Addictive Behaviors Units: a pioneering model of integrated healthcare for addiction

Unidades de Conductas Adictivas: un modelo pionero de integración sanitaria frente a las adicciones

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At the end of the 20th century, Spain faced a social and healthcare crisis marked by the rise in heroin, alcohol, and cocaine use, along with the emerging recognition of behavioral addictions. Confronted with a devastating reality—rising mortality, social disintegration, and the absence of a solid institutional response—the Valencian Community introduced an innovation that would mark a turning point in addiction care in Spain: the Addictive Behaviors Units (UCA).

In 1997, with the approval of Law 3/1997 and its subsequent regulatory development, the Generalitat Valenciana embarked on a structural transformation: integrating addiction care into the public health system. Until then, intervention had relied almost exclusively on NGOs and local organizations, resulting in fragmented care that left much of the affected population without support. The creation of the UCA responded to a clear conviction: addictions are pathologies that deserve the same treatment as any other chronic disease, provided through the public system, with stable resources and specialized professionals.

The UCA were designed as specialized units embedded within the healthcare network, with an outpatient, multidisciplinary, and accessible approach. This design was innovative not only for its functional integration with Primary Care but also for its biopsychosocial model of intervention, which allowed addictive disorders to be addressed

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from a comprehensive perspective: medical, psychological, and social. In practice, this meant opening direct-access care centers, without prior referral, where patients with addiction were treated with the same dignity, confidentiality, and clinical rigor as any other healthcare user.

The impact was immediate. Just one year after implementation, the figures demonstrated a radical change: a 25% increase in treatment initiations for addictions, a 45% increase in new patients treated, and a massive migration from NGOs to public facilities. The message was clear: when the state takes responsibility, citizens respond. The UCA not only improved accessibility but also helped make previously excluded patients visible, contributing to the destigmatization of the drug-dependent and reinforcing the perception that addictions should be treated as a public health issue, not a social deviation.

The Valencian model, unique in Spain at the time, laid the foundation for a modern healthcare strategy in addiction treatment. Other regions began observing its evolution. International recognition soon followed, and today there is no doubt that the UCA model is considered a reference for countries seeking to integrate addiction care into their healthcare systems.

Far from triumphalism, it is necessary to acknowledge that not all achievements are consolidated. More than two decades after their creation, the UCA face significant challenges. First, resources have stagnated. The lack of growth proportional to new demands has generated imbalances between units, incomplete teams, and care overload. Additionally, the patient profile has changed: psychiatric comorbidities, behavioral addictions, and early cannabis use are now more common, phenomena that demand urgent adaptation of the model.

The Valencian Mental Health and Addictions Plan 2024-2027 recognizes these gaps and proposes modernizing the UCA, promoting their integration within a broader community mental health strategy. Addictions cannot be treated in isolation, especially when they coexist with complex mental disorders. Real coordination between mental health services and the UCA is a necessary condition to provide effective responses.

Twenty-eight years after their creation, the UCA remain a paradigmatic example of how well-designed public policy can transform healthcare and social support. Their success lies not only in the number of patients treated but in the paradigm shift they promoted: considering addictions as chronic and complex diseases that deserve professional, free, and dignified care within the public system.

The challenge today is not only to preserve this legacy but also to expand and adapt it. Investing in the UCA is not merely a technical matter; it is a political and ethical decision. In the face of a constantly evolving phenomenon such as addiction, we need agile, well-equipped units connected to the real needs of the population. The UCA have already proven this is possible. Now, it is time to double down on this commitment.