

LESSONS FOR DRUG POLICY SERIES

Innovation Born of Necessity

Pioneering Drug Policy in Catalonia



OPEN SOCIETY
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To Xavier Sánchez Pretel

In memoriam 2013

Innovation Born of Necessity

Pioneering Drug Policy in Catalonia

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Global Drug Policy Program



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Cover photograph: Members of the Castellers of Barcelona building a human tower at the 25th Castells Competition in Tarragona in the Catalonia region of Spain. October 5th, 2014.
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Foreword

To state the obvious, we know more today than we did yesterday about regulating the use, possession, transportation, sale, and production of drugs. As more and more policies have either failed or succeeded, as more studies have been done, as more data has been shared, an increasing number of policy makers are coming to grips with the fact that punitive laws have not reduced the use or availability of drugs. In fact, prohibition has actually led to increased drug use, violence and incarceration rates, and increased rates of HIV transmission, to name just a few of the effects of the law-and-order approach. While we know what works, there is no one-size-fits-all approach to drug policy reform. As documented by the Open Society Foundations and other organizations, evidence of successful reform are in ever-greater abundance, and from a variety of sources.

Innovation Born of Necessity is the first of the Lessons For Drug Policy Series to explore and document drug policy formulation at the state level in Catalonia, Spain. To date, the Lessons For Drug Policy Series has documented best practices in the implementation of drug policy at the *national* level in Switzerland, Portugal, the Czech Republic, and the Netherlands. However, policy reform also happens at the regional, state, and local levels, as we have seen in the recent regulation of recreational use of cannabis in Washington state and Colorado in the United States. As governments prepare for the United Nations General Assembly Special Session on drug policy in 2016, it behooves them to understand and consider all of their options, and there are many.

In Spain, possession of drugs for personal consumption has never been prosecuted criminally. In fact, Spain's Supreme Court has further designated that shared consumption among drug dependent individuals is lawful. However, in 1992, the Public Safety Law made possession and consumption in public places an offence punishable with either a fine or mandatory treatment. The dissonance between the evolution of the laws protecting personal

possession and shared consumption, on the one hand, and the Public Safety Law, on the other, paved the way for the growth of the cannabis activist movement.

While the Spanish Ministry of Health's National Plan on Drugs initially viewed the drug situation in biomedical terms and focused its efforts primarily on preventing and treating heroin use through abstinence, the Catalan response was community focused, motivated by families of youth affected by drug consumption and neighborhood movements that denounced the lack of resources. Days after the creation of the National Plan on Drugs the Parliament of Catalonia, with broad political consensus, passed a law to address the social and health needs of those affected by drug use. The law sought to tap, consolidate, and coordinate existing resources, and led to the formation of the Catalan Drug Dependency Care Network, which is currently composed of therapeutic communities, centers for social integration, dual pathology units, hospital-based detoxification units, crisis units, and harm reduction centers.

Catalonia also offers us an interesting civil society response to the conundrum of the legalization of personal use, but criminalization of sales of cannabis—the cannabis social clubs. The cannabis clubs are non-profit associations whose purpose is the collective cultivation of plants for consumption only by its members. Since their inception in Barcelona in 1991 the concept has spread throughout Spain and Europe more broadly. For members, the cannabis clubs contribute to risk reduction and an empowering group affiliation. For the community, the cannabis clubs offer space for private consumption, thus decreasing public sales and use, which, in turn, should result in decreased police activity and expense. And for the nation, the cannabis clubs generate valuable economic activity in the formal economy by creating jobs, paying taxes, and purchasing goods and services for their operation. Also, while the cannabis clubs have proliferated, an interesting trend has emerged—cannabis consumption has progressively declined among experimental consumers, occasional users, and habitual users.

This series is part of a broader effort to enhance transparent sharing of information, data, and analyses to help us all better understand the many opportunities and challenges in formulating drug policy. We hope that these case studies will inform and inspire policy makers, advocates, and drug users to rethink and redesign drug policies locally, nationally, and globally that are evidence-based and humane.

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I. Introduction

Countries that have decriminalized drugs tend to attract international attention. Portugal, now considered an international role model, decriminalized drug possession in 2001. Similar policies are in place in the Czech Republic and the Netherlands. It is surprising then that Spain, where drug possession for personal consumption has never been prosecuted criminally, has received relatively little attention. The great gap between national and regional policy, and how and why these policies were made, may be responsible for Spain's relative obscurity in the global roster of progressive drug policies.

At the national level, Spain's drug policies are driven in large part by the interests of select political powers that have fluctuated with changes of government, national events, and the rise and fall of the economy. They are more agenda than evidence based. However, the relative independence of the autonomous regions has made it possible to develop drug policies that significantly differ, in purpose and intent, from the national policy. In Catalonia, innovative drug policies have been devised that prioritize public health, are not criminally punitive, and attempt to balance individual freedom with community concerns.

In this report, we explore the case of Catalonia where punitive drug policy at the national level has coexisted with a regional policy that has proactively addressed drug use as a public health matter. We also explore how it is that a legal loophole created by Spain's Supreme Court, in combination with efforts to protect personal freedoms at the regional level, opened the door to the creation of the Cannabis Social Clubs, commonly referred to as the "Spanish Model."

II. Drug Laws in Spain

Though Spain signed and ratified the Hague Convention of 1912, the first international drug control treaty, neither drug consumption nor possession for one's own use has ever been criminally prosecuted in Spain. That said, the history of drug policy making in Spain and its autonomous regions is fraught with efforts both to liberalize and constrict drug use, possession, and sales.

Early drug laws in Spain were extremely limited in scope. Until 1928, neither consumption nor possession of drugs for personal use constituted a crime, and sales of illicit drugs were only subject to administrative fines. In 1928, an administrative standard was established that sanctioned pharmacists who sold controlled substances illegally, i.e., other than pursuant to medical criteria.

Stigmatization of illicit drugs grew as use gradually expanded beyond therapeutic to recreational and became more visible to the public. In 1933, the government enacted the "Vagrancy Act," which, with respect to drugs, only sanctioned socially unacceptable public conduct. The new law permitted incarceration of those suspected, not of committing a crime, but of being capable of committing one. This law, an attempt at legislating morality, fostered growing social stigma against those who used drugs recreationally.

Following the Spanish Civil War (1936–39), during General Franco's 40-year military dictatorship, the number of drug users increased significantly. For those dependent on morphine, and patients with chronic pain, a 1935 regulation authorized, through a "carnet reglamentario para la extradosis," or license, the purchase of psychotropic pharmaceuticals. Pharmacies could legally prescribe psychotropic drugs to those who held this license, which

was issued to drug users by the National Narcotics Control Service. This system was created in order to manage psychotropic drug sales and use, and to avoid potential criminal activity that might result from excessively restrictive measures (Usó, 1995).

After almost 40 years of relative leniency, the 1971 Penal Code Reform introduced penalties for the possession, manufacture, and trafficking of illicit drugs, as well as all acts promoting or favoring consumption. These reforms, however, were tempered by supreme court jurisprudence, which distinguished between possession for personal consumption and possession for distribution. Furthermore, the supreme court allowed that “shared consumption” was permissible among those who were dependent on drugs.

Under democracy, from 1975 to today, Spain’s penal codes, and their corresponding reforms, established prison terms for traffickers that fluctuate in duration depending on popular perceptions of the relationship between drugs and delinquency.

In 1992, a public safety law went into effect, establishing, for the first time, an administrative fine for drug possession and use in public places. Alternatively, violators of the law were given the option to forego the fine in favor of an official drug treatment program. However, in a country with a long tradition of cannabis consumption, possibly due to its proximity to Morocco (one of the world’s largest producers of cannabis), the law was seen as an unacceptable infringement on personal freedom. Thus began, as will be explored in Section Six, the cannabis activist movement that led to the Cannabis Social Clubs.

III. Drug Problems and Policies in Spain

1. The Drug Problem in Spain

Problematic drug consumption first emerged in the early 1970s, during a time of great upheaval for Spain. The country was transitioning from 40 years under a conservative military dictatorship to a liberal democracy. The country's class structure, economic institutions, and political framework were all undergoing major transformation, as were its social values. The effects of the transition, coupled with an economic crisis, were felt acutely by Spain's youth who were living in a climate of political protest and rebellion.

Within five years of the economic crisis, large neighborhoods crowded with kids, like San Ildefonso, 'the lawless city,' popped up, suddenly adding 50,000 inhabitants. The kids in the street drifted not knowing what to do with their time. Delinquency-driven phenomena soon appeared. Alcohol and cannabis were used in new ways and licit substances such as sleeping pills, painkillers, and sedatives were combined with alcohol. As I recall, the first mothers against drugs had kids who were fried from mixing pharmaceuticals and alcohol. For me it was a complex challenge.

(Interview with Jaume Funes, psychologist, social educator, and journalist)

It was in this climate that widespread heroin consumption emerged. Individuals from marginalized social classes saw the newly established black market as an opportunity for income as well as easy access to drugs. The government, by contrast, was slow and ineffec-

tive in its response to this unprecedented problem. It is estimated that by 1980 there were between 60,000 to 125,000 regular heroin users in Spain.

In 1983, the first case of AIDS was diagnosed, and it spread like wildfire.

I was a doctor and a community outreach worker. On Sunday afternoons we took the car down to Barcelona for an excursion or to visit museums with a few of the drug users in our care. I remember that there were five of us in the car, and they began to talk about these North American artists who had become infected by that AIDS stuff. They began to say that yes, there was homosexuality, but also there were some drug addicts who had contracted AIDS. And I remember one said, 'We'll see if this ends up affecting us too!' And so it happened. I think that three or four of those in the car were infected. I had no idea about HIV and AIDS at the time. It was 1985. I often recall that conversation. It was the moment in which a doctor and his patients, all of whom were dedicated to the topic of drugs, had no inkling of what was going to change all of their lives. I was doing work that I thought I understood—helping young people who were struggling to get unstuck and live a full life. With AIDS, this changed into the work of accompanying them to their deaths.

(Interview with Josep Checa, psychiatrist)

For many years there was a general resistance to the distribution of syringes, which had a direct effect on the unchecked number of AIDS deaths. In Spain, HIV transmission mainly occurred in the prisons. The first AIDS cases in Spain were confirmed in 1983 and peaked in the early 1990s. Between 1983 and 1990, 20,000-25,000 people died from drug overdose, 100,000 acquired HIV through injecting drugs, and many more were infected with hepatitis. The highest incidence of HIV infection linked to injecting drug use occurred between 1985 and 1987, with approximately 14,500 infections per year (de la Fuente et al., 2006). New AIDS diagnoses linked to injecting drugs peaked from 1993 to 1995 with more than 3,500 new cases reported each year. HIV mortality from 1995 to 1996 reached nearly 4,300 deaths per year (HIV having been acquired 6-11 years earlier). The first effective antiretroviral treatments were not administered until the end of the 1990s. Several factors subsequently reduced infection rates: the shift from injecting to smoking heroin among many consumers; the establishment of needle exchange programs (Barcelona pioneered these in 1990), and other harm reduction interventions.

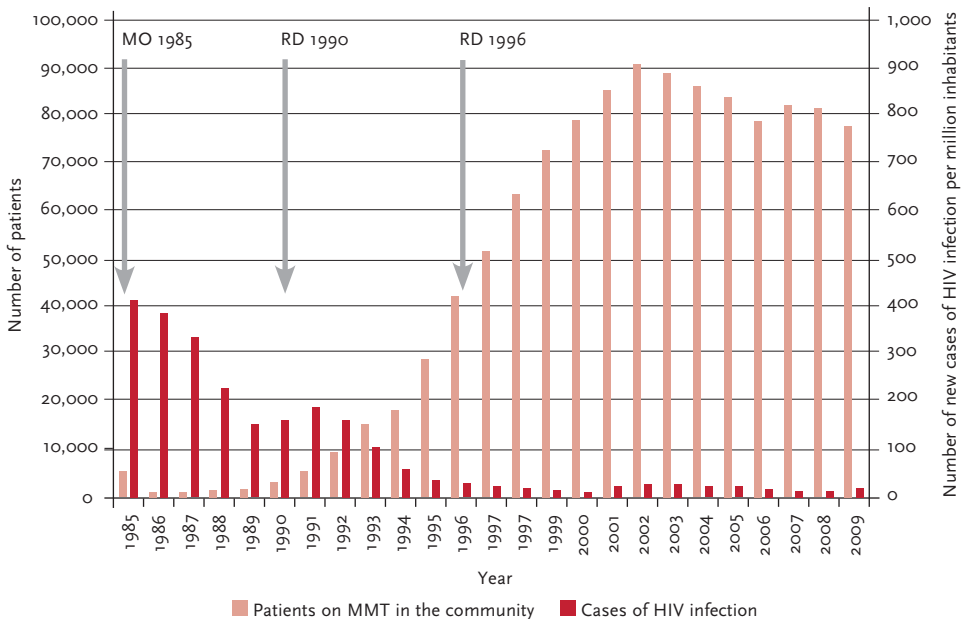
2. The National Drug Program

It wasn't until 1985 that the National Drug Program (*Plan Nacional sobre Drogas* or PNSD) was created under the Ministry of Health. The program's objective was to address trafficking as well as drug use, treatment, and prevention. It did so by first creating autonomous structures that would manage state resources allocated to drug matters.

At the outset, the strategy that guided the National Drug Program was heroin-centric and oriented toward treatment and prevention through abstinence (interview with Oriol Romani, anthropologist). A ministerial order authorizing methadone treatment was enacted in 1983, making use of the “carnet reglamentario para la extradosis,” from the Franco era. However, in 1985, in keeping with the abstinence policy, the National Drug Program enacted a new ministerial order that restricted the criteria for accessing and remaining in methadone maintenance programs. As a result, the number of people in treatment fell from more than 5,000 in 1985 to fewer than 1,000 in 1987 (See Figure 1). From 1983 to 1996, there were various adjustments to the law regarding methadone, which became increasingly liberal, making the criteria for admission to methadone treatment more flexible.

The National Drug Program, the lead organization in Spain in the field of drugs, has contributed to structuring a network addressing the problems derived from heroin consumption, without, until very recently, significantly promoting harm reduction programs. However, the National Drug Program has made a useful contribution in its collection of epidemiological data.

FIGURE 1.
Estimated number of HIV infections among injecting drug users, and the number in methadone treatment in Spain



HIV, human immunodeficiency virus; MO, ministerial order; RD, royal decree.

This chart was prepared based on data obtained from a Bulletin of the World Health Organization entitled “Methadone maintenance treatment in Spain: the success of a harm reduction approach” (citing data obtained from the Delegación del Gobierno para el Plan Nacional Sobre Drogas and Barrio G et al.), available at <http://www.who.int/bulletin/volumes/91/2/12-111054/en/>.

IV. Catalonia and the Consensus

1. The Legislative Pathway in Catalonia

Spain is a country composed of 17 autonomous regions (*Estado de las autonomías*), each with varying degrees of autonomy. Of Spain's 47 million inhabitants, 7.5 million live in Catalonia, the capital of which is Barcelona. Over time, the national government has transferred many of its duties to the autonomous regions. The regions with the highest level of self-government are Andalucía, Catalonia, the Basque Country, Galicia, and Navarre.

In 1981, the autonomous Catalan government took over the administration of health-related matters. However, in the years following the dictatorship, the government of Catalonia found itself seriously underfunded. It was therefore in the hands of the first democratic municipal councils, or local governments, to respond to the drug problem. These councils were urged on by families of youth who were affected by drug consumption as well as by neighborhood movements that were furious over the lack of resources devoted to the crisis.

Just days after the creation of the Spanish National Drug Program, the parliament of Catalonia approved Law 20/1985 for prevention and care in the area of substances that can lead to dependence. The law was approved by broad consensus among all political actors, including even the most conservative political parties in the parliament of Catalonia. The law's objective was to establish and regulate prevention, care, and reintegration measures on behalf of the Catalan government. The measures were to be scientifically based and implemented with respect for self-determination.

Two government coordinating bodies were formed: a commission composed of representatives of the government, the Catalan provinces, and the municipalities; and a technical body, tasked with planning and programming the deployment of the law and coordinating with the National Drug Program.

Law 20/1985 launched the first Catalan drug plan (published in 1987), which, through the Catalan Drug Dependency Care Network, addressed the drug situation on four levels. The first level provided primary health and social care and, depending on the needs of the client, information and referrals to services offered on the other levels. The second level corresponded to the centers for the treatment and care of those living with drug dependency (*Centros de Atención y Seguimiento a las Drogodependencias* [CAS]) and treatment centers, which were specialized centers staffed by multidisciplinary teams that were responsible for the care of people who consume drugs, including alcohol and tobacco. The third level addressed hospital detoxification units, therapeutic communities, and methadone maintenance programs (MMP). And the fourth level focused on social reintegration. In 1987, the Drug Dependency Information System was launched to gather information generated by the four levels of the care network.

In 1988, Barcelona's city council created the first roundtable on drug policies. Representatives from all of the municipality's political groups came to a consensus on a municipal drug plan. The roundtable met with the clear intention that drug issues were not to be used as "political missiles." This forum facilitated the drug plan that was subsequently approved by consensus in the plenary session of the city council, thus ensuring continuity for the health strategies addressing drugs. The consensus was only broken when the conservative parties questioned the locations of rooms for the safe consumption of injected drugs.

The parliament of Catalonia formally constituted in 1997, at the autonomous regional level, a roundtable for a consensus policy on drug dependencies. This agreement took the form of a non-binding resolution and was supported by consensus across all political parties in the parliament of Catalonia. The roundtable agreed on the objectives that would guide future discussions of the drug plan. Critically, the agreement recognized that harm reduction strategies were effective and would be implemented with a commitment to community focus, despite the biomedical orientation of Spain's National Drug Program.

As will be further explored in the following section, these two policy agreements by the city council of Barcelona and the parliament of Catalonia have, over the past 25 years, paved the way for innovation and continuity in health and community interventions.

The parliament of Catalonia passed three other laws in the area of drug dependency: Law 10/1991, Law 8/1998, and Law 1/2002. These laws focused on limiting alcohol and tobacco advertising, availability, and consumption, and emphasized protecting the health of the most vulnerable populations, especially youth. The laws gave the health authorities sanctioning capacity to achieve these objectives.

The first prison-based needle exchange program in Spain was established by the central government in a prison in the Basque Country in 1997. Catalonia is the only autonomous region with authority over prison matters. In 2003, the Catalan government implemented prison-based needle exchange programs through a unanimously approved non-binding resolution.

In 2006, under the left-wing “tripartite” coalition government, composed of parties that were the most supportive of social policies, work turned to crafting a resolution by the parliament of Catalonia in the spirit of the 1997 roundtable. All parties agreed that the policy on drug dependency should be based on: prevention, encouraging educational and training programs, equitably decentralizing public health care, enhancing harm reduction programs, promoting evidence-based intervention strategies, ensuring that the media provides information that destigmatizes the drug problem, and fomenting unbiased political and social debate on drugs.

Finally, in 2009, through Decree 105/2009, the Catalan government created the Interdepartmental Commission on Drugs. The commission has been the coordinating body for addressing prevention, care, harm reduction, reintegration, training, and research on problems related to drug consumption. The commission also coordinates the engagement of citizens, institutions, and nongovernmental organizations addressing drug dependency.

2. Consensus as an Engine for Change

In order to understand the sources of innovation and leadership empowered by political consensus around drug policies in Catalonia, it is necessary to know the historical, social, and political context of this autonomous region within the Spanish state.

The people of Catalonia have campaigned for independence for centuries. The efforts have been defeated on multiple occasions, often with the complicity of political leaders and economic elites of Catalan society, but they have never given up. This constant friction built a Catalan civil society that has organized itself socially, politically, economically, and culturally outside of the state system. From the working class collectives’ resistance in 1855 greatly influenced by anarchism; to the popular cooperative and mutualistic economy organized between 1870 and 1939; to the scientific, literary, and educational institutions that shaped Catalonia’s drive for independence until its defeat in 1939; modern emancipated Catalonia expressed its social solidarity based on collective self-organization.

This Catalan yearning for independence faced extinction in 1939 when the Franco dictatorship prohibited speaking, writing, or teaching in the Catalan language. It forbade the use of Catalan for inscriptions in every aspect of civic life such as in civil registries and

in first names, on tombstones, in names of streets, and in all public and private schools. Despite these restrictions, the collective spirit remained alive through housing cooperatives, secular and mixed schools, publishing houses, popular universities, professional associations, newspapers and magazines, scouting and excursion organizations, unions and workers' assemblies, feminist organizations, and neighborhood associations. It is a testament to the strength of the collective spirit that in Catalonia today there is one association for every 124 inhabitants.¹

The majority of those interviewed for this report believe that it is the historic empowerment of organized civil society, the capacity to generate consensus, and the importance given to the community perspective that enabled Catalonia to forge its unique drug policies.

In places where there is a greater sense of common cause and solidarity, the issue of drugs has had a better response. I think that is why there is a stronger response here than in other autonomous regions in Spain. We have grown tired saying that it is a community problem and, as such, the solution is through the community, not only through the professionals or the politicians. Where there is a community, there is a response.

(Interview with Andreu Obrador, psychologist)

In addition to drug policy, Catalonia has created pioneering social and health policy regarding women's issues, sexuality, prostitution, and mental health. In the following section we will further elaborate on Catalonia's pioneering response to drugs.

2.1 The Professionals

In Barcelona in 1984, a group of experts from a variety of disciplines, including psychology, medicine, the law, and anthropology, formed the Igia Group. The objective of the Igia Group was to create a space for reflection and debate to fully understand the complex reality of drugs. It was conceived as a center for thinking, training, investigation, social impact, and later for offering services.

The Igia Group functioned as an incubator of ideas and projects that, over the years, have been replicated throughout the country. The Igia Group's initiatives include needle exchange programs, peer work, training, program evaluation, publications, associations of drug users, drug consumption rooms, and conferences, including five sessions of the Latin American Conference on Harm Reduction (*Conferencia Latinoamericana de Reducción de Daños*).

1. Source: Registry of Catalan entities.

The Igia Group established a reference point, without which it would be difficult to explain the evolution of this field and the paradigm shift that has occurred over the last 30 years. From the start, while society was reeling from the shock over the high visibility of heroin consumption, Igia Group members were searching Europe and the scientific community for models of effective treatment and harm reduction programs. In 1989, with financing from the National Drug Program, it published a study, *Rethinking Drugs: A Hypothesis on the Effects that a Decriminalized Drug Policy Would Have on Social Aspects, Consumption Patterns, and Recovery Systems* (*Repensar las drogas: Hipótesis de la influencia de una política criminal liberalizadora respecto a las drogas, sobre los costes sociales, las pautas de consumo y los sistemas de recuperación*). The report proposed a radical shift in the limited public debate on drugs. The Igia Group blazed new trails in understanding that drugs cannot simply be conceived of as a health issue or as a socio-cultural phenomenon linked to a given historical reality. Most profoundly, the Igia Group found that it was *the state's reaction* to the drug phenomenon that was, in fact, the most important element to observe, reflect on, and consider altering.

Most of the experts who founded the Igia Group were eventually appointed to governmental positions addressing drugs in Catalonia, helping to institutionalize the harm reduction model. The Igia Group was the tip of the spear of a team of experts dedicated to addressing drug dependency. These experts shared a set of characteristics, as do the majority of those people interviewed for this report. In the 1980s, many in the field were driven by a social consciousness, were personally connected with the reality/conflict in which they worked, and did not only propose changing the habits of people using drugs, but wanted to go further to transform the neighborhoods and the communities in which they lived.

2.2 A Grassroots Response

In the early 1980s, the first institutions to respond to the problems of heroin consumption were associations of parents and the neighborhoods hardest hit by the problem. Communities pressed the city councils, which lacked the capacity to deal with the issue, to establish programs to care for people affected by heroin use. At the time, the city council of Barcelona delegated care for people with drug problems to the social initiatives of nongovernmental organizations.

This approach created a new model for responding to drug problems. In Catalonia, although the initial orientation was very much based on abstinence, interdisciplinary teams of doctors, psychologists, and social workers provided professional care. This suggests that they wanted to approach the reality of the subject in all its complexity.

(Interview with Josep Rovira, social worker)

The dynamic that catalyzed Catalonia's current model was its early commitment to a public health perspective that provided a broad range of treatment options within a networked response.

The user has to be integrated into the family, the neighborhood, and the city. We created a volunteer corps and gave them the opportunity to overcome their fears of those dependent on drugs. They got to know the person behind the illness. In this way they became active advocates within the community.

(Interview with Felisa Pérez, psychologist)

The majority of interviewees for this report believe that one of the keys to the implementation of the harm reduction programs was the personal nature of the problem. At the time, several of the people who occupied the highest political posts had a sibling or close family member who struggled with heroin consumption. For some, the problem had been fatal. The sensitivity that this experience gave them was instrumental in their support for harm reduction.

There are two other singularities to highlight about the Catalan response. In 1986, the Universidad de Barcelona created the first master's degree in Europe specific to drug dependencies. This program has contributed, to a certain extent, to maintaining a uniform body of knowledge among many of the professionals that work in the field. Another factor that has, over the past 30 years, facilitated a consistent model of care for drug dependency in Catalonia is the work of Dr. Joan Colom Farrán. Currently the deputy director general for substance abuse in Catalonia's Department of Health, Colom has occupied the highest post in the area of drug dependency since it was first established.

2.3 The "Not In My Back Yard" Response and Political Consensus

Police pressure in central Barcelona increased sharply during the Summer Olympic Games in 1992. Injecting drug use had been highly visible in the city center at the time. Trafficking was pushed to highly marginalized neighborhoods on the city's edges. By 2001, despite not having public financing, and being in an already precarious situation, a group of nonprofit organizations opened the first drug consumption room in Can Tunis, one of Barcelona's socially and economically marginalized neighborhoods. The room closed shortly thereafter.

In 2003, the city of Barcelona opened the first drug consumption room in the city's center in collaboration with the Red Cross. It did so without controversy, perhaps because it was surrounded by public services such as a fire station, health services, and a school with which it had agreed to open after 5:00 p.m. In 2004, because the capacity of the first

room was insufficient to meet its users' needs, another room opened in the same neighborhood with many more facilities and health care services. This was the Sala Baluard, now an international model, which continued to expand its services, even providing a room for smoking heroin, in order to increase contact with the drug using population. But two rooms in a single zone couldn't meet all of Barcelona's needs, so residents pressured politicians to open more drug consumption rooms in other neighborhoods.

However, when Barcelona announced plans to open a third drug consumption room in 2005 in the Vall d'Hebron neighborhood, it aroused the "not in my back yard" effect. Over several months, neighborhood residents stopped traffic on one of the city's main thoroughfares causing traffic chaos throughout Barcelona's affluent Zona Alta. The neighborhood residents argued that the room would increase the presence of drug users in the neighborhood and that they would inject heroin in the streets. They also worried that the high schools would be overrun by heroin. At their peak, the protests brought out approximately 3,000 people. Sometimes whole families, including grandparents, children, and pregnant women joined the actions.

An authentic civic siege was created...the people using drugs and the professionals serving them were threatened...they took shifts to guard the room and carefully controlled the number of people who entered and left the center.

(Interview with Joan Colom, doctor)

The neighborhood movement delivered approximately 5,000 signatures to Barcelona's city council denouncing the project. The case was heavily covered in the media. In general, the media were in favor of the drug consumption rooms and portrayed the neighborhood residents as antisocial and uncooperative.

Nine months after the conflict erupted, the parliament of Catalonia approved a non-binding resolution in which all political parties committed themselves not to support the forces that opposed safe drug consumption centers. At the same time, the new room was relocated to an existing space attached to and integrated with a large hospital center. Though they remained for another year, the crowds of neighborhood residents gradually subsided. However, throughout the entire controversy, the activity of the room never ceased.

During the next five years, no mention was made of opening other drug consumption rooms until 2010. At that time it was agreed that Barcelona's 10 districts should each have their own room. These rooms were established throughout the city without any of the earlier backlash.

V. Public Health and Harm Reduction Initiatives

In 1976 I worked in the Hospital Clinic of Barcelona and had my first experience with heroin users. Some 16 to 20 people arrived, not by their own volition, but rather accompanied by the police. The police had raided traffickers and said they had withdrawal symptoms. We had never treated heroin users, only alcoholics and morphine addicts, but they brought them to us because they thought we understood dependency. I remember, days later, some psychiatrists came to see what a drug addict was like. They were curious to see something that they had only read about in books.

(Interview with Ernesto Sierra, psychologist)

1. The First Interventions in Catalonia

In the late 1970s, the psychiatric institutions, and some therapeutic communities directed by ex-drug addicts, addressed the demand for care of those struggling with heroin use. In 1978, Barcelona's city council opened the first unit dedicated to serving heroin users and parents of users. Following the first democratic municipal elections in 1979, a few other local municipalities, responding to pressure from affected families, established small centers of care, though health was not their area of expertise. These centers were often dependent on social services or charity. In 1981, the Red Cross was the second institution to respond to the

heavy demand for care of those affected. The local initiatives, often forged by NGO's, were replicated until, in 1985, a regional law brought the interventions generated hitherto under a single umbrella. During this period, heroin consumption was socially condemned and thought of as an immoral and illegal practice. This image had direct implications for therapeutic "care" where morality prevailed over medical doctrine. Those receiving care had to demonstrate their motivation to abstain from using or face the possibility of expulsion from treatment. The approach to treatment was entirely directive and prescriptive. The annual retention rate for drug-free treatment was 5 to 10 percent (Colom, 2000).

2. Delivering Care Through the Biopsychosocial Model

In the late 1980s, drug care followed the public health paradigm. There was a strong move to establish centers for the treatment and care of those living with drug dependency (CAS). Many of the CAS were managed by nonprofits and NGOs with a community view of care and by professionals with a commitment to social change. They followed the biopsychosocial approach that considers biological, psychological, and social factors and their complex interactions in understanding drug use, dependence, and health care delivery. The CAS were public outpatient treatment centers providing direct access to care, thus bypassing the necessity for consultation with a primary caregiver. From the outset, the centers employed professionals from different disciplines with crosscutting models for cooperation with other centers. Since their inception, the CAS treated people with problems relating to the consumption of alcohol, tobacco, and illicit drugs.

The first center offering a methadone maintenance program (MMP) was created in 1986 in the center of Barcelona, despite opposition from the neighborhood residents and a large number of health professionals who, at that time, were firm supporters of the abstinence paradigm. Low threshold MMPs, within the harm reduction policy framework, proved highly effective, such that 86 percent of overdoses and 38 percent of deaths due to HIV/AIDS could have been avoided had the heroin users been in an MMP (Brugal, 2005).

The CAS' collaborative approach to care made fertile ground for the incorporation of harm reduction. At the time, Spain had the highest prevalence of HIV in Europe, and Barcelona had the second highest mortality rate of any city in Europe. In 1989, in Barcelona alone, 173 people died from heroin overdoses and 100 people died from AIDS (Brugal, 2005). In the early 1990s, this catalyzed the availability of methadone maintenance and outreach programs that addressed basic social and health matters with user-friendly locations and operating hours. It took several more years to expand the needle exchange programs since

they continued to be viewed as promoting consumption. The NGOs were the first to implement these programs in “hot zones” for injection use, and other so-called “low threshold” strategies to serve people who remained outside the system (Pretel, 2008). Within just a few years, sterile needles were distributed through primary care services, street educators, treatment centers, hospitals, vending machines, penitentiaries, and drug consumption rooms.

A cornerstone of harm reduction’s implementation was an agreement with the Association of Pharmacists that permitted pharmacies to offer methadone maintenance programs and, with more difficulty, syringes.

3. The Incorporation of Harm Reduction

In 1991, Barcelona hosted the 2nd International Conference on the Reduction of Drug Related Harm. Local participation was low and Spanish presentations represented just 6 percent of the total, none of which were during the plenary. Despite the fact that it was hosted in Spain, the country’s participation was well behind that of Great Britain (35 percent), the United States (17 percent), Holland (14 percent), Germany (10 percent) and Australia (8 percent) (del Río, 1998).

It was not until the late 1990s that harm reduction programs became conventional. For implementation to be effective, the professionals addressing drug use had to move beyond prevailing moralistic attitudes. The user came to be considered the *subject* of therapy, rather than the *object*.

It was the moment to admit that we drug professionals, generally speaking, had no idea about drugs. We only knew how to treat people who already had the personal tools or the family support to try to abstain.

(Interview with Carles Sedó, educator)

It was assumed that drug users had an inherent capacity to change, ongoing consumption notwithstanding. Various objectives for the people using drugs were established based on this assumption. They were to avoid progressing to intravenous injection, take measures to prevent transmission of hepatitis and HIV, build the capacity of peer work, and prevent heroin overdoses (the current program has trained 4,000 users, and distributed more than 4,000 Naloxone kits²). Initiatives were customized to reach those in marginalized neighborhoods where drug trafficking and consumption was prevalent. Coffee and

2. Interview with Xavier Major, doctor.

conversation centers, consumption rooms, street work, and training active users were all a part of this approach. The work was coordinated with the departments of health, justice, and the interior. This collaboration included, for example, making recommendations to the police and ceding management of the penitentiary-based CAS to the Department of Health, not to the Department of Justice, which was otherwise in charge of the prisons. This decision facilitated the inception of methadone and needle exchange programs in the prisons, which continue to struggle.

At the time, we had a lot of opposition from the prison professionals. However, today those same professionals won't let us open a prison without a methadone program.

(Interview with Xavier Major, doctor)

The implementation of harm reduction programs led to a decline in overall mortality rates in Barcelona, which, between 1996 and 1999 dropped by 76 percent. Deaths due to AIDS declined by 85 percent. Deaths due to an overdose, which had begun to decline earlier, fell by 83 percent between 1992 and 1999 (Brugal, 2005).

In 2004, clinical trials began for the oral administration of heroin. The results were positive and boosted support for implementing this alternative. However, the process of designing and executing the trial was highly politicized at the national level and, despite explicit demand from a large number of the professionals in Catalonia, to date, this strategy has yet to be implemented.

In the past five years, there has been a move to functionally integrate drug dependency and mental health services. This would be done by coordinating the interventions administered to the pathologies that are common to the two networks and the preparation of joint protocols.

4. Risk Reduction Programs in Nightspots

While heroin use was declining and its users were treated with more dignity, cocaine consumption was on the rise. At the same time, recreational drug use, often combined with alcohol consumption in nightlife venues, emerged as a new social problem. Poly-consumption became widespread. In 1997, Energy Control, the first of several risk reduction programs that focused on nightspots, was founded. This reaction was spurred by the lack of involvement and participation of people whose consumption differed from the familiar patterns of intravenous drug users and alcoholics.

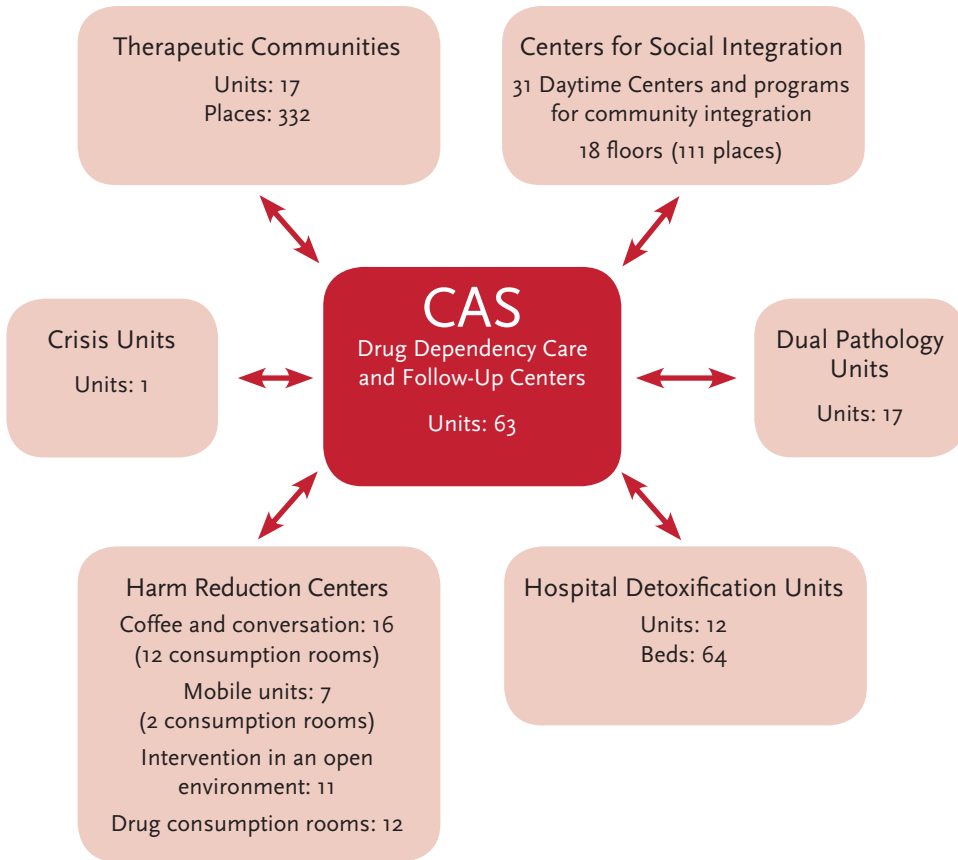
The principles underlying risk reduction are the same as for harm reduction, but are directed at a population that, for the most part, does not have ongoing drug use problems. Also, the population targeted for risk reduction intends to continue consumption and may or may not be concerned about the potential risks. In risk reduction, groups of young volunteers with peer-to-peer training visit spots for a few hours to make contact with consumers. One of the main strategies for connecting with the target audience is to offer a chemical analysis of substances to determine the potency and degree of adulteration. At the international level, there is a debate as to whether or not the distinction between harm reduction and risk reduction is purely ideological. What is certain is that in Catalonia there is a tradition of organizations that work under the paradigm that distinguishes the two strategies and the governing documents of the Department of Health³ itself reflects and drives this distinction.

5. Drug Consumption Rooms

In the past 10 years, the Catalan government's position on drug consumption rooms has evolved. While initially it did not support them, the government eventually began implementing them in zones with high-risk consumption. Today, the government is committed to each of the city's 10 districts having the capacity to offer the service of hygienic consumption. Without a doubt, the efficacy of these units has led to this radical shift in the government's position. Improvements in user health and in the security of the community have been profound. In 2012, 3,557 people, who might otherwise have been reluctant to contact the care network, used Barcelona's drug consumption rooms. Also, the number of used syringes found in public places in Barcelona fell by 77 percent, from 13,100 in 2004 to roughly 3,000 in 2012 (ASPB, 2012).

3. *Subdirecció General de Drogodependències* (2008) Ch. 3, p. 333.

The Structure of the Catalan Drug Dependency Care Network



VI. Cannabis Social Clubs

A cannabis social club is a legally constituted nonprofit association of cannabis consumers. A cannabis social club collectively cultivates cannabis plants for its members so that they may avoid the risks of purchasing cannabis from the black market. These entities have never had specific regulations within the Spanish legislative framework, but rather are simply grouped within the regulatory framework for nonprofit associations. Cultivation of cannabis plants meant for personal consumption is not criminally prosecuted, and there is no specific standard as to the number of plants that a person can grow for their own consumption. This legal gap regarding quantity of plants allowed for personal consumption, coupled with the supreme court's jurisprudence permitting shared consumption, opened the door to the cannabis social club model. This construct allowing legal access to cannabis, known internationally as "the Spanish model," has had a special impact in Catalonia.

1. The Catalan Breach

Under the Public Safety Law passed in 1992, an administrative fine could be issued for possession and consumption of drugs in public places. It also allowed for the seizure of the substance. In response, peaceful protests called "smoke-ins" were organized in cities around Spain. Cannabis activism had emerged in the previous year with the establishment of the

Ramón Santos Association for Cannabis Studies (ARSEC) in Barcelona.^{4,5} ARSEC sought to educate, conduct research, and report on government activities related to cannabis as well as offer legal representation to members caught up in the legislative and jurisprudential ambiguity around drug use.

In 1994, in an action later referred to as the Catalan Breach, one hundred members of ARSEC signed an agreement to plant and cultivate 200 plants. Within months of starting cultivation, the Civil Guard (*Guardia Civil*), a branch of the Spanish police, seized the plants without a judicial order. Four members of ARSEC were accused of drug trafficking. The accused were acquitted in their trial before the provincial court (*Audiencia Provincial de Tarragona*), but the prosecution appealed. Three years later, the supreme court sentenced the accused to four months and a day of prison (which was later suspended). They were also fined €3,000 for the crime of “negligent endangerment” (Marín, 2008); where there are reasonable grounds for deducing that the accused possessed the substances with the intention to sell them. Crimes against public health that are deemed “negligent endangerment,” are characterized by the existence of potential for harm.

The ARSEC case inspired the next generation of cannabis activists. In 1999, a gardening store opened in Barcelona that legally sold marijuana seeds; it was the first grow shop. The grow shops offered their customers the culture of cultivation and the technology to make it possible. Publications dedicated to spreading cannabis culture, like *Hemp (Cáñamo)* magazine, founded in 1997, also played an important role as channels of communication for cannabis consumers.

2. The Basque Breach

In 1995, there were 10 cannabis associations throughout Spain. In 1996, the state coordinator for the normalization of cannabis (*coordinadora estatal para la normalización del cannabis*) was formed. From this body arose the, “Against the ban, I am planted” (“*Contra la prohibición, me planto*”) campaign in support of ARSEC. Of the eight signatory associations, only one actually engaged in an act of protest—by planting cannabis in 1997. The Kalamudia

4. ARSEC is considered the first cannabis association, even though the Asociación de Consumidores de Derivados del Cannabis had been founded in Madrid in 1987. Other than its having been founded, there is no record of any activity since then. However, before the rise of the cannabis association movement, activists like Fernanda de la Figuera became a role model after facing trials for cannabis cultivation in Malaga and was acquitted.

5. In 1993, the Associació Lliure Anti-Prohibicionista (ALA) was founded in Barcelona as a nucleus of activism and debate in synergy with others, like ARSEC.

de Bilbao Association, whose spokesperson was the well-known activist Martín Barriuso, planted 600 plants for 200 members, incorporating lessons learned from the ARSEC case. From the start, they notified the prosecutor's office and the police of their intentions and invited the press to visit the crop. Although Kalamudia was charged with a crime against public health, the trial court dismissed the case and rejected the prosecutor's petition to destroy the plantation. From that moment until May 2013, in the Basque Country alone there have been 21 judgments of various kinds, all favorable to cannabis social clubs, finding no crime in their functioning.⁶ Kalamudia was able, without any opposition, to plant a second and third annual harvest.

3. The Cannabis Social Club Format

Several elements influenced the current model of the cannabis social club. First, the Junta de Andalucía, an autonomous government, instructed Andalusia's Institute of Criminology to produce a legal report, known as the *Muñoz & Soto Report*, on how cannabis could be administered to the ailing without breaking the law (Muñoz y Soto, 2001). The most significant suggestion of the report was that the dispensary should only be accessible to adult habitual cannabis smokers who would receive small quantities for on-site consumption. It was also recommended, that there be no profit motive, nor diversion of cannabis outside the club. These measures incorporate the supreme court's jurisprudence on shared consumption⁷ into a model for regulating cannabis.

In 2001, Barcelona's Cannabis Tasters' Club was formed. This was the first association with the express purpose of offering a private consumption space to its members. The following year, in the Basque Country, several cannabis social clubs were established that distributed collectively cultivated harvests to their members. Though, in order to be a member, one had to have previously consumed cannabis, these first cannabis social clubs made allowances for first-time therapeutic consumers (Barriuso, 2005) if they provided a medical report verifying their illness.

While dozens of cannabis social clubs were formed, a few lawsuits were brought against them demanding that they cease. These suits, however, were not instigated as a global strategy by regional and national authorities, but were the result of police action against cannabis cultivation. The cannabis social club cases that went to trial gave favorable

6. Interview with José Afuera, activist.

7. The supreme court doctrine was developed in judgments on groups of heroin and cocaine users that bought drugs together on the black market to consume together later.

publicity to the model, since all those charged were cleared of the accusations, and a few cannabis harvests were even returned several months after being seized.

In the first decade of the 21st century, the number of cannabis social clubs increased in a linear fashion. In 2009, Catalonia alone had 14 cannabis social clubs. During this decade, the Federation of Cannabis Associations (FAC) took the lead on public representation of the cannabis movement and facilitated connections between most of the cannabis social clubs.

4. The Rasquera Case

Rasquera is a small agricultural village in southern Catalonia with just over 900 inhabitants. In early 2012, the name Rasquera was heard around the world when the mayor presented a development plan to address the economic crisis. Among other measures, the plan proposed creating a public company that would manage cultivation for a 5,000 member cannabis social club in Barcelona. Since it was a delicate matter, the council called for a referendum on the proposal. Fifty-six percent of voters favored the plan. However, at the behest of the prosecutor's office, a judge quashed the contract between the municipality and the cannabis social club.

In order to understand what happened in Rasquera, one must look at earlier dynamics in Barcelona. The cannabis social club model advocated by FAC during the first decade of the 21st century was an experiment begun by cannabis activists and their legal representatives. As the cannabis social club model took hold, new actors came in and took center stage. Among these were lawyers representing clients who pushed for models with higher limits and budgets than those advocated for by the FAC. The most significant changes were a substantial increase in the allowable number of members and a more hierarchical (and less cooperative) decision-making process in the cannabis social clubs. Another qualitative leap in the new model was in the private space for members, which became indistinguishable from other spaces for socializing, such as bars, lounges, or the best coffee shops in Amsterdam. The process of redefining the cannabis social club model accelerated in Barcelona and has meant that, starting in 2010 and continuing to this day, the number of cannabis social clubs has increased exponentially. By mid-2014, there were an estimated 400 cannabis social clubs in operation in Catalonia, 250 of which were in Barcelona. Including all of the entities in the city, there are roughly 165,000 members (Mumbrú, 2013). The Rasquera Case was only possible because of Barcelona's manifest and diverse cannabis social club reality, offering an ongoing alternative to prohibitionist drug policies and a viable avenue to meet considerable demand.

5. The Response of Spanish Institutions

Although the cannabis social club phenomenon began at the start of the century, more than a decade passed before Spain's executive and legislative branches made any public pronouncements on the issue. Matters concerning the clubs, and the considerable expense of addressing these, were left to the police and the judiciary. Thus, for a decade, as the highest authority to address the issues that arose from the cannabis social club phenomenon, it was the judiciary, based on pronouncements in various actions and accusations against those involved, that lent legitimacy to the cannabis social club model.

Then, in the summer of 2013, the office of the attorney general issued an order to all prosecutors' offices with instructions on the "associations promoting cannabis consumption." The order was highly confrontational; all of the cannabis social clubs stipulate in their bylaws that their purpose is not to promote consumption. It was also unreasonable as it urged all prosecutors to investigate cannabis associations to ascertain whether they have obtained a certificate to grow cannabis from the Spanish Agency for Medicine and Health Care Products. This condition is impossible to fulfill since cannabis, in its natural form, is not considered a medicine or a health product under Spanish law.⁸ For the prosecutors' offices, any act of cultivation is illicit if it is not administratively authorized, including for private use. Furthermore, the prosecutors' interpretation of the "shared consumption" doctrine was completely restrictive.

Just days after publication, the president of Judges for Democracy found the attorney general's order "disproportionate," because, "One cannot put *illegal traffic* and *shared use* on the same plane," especially when the organizations cited are trying to avoid illegal drug trafficking networks. The order represents, "a step backwards," and moreover, the "criminalization" of these associations would work precisely in favor of illegal trafficking. A milder reaction came from the Progressive Union of Prosecutors, which simply found that the instruction should be interpreted "very broadly" (Magraner, 2013).

The director of the National Drug Program also made a public pronouncement on the matter. Despite, "respect[ing] the right of association," the National Drug Program was against the cannabis social clubs, "because, if the state favors a legal market, it will increase the associated mortality in the context of road safety."⁹ They found that the pro-cannabis "lobbyists" were "trivializing" its effects.

8. In 2001, the parliament of Catalonia, at the urging of the Ágata association to help those with breast cancer, unanimously requested that the central government legalize the use of therapeutic cannabis. To this day, only the commercial extract Sativex is available to treat just a few diseases.

9. TV3, Documentary "30 Minutes. Rasquera:" <http://www.tv3.cat/videos/4329931/Rasquera-que-fem-amb-la-marihuana> (viewed 2/14/2014)

In July 2014, the council of ministers approved the Law for the Protection of Public Safety, known by detractors as the Gag Law, proposed by the Spanish Popular Party (PP) that currently governs with an absolute majority. The new law will be more punitive than its predecessor, the Public Safety Law of 1992, which, as discussed earlier, was one of the triggers of the cannabis movement in Spain. The Law for the Protection of Public Safety eliminates the option of mandatory treatment in lieu of paying a fine for public drug possession or consumption for adults; it will continue to permit the private consumption of cannabis, but would administratively sanction its cultivation in areas visible to the public; and would double the minimum fine for public possession of illicit drugs, from €300 to €601. Without a doubt, this law is a direct attempt by the government to bureaucratically stifle the cannabis social clubs, since it mandates a fine of €601 to €30,000¹⁰ for “acts of planting drugs not constituting a crime in areas visible to the public,”¹¹ and provides, among its injunctions, for the ‘suspension or closure of venues,’” in which drugs are being consumed.

Unfortunately, Spain is repeating the pattern of relying on laws that increase repression and punish people who use drugs, cannabis users in particular. The aforementioned draft law also contains measures that threaten to limit the exercise of fundamental rights, such as the right to protest and freedom of expression. The Council of Europe’s Commissioner for Human Rights found the law to be “highly problematic” (EFE, 2013).

6. The Response of the Basque Country, Catalonia, and Navarre

The only autonomous regional governments that have demonstrated a willingness to openly debate the cannabis social club phenomenon have been the Basque, Catalan, and Navarre parliaments.

In the Basque Country, the forum organized in 2011 by the Ararteko (ombudsman) was decisive. This forum, a space for open discussion that emerged from the civil rights movement, and police operations against cannabis social clubs, precipitated a 2012 commission in the Basque parliament. Driven by all of the political parties in the chamber, the commission was to study the regulation of cannabis social club activities. The commission

10. The law provides that if three serious infractions are committed within two years, this can be deemed very grave infraction, carrying a fine of €30,000 to €600,000.

11. http://www.lamoncloa.gob.es/serviciosdeprensa/notasprensa/Documents/Proyecto_LOPSC_11-07-14.pdf (viewed 2/14/2014).

was suspended shortly thereafter due to an early call for elections. The new government, also by consensus among all parties, reconstituted the commission in the summer of 2013. During the commission, more than 40 experts gave their opinions. The final report of the commission was published in October 2014 with the support of all of the political parties except for the Partido Popular (currently the ruling party). The report requested that the Basque government include the activities of the cannabis social clubs in the Basque Law on Addictions. It also requested that more legal support be given to defend cannabis cultivation for the collective use of club members (Eldiario 2014). Meanwhile, police operations and criminal trials against cannabis social clubs continue.

The reaction by regulators in Catalonia came later. In 2012, just after the Rasquera case captured the headlines, the Catalan Department of Health initiated a process of reflection at three levels; with those affected and their representatives;¹² among all of the political parties in the Commission on Health Policy in the parliament of Catalonia; and finally, through an interdepartmental commission formed by the General Directorates of the Catalan Police, Justice, Local Administration, and the office of the Spanish Attorney General in Catalonia. The Department of Health's objective was, "to reach the broadest consensus on regulating a system that has, in recent years, grown without any structure."¹³ In contrast to the Basque Country, where civil rights have been the focal point, in Catalonia the regulation of the clubs is legitimated as a function of the harm reduction paradigm. According to the Department of Health, "European health policies on drugs are moving toward public health policies that prioritize the health of consumers and address risks, following a model similar to what was developed in the 1980s and 1990s for heroin consumption."¹⁴

In the meantime, in August 2014, the city of Barcelona ordered the closure of 50 cannabis social clubs, approximately one-quarter of the city's total locations. The official reasons given for the closures were deficiencies in club management and poor ventilation systems. However, according to representatives of the cannabis social clubs, these reasons were not made clear and appear to have been arbitrary. At the same time, the actions of city hall provoked many of the cannabis social clubs to join the Federation of Cannabis Associations that represent them.

12. Two federations cover 20-30 percent of all the cannabis social clubs in *Cataluña: the Federación de Asociaciones de usuarios de Cannabis de Catalunya* (CATFAC) and the *Federación de Asociaciones Cannábicas Autoreguladas de Catalunya* (FEDAC).

13. *Departamento Salud* press release http://premsa.gencat.cat/pres_fsvp/AppJava/notaprem-savw/detall.do?id=219848 (viewed 14/02/2014).

14. *Ibid.*

Since the attorney general's 2013 order, mentioned in the previous section, the Catalan government has reported 258 cannabis social clubs as potential illicit drug trafficking organizations operating under false pretense as nonprofit organizations. Thus far, the attorney general has initiated investigations into 40 of these cases (Economía digital, 2014).

In January 2015, the parliament of Catalonia approved a resolution regarding the public health criteria for cannabis social clubs and the conditions under which the municipalities of Catalonia could approve their operation. These criteria, disseminated by the Catalan Health Department, will provide information and guidance on how to reduce the risks and harms associated with cannabis consumption; training for those responsible for dispensing cannabis in the cannabis social clubs; and early detection, monitoring and derivation of problematic consumption. The criteria also prohibits the use of other drugs and alcoholic beverages; restricts sales of tobacco; requires compliance with the Spanish tobacco law; sets the minimum distance between club locations and schools and health care centers; restricts opening times to a maximum of 8 hours per day, with closures at 10pm during the week and 12pm during the weekends; prohibits use of advertising; requires compliance with the sanitation laws and norms and environmental standards; and prohibits neighborhood disturbance. The criteria requires that members must be 18 years or older; regular cannabis users; hold membership in only one cannabis social club; and be endorsed by another member. Also, to avoid cannabis tourism, there is a 15-day waiting period between application submission and membership approval.¹⁵

In the summer of 2014, a third autonomous region, Navarre, initiated the process of regulating the activity of the cannabis social clubs. In this case it was civil society, urged on by cannabis activists that proposed a popular legislative initiative to regulate the cannabis social clubs. They needed only 5,000 signatures to move forward and they received more than 10,000. As a result, the Navarre parliament approved the proposal for the regulation of cannabis social clubs in December 2014.¹⁶

As of the writing of this report, none of the aforementioned regulatory initiatives have addressed the cultivation of cannabis and its transportation to the social club locations.

15. Parliament of Catalonia (2015): Resolution SLT/32/2015, of the 15th of January, approves the criteria for public health guidance for the cannabis associations and their social clubs and the conditions under which they may operate in the municipalities of Catalonia. Published in DOGC, January 29th, 2015, no. 6799.

16. Official Bulletin of Navarre (BON). Statutory Law 24/2014, of the 2nd of December, Regulation of the Cannabis Users' Collectives in Navarre.

7. The Data, or Lack Thereof, and its Interpretation

Critically, one of the most vexing issues at this time is the possibility of, but as yet not fully attained, empirical evidence about what is happening in the field. This lack of data makes it difficult, for example, to show the effectiveness of the cannabis social club model. To even speak of a cannabis social club model is complicated, since various ways of understanding how they function coexist. Current sources of information are very limited or biased.

Based on available data, we know that the increase in cannabis social clubs has not, in fact, led to an increase in consumption levels. If we analyze the data for Catalonia, the region with the highest concentration of cannabis social clubs, from 2007 (the year in which the cannabis social club was popularized) to 2011, all of the figures for cannabis consumption dropped (Table 1).

Table 1. Prevalence of cannabis consumption in the population aged 15–64

	2007	2009	2011
Any time ever	34.4%	34.9%	28.5%
Any time in the last 12 months	14.1%	12.4%	11.3%
Any time during the last 30 days	9.7%	8.7%	8.1%
Daily consumption	1.7%	2.2%	1.5%

Report on the results of Catalonia survey EDADES 2011 (EDADES, 2011).

From 2007 to 2011, a time when the cannabis social clubs in Catalonia proliferated exponentially, cannabis consumption progressively declined among experimental consumers (any time ever), occasional users (any time in the last year) and habitual users (any time in the last month). At the same time, requests to commence treatment increased. The only indicator that comes close to reflecting problematic consumption is for those who reported consumption in the last 30 days. It is surprising that, while that indicator has been steadily falling over the years, treatment requests have been increasing: 706 in 2007; 1,069 in 2009; and 1,538 in 2011 (Generalitat de Catalunya, 2007; 2009; 2011). The increase in treatment requests may not be due to an increase in problematic consumption (consistent with the epidemiological figures), but an increase in treatment requests simply to avoid paying the administrative fine for public possession or consumption. Since this period, 2007 to 2011, coincides with a serious economic crisis in Spain, many users may not have been able to afford the administrative sanction fee.

There are two key indicators that could help us ascertain the impact of the cannabis social clubs; the first is the number of administrative sanctions issued for public drug

possession or consumption; and the second, the number of arrests and charges for drug trafficking. In the Barcelona metropolitan region, where there has been an increase in cannabis social clubs over the last three years, reaching more than 200 in 2014, the number of sanctions for public drug consumption and/or possession were 22,232 in 2009; 27,674 in 2010; and 21,953 in 2011 (*Report of the Department of the Interior*, 2009; 2010; 2011). Arrests and charges for drug trafficking have decreased in Barcelona from 2,006 in 2011 to 1,817 in 2012 (Ministry of the Interior, 2012). This data refers to administrative sanctions and trafficking arrests for all drugs. Even though there are no specific data available for cannabis, we can extrapolate from the national data that 54.6 percent of the drug trafficking related arrests and 85.7 percent of the administrative sanctions are cannabis related (OEDT, 2011). There does not appear to be a correlation between these indicators and the rise of cannabis social clubs in Barcelona. There are also many other as yet unknown factors that could have a role in explaining these figures such as the lack of data related to cannabis prevalence since 2011, a possible increase in law enforcement activity, etc.

Another element to consider is confiscation rates. While the total amount of cannabis seized in Spain fell 8.53 percent from 355,904 kg. in 2011 to 325,562 kg. in 2012 (Ministry of the Interior, 2013), in Catalonia it has increased significantly, from 2,500 kg. of marijuana in 2012 to 5,300 kg. in 2013 (*El Periódico*, 2014). One might assume that the increase in the number of cannabis social clubs has led Catalan consumers to cease their reliance on the traditional supply networks. This, in turn, may have necessitated a greater number of native-grown crops, thus increasing crop seizure by the police. Cannabis social club proliferation and the consequent change in the supply networks, shifting from the traditional narco-trafficking networks toward the modern cannabis social club circuits, has gradually been transforming hashish culture in Catalonia to being more marijuana oriented. As such, the amounts seized in 2013 would reflect this change in the supply networks and in the greater consumption of marijuana instead of hashish, and that these amounts would correspond with the increased demand from the Catalan social clubs.

These figures are difficult to interpret, and any preliminary conclusion one might want to draw, as a consequence of the proliferation of cannabis social clubs, would necessarily be highly speculative. The situation of the cannabis social clubs is not a reality that has been quantified by official agencies; what is known of their activities comes as much from what those in charge of them say, as from what appears in the news media. Police records are inconsistent. There have been times when the police surveilled entrances to cannabis social clubs, recording and fining people who passed between them and the street. And there have been times when no problems occurred. The police have intervened in some clubs and not in others, without any discernible criteria. Through informal conversations that the authors of this report have had with dozens of directors of cannabis social clubs, the general impression is that police interventions are arbitrary. Given the lack of data, it is

difficult to interpret the above-mentioned fluctuations, which may be due to multiple factors, including happenstance.

Young people, including adolescents, are the segment of the population that are most often fined for public consumption or possession (more than 80 percent). This happens to be the very population with the least resources, the highest prevalence of consumption, and the most visible presence in public spaces, such as venues for socializing. The population profile of youth differs greatly from the members of the cannabis social clubs. Many cannabis social clubs only admit members over age 21 and cannabis prices in the clubs are slightly higher than in the black market. Be that as it may, the data converges toward both a decline in the prevalence of habitual cannabis consumption, and a decline in police interventions in public places, coinciding with the proliferation of cannabis social clubs in Barcelona.

Paradoxically, while the cannabis social clubs were created in order to avoid purchase from the black market, when there is a police intervention or a robbery, they are obliged either to cease their activity (in which case their members go back to buying in the black market) or buy from the black market in order to supply their members. Crop theft is not uncommon, and there have been instances of violence or extortion by organized groups that are difficult to report since the object of the crime is an illegal substance, thus leaving the victims legally unprotected. The lack of regulation pushes cannabis social club members toward the black market, contradicting the very purpose for which the clubs were conceived. Conflicts also arise within the cannabis social club sector, such as internal accusations of “bad practices” or connivance with the black market, since there are no rules of conduct that would afford stability, broad consensus, and cooperation. Furthermore, it is frustrating to see police operations target precisely those people who have dedicated themselves to publicly explaining their positions and collaborating actively with all of the relevant institutions. The national government’s position is clear; the problem is not that there is a market or demand for cannabis; the problem is that the cannabis social clubs are highly visible. The laws, by default, favor the large mafias that operate outside of the law in the black market, with greater capacity and are, by their nature, less visible.

8. Innovation Born of Necessity

Twenty years since the first collective cultivation by ARSEC in Catalonia, the cannabis movement in Spain has become a global point of reference. At the same time, successive national governments have persisted in escalating the repression and punishment of people who consume. The coexistence of these opposing forces has had many and varied implications. The debate over the cannabis social clubs exemplifies the complexity involved in advancing toward more sustainable drug policies.

Before the launch of the new Law for the Protection of Public Safety, which will punish cannabis consumers and those responsible for the cannabis social clubs with high administrative fines, the autonomous regional parliaments of Catalonia and Navarre have made their proposals for regulating cannabis social club activity. At this point a variety of elements will converge, or collide.

As is well known, Catalonia, the Basque Country, and Navarre have historically been territories with a tradition and claim of self-government within the framework of the Spanish state. The tension from this claim is reflected at many levels, and their respective drug policies are but one example. For more than 20 years, these two regions spearheaded the implementation of harm reduction programs in Spain. The case of the cannabis social clubs has much in common with this process, but there are also notable differences. Comprehensive regulation of cannabis social club activity would require standardizing aspects of operations such as cannabis cultivation and transport, which are the bailiwick of the central government (the Drug Law [*Ley de Estupefacientes*] or the penal code).

There are several possible solutions to address the lack of synchronization and gaps in regulation between the state and regional level:

- ▶ Enact partial regulation similar to the Dutch policy of tolerance.
- ▶ Employ regulation that impinges on matters under national jurisdiction (though this would add to existing tensions between the autonomous regional governments and the national government).
- ▶ Solicit the transfer of matters currently under Spanish state authority to the autonomous regional governments. This would take so long that it would slow down the regulation process significantly.
- ▶ Issue standards, edicts, and licenses at the municipal level thus creating varying and even contradictory situations among neighboring municipalities.¹⁷

The fact that these territories have their own police forces, with roles in the fight against narco-trafficking, could make regional regulation possible through the development of protocols for actuation implemented by the different departments of the autonomous regional

17. The first concrete governmental response has emerged in the local context. The cities of Girona (Catalonia) and San Sebastian (Basque Country) have already approved municipal licenses for cannabis social clubs. Barcelona's city council announced in June 2014 a one-year moratorium on opening new cannabis social clubs, with the purpose of coming to an agreement on its own municipal standard. Other smaller municipalities, including for example, Castelldefels, Badalona, Sabadell, Sant Adrià de Besòs, Sitges, Vilafranca del Penedès, Vilanova i la Geltrú and seven more (Catalonia), have vetoed the opening of new cannabis social clubs during the next year.

governments and the regional police. These protocols may also promote transparency in their dealings with the cannabis social clubs. That said, the Spanish state's two security forces, which also have roles relating to organized crime and narco-trafficking, continue to be active in the two regions, albeit with a more diminished presence. Furthermore, the attorney general opposes the cannabis social clubs and continues to act as the prosecutor for the state.

The emergence of the cannabis social clubs has generated yet another paradox: while the debate about their regulation monopolizes much of the public's attention, it risks neglecting the fight to defend the rights of growers and individual consumers. In discussing only collective rights, there is a danger of diminishing the importance of individual rights.

Beyond the political contingencies, the cannabis social club model has proven, in its rapid expansion, to be successful, to the extent that a substantial number of consumers prefer it to the black market. The cannabis social clubs have been beneficial at several levels of society:

- ▶ For their members, the cannabis social clubs offer group affiliation, individualized treatment, mutual trust, democratic functioning, peer training (which contributes to risk reduction), the absence of profit, access to products with known ingredients and reliable quality, assistance on legal matters stemming from consumption, and affiliation with a network of similar organizations. The work that the cannabis social clubs do with people who consume cannabis for therapeutic reasons is also fundamental. The vast majority of cannabis social clubs have “therapeutic members.” It is an open secret that many of these members were informally “referred” to the cannabis social club by doctors who suggest they try cannabis as a medicine.
- ▶ For the community, the cannabis social clubs provide a space for private consumption that did not previously exist and, as such, presents an alternative to consuming in public. This decreases the visibility and the volume of buying and selling in public and, in turn, should result in a decrease in police effort and expense in connection with pursuing these transactions. Also, cannabis social clubs bring consumers closer to the harm reduction programs and health care provided by the public network or the NGOs that work in this area. There are already various research projects underway such as programs for reducing the risks of using cannabis as well as other drugs and even tobacco addiction treatment. Thus, the cannabis social club model improves our understanding of the reality of cannabis consumption and, accordingly, provides an avenue for public health interventions. One of the most obvious achievements of the cannabis social clubs is that they move consumers away from the black markets for drugs, thus reducing the purchase of drugs with higher health risks. It is pertinent to remember that it was precisely this argument that legitimized the establishment of the coffee shops in the Netherlands.

- ▶ Unlike the Dutch model, the cannabis social clubs are closed spaces and consumers can only access them upon direct invitation by another member, such that it does not promote cannabis use among new consumers. The absence of a profit motive also puts a brake on the mechanism of promotion. The concept of shared cultivation, where the total volume reflects the estimated consumption of the members as a group (which has an upper limit that is usually 2 or 3 grams per day per member) means that there is no surplus production that could be diverted to the black market. Cannabis social club members are always of the legal age for consumption, though many clubs have increased their minimum age to 21 years.
- ▶ For the nation, the cannabis social clubs offer a critical financial benefit. The cannabis social clubs emerged during a historic economic crisis. It was no coincidence that when Rasquera presented its “crisis plan,” it was the municipality with the third highest public debt ratio in Catalonia (*El Periódico*, 2013). In 2013, Spain was the southern European country with the most extensive underground economy (28 percent of GDP), the most tax fraud (8 percent of GDP) (Europa Press, 2013), and the highest rate of youth unemployment (57.7 percent in November 2013) (*El Diario*, 2014). We estimate that the Spanish spend some €546 million annually in the black market.¹⁸ Though the cannabis social clubs have no profit motive, they generate significant economic activity. The cannabis social clubs create jobs and pay taxes. They participate in the economy by paying for rent, utilities, communications, transportation, legal advice, agricultural expertise, and cultivation materials. For example, a cannabis social club with 600 members requires roughly 10 employees to manage operations. If a million and a half people (a little more than 60 percent of daily users and frequent consumers (OEDT, 2011) purchased their cannabis from a cannabis social club, some 25,000 jobs would be generated. This would generate €197 million in social security contributions, €100 million in income taxes, and €114 million in value-added tax, for an aggregate of €411 million per year in direct revenue. Indirect revenue would also be generated by this sector through the employment of 25,000 citizens, which, in turn, would save the state €250 million per year in unemployment benefits.

Beyond the basic protection of individual and collective rights that would come with comprehensive regulation of the cannabis social clubs, the scale of the potential income, and the attendant savings in police and judicial resources, represents an opportunity to combat one of the country’s greatest economic and social crises.

18. According to the 2011 survey by the *Observatorio Español de Drogas (2011)*, 7 percent of the Spanish population aged 15 to 64 consumed frequently and 1.7 percent daily. The calculation uses 10 euros per month for the former and 60 euros for the latter.

Lastly, the value to civil society that members of the cannabis social clubs bring, in organizing themselves and creating spaces for discussion, is noteworthy. The cannabis social clubs, as a social initiative and struggle, connect people who together foment cannabis culture and group life. In early 2014, there were 11 federations throughout Spain serving as umbrellas for a significant portion of all cannabis social clubs, ranging in number from 800 to 1000 legally constituted entities. As a result, the “Spanish Model” is now discussed, replicated, and improved upon well beyond Spain’s borders.

The cannabis social clubs reinforce the social fabric, the protection of health, and the formal economy, thus contributing to a more democratic society. While its alternative, the black market moves in precisely the opposite direction.

VII. Conclusions

The facts that Spain has never criminalized personal drug use and has allowed shared consumption are unique in the international spectrum of drug policies. Although it may seem paradoxical, this legal and jurisprudential reality coexisted in Spain with successive national policies that have addressed the drug issue with repressive laws that prioritized prohibition over the protection of health, social, and cultural interests.

The relative independence of the autonomous regions has made it possible for certain territories to develop drug policies that stray from national policy. In Catalonia, drug policies are guided by parliamentary consensus, which has permitted the development of more inclusive measures. The prevalence of the harm reduction approach for problematic drug users, the social phenomenon of the cannabis social clubs, and the educational alternatives to the administrative sanction on public drug consumption among minors are examples of how Catalonia has addressed the drug problem with solutions that are not criminally punitive.

However, harm reduction and community development strategies have always been, and still remain, palliative approaches to wounds made by ineffective drug policies in the health, legal, and social spheres that, in Spain's case, came too little and too late. It is no coincidence that Spain currently has the highest prevalence of paternally transmitted HIV in the European Union. Circumscribing the legal security of drug users to these spaces can create ghettos, reaffirm stereotypes (that users of harm reduction or the cannabis social clubs share a series of routines, values, and tastes with others like them), and definitively isolate drug users from society. Legislation that punishes users confines them to seeking out places in which they feel protected, places where they can take refuge. Legislative change

needs to go beyond regulating the cannabis social clubs and allow drug possession that is not destined for trafficking in public spaces. Without this protection it is not possible to fully assess the efficacy of non-repressive drug policies.

Policies based on harm reduction reduce harm. But the harm reduced is more from the system, than from the drugs. Heroin does not transmit HIV or the hepatitis virus, and overdose deaths are preventable accidents. Beyond the right to individual freedom, the implementation of policy alternatives to those based on prohibition is the only way to address the public health crisis that stems from the drug problem. These policies can only be established when the drug problem is not used as a tool of political strategy, but is addressed by parliamentary consensus that puts ideologies aside.

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Global Drug Policy Program

Launched in 2008, the Global Drug Policy Program aims to shift the paradigm away from today's punitive approach to international drug policy, to one which is rooted in public health and human rights. The program strives to broaden, diversify, and consolidate the network of like-minded organizations that are actively challenging the current state of international drug policy. The program's two main activities consist of grant-giving and, to a lesser extent, direct advocacy work.

At present, global drug policy is characterized by heavy-handed law enforcement strategies which not only fail to attain their targets of reducing drug use, production, and trafficking, but also result in a documented escalation of drug-related violence, public health crises, and human rights abuses.

Open Society Foundations

Active in more than 100 countries, the Open Society Foundations work to build vibrant and tolerant democracies whose governments are accountable to their citizens. Working with local communities, the Open Society Foundations support justice and human rights, freedom of expression, and access to public health and education.

Drug policies that are based on human rights and promote public health are a priority for the Open Society Foundations. Our efforts focus on promoting collaboration and expanding the range of stakeholders committed to drug policy reform, empowering drug users to advocate for their rights at the national and international level, and supporting research into the economic and social costs of current drug policies.

Innovation Born of Necessity: Pioneering Drug Policy in Catalonia is the fifth in a series of publications by the Open Society Foundations' Global Drug Policy Program that documents positive examples of drug policy reform around the world. We hope these case studies will inspire policy makers and advocates in consultation with people who use drugs and others affected by drug policy to design rights-centered policies that are scientifically sound and humane.

Innovation Born of Necessity is the first of the Lessons For Drug Policy Series to explore policy formulation at the state level. It documents how, despite more punitive policies at the national level, Catalonia implemented a community-driven, public health centered approach to its heroin epidemic. Catalonia is also the birthplace of the cannabis social clubs, a truly innovative response to the confluence of contradictory interests and laws. This report offers a valuable analysis of the cannabis social clubs' emergence, functioning, struggle to remain viable, and potential value to Spain as a whole. *Innovation Born of Necessity* offers inspiration and vision for policymakers at every level searching for alternative approaches to addressing drug use, treatment, and harm reduction.

In addition to drug policy reform, the Open Society Foundations work around the world to advance health, rights and equality, education and youth, governance and accountability, and media and arts. We seek to build vibrant and tolerant democracies whose governments are accountable to their citizens.

