can be covered, and certain weaker aspects of the work to combat addictions can be reinforced (legislation on alcohol and minors, for instance) and new mechanisms created to make it possible to deal with an environment that is evolving at top speed (such as the Early Warning Network for the detection of NPS).

## STRATEGIC OBJECTIVES

- 11.3.1. Enact comprehensive legislation on alcohol, with particular emphasis on minors.
- 11.3.2. Develop new reference regulations, protocols for the NPS detection early warning network (including operational guidelines).
- 11.3.3. Revise and prepare legislation or procedures that could contribute to making the Seized Assets Fund (for assets seized in relation to drug trafficking and other related crimes) more efficient.
- 11.3.4. Revise legislation and put forward amendments if appropriate referring to advertising on gambling, sports betting and online gaming.
- 11.3.5. Reinforce the oversight of compliance with the current legislation concerning addictions.

## 11.4. International cooperation

### COOPERATION SPHERES:

#### MULTILATERAL:

- UN and other international organisations
- European Union
- Priority geographical areas:
  - Latin America and the Caribbean
  - North Africa and the Middle East

#### BILATERAL:

- Priority will be given to countries in the areas above.

### STRATEGIC OBJECTIVES

- 11.4.1. Coordinate and drive forward Spain's political and technical engagement in the international scenario on addictions.
- 11.4.2. Develop policies to combat addictions in the framework of the current EU Drugs Strategy (2013-2020), and maintain and strengthen relationships with third countries to tackle addictions.



11.4.3. Follow through and contribute to compliance with the operational recommendations in the UNGASS outcome document “Our joint commitment to effectively addressing and countering the world drug problem”, with special emphasis on the defence of human rights.

11.4.4. Promote the integration of cooperation into the work done on addictions in general political relations and in the framework agreements Spain signs with its partners.

## 11.5. Communication and dissemination

The new National Strategy on Addictions 2017-2024 envisages actions to reinforce communication and knowledge management in the National Drugs Plan designed to strengthen the role of the Government Delegation for the National Plan on Drugs as the national reference centre for knowledge on addictions.

### STRATEGIC OBJECTIVES

11.5.1. Promote the role of the Public Administrations as reference institutions for knowledge about addictions through accurate, reliable and contrasted information and so reinforce the role of Government Delegation for the National Plan on Drugs as the reference point for information on addictions:

11.5.1.1. Build up the website with evidence-based information (publications, thematic documents, best practices manuals, etc.) in a structured way. The aim is for the National Drugs Plan website to contain the best, most complete and most accessible documentation centre on drugs in Europe, open to the general public and to practitioners.

11.5.1.2. Actively disseminate relevant information to stakeholders.

11.5.2. Contribute to the exchange of knowledge and experiences by creating spaces for communication between practitioners working on drug dependence and addictions and making use of ICTs.

11.5.3. Incorporate the active participation of users, practitioners, institutions and of the society at large through channels enabling identification of their needs and expectations.

## 11.6. Evaluation and quality

The proposal will be for any actions developed in this area to be agreed on and led by the Interautonomic Commission and approved by the Sectorial Conference. The actions will then be implemented in collaboration with universities and civil society (preparation of materials, online questionnaires, etc.).

Work will revolve around three key areas:

- Accreditation
- Best practices
- Services catalogue (methodology, minimum service provision, etc.)

### STRATEGIC OBJECTIVES

11.6.1. Establish a minimum services portfolio for the whole of Spain in which the characteristics of the therapeutic itinerary are specified and the absence of any barriers to access is ensured.

11.6.2. Promote knowledge of the minimum services portfolio on offer in the prevention, treatment and care and social incorporation programmes as a way of ensuring it is used and implemented effectively and efficiently.

11.6.3. Establish a common system of evaluation for actions carried out by the Public Administrations and third sector organisations intervening in drug addictions; promote as far as possible the systematic evaluation of all the programmes and actions, particularly of the findings and results in all areas (prevention, treatment and care, insertion, etc.).

11.6.3.1. Establish contrasted criteria for programme evaluation, especially for prevention programmes where evaluation is more complex.

11.6.3.2. Promote the creation of a minimum set of indicators required for evaluation purposes in line with the different programmes.

11.6.3.3. Promote the use of data broken down by gender and analysed from a gender perspective when programme evaluations are carried out.

11.6.4. Establish and disseminate through the website a catalogue of best practices based on programmes accredited by the National Drugs Plan with the aim of making those programmes the ones primarily implemented by the Public Administrations.

**N.B.:**

This Strategy shall be deemed in force until a new Strategy is adopted.

**NATIONAL  
STRATEGY  
ON  
ADDICTIONS**

2017-2024

**ANNEXES**

## FOREWORD

The National Strategy on Addictions 2017-2024 for which I am both delighted and honoured to write these introductory remarks as Minister for Health, Social Services and Equality and the person ultimately responsible for the National Drugs Plan in Spain, is the third Strategy document of this kind prepared since the Plan was set up more than thirty years ago.

Like the two Strategy documents that came before it, this Strategy is technically a document analysing the situation of drugs and drug addictions in Spain, a planning document setting out the goals to be achieved and a common framework for work establishing the areas for action and objectives to be reached over the next eight years.

From a political standpoint, however, which is the aspect I would like to bring to the fore now, this Strategy is a firm, resolute and fully conscious commitment made by my Ministry and particularly by the Department of the Secretary of State for Social Services and Equality and the Government Delegation for the National Drugs Plan to work and endeavour to the best of our abilities to prevent any kinds of addictions in our country and to support all those people who find themselves in a difficult situation as a consequence of addictions.

Obviously it is not something that can be taken on solely and exclusively by this Ministry alone. All of the institutions, bodies, entities, professionals, practitioners, volunteers and family members who for many years now have shouldered responsibilities in this field are also involved in this task.

As a result, although the initial driver of this Strategy was the Government Delegation for the National Drugs Plan, it has been prepared with the participation of all levels of government and stakeholders involved in the plan. They include numerous bodies in the General State Administration including the law enforcement and security agencies, all of the Autonomic Drugs Plans, the Spanish Federation of Municipalities and Provinces as well as hundreds of NGOs in the sector, scientific societies, research centres and professionals in different disciplines and fields of action.

All of them have contributed concrete ideas, suggestions and approaches that have enriched the final text and without which the Strategy would not have been the document it is today with all it contains.

As a result, this document is the outcome of a consensus in which the prevailing idea has been the objective of agreeing guidelines that will help us to achieve a society that is freer and more solidarity-minded, with citizens with an ever better standard of health and who as far as possible are able to take their own independent decisions on their lives and their future.

Undoubtedly, over the more than thirty years the National Drugs Plan has been in existence addictions have undergone very substantial changes both in Spain and internationally.

The profile of drug users has changed significantly, with a notable presence in quantitative and qualitative terms of very young sectors of the population and with the constant appearance of new substances in this market.

In addition, so-called “non-substance addictions” or behavioural addictions where there are no actual drugs involved (compulsive gambling, the Internet, video gaming, screens, etc.) have burst onto the scene over recent years and are making their presence felt in the area of treatment demands. Together with these new addictions there is also a concern today about the misuse of certain medication drugs (with or without a prescription) that may give rise to addiction-related problems as well as causing health problems.

This new Strategy has taken on board those changes and from the title itself (National Strategy on Addictions and not simply on Drugs as in the previous cases), and in greater detail throughout the whole of its contents it analyses the challenges posed and puts forward an approach to addressing them by taking into account the available evidence we have today.

In addition to the above, I would like to point out another hallmark of this Strategy, that is the emphasis it places on the gender perspective and the way it incorporates gender within the text itself. In a Ministry like the one I head and whose very name includes the word “equality”, it is essential to deal with everything to do with the different way drug use and behavioural addictions affect men and women both personally and as a result of substance use by their partner.

In this latter case, we cannot overlook the consequences that alcohol consumption and drug use often have in relation to the abuse of women or the substances many women working as prostitutes are forced to take directly or indirectly.

On this subject, I think this is the right time to bring to your attention the recent “State Pact against Gender Violence” adopted by the Plenary of the Congress last September and endorsed by the Sectoral Equality Conference at its meeting on 27th December. This Pact supplements to a certain degree what the Strategy sets out with regard to the situation I have just described.

The State Pact against Gender Violence has enjoyed the support and the collaboration of all the Public Administrations and the social sectors most involved in this issue and we are sure that it will be a crucial step towards eradicating violence against women as it is rolled out.

Since the creation of the National Drugs Plan in 1985, Spain has played a prominent role in all the international bodies and platforms that exist on drugs and drug addictions and continues to do so today. Spain’s contribution has been rated very positively in all of these spheres and its pioneering role in many of the activities developed in our country has been acknowledged.

I am sure that the implementation of this Strategy –to be supplemented by the roll-out of the Action Plans that will be developing it over the eight years it will be in force– will consolidate more effectively the drugs policies put in place in our country, at the same time as it will contribute to making the programmes and actions more effective and achieve better results.

Let me end by wholeheartedly thanking everyone involved in making the preparation of this document possible for the excellent work they have done. Likewise, I want to state my appreciation for all of those people who in a professional or voluntary capacity give their best efforts to working on this issue. I want to restate my commitment to all of them as well as to the people affected by addictions, to the members of their families and to the people around them, that I will do my utmost to strive to achieve as far as possible an addiction-free society that can allow every member of society the chance to have a full life.

**DOLORS MONTSERRAT MONTSERRAT**

Minister for Health, Social Services and Equality



## INTRODUCTION

The most distinctive feature of Spain's drugs policy over the last twenty-five years has been its predominantly public health approach, as opposed to all those countries that tackled the "war on drugs" by essentially focusing their policies solely on supply control without coming up with a response to the demand for drugs which was taking hold in their countries with the outcomes we know today.

The realisation that no matter the efforts we might make behavioural addictions and substance use cannot be eradicated –what some have called the failure of the war on drugs– led us to pioneer the implementation of harm and risk reduction strategies. We were often the targets of criticism from those who derided any approach that was not seeking to control supply and drug-free programmes. In Spain's case, particular emphasis was placed on striking a certain balance between supply control (essential because of our geostrategic position) and the reduction in demand that was clearly incentivised, as regards for example, the use to which the Seized Assets Fund was put.

Today we know –and this is something that has been acknowledged by the World Health Organisation (WHO)– that Spain's opioid substitution strategy (for example) has been a success in terms of public health because of the number of people who as a result have been given back the chance to enjoy a fully integrated, active life with their own rights in the community. Now with the UNGASS 2016 declaration all states are encouraged to follow that same track and by inference Spain and other countries that have been taking that approach for decades are encouraged not to give it up.

That is why public health always has a communitywide orientation and this Strategy also has room for actions targeting any person directly affected by the addiction, either because they live with an addict or might be potentially affected in the future, but always on the understanding that individual action also has an impact on the community as a whole (in terms of safety and security, in economic terms and health terms, etc.).

By keeping the focus on the individual we want to give priority to collective health because drug use has a spillover effect beyond the person who uses drugs to the society as whole and because everyone is capable of developing a harmful use of substances or an addiction at some point in their life. All of the above is notwithstanding actions to improve lost health and the necessary processes for rehabilitation-reinsertion covering additionally all of the people affected around an addict.

## EXECUTIVE SUMMARY

Spain's National Strategy on Addictions 2017-2024 [*Estrategia Nacional sobre Adicciones*, ENA 2017-2024] is a document that has been prepared with the participation and consensus of relevant stakeholders, including all the Public Administrations, non-governmental organisations (NGOs) in the sector, scientific societies, research centres and all public and private bodies with any involvement in the National Drugs Plan [*Plan Nacional sobre Drogas*, PNSD].

This current National Strategy builds on and is informed by the two previous strategies (the National Drugs Strategy 2000-2008 and the National Drugs Strategy 2009-2016), as well as by the three Action Plans developed under both Strategies. Moreover, this document is informed by the findings of the evaluation of the two earlier Strategies and of the Action Plans mentioned above as well as by the analysis made of the situation in Spain with regard to drugs and drug addictions in the period 2009-2015. The National Strategy on Addictions 2017-2024 also draws on the EU Drugs Strategy (2013-2020), on the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Strategy 2025, as well as on other national strategies developed by other countries with a similar context.

Approximately one third of the 30 countries monitored by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) currently include legal substances and other addictions within the scope of their strategies on addictions. In fact, in numerical terms, there are more consumers and users in Europe of legal addictive substances such as alcohol, tobacco and certain pharmaceutical drugs than any other substance.

According to data from the Household Survey on Alcohol and Drugs in Spain, EDADES 2015-16, **the drugs with the highest prevalence of use in Spain in the population aged between 15 and 64 are legal substances:** alcohol (consumed in the previous year by 77.6% of the population) and tobacco (40.2%), followed by hypnotosedatives, 12%, obtained either with or without a prescription. At the same time, one third of the Spanish population have used some form of illicit drugs at least once in their lifetime, with usage mainly concentrated in young people aged between 15 and 34. The illegal drugs most used in Spain are cannabis (9.5% have used it in the last year) and cocaine (2%). The trend in heroin use remains stable at very low levels (0.1%). Moreover, 12% of Spaniards who drive a car have used an illicit substance and/or alcohol before driving at some time.

**From a gender perspective**, the key fact to be highlighted is that hypnotosedative drug use is the only drug use in Spain in which the prevalence of women is greater than men. According to the EDADES survey, 65% of the people who used hypnotosedative drugs in 2015 were women and 57% of them were aged between 45 and 64. 3% of women in Spain qualify for hypnotosedatives problematic use.

The World Health Organisation (2010) has identified alcohol abuse as one of the risk factors in violence perpetrated against an intimate partner and in sexual violence. In addition, women who have been victims of intimate partner violence or sexual violence are almost twice as likely to suffer alcohol-related problems themselves.

As far as **other behavioural addictions** are concerned, there is a broad consensus within the scientific and professional community that gambling is an addiction. For other behaviours that are currently often identified as possible addictions (misuse of the Internet, digital screens and other information and communication technologies, etc.) more information is still needed on the consequences of their use and abuse in order to reach a scientific consensus on their classification as behavioural addictions.

According to research carried out by the Directorate General for the Regulation of Gambling [*Dirección General de Ordenación del Juego, DGOJ*], 76% of the resident population in Spain stated that they had gambled in the last year, and 0.9% are classified as compulsive or pathological gamblers. Some 69.6% of pathological gamblers in Spain are male. The age groups most affected are the 25-34 and the 55-64 age groups. Offline gambling is the most used method although there has been an upturn in online gambling. As the degree of gambling pathology rises, the expenditure on online gambling is higher.

The mean age of onset in gamblers with problems is 19. However, 44.8% of people who have a gambling-related pathology acknowledge having gambled before the age of 18.

According to the data in the 2015 ESTUDES Study on the Use of Drugs in Secondary Schools, 18% of the population of adolescents and young people aged between 14 and 18 misuse information and communication technologies (ICTs). In this percentage of the population the school failure rate tends to be higher and drug use is more frequent.

From the standpoint of **supply control**, the key overall indicators are seizures of substances, arrests for drug trafficking and official complaints filed about infringements of Organic Law 4/2015. In Spain, the trend in the volume of drug seizures varies depending on the type of substance seized. For instance, in 2016 a considerable reduction in cocaine seizures (down more than 40% in the last four years) and cannabis resin was recorded whereas seizures of all other drugs rose (herbal cannabis up by 30% and cannabis plants by 311%). Seizures of heroin remain stable. Arrests and the number of reports for drug use and possession remained stable in 2016 although the trend in the last four years is downward. Nevertheless, Spain is the country where more cocaine is seized and larger amounts are seized than in any other European country. Likewise, Spain is still seizing each year more than 75% of the cannabis resin confiscated in the EU and half of the world total. Furthermore, there are evident signs of the professionalisation of herbal cannabis production and trafficking in Spain where cannabis is now being grown not only for local consumption but also for export.

By drug families, the group of substances for which most arrests were made is the cannabis family (52.82%), followed by cocaine substance-related arrests (27.95%). In a breakdown by drug families, the leading groups for reports filed were cannabis-related (84.37%) and those related to cocaine substances (10.44%).

2016 was another growth year for regulated gambling with an estimated **gambling margin** (profit) of almost €8,399.71 million, 3.03% up on the previous year. The rise in betting activity and other gambling is primarily due to online gambling.

The findings of the **Evaluation of the National Drugs Strategy 2009-16** record a positive development for the actions taken in the area of demand and supply reduction although there is still room for improvement.

In addition to these data, there are **challenges** to be addressed by the National Strategy on Addictions 2017-2024, including the following:

- Increased prescription of medicines with addictive potential.
- The social “normalisation” of illegal substance use, high-risk consumption of alcohol and polydrug use (especially cannabis and other substances), and in adolescents the low perception of risk about this type of use and consumption.
- The growing role of new technologies and the Internet as a means to obtain substances, as facilitators of access to and drivers of other behavioural addictions (betting and online gambling), and as a forum for the exchange of “information” and instructions about substance use.
- The challenges in prevention and health care in specific population groups like the ageing population with problem substance use (increased chronicity and co-morbidity); in people with a dual pathology; women, adolescents and/or young people and other groups in a vulnerable situation: ethnic minorities, immigrants, the homeless, and others.
- The difficulty for labour market integration of people with disorders due to substance use.

Likewise, it is necessary to effectively incorporate the gender perspective and gain more knowledge about types and forms of use and the problems associated among population aged over 64 for which no data currently exist.

In this context, the **National Strategy on Addictions 2017-2024 provides a reference framework** with an integrated, balanced and evidence-based approach for all the Public Administrations, authorities at all levels of government engaged in the National Drugs Plan, and any other stakeholders. They will be able to use this reference framework with the degree of flexibility required to put in practice plans and programmes related to addictions that fall within the scope of their competences, harnessing any synergies that might be generated through coordination and collaboration between all stakeholders; the framework can also be used for any actions that might be undertaken by the National Drugs Plan in the international context.

The **general objectives** of the Strategy are to: delay the onset age of addictions; lessen the presence of and the use of substances with addictive potential and behavioural addictions; and lessen the damage and harm associated with the use of substances with addictive potential and the harm caused by behavioural addictions.

Therefore, the ambition of the ENA 2017-24 is for the harm associated with the use of substances with addictive potential in Spain and the harm caused by behavioural addictions to have been reduced by 2024 through the implementation of policies on drugs and addictions designed to lessen their presence and use, with actions targeted at people and their setting, families, the community and society as a whole, thus contributing to building a healthier, better informed and more secure society.

This Strategy 2017-2024 is underpinned by an integrated public health approach and the values of universality, consistency and collaboration between the Public Administrations, attention to diversity, social co-responsibility and public responsibility. Its guiding principles are: equity; the gender perspective; transparency; scientific evidence; participation; an intersectoral and interdisciplinary approach; quality; and efficiency and sustainability.

**The National Strategy 2017-2024** covers addictive substances and/or drugs, whether legally sold (like alcohol, tobacco or certain pharmaceutical drugs), or excluded from legal sale and includes new psychoactive substances too. In addition, unlike previous strategies and, in response to the evolution of the addictions phenomenon in Spain, this Strategy envisages the inclusion of non-substance addictions and behavioural addictions, with special emphasis on betting (offline and online), but also videogames and other addictions through new technologies.

**The structure of the National Strategy on Addictions 2017-2024** has been aligned as far as possible with the EU Drugs Strategy 2013-2020, albeit with the appropriate modifications and adaptations required to reflect the situation as it is in Spain. Consequently, the National Strategy on Addictions 2017-2024 is designed around two overarching goals with a number of different strategic objectives grouped within several policy action areas. These areas are supported in turn by six cross-cutting themes.

The **goals** are:

- a) “To achieve” a healthier and better-informed society through a reduction in the demand for drugs and in the prevalence of addictions in general, taking actions on:
  - Preventing and reducing risk.
  - Integrated and multidisciplinary care.
  - Harm reduction.
  - Social incorporation, with special emphasis on employment integration.
- b) To “have” a more secure society by reducing the supply of drugs and controlling any activities that might lead to addictions, taking actions on:
  - Reducing and controlling supply.
  - Revision of legislation.
  - National and international judicial and law enforcement cooperation.

The **cross-cutting themes** are: coordination, knowledge management (information systems, research and training), legislation, international cooperation, communication and dissemination, and evaluation and quality.

The Strategy will be rolled out through two consecutive **Action Plans**: from 2017 to 2020 and from 2021 to 2024. These two plans will include a list of specific actions to be implemented together with the bodies, entities or administrative units responsible for their implementation as well as the indicators and instruments for those actions to undergo evaluation.

## EVALUATION OF THE NATIONAL STRATEGY ON ADDICTIONS 2017 -2024

Evaluation of public policies is a fundamental part of public management and over recent years it has become an essential requirement for Public Administrations. Evaluation is essential for the formulation of effective policies and so helps to guarantee that the policies and programmes have the desired effect, are cost-effective and have no unforeseen negative consequences.

In addition, public policy evaluation enables accountability to society about the use made of public resources thus increasing transparency and social participation. Moreover, it contributes to better knowledge about the effects of the actions implemented and about mechanisms that explain those effects. This fosters the use of evidence and good practices and –progressively– the efficacy and efficiency of the actions taken.

The importance of evaluation has been recognised in all of the EU’s drugs strategies and in the strategies of many member states. Just like the earlier National Drugs Strategies and other public sector strategies, Spain’s National Strategy on Addictions 2017-2024 includes an evaluation proposal whose general aim is to assess through a scientific approach the Strategy’s implementation as well as the degree of achievement of its objectives and their impacts.

Specifically, this evaluation must assess to what extent the three General Objectives of the National Strategy on Addictions 2017-2024 have been achieved. Those three objectives are:

- Lessen the damage and harm associated with the use of substances with addictive potential and the harm caused by behavioural addictions.
- Lessen the presence of and use of substances with addictive potential and behavioural addictions.
- Delay the onset age of addictions.

To do this the proposal is to evaluate the effective achievement of the Strategic Objectives and the interventions described in the Strategy as well as the efficiency of the resources and mechanisms put in place to achieve the aims set out.

A **mid-term assessment** of the Strategy and an evaluation of the Actions Plans through which it will be implemented in the periods 2017-2020 and 2021-2024 will allow us to know whether the interventions proposed are being put in practice as envisaged, whether the strategic objectives are being reached, and if there are any deviations to detect them early and propose the appropriate corrective measures.

As in previous evaluations, this evaluation should be designed to include the following criteria:

- Adoption of an objective and high quality methodology. The best way to do this is by using a mixed method approach involving the collaboration of external agents to guarantee these two aspects.

- The right balance between the need for knowledge with the available resources by placing priority on the measurable indicators within the existing information system. There is a methodology developed for the evaluation of the National Drugs Strategy 2009-2016 and in the evaluation of the Strategy 2000-2008 to do this. Notably work was done in those evaluations to identify the key indicators and sources of information that can be used to monitor the actions and outputs of the National Strategy on Addictions 2017-2024.

As far as possible the indicators to provide information on the degree of achievement of the objectives should be the same ones used in 2009-2016 Strategy so that long-term monitoring can be carried out. For any new objectives and actions that were not part of the previous Strategies because this current National Strategy has a broader scope, the priority will be to identify the necessary indicators and information sources (and the data collection for that purpose) in the 2018-2020 Action Plan.

- Participation in the evaluation of all the agents and institutions at all levels forming part of the National Drugs Plan and any other stakeholders in the Strategy, including, inter alia, Public Administrations, NGOs, scientific societies, consumer associations and social partners.
- Analysis of the contribution of the National Strategy on Addictions 2017-2024 to building a healthier, better informed and more secure society.
- Assessment of the presence, promotion and development of the guiding principles of the National Strategy on Addictions 2017-2024 through the actions undertaken:
  - Equity
  - Gender perspective
  - Transparency
  - Scientific evidence (good practices)
  - Participation
  - Intersectoral and interdisciplinary approach
  - Quality
  - Efficiency and sustainability
- Establishing the ideal periods to undertake the evaluation. It should include an analysis of the baseline situation starting from the evaluation of the previous National Drugs Strategy 2009-2016 and for those objectives not envisaged in that earlier Strategy, of the information gathered moving forward as of the 2018-2020 Action Plan; a mid-term assessment and a final evaluation that offers a vision of the results obtained and the mechanisms explaining them.
- The timing of the evaluations should be determined in a way that ensures their contribution to a continuous decision-making process allowing the final objectives set out to be attained.
- Inclusion of mechanisms enabling better knowledge to be gained about causal relationships including an analysis of the contextual factors that help with their understanding.



To establish those causal linkages the Action Plans to be developed by the Strategy will include the following activities:

- Give priority when selecting interventions to those for which there is reasonable evidence about their efficacy or effectiveness.
- Classify the objectives as process, product and output objectives. For early detection of any deviations in the interventions the evaluation of the Action Plans should include a review of the progress of the process and outputs indicator that will additionally provide a strong boost to the achievement of the objectives proposed.

Once the National Strategy on Addictions 2017-2024 has been approved and the Action Plan 2018-2020 has been prepared, the concrete objectives of the evaluation and the methodology to undertake that evaluation will be established in collaboration with all the stakeholders involved in the PNSD.

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- [MELILLA. II Plan sobre Drogas y Adicciones Ciudad de Melilla 2014-2017](#)
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## LIST OF ACRONYMS

<b>COPOLAD</b>	Programa de Cooperación entre América Latina, el Caribe y la Unión Europea en Políticas sobre Drogas (Cooperation Programme between Latin America, the Caribbean and the European Union on Drugs Policies)
<b>DGOJ</b>	Dirección General de Ordenación del Juego (Directorate General for the Regulation of Gambling)
<b>DGPNSD</b>	Delegación del Gobierno para el Plan Nacional sobre Drogas (Government Delegation for the National Plan on Drugs)
<b>DGT</b>	Dirección General de Tráfico (National Traffic Authority)
<b>EDADES</b>	Encuesta Domiciliaria sobre Alcohol y Drogas en España (Household Survey on Alcohol and Drugs in Spain)
<b>EMCDDA</b>	European Monitoring Centre for Drugs and Drug Addiction
<b>ENA</b>	Estrategia Nacional sobre Adicciones (National Strategy on Addictions)
<b>EPAD</b>	Encuesta a Profesores de Enseñanzas Secundarias sobre Drogas y otras Adicciones en España (Survey of Secondary School Teachers on Drugs and other Addictions in Spain)
<b>ESDIP</b>	Encuesta sobre Salud y consumo de Drogas a los internados en Instituciones Penitenciarias en España (Spanish Survey on Health and Drug Use among prisoners)
<b>ESTUDES</b>	Encuesta Estatal sobre Uso de Drogas en Enseñanzas Secundarias (State Survey on the Use of Drugs in Secondary Schools)
<b>EU</b>	European Union
<b>EUROPOL</b>	Oficina Europea de Policía (European Agency for Law Enforcement Cooperation)
<b>FEMP</b>	Federación Española de Municipios y Provincias (Spanish Federation of Municipalities and Provinces)
<b>ICTs</b>	Information and Communication Technologies
<b>INTCF</b>	Instituto Nacional de Toxicología y Ciencias Forenses (National Toxicology and Forensic Sciences Institute in Spain)
<b>JITs</b>	Joint Investigation Teams
<b>NPS</b>	New Psychoactive Substance
<b>OEDA</b>	Observatorio Español de las Drogas y las Adicciones (Spanish Observatory on Drugs and Addictions)
<b>ONCE</b>	Organización Nacional de Ciegos Españoles (National Organisation for the Blind)
<b>NGO</b>	Non-Governmental Organisation
<b>NHS</b>	National Health Systems
<b>PADs</b>	Planes Autonómicos de Drogas (Autonomic Drugs Plans)
<b>PNSD</b>	Plan Nacional sobre Drogas (National Plan on Drugs)

## LIST OF ACRONYMS

<b>RGIAJ</b>	Registro General de Interdicciones de Acceso al Juego (General Register of Gambling Access Bans)
<b>SEAT</b>	Sistema Español de Alerta Temprana (Spanish Early Warning System)
<b>SELAE</b>	Sociedad Estatal de Loterías y Apuestas del Estado (State Lotteries and Betting Organization)
<b>SENDA</b>	Sistema Estadístico de Análisis y Evaluación sobre Crimen Organizado y Drogas (Statistical Analysis and Evaluation System on Organised Crime and Drugs)
<b>UN</b>	United Nations