Proyecto Hombre observatory on the profile of drug addicts

2012 REPORT

PROYECTO HOMBRE ASOCIACIÓN

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Obra Social "la Caixa"

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All persons under treatment and their families Thanks for trusting us. Forever thanks.

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PRESENTATION

Luis Manuel Flórez García

President of the association Proyecto Hombre

Proyecto Hombre was born as a supportive answer with regard to the treatment of heroin epidemic. Since the inception of Proyecto Hombre Association in the 80s, it has been an obligation for us to offer an adequate social, humanistic and supportive response to the problems of drug abuse and addiction. Moreover, one of our major objectives has been to adapt ourselves to the realities of the people who suffer from these problems (not just those receiving treatment but families, couples, friends, colleagues...).

Subsequently, our commitment in search of the solution of addiction in general, has evolved into prevention, social and work and we have recently started to expand into research. In any case, the process has been similar: from the learning phase to autonomy, we have always worked in collaboration with both public and private institutions, as well as other NGOs. From the beginning we have been aware of the fact that we alone could not accomplish our mission and that we needed to join forces and unite synergies in the face of such complex and changing a problem as the addiction world is. This conception is inherent to the very notion of "Proyecto Hombre": the national center network makes sense in terms of each of these treatment programmes. Diversity is what unites us; it is the ability to adapt ourselves to the different realities what strengthens us. It is, finally, the comprehensive vision of a national Association to give us an open-mindedness to pass from local to global and back to our surrounding environments. It is a slow but very enriching process.

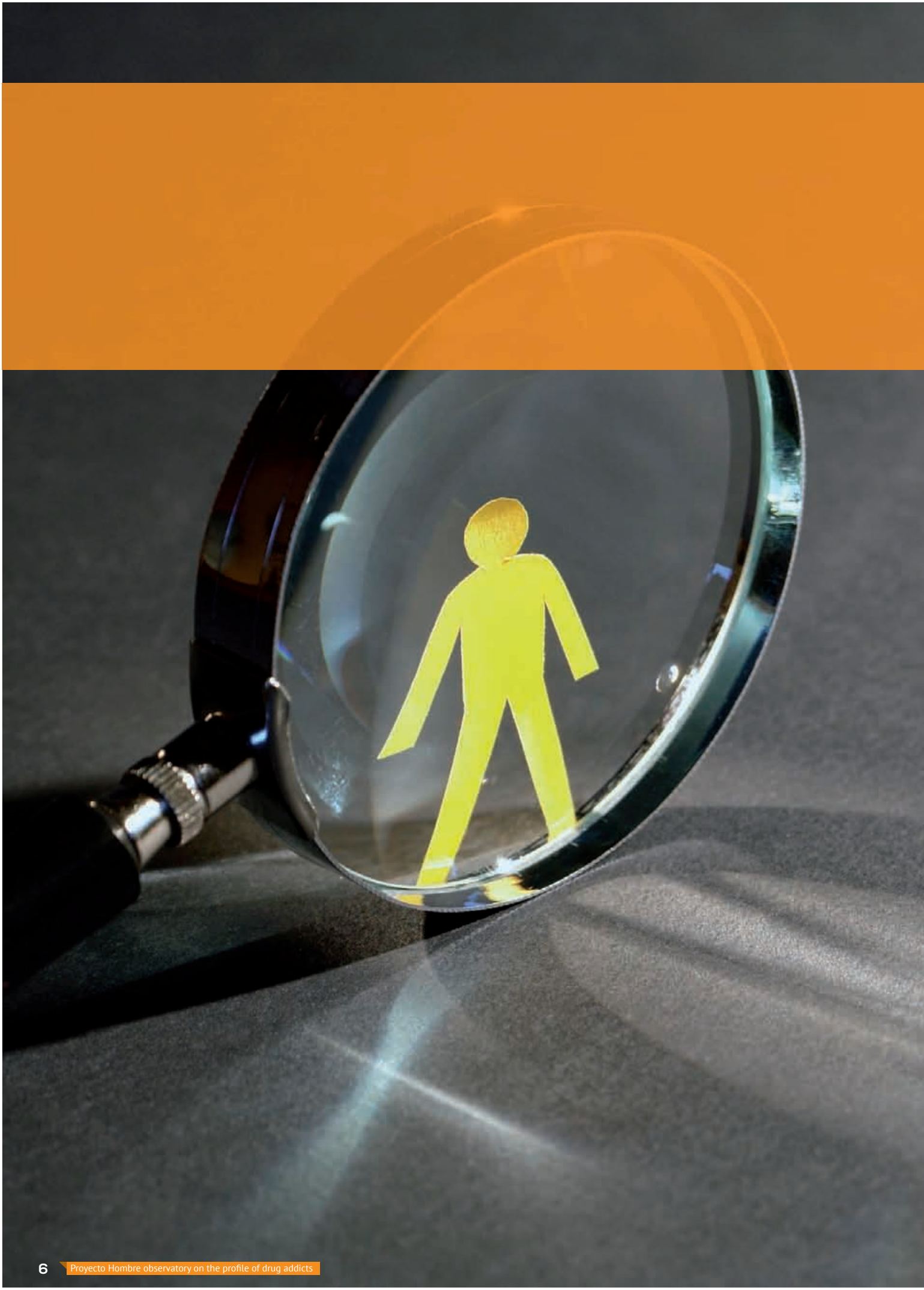
In this report we define a series of characteristics of drug addicted people who have been treated at Proyecto Hombre Centers in 2012. We intend, thus, to adjust the devices and programmes to the personal and social situation of people who, for whatever kind of addictive problem, come to our centers in search of help. We work in pursuit of continuity, in order to continue studying the evolution of the people under treatment in Proyecto Hombre. We need this continuity for us to be able to offer better, more adapted and evolved programmes. In these hard times we are going through, we cannot lose sight of our commitment to work increasingly better. We need to render every euro, every effort, every working hour profitable. In short, we want to be more and more effective and efficient.

In this "Report on the profile of drug addicts" there are several key points which are worth mentioning: our own long-lasting effort aimed at achieving the suitable technical and technological development; the participation of the Centers and Proyecto Hombre programmes all over Spain; the Alliance with the National Drug Plan and Obra Social la Caixa, without which this project would have been impossible; the technical collaboration of the Drug Addiction Institute at Complutense University of Madrid, in addition to other outside consultants who have enabled the preparation of this report; the internal R+D and Assessment commissions; the Training Center of Proyecto Hombre Association...

We wish to mention the opportunity, in the light of the data presented in this 2012 Report issued by Proyecto Hombre Observatory, for public policies in drug dependence and addiction treatment and prevention to be aligned with this project taking this reference for the scientific and sociological value it contains. We believe in partnership with other public and private entities, as a way to achieve our goals. This report is an example of how we can join forces in order to transform our social context, however unfavourable it may be today. We would like to offer this Report non only for its knowledge but for the possible influence on public policies it may have, either in terms of treatment, social and work reintegration, early detection, early intervention and prevention of drug addiction. Proyecto Hombre has offered an outstretched hand to collaborate on these policies with humility and social commitment.

Finally, the fundamental key of this Report is its goal of helping people in treatment. These people and their family and social environment are our true reason for being. None of this would be significant without them. For Proyecto Hombre this effort would be meaningless without the people.

It only remains to thank all participants and all of you. We kindly ask you to read it and think about all that has been written, not forgetting that behind the cold data there are people, human beings who once went down the wrong path but have been able, along with their families, to take a new direction, putting life to years and not years to life.



1

The information collection tool: The EuropASI

The World Health Organization and the American Psychological Association have made great efforts to classify the use-abuse disorders and/or drug addiction. However, many of the tools developed for this purpose have failed to adequately capture the clinical reality, or the clinical severity of individual drug users. Numerous attempts have resulted in gravity rates lacking psychometric characteristics (reliability and validity), concordance or test-retest reliability, which, as a result, have led to partial evaluations of the reality of the individual drug user. These deficient assessment tools hinted at the need to adopt pragmatic measures that would allow us to assess intensity and clinical severity, as well as the need for care and treatment to individual users, in a standardized way.

“The adoption of the ASI in Europe makes sense as to evaluate programmes to determine their efficiency and scientific legitimacy of addiction treatment, professionalization, internalization and unification of a diverse system.”

The most solid attempt to achieve this end is to be found in the EuropASI.

The EuropASI is the European version of the fifth version of the ASI (Addiction Severity Index), developed in the USA by McLlelan, 1990). The ASI was created in 1980 at the University of Pennsylvania with the aim of obtaining an instrument that could deliver relevant information for the initial clinical evaluation of patients with drug abuse problems (including alcohol), and, in this way, of planning their treatment and/or taking patient referral decisions as well as with research purposes. The adoption of the ASI in Europe makes sense as to evaluate programmes to determine their efficiency and scientific legitimacy of addiction treatment, professionalization, internalization and unification of a diverse system. It is a semi-structured and standardized interview, widely used in the clinic for the multidimensional diagnosis of those aspects and areas of life that may have contributed to some extent to substance abuse syndrome, thus allowing a contextualization of the syndrome from a bio-psycho-social perspective (Mayor, 1995). Also, this interview allows assessment of the severity of consumption.

The EuropASI can be used with a threefold purpose. On one hand, an interview is essential in clinical practice. The interview provides information for the doctor to make a multidimensional diagnosis of the addictive problem of the patient at the same time

that relates it to the biological, psychological and social context of the patient. Thus, this information will be vital for the development of a person's full profile to allow the planning of an intervention or holistic treatment, adapted to the reality of each person. A second objective, related to the first one, is the implementation of drug user supervision, once the second interview has been made with the EuropASI, which allows the therapist to have information on the patient's progress, to determine whether some aspect of the patient's context has changed that might lead to restructuring the treatment, etc.

Finally, the EuropASI emerges from the efforts made by a research group to adapt the ASI, in order to use this instrument in European population. Therefore, the third purpose of this interview would be its use in the scientific field by those researchers specializing in the study of drug addiction. This interview makes it possible to obtain severity indices of drug abuse as well as highly relevant socio-demographic information of individuals for the development of this research.

The EuropASI, in addition to exploring drug and alcohol consumption of the individual, one of the central areas of the interview investigates six other areas, in order to further understanding of the reality of the drug addict. Such areas are:

- Physical health (16 items)
- Employment and resources (26 items)
- Drugs and alcohol (28 items)
- Legal status (23 items)
- Family history (51 items)
- Family and social relationships (26 items)
- Mental health (22 items)

Each of these areas consists of a set of objective items and critical items in the assessment, a self-assessment to be made by the patient, a severity assessment to be made by the interviewer and a score of validity of the information obtained that will be also carried out by the interviewer.

Each area has a number of items that are considered as target of the area to be evaluated, within which there is a subgroup of items called critical items that will be those to which the interviewer must pay attention in order to estimate the severity of the individual in that area.

In each area there are two items for the individual's own self-evaluation in which that person will have to indicate on a scale of 0 (none) to 4 (extreme) the degree of discomfort and worries undergone in the last month in that area and the degree to which that person considers important to receive treatment in the above mentioned area.

Gravity in the area is estimated by the interviewer once the entire interview is finished, thus considering the need for treatment or the need to implement a new treatment for the individual in this area on a scale ranging from 0-1 (there is no real problem; treatment, help or diagnosis are not indicated) to 8-9 (extreme problem, treatment is absolutely necessary).

> The EuropASI, in addition to exploring drug and alcohol consumption of the individual, one of the central areas of the interview investigates six other areas, in order to further understanding of the reality of the drug addict.

Finally, the interviewer should assess the validity of the information given by the individual, based on the patient's answers after checking and asking when there is contradictory information (e. g., the patient says that he had no income, but indicates a € 600 spending on drugs). Specifically, the interviewer should assess whether the individual has a distorted image of himself and if he is unable to understand the issues that have been raised.

The EuropASI consists of a series of items marked with an asterisk (those items that involve change) which are the questions that must be reformulated for the EuropASI to be used in a second interview, as a follow-up of the patient. We recommend a second interview within one month of the completion of the first one, in order to evaluate the results of interventions carried out so far.

2

Data analysis

Initially the idea was to develop a General Profile of drug dependencies with the global data drawn from the patients treated in Proyecto Hombre. To do this, a series of indicators from EuropASI were selected to specify that profile. The data collection was done in a transversal way, due to the fact that the EuropASI allows an evolution with a longitudinal trend that we will bring up in future studies (Bobes, 2007).

After selection of these indicators and the sample closing we realized that we could develop drug groups by Segmentation (Escobar, 2007), using the shared characteristics that define or are derived from the consumption of substances (also from other addictive problems, although in the sample are minority). From these groups, we establish a series of homogeneous profiles with common patterns of addiction, as well as proposals for future studies (prospective methodology). Despite the difference in sample size, an analysis of gender indicators has been carried out, describing the main differences among people in treatment in terms of being male or female.

The variables that have been studied, on which profiles have been built, are: age, gender, marital status, family nucleus, family problems, relationship problems, educational level, source of income, debt / financial problems, use of substances, route of administration, time of consumption, age of onset, previous treatments, disease/HIV, overdose/Delirium Tremens, legal status, criminal history. In the overall profile we have also considered the variables of nationality and origin.

We must recognize that the selection of these indicators was determined by the intention of providing practical utility to the study: it is not the usual investigation, but a project to find the main features of those patients attended by Proyecto Hombre during the year 2012.

For the analysis, as previously explained, we could count on the participation of 2,910 people. The procedure allowed us to deal with a number of socio-demographic variables which were grouped according to a predetermined criterion (primary substance, gender). The procedure gave us descriptive statistics for the final profiles.

The statistics used for the analysis were:

- Frequencies: percentages of the different response categories in qualitative variables.
- Medium results: average values of quantitative variables.
- Contrast medium: comparison of medium values obtained in two quantitative variables.
- Coefficients of contingency: indicator of statistical association between variables.
- Anova: comparison of the values obtained in more than two quantitative variables.
- Pearson X2 test: Comparison of the distribution of responses in the different categories of two or more qualitative variables.
- Independent sample test: it allows us to see gender differences (or the main substance) in each of the variables. We used the Levene Test for equality of variances and the T-test for independent samples.
- Multivariate Contrasts: for the analysis of several variables at once, we have also used statistics such as Pillai Trace, Wilks' Lambda, Hotelling's Trace, and Roy's largest root.

In this unit we shall proceed to present the main statistical results. We shall detail some differences, although the most important conclusions are included in section 5. The general data of the total sample can be found in Annex I.

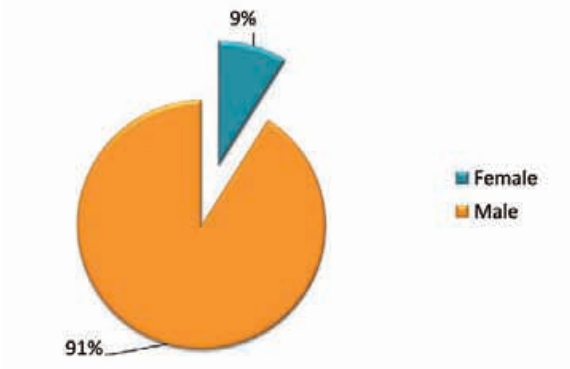
An analysis of gender indicators has been carried out, describing the main differences among people in treatment in terms of being male or female.

2.1. GENERAL DEMOGRAPHIC DATA

GENERAL DATA

Of the 2,910 EuropASI used in the study, 90.9% of the sample were men and 9.1% women.

GENDER BASED SAMPLE DISTRIBUTION



The average age is 35.5 years old (Dt 10'828) with sections ranging in age between 17 and 65. Age frequencies are distributed as follows:

26.4% are in the age group between 18-28 years old.

31'7% is aged between 29-38 years old.

Another 22'3% can be found in the age range of 39-48 years old.

NATIONALITY

99% are Spanish, with very minor percentage of people from other countries (mainly Morocco, Colombia, Portugal, Germany and Ecuador).

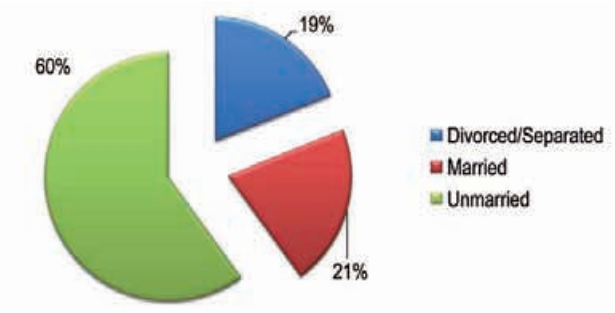
ORIGIN

44.5% of people in treatment come from a city with more than 100,000 inhabitants. 27.6% live in a city of 10,000-100,000 inhabitants. 20% comes from the rural area.

MARITAL STATUS

Of those patients in treatment that were studied, most are unmarried at the time of the interview (60%). Of the rest, 21% were married and 19% were separated or divorced.

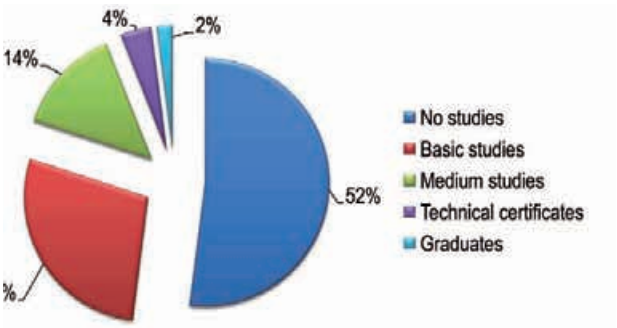
MARITAL STATUS



LEVEL OF EDUCATION

This information is especially significant: 79.2% of the total sample has only basic or no education, and people with media studies represent 14%; 4.1% have a technical certificate, and only 2% are university graduates. In the profile distribution we shall mention the characteristics of this analysis.

LEVEL OF EDUCATION

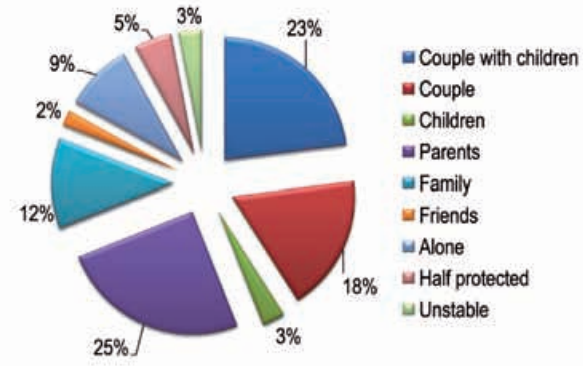


COEXISTENCE NUCLEUS

As for the coexistence nucleus, 9.2% of users live alone; of the rest, most live, namely around 37%, with a member of the biological or nuclear family, 18.1% with a partner, and 23.2% with partner and children and 2.6% only with the children.

With respect to the family of origin, 24.7% reported living with parents, 12.6% with another family member (siblings, grandparents, uncles ...), the 4.8% live in some kind of protected environment (housing supervised / semi-supervised, lodging) and, finally, 3.3% are without stable housing (homeless occasional residences).

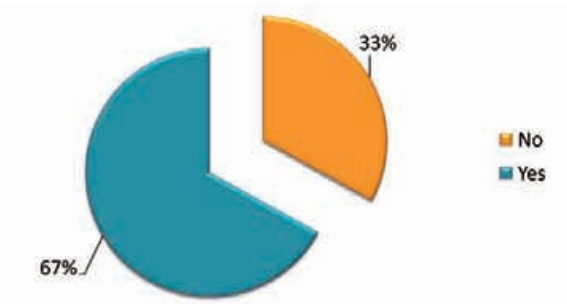
COEXISTENCE NUCLEUS



CONFLICTS AND FAMILY PROBLEMS

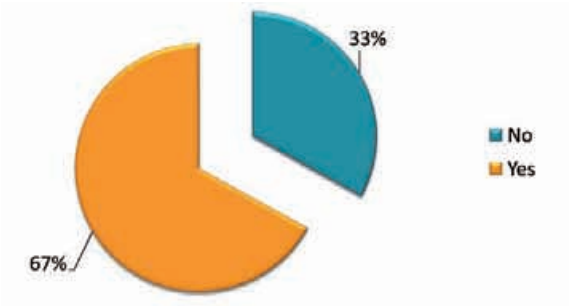
We define "conflict", as described in the "EuropASI Manual", as "serious problems of sufficient duration or intensity to jeopardize the relationship. These are serious conflicts (major disputes, verbal aggression) and not just differences of opinion. They include lack of communication, lack of trust or understanding, hostility or arguments" (Bobes, 2007). 67.4% of the interviewees report having at the time of admission to treatment serious problems regarding the family.

FAMILY PROBLEMS



A similar percentage (67.3%) acknowledges having relationship problems.

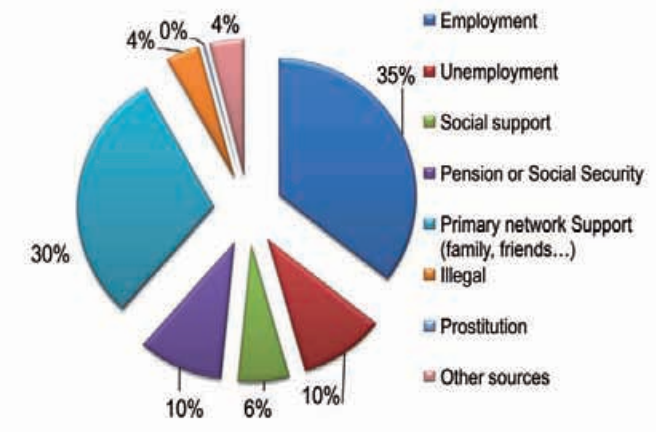
RELATIONSHIP PROBLEMS



SOURCES OF INCOME / EMPLOYMENT PATTERN

Approximately 46% is part of the active population (35'3% in paid employment, and 10.5% in unemployment compensation). In terms of sources of income of the rest of the sample, they are shared between friends and family support (30.7%) and social benefits, pension or social security (9.6%).

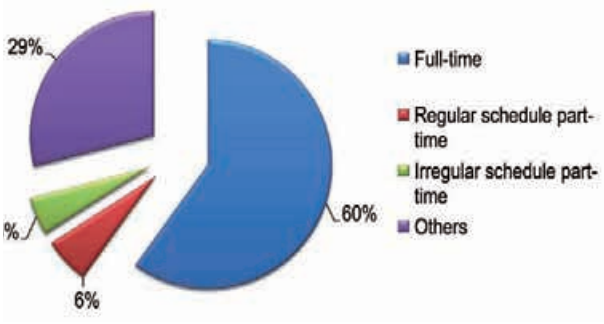
SOURCES OF INCOME



On a minority level, people in treatment receive income from illegal activities (3.8%), prostitution (0.2%), etc.

As for the pattern of employment, 60'2% work full time, 6'1% are regular schedule part-timers and 4'9% are irregular schedule part-timers.

WORKDAY



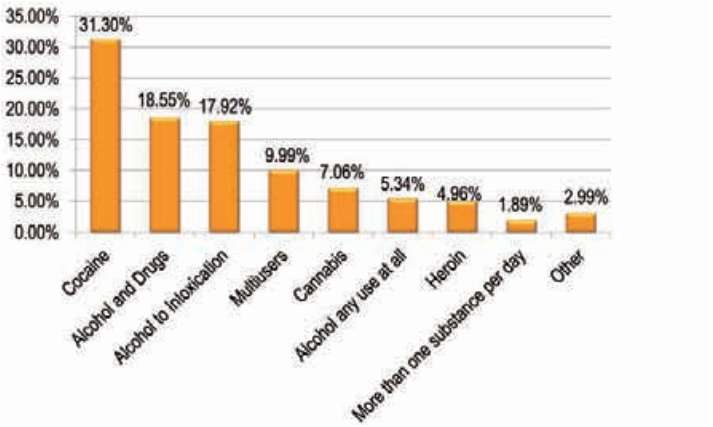
SUBSTANCE USE

With respect to the main used substance (reason for seeking treatment):

- The most abused, alone or with other drugs, is alcohol (41.7%), both by people who admit they have a problem with alcohol (whether large quantities as any type of consumption) and those that consume alcohol and other drugs (double addiction).
- The next substance recognized as main reason for treatment or primary substance is cocaine (31.4%) via snort or nasal.
- 12% of our patients declare that they are multiusers of psychoactive substances, especially the mix of "heroin-cocaine" called "speedball" or "scrambled". Above all, they use inhalants, being a minority that uses the parenteral route.

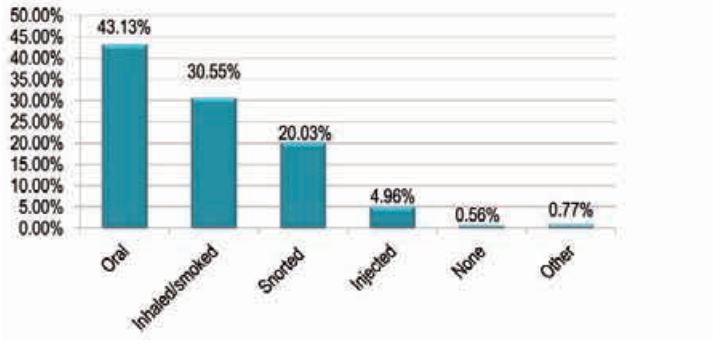
In a smaller percentage we also find cannabis to be the main substance (7%), amphetamines (0.8%), and benzodiazepines (0'6%). Heroin as the primary substance should be mentioned separately: although there are some patients who admit to be essentially heroin users (5.1%), the concept "multiuser" has features that allow us to integrate both groups in a single profile.

MAIN SUBSTANCE FOR WHICH TREATMENT IS DEMANDED



The most common administration routes are oral (43.1%), inhaling / smoking (30.8%) and snorting (19,9%). Injected form occurs in only 5% of cases.

ADMINISTRATION ROUTES

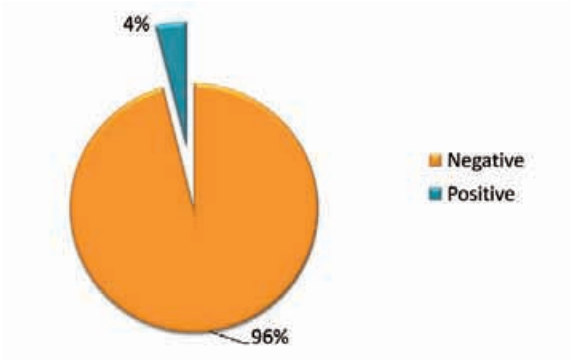


The average age of problematic use onset of the main substance which demands treatment is 19.8 years old. The average consumption time, measured in years, before seeking treatment is fourteen years .

HEALTH

In relation to health and disease indicators, given the relevance it has had on drug addiction programmes in Spain, it should be noted that only 4.2% of Proyecto Hombre users that participated in the survey, received a positive HIV test, with analysis performed in the six months prior to treatment. Subsequently we shall mention the profile associated with HIV infection.

HIV

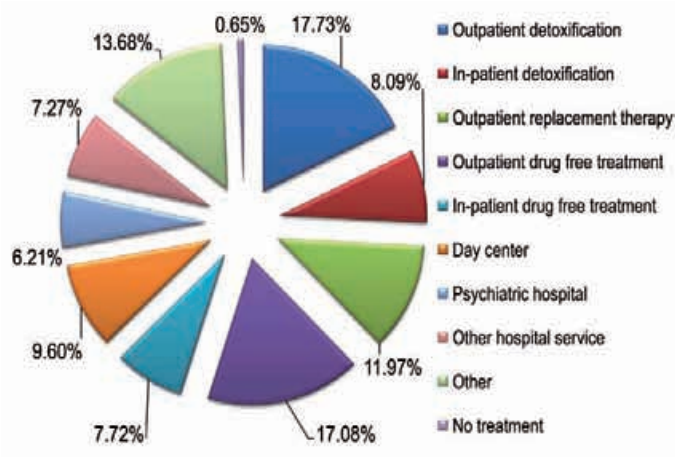


As for how often people in treatment have suffered overdose or delirium tremens, approximately 50% have suffered some critical episode (0'48 overdose per person, 0'5 delirium tremens per person).

Regarding admissions prior to treatment, most patients have received (or receive in parallel) treatment through other network resources, outpatient treatment having the greatest impact. In this way, outpatient detoxification is the first, followed by outpatient drug free treatment, outpatient replacement therapy, and the day center.

The value attributable to other treatments is 13.68%.

ADMISSION TO PREVIOUS TREATMENTS

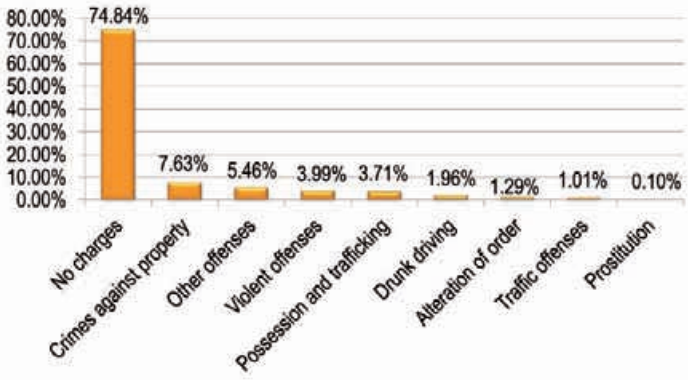


LEGAL SITUATION

The 34.5% of Proyecto Hombre patients declare having committed some minor offenses. Also this data is closely linked to a particular profile of users that we shall describe in groups according to variables.

Upon completion of treatment, most of the people attended (74.8%) claimed to be without charge. The most frequent misdemeanours committed by people that did have charges include crimes against property (7.8%), violent offenses (4%), drug possession and trafficking (3.8%) and other offenses (5.4%).

CURRENT LEGAL SITUATION



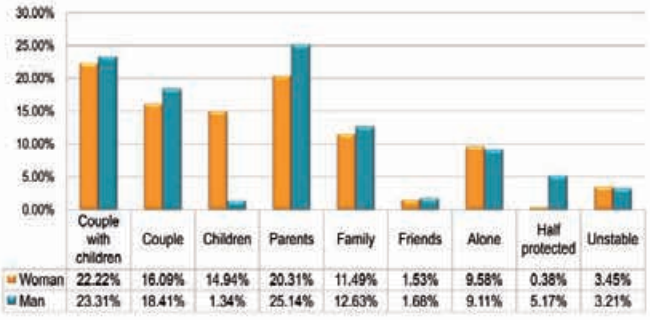
2.2. GENDER BASED SOCIODEMOGRAPHIC DATA

GENERAL

Regarding global percentages of access to treatment, as mentioned above, the number of women who receive it in comparison to men is of a woman for every nine men. Therefore, we must interpret the data taking into account the difference in sample sizes between the two sexes. This limitation has been presented in some research works by Nuria Romo (Romo, 2002) among other researchers. Women access to treatment remains an objective to develop in Proyecto Hombre centers.

One of the issues that Romo explains in her studies is the perception of family responsibilities assumed by women addicts. In this case, it should be noted the difference: the percentage of women with dependent children is 37'3% while only 24'6% of men is in this situation.

WOMAN - MAN COMPARATIVE ANALYSIS: COEXISTENCE NUCLEUS



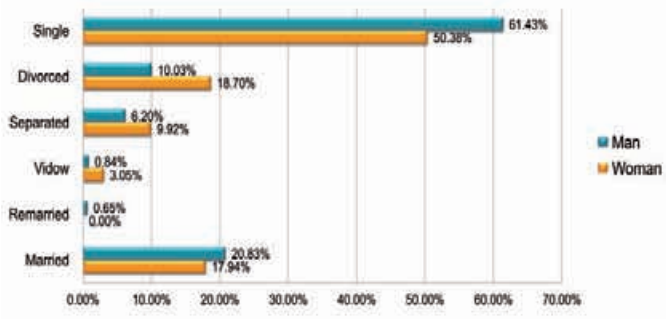
	Couple with children	Couple	Children	Parents	Family	Friends	Alone	Half protected	Unstable
Woman	22.22%	16.09%	14.94%	20.31%	11.49%	1.53%	9.58%	0.38%	3.45%
Man	23.31%	18.41%	1.34%	25.14%	12.63%	1.68%	9.11%	5.17%	3.21%

No differences were observed in terms of the average age of both groups.

MARITAL STATUS

The percentage of single males in treatment is higher than in women (61'4% vs. 50'4%). To this difference should be added a nuance in the percentage corresponding to the global set of situations where there exists a break-up (separation, divorce, widowhood), which is also higher in women (31.8% vs. 18%).

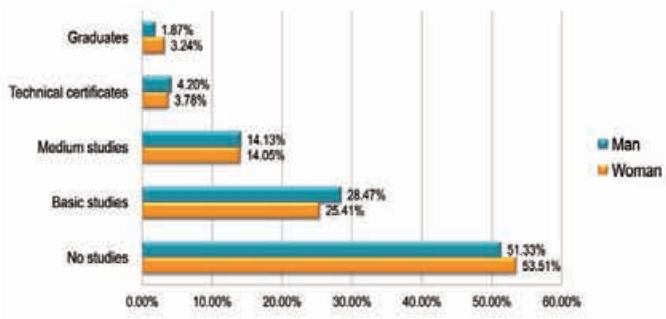
GENDER BASED COMPARATIVE ANALYSIS: MARITAL STATUS



LEVEL OF EDUCATION

In respect to the level of education, there are not significant differences, being the distribution of the percentages very similar in terms of educational level.

GENDER BASED COMPARATIVE ANALYSIS: LEVEL OF EDUCATION

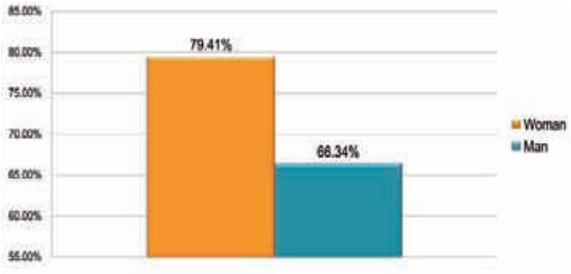


COEXISTENCE AND FAMILY PROBLEMS

We have found matter of analysis in the perception that men and women have of these problems.

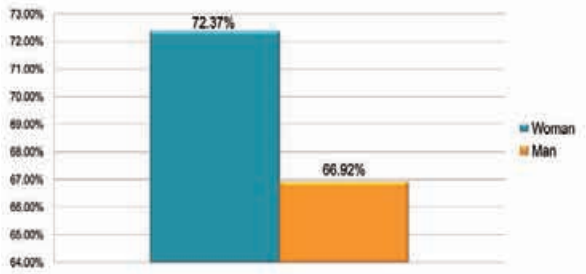
- With respect to the perception of family problems there are some differences, the percentage of which is 79.4% in women and 66.3% in men.

WOMAN - MAN COMPARATIVE ANALYSIS: FAMILY PROBLEMS



- There are also differences regarding the perception of problems with a partner: 67% of men find they have problems with their partner, compared to 72.3 in women.

WOMAN - MAN COMPARATIVE ANALYSIS: RELATIONSHIP PROBLEMS

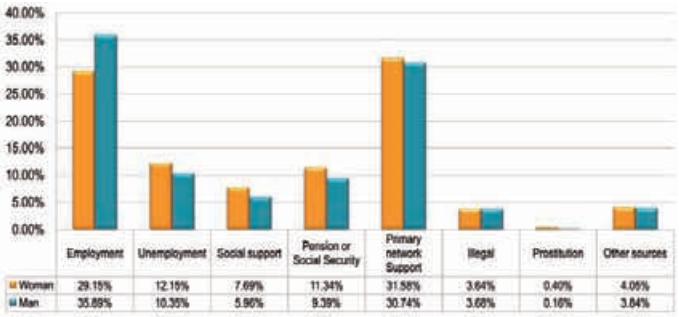


In both cases, women show greater sensibility to detection and acknowledgement of these problems.

SOURCES OF INCOME

In regard to the source of income, the only notable difference is that 29.1% of women say that their biggest source of income in the last month, before starting treatment, was their work compared to 35.9% of men.

WOMAN - MAN COMPARATIVE ANALYSIS: SOURCE OF INCOME



	Employment	Unemployment	Social support	Pension or Social Security	Primary network Support	Illegal	Prostitution	Other sources
Woman	29.15%	12.15%	7.69%	11.34%	31.58%	3.64%	0.40%	4.05%
Man	35.89%	10.35%	5.96%	9.39%	30.74%	3.68%	0.16%	3.84%

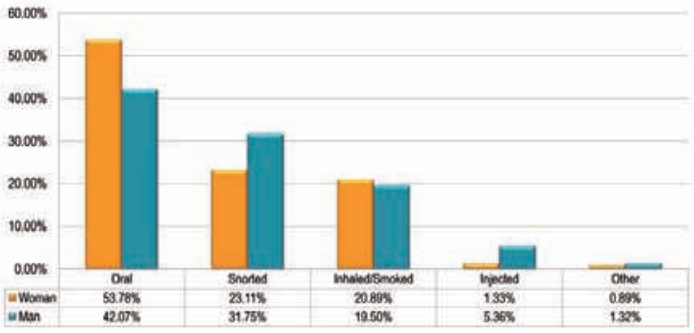
Of women, 3.5% declare themselves to be polyconsumers, compared to 10.6% of men. 31.75 % of men and 20.95% of women choose to use inhalants.

USE OF SUBSTANCES

There are differences between men and women in the main substances they use.

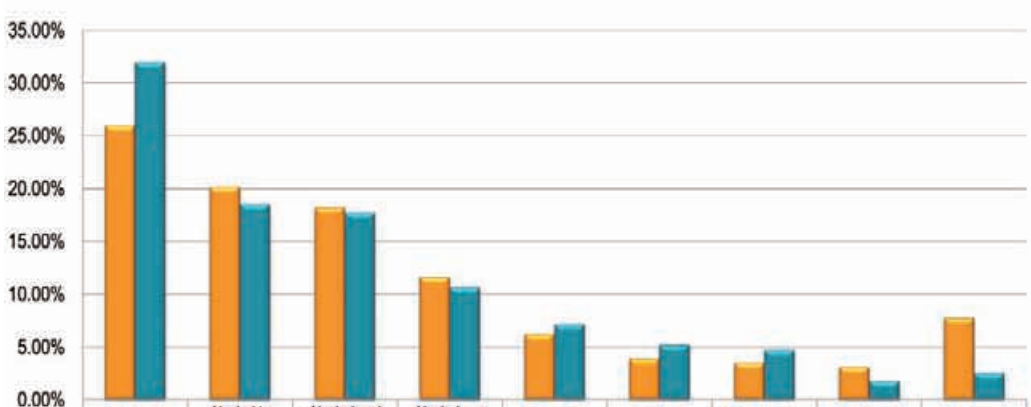
First, the preferred substance used by women is alcohol and the second highest use corresponds to cocaine. In men the percentage is just the opposite: there is a higher percentage of cocaine users, followed by the percentage of alcohol consumers. Men present a higher percentage of polydrug. In women we find a higher percentage of consumers of other substances (psychotropic drugs). Besides, we found a higher percentage of women related to problems without substance abuse.

WOMAN - MAN COMPARATIVE ANALYSIS: ADMINISTRATION ROUTE



	Oral	Snorted	Inhaled/Smoked	Injected	Other
Woman	53.78%	23.11%	20.89%	1.33%	0.89%
Man	42.07%	31.75%	19.50%	5.36%	1.32%

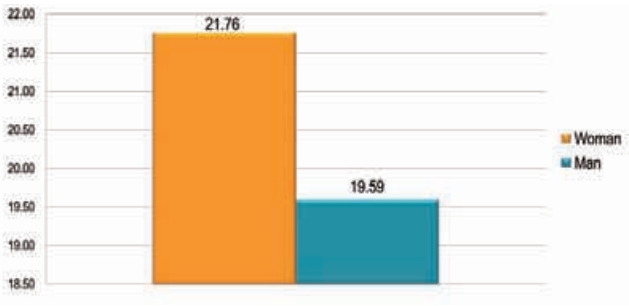
WOMAN - MAN COMPARATIVE ANALYSIS: MAIN SUBSTANCE FOR WHICH TREATMENT IS DEMANDED



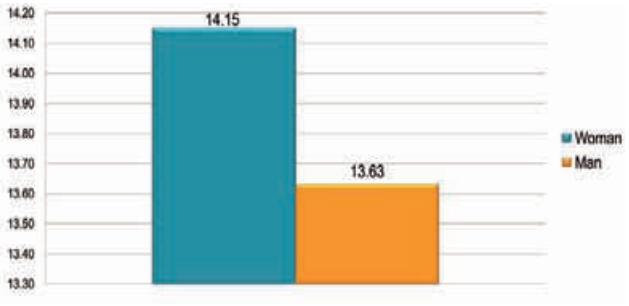
	Cocaine	Alcohol to Intoxication	Alcohol and Drugs	Alcohol any use at all	Cannabis	Heroin	Policomsuption	Anphetamines	Other
Woman	25.87%	20.08%	18.15%	11.58%	6.18%	3.86%	3.47%	3.09%	7.71%
Man	31.94%	18.48%	17.68%	10.62%	7.13%	5.18%	4.72%	1.76%	2.50%

The average age at onset of primary substance use is higher among women (21.8 years) than men (19.6 years).

WOMAN - MAN COMPARATIVE ANALYSIS: AVERAGE AGE AT DRUG USE ONSET (YEARS)



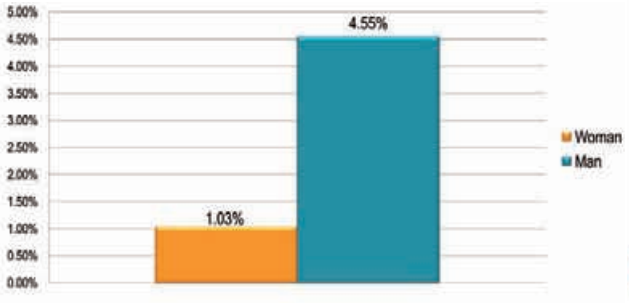
WOMAN - MAN COMPARATIVE ANALYSIS: AVERAGE TIME OF DRUG USE (YEARS)



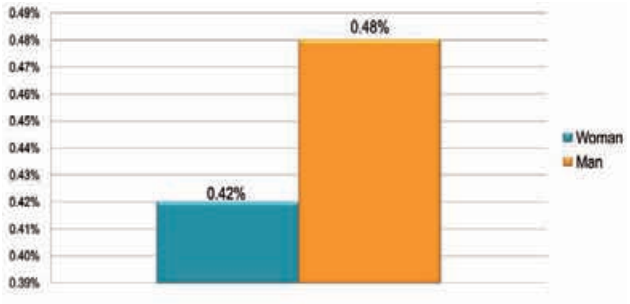
HEALTH

With reference to the incidence rate of HIV-AIDS among people under treatment included in this study (4.2%), the male population has a higher percentage (4.5%) than the female population (1%).

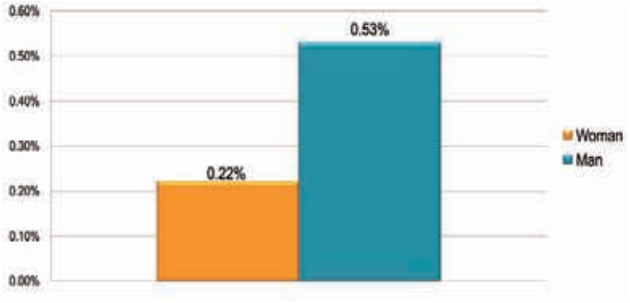
WOMAN - MAN COMPARATIVE ANALYSIS: HIV POSITIVE



WOMAN - MAN COMPARATIVE ANALYSIS: OVERDOSE

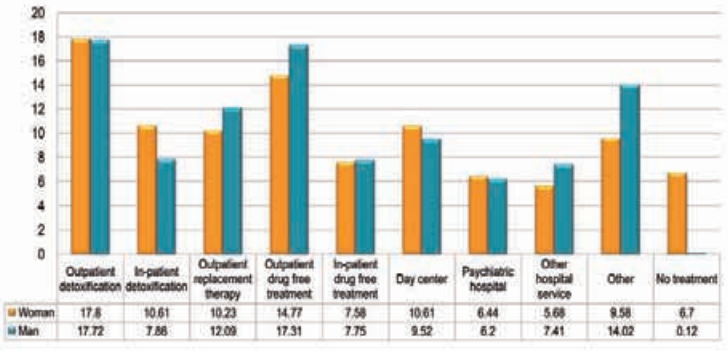


WOMAN - MAN COMPARATIVE ANALYSIS: DELIRIUM TREMENS

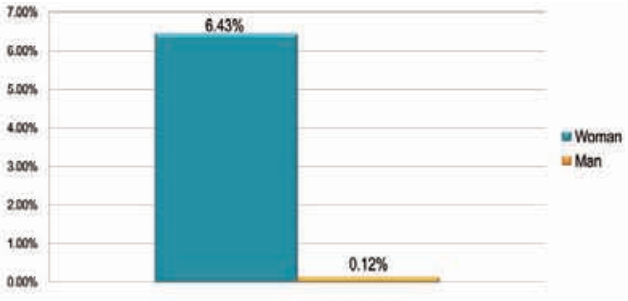


As for previous admissions to treatment, we find a higher percentage of women who have not previously accessed to treatment (6.43%) than men (0.12%). In this way, Proyecto Hombre is their first admission to a programme of addiction treatment.

WOMAN - MAN COMPARATIVE ANALYSIS: PREVIOUS TREATMENTS (DISPERSED)



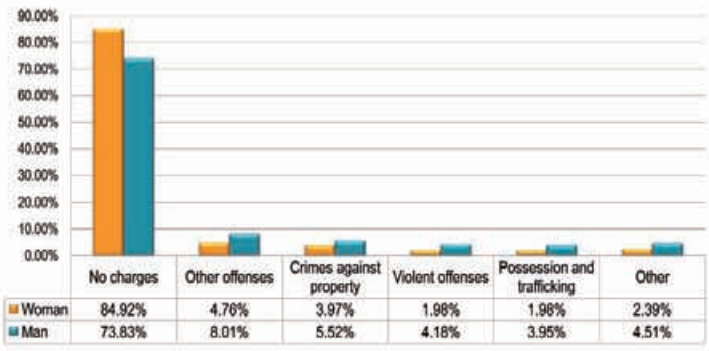
GENDER BASED COMPORATIVE ANALYSIS: WITHOUT PREVIOUS...



LEGAL SITUATION

Finally, there is a greater incidence of male population that has committed offenses (36.2%), in comparison to female population (16.5%).

WOMAN - MAN COMPARATIVE ANALYSIS: CURRENT LEGAL SITUATION



	No charges	Other offenses	Crimes against property	Violent offenses	Possession and trafficking	Other
Woman	84.92%	4.76%	3.97%	1.98%	1.98%	2.39%
Man	73.83%	8.01%	5.52%	4.18%	3.95%	4.51%

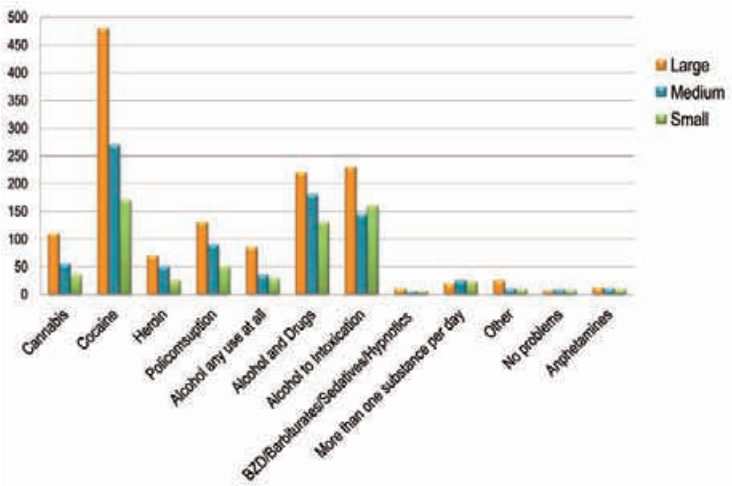
At the time of data collection, both groups are above 70% of the people without charges, the percentage of women (84.9%) being higher than that of men (73.8%).

2.3. DEMOGRAPHIC DATA PER SUBSTANCES

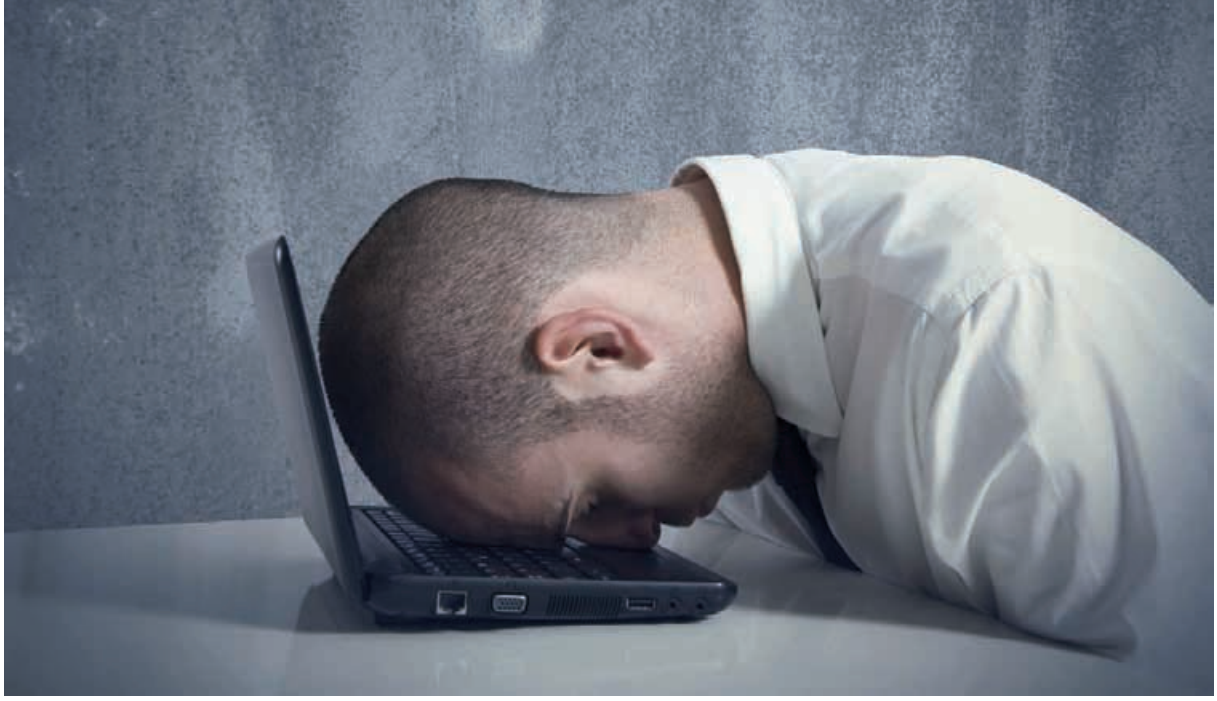
As discussed above, once completed the analysis of the general sample we decided to classify drug addicts according to the main substance of consumption, in order to identify the main variables identified with each type of user. We shall comment some of the differences we have found and we shall establish profiles of patients.

ORIGIN OF SUBSTANCES

COMPARATIVE ANALYSIS OF SUBSTANCES: ORIGIN



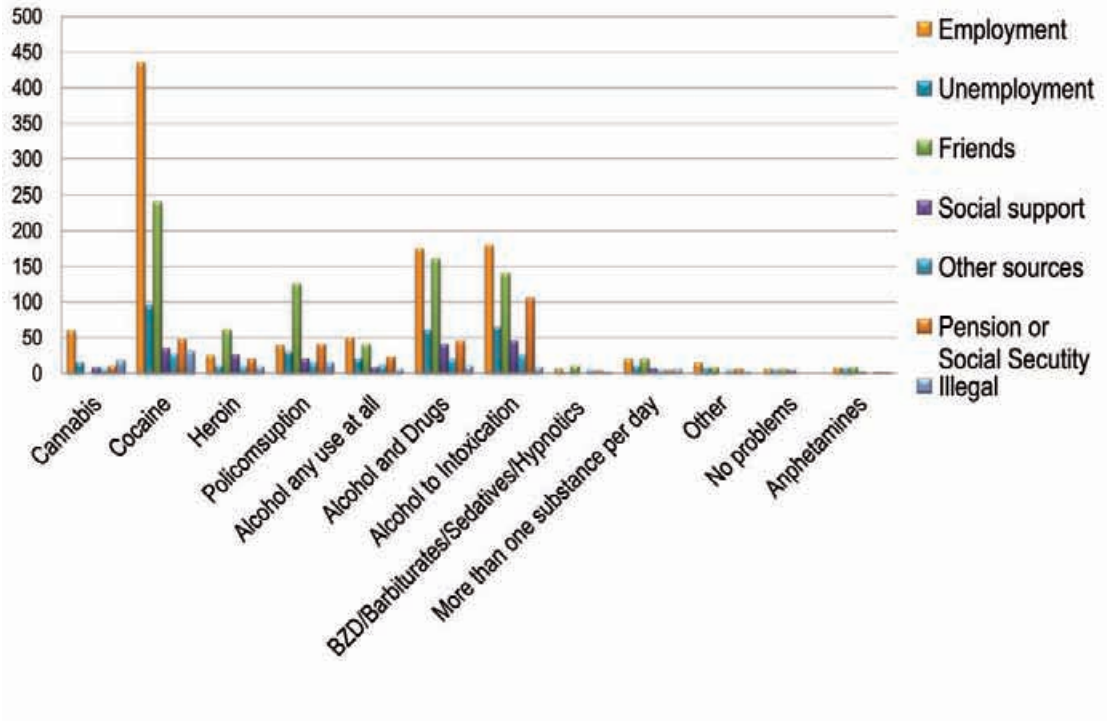
The graph indicates that the highest proportion of people from rural areas consumes alcohol in large quantities (bar 7). In urban areas, the largest consumption is of cocaine (bar 2) as main substance. We can observe alcohol and drugs (bar 6) are very homogeneous in the three areas of origin.



SOURCE OF INCOME / EMPLOYMENT STATUS

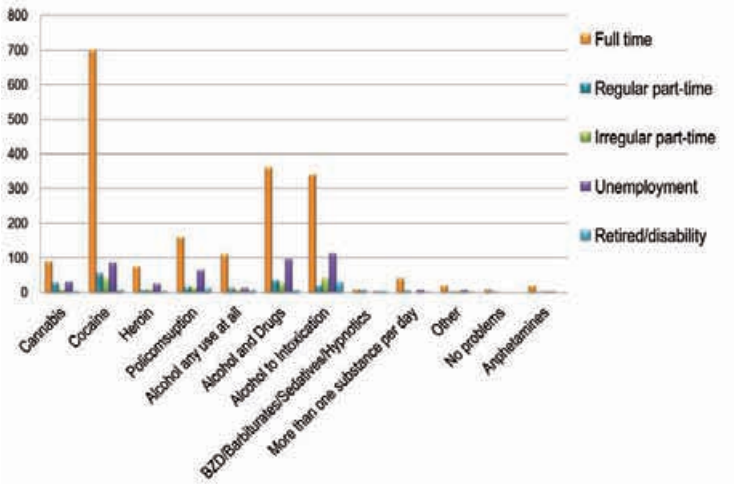
So, we can highlight that, of those whose main source of income is work, 48.3% use cocaine and 35% alcohol. Employment is the main source of income only for 19.6% of heroin users and 14.1% of polydrug addicts.

COMPARATIVE ANALYSIS OF SUBSTANCES:
SOURCE OF INCOME / EMPLOYMENT STATUS



As for the employment pattern, we find the following distribution:

COMPARATIVE ANALYSIS OF SUBSTANCES: EMPLOYMENT PATTERN

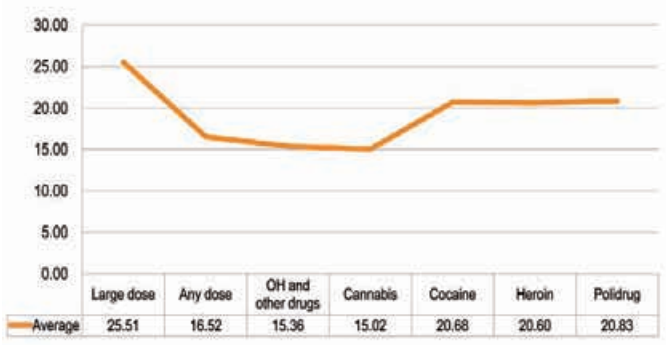


Again, it is clear that people using cocaine (bar 5) and alcohol (bars 6 and 7), are those having a higher stable work pattern (they also have easier access to unemployment benefit for having worked previously).

AGE DURING TREATMENT/ YEARS OF CONSUMPTION

With regard to the age of onset, substances used more prematurely are cannabis (15'33 years on average, DT 3'253) and alcohol (16'61 years, SD 6'381). Late substances as major problem are alcohol in large amounts (25.4 years, DT 10'245) and benzodiazepines (23'67 years DT 10'828).

COMPARATIVE ANALYSIS OF SUBSTANCES: AVERAGE AGE AT ONSET OF DRUG ABUSE

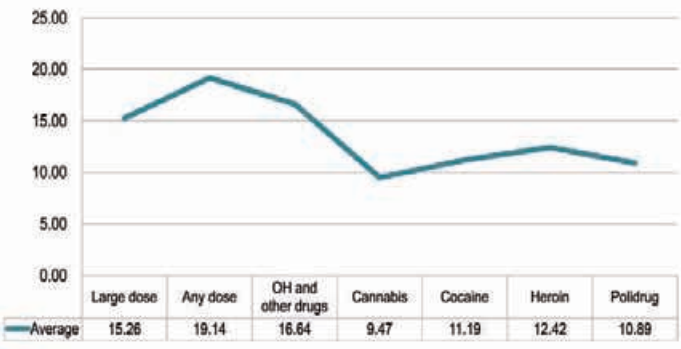


	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
Average	25.51	16.52	15.36	15.02	20.68	20.60	20.83

The average age of people that recognize specific problems with alcohol is 42.7 years, significantly higher than the average age of people who use the rest of substances, which is around 35 years. Also the cannabis group has a lower average age, which is 26 years.

The average consumption age before starting treatment, with regard to any dose of alcohol is 19 years (SD 12'552). As for alcohol users in large quantities is 15 years (SD 10'371). For polydrug users is 14.4 years (12'478 DT). For cocaine addicts is 11.5 years (SD 8'376), cannabis 9.5 years (SD 6'783) and heroin 12.4 years (7'766 DT). These data indicate that people who consume alcohol take longer to request treatment, perhaps because of the social acceptance of its consumption and the difficulty in becoming aware of the problem.

COMPARATIVE ANALYSIS OF SUBSTANCES: AVERAGE USE (YEARS)

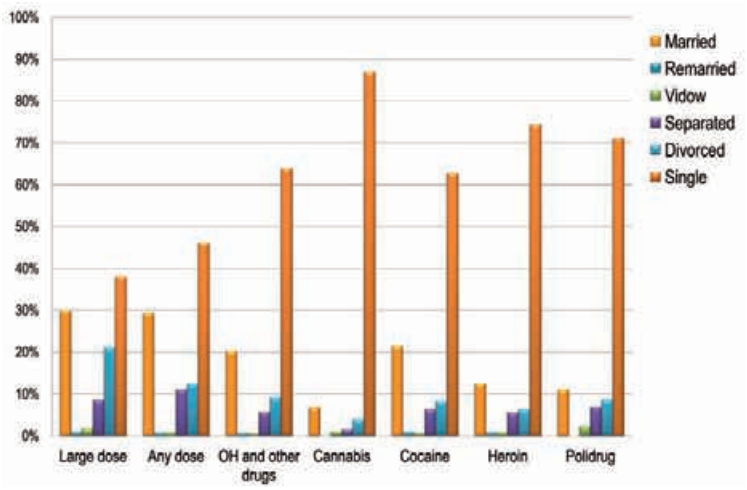


	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
Average	15.26	19.14	16.64	9.47	11.19	12.42	10.89

MARITAL STATUS

In terms of marital status, 86.9% of cannabis users are single; the same as 74.3% of people who use heroin, 71.1% of polydrug users, 62.7% of cocaine, 37.9% of people who consume alcohol in large quantities or 46% in any dose, are single.

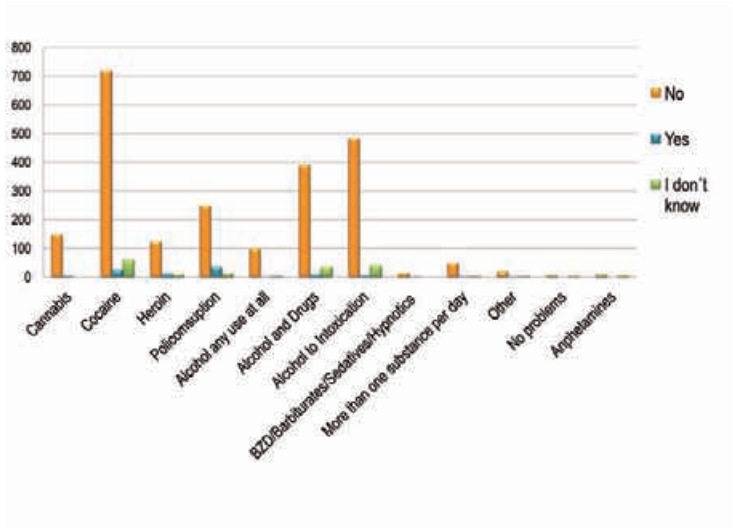
COMPARATIVE ANALYSIS OF SUBSTANCES: MARITAL STATUS



HEALTH

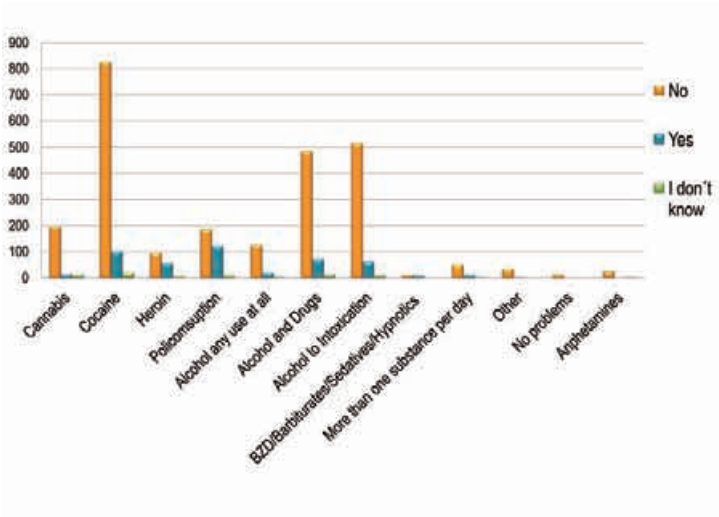
Profiles with higher incidence of HIV-AIDS are polydrug use (11.5%) and heroin (7.5%). Remarkable are the incidences of HIV infection in "Alcohol and drugs" (3.4%) and cocaine users (3.8%), with interpretations different from the aforementioned profiles.

COMPARATIVE ANALYSIS OF SUBSTANCES: HIV



Regarding other infections, such as Hepatitis C, we find the following data:

COMPARATIVE ANALYSIS OF SUBSTANCES: HEPATITIS C



In proportion, the groups which reflect more cases of Hepatitis C are among heroin users and polydrug (bars 3 and 4).

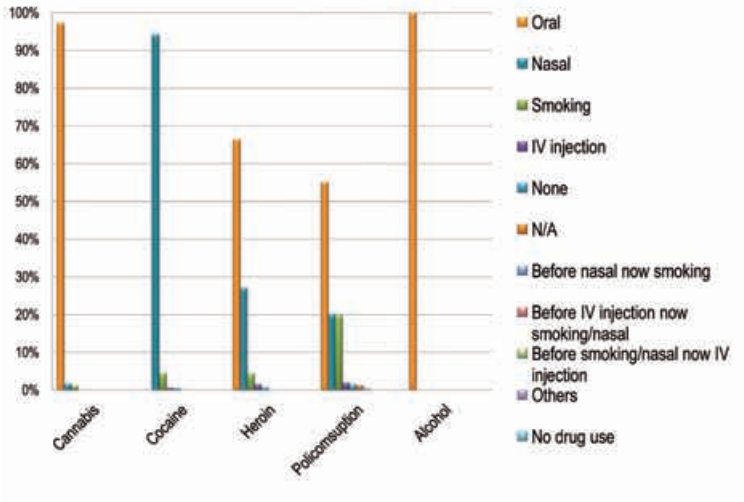
As for overdoses, the outstanding profile in this critical episode is the heroin group (1.09 episodes per person) and also polydrug users (1.27 episodes per person).

In relation to episodes of delirium tremens, 1'22 episodes per person in consumers of alcohol in any dose.

ADMINISTRATION ROUTES

In relation to administration routes, the injected one is used only by 4'99% of people treated according to the general sample, this group corresponding to 27'14% of heroin users and 19'77% of polydrug who maintain that route. 55.13% of polydrug users and 66'43% of heroin addicts use the smoking or inhalation routes. Cocaine users mostly choose the nasal or snorted routes.

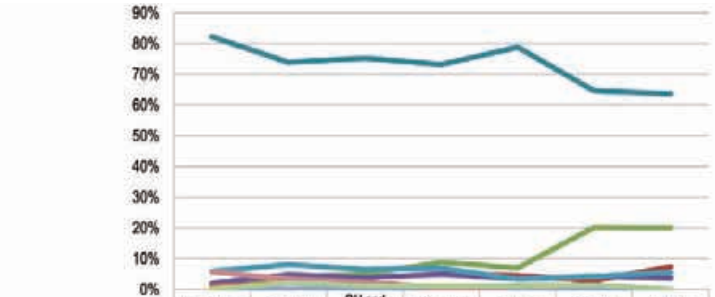
COMPARATIVE ANALYSIS OF SUBSTANCES: ADMINISTRATION ROUTES



LEGAL SITUATION

With respect to offenses, 66% of polidrug users, and 64.6% of heroin users accept having committed some kind of offense. Percentages are lower in cocaine users (28'48%), cannabis (30%) as well as alcohol and drug users (33%).

COMPARATIVE ANALYSIS OF SUBSTANCES: CURRENT LEGAL SITUATION

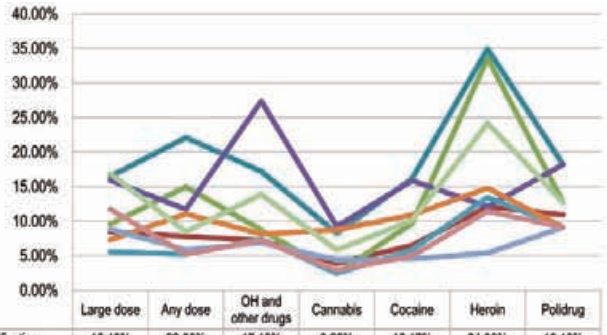


	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
No charges	82.17%	73.83%	75.24%	73.17%	78.79%	64.58%	63.64%
Other offenses	1.16%	2.01%	3.78%	4.88%	4.46%	2.78%	7.27%
Crimes against property	1.94%	4.03%	4.91%	8.78%	6.92%	20.14%	20.00%
Violent offenses	1.94%	4.70%	3.78%	4.88%	3.46%	4.17%	3.64%
Possession and trafficking	5.81%	8.05%	6.43%	6.83%	3.24%	4.17%	5.45%
Alteration of order	0.78%	2.01%	2.27%	0.49%	1.23%	1.39%	0.00%
Drunk driving	0.00%	0.00%	0.19%	0.00%	0.00%	0.00%	0.00%
Traffic offenses	5.62%	3.36%	2.27%	0.00%	0.89%	1.39%	0.00%
Prostitution	0.00%	2.01%	1.13%	0.98%	1.00%	1.39%	0.00%

PREVIOUS TREATMENTS

People using heroin (35%) or polydrug (24.8%) have been in a higher percentage in detoxification programmes, either outpatient (12.1%), and in-patient (16'3%). 33.5% of hheroin users have been part of a replacement programme. 24.5% of polydrug users have also participated in maintenance programmes (methadone).

COMPARATIVE ANALYSIS OF SUBSTANCES: ADMISSION TO PREVIOUS TREATMENT

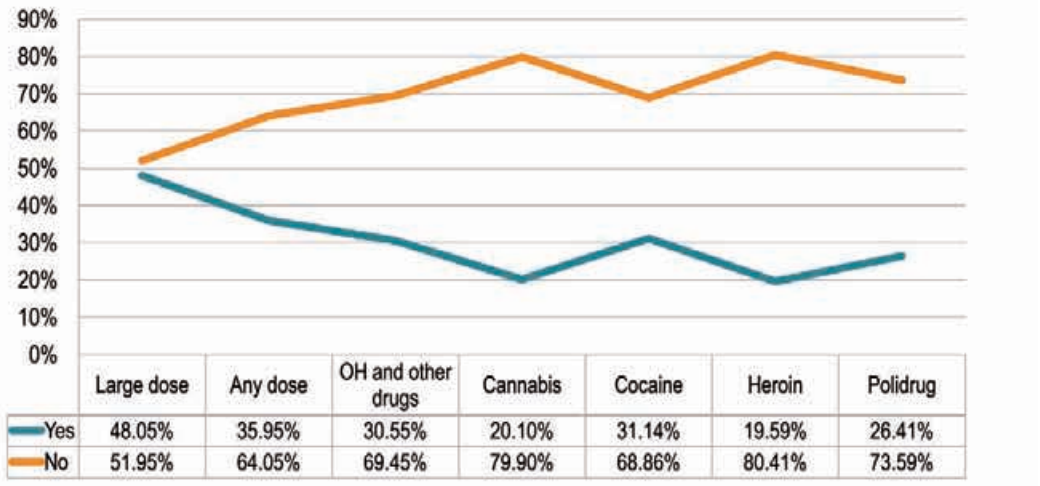


	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
Outpatient detoxification	16.48%	22.08%	17.19%	8.25%	16.17%	34.90%	18.18%
In-patient detoxification	8.43%	7.79%	7.21%	3.88%	6.49%	12.08%	10.91%
Replacement therapy	9.58%	14.94%	8.69%	2.43%	9.68%	33.56%	12.73%
Outpatient drug free treatment	15.90%	11.69%	27.36%	9.22%	15.84%	12.08%	18.18%
In-patient drug free treatment	5.56%	5.19%	7.39%	2.43%	5.83%	13.42%	9.09%
Day center	7.28%	11.04%	8.13%	8.74%	10.89%	14.77%	9.09%
Psychiatric hospital	8.81%	5.84%	6.84%	4.37%	4.51%	5.37%	9.09%
Other hospital service	11.69%	5.19%	7.21%	2.91%	4.95%	11.41%	9.09%
Other	16.86%	8.44%	13.86%	5.83%	10.12%	24.16%	12.73%

MARRIAGE AND FAMILY CONFLICT

Marital problems have higher rates among heroin users (80.4%) followed by cannabis (79.9%), and polydrug users (73.6%).

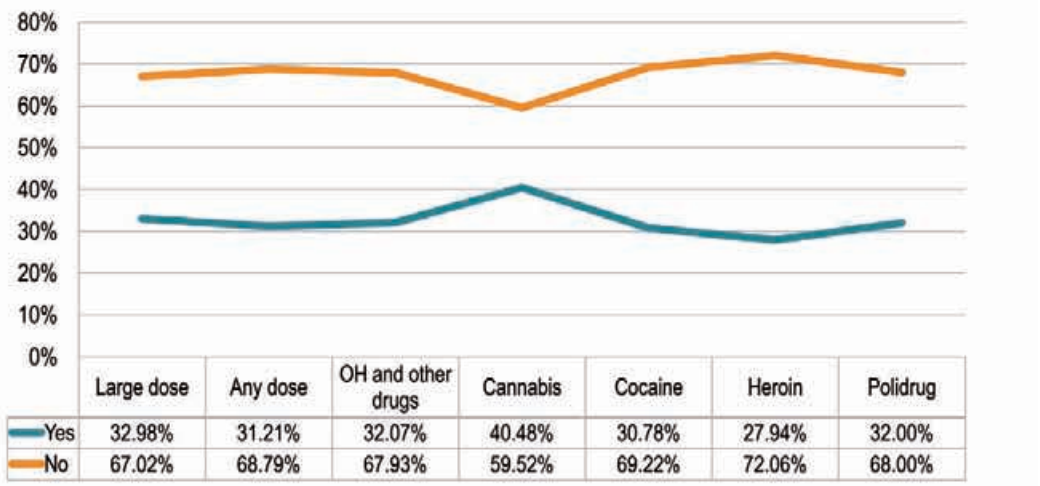
COMPARATIVE ANALYSIS OF SUBSTANCES: RELATIONSHIP PROBLEMS



	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
Yes	48.05%	35.95%	30.55%	20.10%	31.14%	19.59%	26.41%
No	51.95%	64.05%	69.45%	79.90%	68.86%	80.41%	73.59%

As for family problems, the percentage is similar in all (approximately 68%), except in the case of cannabis, which is 59.5%.

COMPARATIVE ANALYSIS OF SUBSTANCES: FAMILY PROBLEMS



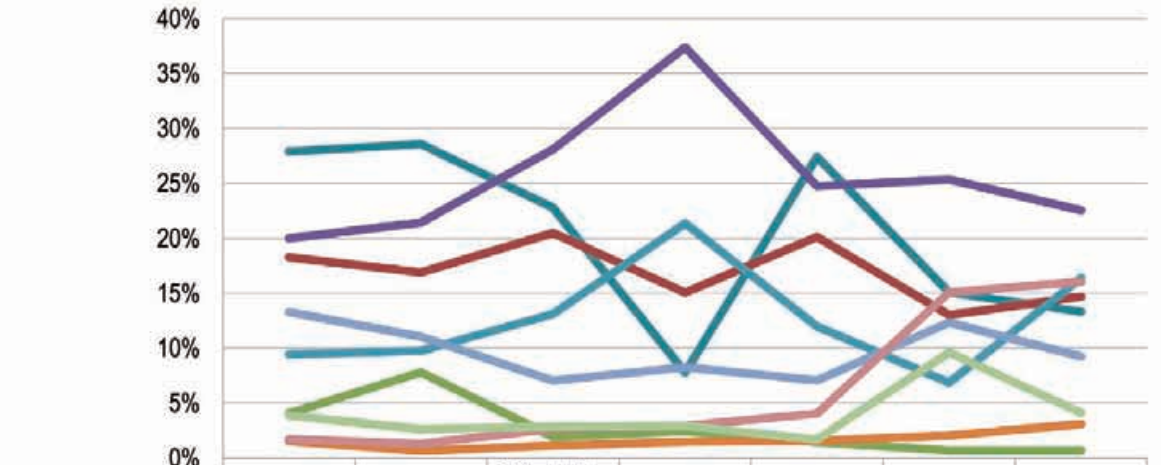
	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
Yes	32.98%	31.21%	32.07%	40.48%	30.78%	27.94%	32.00%
No	67.02%	68.79%	67.93%	59.52%	69.22%	72.06%	68.00%

COEXISTENCE

There are two peculiarities in this indicator:

- Individuals using cannabis live with their families of origin in 58% of cases.
- Individuals using heroin and people with polydrug problems live in protected or unstable milieu in 24'6% and 20'1% of cases respectively.

COMPARATIVE ANALYSIS OF SUBSTANCES: COEXISTENCE NUCLEUS



	Large dose	Any dose	OH and other drugs	Cannabis	Cocaine	Heroin	Polidrug
Couple with children	27.88%	28.57%	22.77%	7.77%	27.40%	15.07%	13.31%
Couple	18.27%	16.88%	20.49%	15.05%	20.13%	13.01%	14.68%
Children	4.04%	7.79%	1.90%	2.43%	1.45%	0.68%	0.68%
Parents	20.00%	21.43%	28.08%	37.38%	24.72%	25.34%	22.53%
Family	9.42%	9.74%	13.09%	21.36%	11.97%	6.85%	16.38%
Friends	1.54%	0.65%	1.14%	1.49%	1.57%	2.05%	3.07%
Single	13.27%	11.04%	7.02%	8.25%	7.05%	12.33%	9.22%
Half protected	1.73%	1.30%	2.66%	2.91%	4.03%	15.07%	16.04%
Unstable	3.85%	2.60%	2.85%	2.91%	1.68%	9.59%	4.10%

After analyzing the data, there was the possibility of extracting four profiles of individuals under treatment involving different characteristics. We have grouped into one of these profiles heroin and polydrug use, based on similar characteristics:

A.Profile whose main consumption substance is **Alcohol:**

- With a higher average age and longer consumption time.
- Married couples and structured coexistence nucleus.
- With marriage and family problems.
- Although composed mostly of men, has it the highest percentage of women under treatment.
- Over a third of these users have employment as a source of income.
- Does not present infections (HIV or hepatitis C).
- It has a lower percentage of legal problems.
- Their previous treatments have been mostly outpatient (either detoxification or drug-free).

B.Profile whose main consumption substance is **Cocaine:**

- They are mostly men.
- Employed in 50% of cases.
- Most of them are singles (although less than heroin and polydrug users).
- With marriage and family problems (those with recognized partners).
- Have an average age younger than alcohol consumers.
- They are not very stable in the maintenance of the couple. In this aspect, they are more like the rest of consumption profiles.
- Low commission of offenses.
- Scarcely affected by HIV and hepatitis C (infected cases are possibly due to sexual risk behaviour).

C.Profile whose main consumption substance is **Polydrug** and **Heroin**:

- They are mostly men.
- With higher percentage of marital and family problems.
- Most of them are singles and do not live with their children just before treatment.
- It is the group with the highest percentage of coexistence in protected and unstable milieu.
- They receive their income from the family, pension and social support.
- It is the profile with the highest percentage of offenses and prison experiences.
- This profile includes mostly the cases of people affected by HIV, hepatitis C and previous overdose.
- A high percentage has received previous replacement therapy.

D.Profile Profile whose main consumption substance is **Cannabis**:

- They are mostly men.
- Mostly singles (almost 9 out of 10).
- They live with their family of origin.
- With lower perception of family problems.
- Their income comes from the family and friends.
- They represent the youngest group and with less consumption time.
- They are not affected by HIV, hepatitis C, overdose or delirium.

2.4. NOTES ON DATA ANALYSIS

In this global study there are some points that suffer the drag effect of the typologies to which they are associated. The differences between some types of drug addicts and others are so large sometimes that we find it necessary to make the analysis according to the various groups of variables classified with a predetermined criterion (primary substance, gender).

We thus seek to avoid for the general sample to be "contaminated" by some factor (prison admissions, HIV, administration routes, income). In other cases, however, the similarity between profiles indicates us that there are common factors of social context which require a global approach (age of onset, educational level, family conflicts, marital conflicts...). In the next chapter we shall expound them.

3

Conclusions and proposals for action

3.1. CONCLUSIONS:

- After completion of the data analysis, in the opinion of Proyecto Hombre addictions in Spain are a **social urban, male and adult phenomenon.**
- It should be noted a **remarkable change and a clear evolution in the form and type of consumption by people under treatment. Heroin has little relevance today as main substance, while alcohol and cocaine are prevailing.** As to how drugs are being used, the "injected" route of administration is practically disappearing. This is related to the low incidence of people affected by HIV in our centers. Incidentally, and in relation to the area of health, specifically to infectious diseases, **the scarcity of HIV-AIDS cases (4.2%)** is most positively valued.
- In this direction, we can differentiate **three consumption profiles** that entail different characteristics. We shall include in one of these profiles, heroin and polydrug use, in view of the fact that both cases are associated with similar characteristics.
  - **A. Profile** whose main consumption substance is **Alcohol**.
  - **B. Profile** whose main consumption substance is **Cocaine**.
  - **C. Profile** whose main consumption substances are **Polydrug** and Heroin.
- In addition to these main profiles there are, on a minority level, **other profiles that also have different characteristics such as people addicted to cannabis, mostly younger, single, with relationship problems and low employment.** This should be taken into account for it might be a profile to gain more relevance in the near future, requiring like the rest, a more specific attention (prospective methodology).
- The evidence of these profiles of people under treatment makes us suggest the need for **more intense awareness of the problems related to these addictions.** Besides, the data of "Average consumption time" before treatment (above 10 years in all substances except cannabis) allows us to recommend the **development of strategies and early intervention protocols** in order to act effectively, with better prognosis and with minimal damage to people.
- As mentioned before, alcohol is the most used substance (41.7%), as well as being the more accessible one, cheaper and less socially sanctioned. Although in some schools there are specific programmes to treat alcohol addiction, probably it might be necessary to study the possibility of widening this work in different intervention and prevention resources. In addition, we must analyze the tendency in later years of alcohol consumption (especially in the form known as "alcohol and other drugs", to determine the impact of economic crisis on consumer style: drug users of other substances might have, at this late stage, turned to alcohol as main substance for economic reasons), that might become a trend during the crisis.
- It should be noted the low **educational level** of our users, regardless of being male or female. We find it excessive the percentage of uneducated people (51%) or with only basic studies (28%) under treatment. It has grown necessary to implement a specific strategy in this area, either within our own resources or in coordination with external training resources, in order to improve employment opportunities for people under treatment. So far we had not had such clear evidence on the correlation between drug use, school failure and severe consequences in their lives.

> We recommend the development of strategies and early intervention protocols in order to act effectively, with better prognosis and with minimal damage to people.

- With regard to employment, **it is noteworthy that almost half of interviewees are part of the employment circuit** (either already employed or collecting unemployment benefits). With this variable, we find a polarization problem among **cocaine users (normalized and employed) and traditional polydrug and heroin users (unemployed and uneducated).**
- **The gender-based distribution of the sample (91% men, 9% women) indicates that there is a major problem in treatment accessibility for women.** It would be advisable to analyze the reasons for this marked imbalance in treatments, and to study proposals for improvement. It is important to consider the consequences that this fact has on our care resources, as it is obvious that they become masculinised social systems that influence one way or another in their very functioning and effectiveness. It seems necessary to design and offer treatment options more adapted to the demands and conditions of women with addiction problems, especially **to prevent further maintaining the "invisibility" of women in addictions and the possible "multifactorial vulnerability"** to which many of them might be doomed: the fact that she is a woman, a drug addict, uneducated, with family...

In this sense, we have analyzed some of the most notable **differences** that exist between **men and women**, to be considered when designing the different treatment approaches, taking into account the gender perspective:

- Coexistence "only children" occurs more often in women (15%) than men (1.3%) before entering treatment resources, which may be related to the difficulty in accessing the same, since it implies a separation of them, hard to bear, more for small children.
- Women are more aware of the existence of family problems, both with the partner (72'3%) and with the family of origin (79.4%), and, in any case, it is a very high percentage, which necessarily means specific work on this aspect of emotional relationships and the role that each one can assume in the family.
- In terms of employment status before consenting to treatment, and according to the data obtained, we can conclude the existence of greater difficulties for women in regard to employment (only 29% are employed), something that obviously should be considered in designing the insertion itinerary of our patients. Obviously this is directly related to the educational aspect and career guidance, taking into account their specific needs and wants, as well as their possible lack of expectations.
- There are also differences in consumption profiles and associated behaviours (main drug type, route of administration, age of onset, delinquency...), that may be related to different patterns of behavior that in turn would be useful in the design of differentiated therapeutic approaches.

  Sometimes the type of consumption among women makes for the problem of addiction to remain more "hidden", thus being less accessible to treatment.

- There is another "invisibility" that has been less studied in Spain: the percentage of immigrants in Proyecto Hombre treatments is 1%, while the nationality distribution is even more fragmented. We know that the percentage of foreign people with addiction problems is greater for two reasons:
  - On the one hand, there is a statistical reason, as explained in the AGES Survey 2012 National Drug Plan. Approximately 4% of the people living in Spain have addiction problems.
  - On the other hand, the percentage of immigrant people with substance abuse problems entering the prison circuit is greater (according to data from Penitentiary Institutions).

This scenario compels us to recommend actions aimed at intervening directly and effectively with immigrant population, as well as to carry out research work and studies to resolve resistances and difficulties that may favour this problem of "invisibility" (Molina Fernández, 2010).

Proyecto Hombre, since its inception, has viewed family as one of its basic "pillars" in terms of functioning, support and recuperation of the individual. In our treatments we have always developed the therapeutic work attending family and couple relationships, offering them an important role in the process.

The data once again confirm the need for this line of work, taking into account the continuing evolution of family patterns that exist in our society, and the fact of their requiring from us an effort to adapt ourselves to that reality, with the changes it entails in our work plans.

We are aware that they can sometimes be confused with lack of involvement or delegation on the families' part.

> "Proyecto Hombre, since its inception, has viewed family as one of its basic "pillars" in terms of functioning, support and recuperation of the individual."

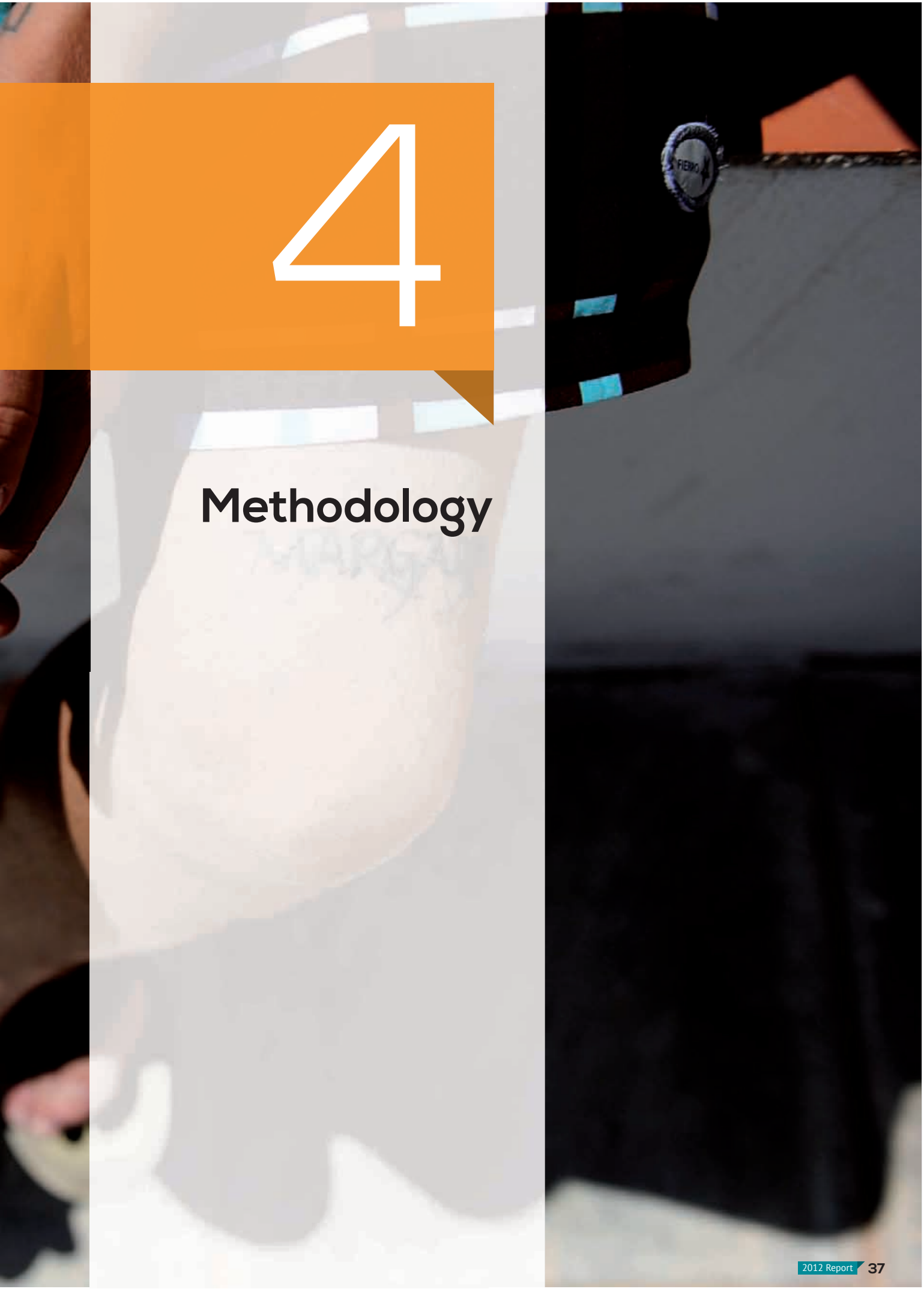
3.2. RECOMMENDATIONS AND PROPOSALS FOR ACTION

- It is easy to recognize the need for **different treatment alternatives that suit the existing different types of profile.** We are glad to find in Proyecto Hombre centers a great variety of programmes that seek to respond to these needs. However, we must not stop checking constantly the changing variables that make consumption patterns and the needs of our users to evolve and thereby making our treatment offers evolve too.

Continued work is needed to review and deepen into the differences and nuances that characterize the people we serve.

- It is rather curious to see the high relevance attributed to traditional treatment methods (based on the approach to opiates problems), in contrast with the small sample of people under our treatments that respond to this also "traditional" profile of polydrug/heroin users. We must also remember that this drug user profile corresponds to the social identity of "drug-addict" in the Spanish collective imagination.
- We focus on a comprehensive treatment model capable of diversifying its responses, while considering a great individualization in treatment through work plans that are more adapted to each person.
- With respect to commission of offenses, it would be necessary to further deepen into those cases of people in prison during the treatment, and the effects of prison and other detention centers in relation to addictive disorder and viceversa. We also need to analyze the consequences that these situations cause (either through causal relationship or as comorbid situation) at the time of social reintegration (family and work), and the possible actions that could be undertaken in accordance with the analyzed results that are related to:
  - Comprehensive intervention patterns.
  - Diversity of profiles and characteristics.
  - Low level of education.
  - High percentage of marriage and family problems.
  - Low incidence of HIV, risk of a possible rebound from the current risk factors (sexual and IV drug user practices).
- Studies on drug dependence are critical in the current circumstances: early intervention on the problems, improvement of Quality in our service, increase of effectiveness in interventions to make them suitable for real users. Innovation in the programmes is a must for this adaptation to the new realities. In this project, for us it was as important to work on this report as the whole process of technological development, practical application, data analysis and development of conclusions. The Process+ Results sequence especially raised from Innovation, Development and Diffusion.
- We think it necessary to find a format for collecting information that allow us to include in the analysis "secondary addictions" and not just consumption of more than one substance, whether as a bridge, as a substitute or parallel use. Above all in the case of addictions that are not ordinarily considered as the main problem (benzodiazepines, pathological and on-line gambling, especially). In this study, although we have some extracted data, we think it more prudent to ascertain some variables (the increased use of anxiolytics and benzodiazepines as secondary substance, or the combination of cocaine + alcohol + new technologies). Also the economic variables (purchasing power, debts) should be analyzed in future studies.

"Continued work is needed to review and deepen into the differences and nuances that characterize the people we serve."



4

Methodology

4.1. OBJECTIVE

The main objective in this study is to improve our knowledge of the profile of users and the current situation of drug addiction in Spain in order to raise awareness awareness throughout society about the reality of this phenomenon.

To achieve this, we analyze the diversity of profiles of people receiving treatment In PH and the clarification of the most significant sociodemographic and psychosocial variables related to addictive behaviours. We believe that, in this way, we will help to contextualize the current social problem of drug dependence and addiction in Spain.

"When talking about drug use three interacting elements are being considered: the substance or substances used, the person that uses it and the context in which consumption occurs. To overlook this fact attaching a disproportionate or unique importance to any of these three elements, means altering a priori any rigorous analysis made of the problem and any solution it should be given to" (Becoña and Martin, 2004).

The definition of these profiles will facilitate the design, adaptation, implementation and social impact (Chambers, 1995; IUDC, 1997) of interventions increasingly effective and individualized, from the perspective of a comprehensive approach based on the biopsychosocial model (Mayor, 1996, Jaffe, 1982; Bobes, Bascarán, et al., 2007). Thus, we shall adapt treatment programmes to the social and health needs of the population served, expanding the perspective of the classical treatment programmes.

This project is committed to continuity. In later years, we hope to outline tendencies and developments in the use of drugs by people under drug dependence treatment in Spain, as well as in the psychosocial and demographic characteristics of these people attended in treatments.

> PH Nemos, through a computerized form, integrates different tools for the collection and processing of information.

4.2. DEVELOPMENT PROCESS

From the outset, the aim was to develop a demographic report using data extracted by our own R&D team and analyzed by Proyecto Hombre Association itself. It seemed to us as important to develop this report as to succeed in generating technology and methodology to carry it out on a regular basis and by the institution itself.

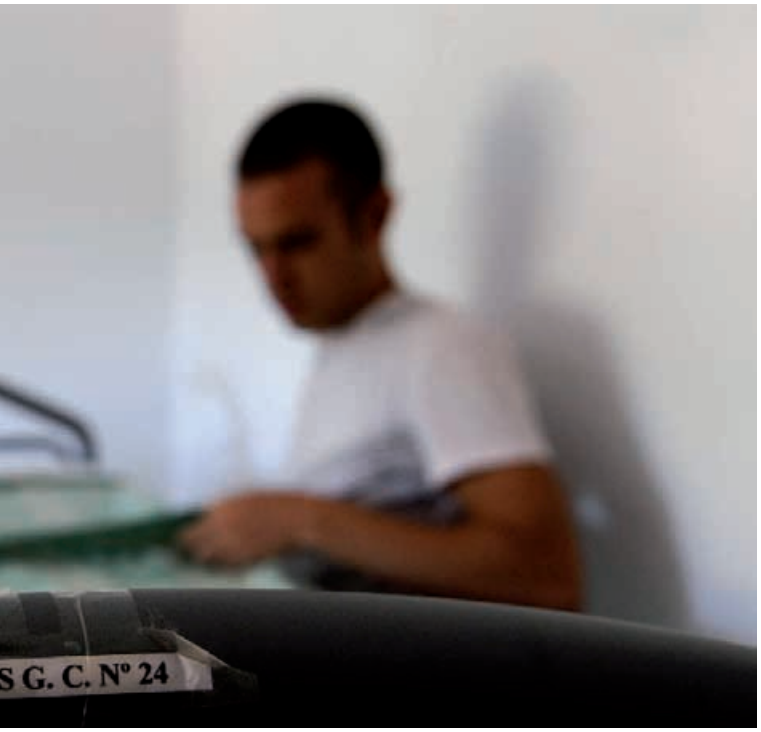
For the completion of this report the PH Nemos application has been optimized. Given the volume of therapeutic data that has been collected in recent years, it has become imperative to create a query pattern for the analysis that allow us to obtain information in a dynamic and immediate way. With the development of this pattern, Proyecto Hombre has a tool that allows processing, calculation, error control and contrast of the data collected.

PH Nemos, through a computerized form, integrates different tools for the collection and processing of information: EuropASI, Initial Family Registration (RIF), Initial Teens Registration (RIA), Admission Sheets to Treatment, Legal-law Report and others. For this report, we have analyzed data from EuropASI.

4.3. SAMPLE DESIGN

For this study, as an initiative and an internal learning process, we have tried to use a system for collecting information using our own data and a specific statistical analysis for the report. To achieve this, we proposed several perspectives on the sample design. Finally, two particular decisions were taken:

- It was decided to conduct the study on a national simple and not to fragment results on a local and/or autonomic level; despite the obvious interest that a study of this kind has in specific contexts, the simple size disparity among PH centers and other, forced us to choose to analyze the information contained in state-wide database. However, we must emphasize that there are geographic areas with sufficient simple size to provide meaningful results (Murcia, Asturias, Baleares, Seville, Malaga, Madrid, Galicia).
- As data collection instrument, we chose to use the above mentioned EuropASI. Being aware of the diminution that this decision entails of the sample size, we chose to use a validated and internationally recognized tool.



The complete sequence, to make the information more precise, was as follows:

- In 2012, the database of the PH Nemos application collected **15.799** ATTENDED PEOPLE, counting itinerary and pre-itinerary.
- Of these ATTENDED PEOPLE, **8.995** would have moved to the Interview phase.
- Of these interviewees, **6.280** would have been ADMITTED to some of the programmes PHA has for the different adult profiles.
- The EuropASI was applied to 3.280 people under treatment (52,8 %), taking into account that the EuropASI is used with people who are abstinent from alcohol and other drugs after the first month under treatment (this is the moment with the highest percentage of dropouts and relapses).

> EuropASI is used with people who are abstinent from alcohol and other drugs after the first month under treatment (this is the moment with the highest percentage of dropouts and relapses).

Besides, we included a number of criteria to fit the data collected, even at the cost of reducing considerably the sample: we did not use incomplete questionnaires. Even though they had valid data, we have used only the first EuropASI application of each user, being aware of the usefulness and abundance in contrasting the evolution of treatments. Finally, one EuropASI was used per person, even if that person had been admitted more than once, or had been through more than one programme.

Finally, after having applied the validation criteria of the questionnaire, the simple would be reduced to 2.910 people attended in the various PH centers, during 2012, to whom the EuropASI had been applied according to the above mentioned validation criteria.

Once gathered the information collected with the EuropASI application we carried out a descriptive analysis of the data. When describing these data we have taken into account gender and the main substance used by the tested person. It was not our intention to compare but describe these differences. Nevertheless, comparisons have been impossible, especially when we find significant differences.

The sample consisted of 2.636 men and 264 women.

For the analysis we also organized groups according to the main substance consumption. In particular, for those substances that would imply at least 5% of the sample.

Finally, these are the variables that were selected:

SUBSTANCE	REPRESENTATIVE % OF THE SAMPLE
Alcohol in any dose	5,55%
Alcohol in large quantities	18,80%
Alcohol and other drugs	19,49%
Cannabis	7,42%
Cocaine	32,74%
Heroin	5,37%
Polydrug use	10,63%

> The need for reliability parameters when it comes to developing a rigorous sociodemographic report is based on the principles of statistical validity.

4.4. DATA COLLECTION AND VALIDATION CRITERIA

In order to obtain relevant information on people under treatment in PH adult programmes, it was necessary to collect and process the internal data using various sociodemographic indicators, extracted from the database and calculated directly by Nemos PH application.

All data extracted from the EuropASI have been used according to direct notes in order to avoid opinion indicators (both from users and from pollsters), because of the difficulty in maintaining the strictest reliability (due to the possibility of checking if the pollsters had noted differently). Given this doubt, we chose to discard all that (otherwise huge) amount of information.

We have used quantitative methodology, specifically a descriptive analysis (Corbeta, 2003). Data processing was carried out using SQL software. As a support tool in the statistical analysis, we have used the originally called Statistical Package for the Social Sciences (IBM SPSS) version 21.0.

To improve the quality of this information and its collection efficiency, intensive training was proposed early in the project to train technicians in the use of the applications and the technical concepts related to Evaluation: criteria, indicators, matrices, assessment design, data analysis, etc. (Ammon, 2006).

It was decided to delete the information that was not reliable (we used neither the valid data, nor the indicators individually but completed questionnaires), establishing contingency comparative analysis (not including other comparative statistics), in order to ensure the validity of the study. In addition, after the analysis of the data done with SQL, the same operation was repeated ("double check") using the SPSS 21.0 programme.

The need for reliability parameters when it comes to developing a rigorous sociodemographic report is based on the principles of statistical validity. We have taken into account the following validation criteria (León and Montero, 2002; Pardo and Ruiz, 2010):

- Reliable and objective information, discarding the opinion indicators of the EuropASI, as well as those surveys that were uncompleted or with empty spaces.
- Correct mechanization of all the fields to contrast.
- Rigorous data collection in relation to the training of the persons responsible for having the documents completed.
- Updated data (users who were being treated at a PH center between 1/01/2012 and 31/12/2012).
- Filtering with regard to the validity of the information and their collection compared with the sources of origin.
- Significance of the global sample, as explained in section 3.3, eliminating the effect of sample size bias in PH centers with reference to small samples (Amón, 2006).
- "Double check" of the data obtained with SQL and SPSS.

4.5. PHASES OF THE STUDY

When we considered the draft of 2012 Report, we wanted to reveal a part of the experience accumulated by Proyecto Hombre over twenty eight years of work the field of drug addiction. Both the desire to improve and the acquired technical knowledge had to be integrated in this project. To achieve this, we conceived a design that would include different phases and levels of participation.

The design process can be summarized in the following phases:

The "Documentary Compilation" refers to our search for similar experiences, not only in drug addiction. We have consulted various studies of sociological and psychosocial profiles in order to develop this Report, such as the profile studies carried out by UNAD (2005, 2007, 2009) and researches as those made by Graña (2007) and Pérez del Río (2011).

We organized a course at the beginning of the project, especially designed for technicians to collect information, in which course they learnt how to use the EuropASI, its administration and analysis, as well as a specific session on Report Elaboration.

After the course, the R&D team of Proyecto Hombre Association was in charge of Data collection, as well as the necessary guidance to solve technical problems arising from the use of PH Nemos application.

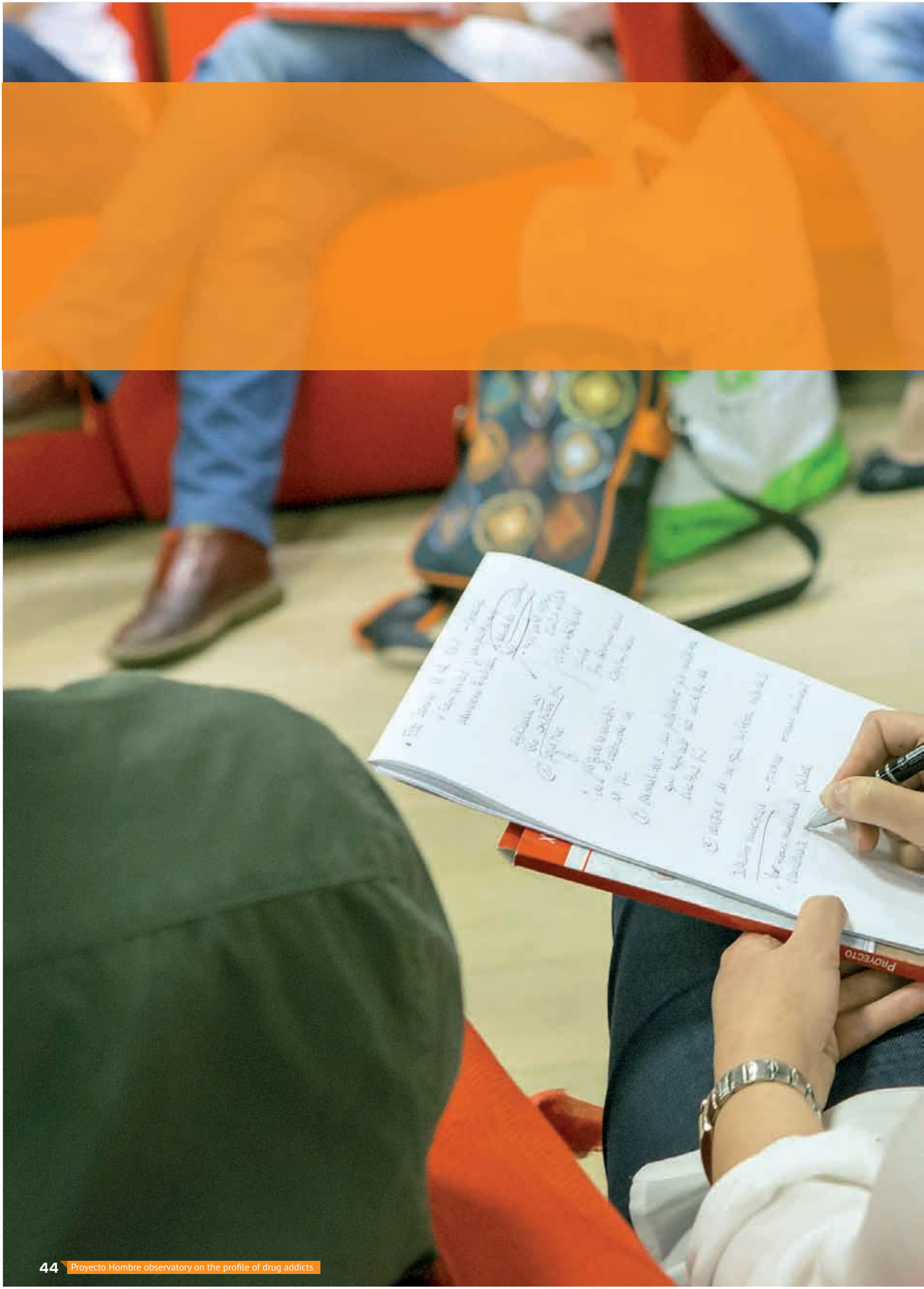
Once finalized the data collection, the team made up of the Training Center, the Assessment Commission and the external advisors have carried out the analysis of the most significant data.

The next step was the drafting of the Report, that included the elaboration of Recommendations and Conclusions: suggestions for improvement and future action plans.

The schedule was as follows:

As a transversal axis of the Project, we added Evaluation Process+ Results. We did not only attempt to evaluate the elaboration of the study but also to value the effort made by PHA to start this project, wich is a significant aspect in the Innovation and Diffusion strategy that this Institution has been carrying out since 2011.

In the Metaevalutation scheme of this project we have included a series of Impact indicators, understood this judgement as analysis of the unexpected effects (those we did not consider before carrying out the activity, both positive and negative effects) and their ability to influence, modify and make proposals and viewpoints on the social context, especially the possibility of updating and improving care treatments to the different profiles of people with addiction problems in Spain.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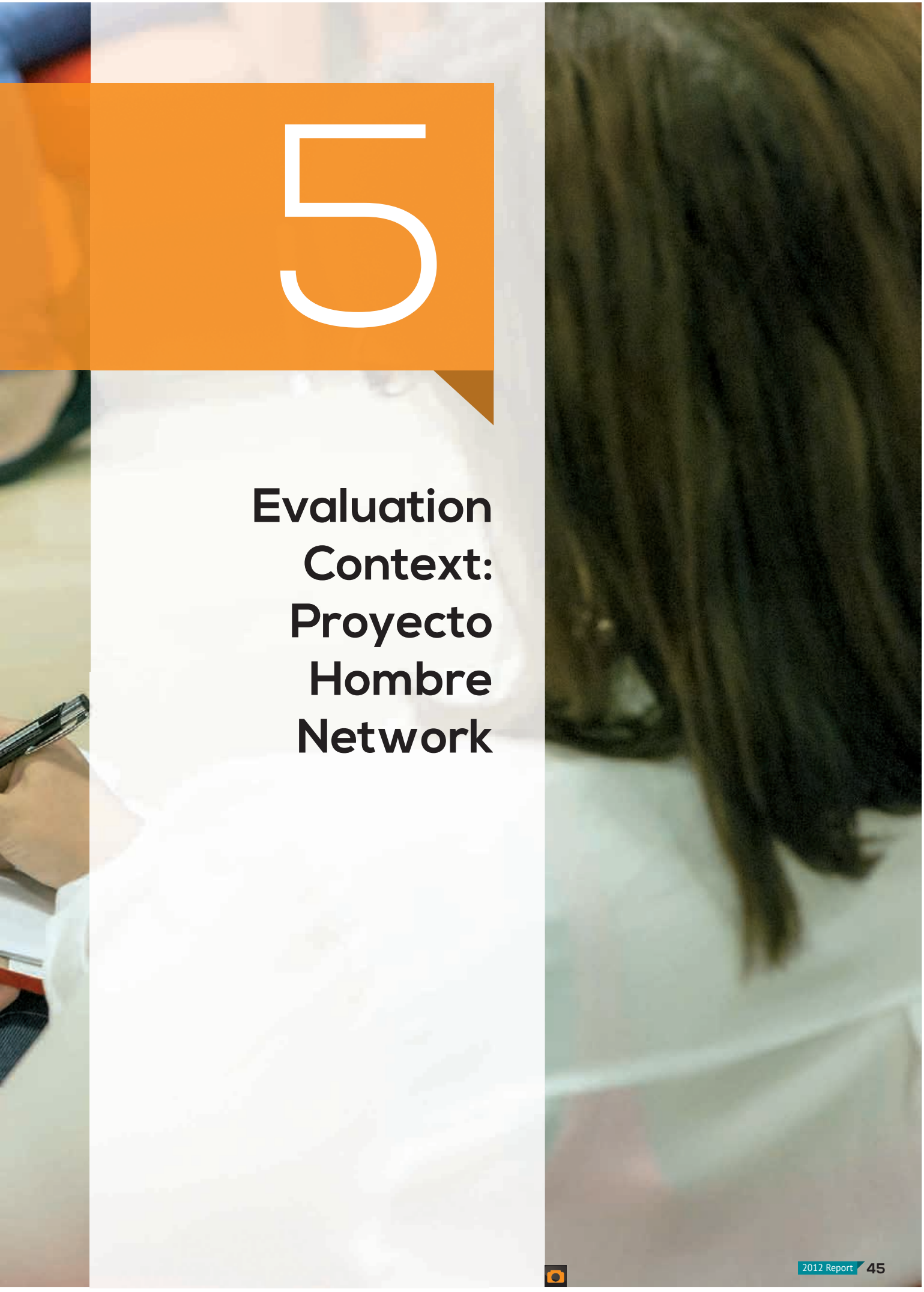


5

Evaluation Context: Proyecto Hombre Network

Proyecto Hombre is an educational-therapeutic programme born in Spain in 1984, aimed at prevention, treatment and rehabilitation of people with drug dependence and addiction problems.

Proyecto Hombre Association is composed of twenty six centers, in a total of fifteen autonomous communities of Spain, attending every year more than 19.000 people with addiction problems and their families. Each center is managed independently and shares with other centers the therapeutic method and the same philosophy, which means that the centers share their mutual experience, working on a basis of mutual support and cooperation as well as sharing training and research.

> The work in the various areas in which Proyecto Hombre operates is carried out in diverse Commissions consisting of Proyecto Hombre specialists and external advisors.

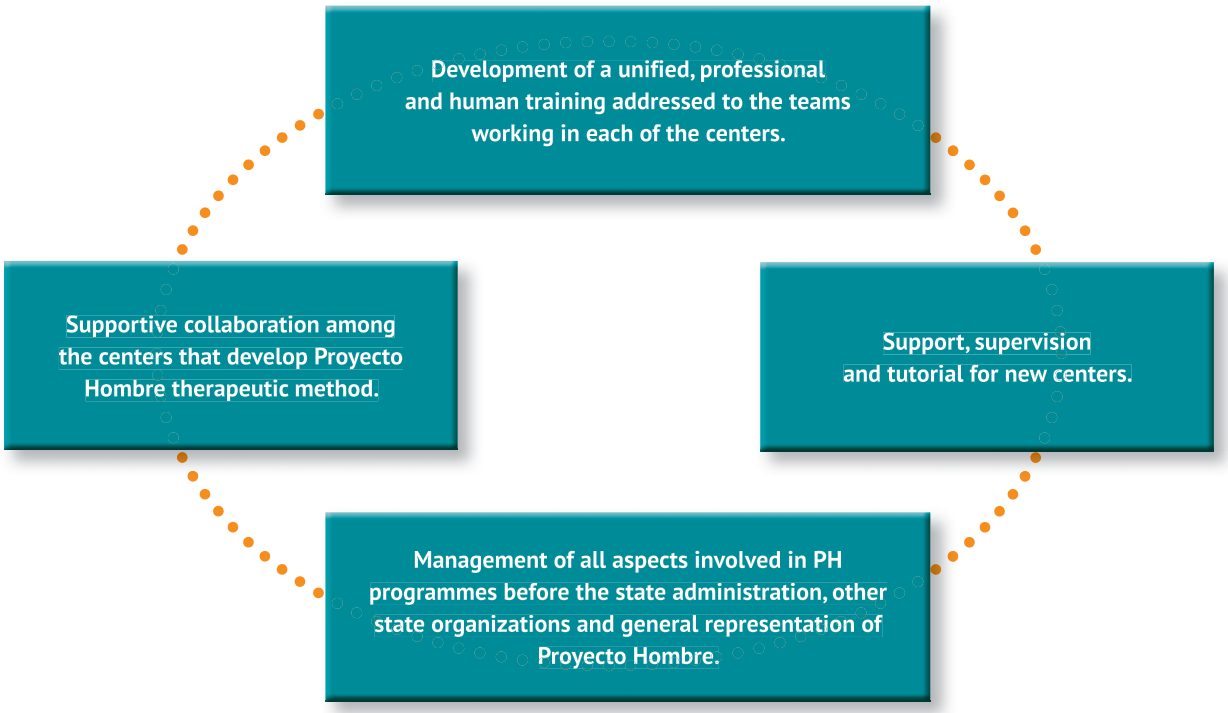
PROYECTO HOMBRE ASSOCIATION INTERNAL NETWORK

- ALICANTE
- ALMERÍA
- ASTURIAS
- BALEARES
- BURGOS
- CÁDIZ
- CANARIAS
- CANTABRIA
- CASTELLÓN
- CASTILLA-LAMANCHA
- CATALUÑA
- CÓRDOBA
- EXTREMADURA
- GALICIA
- GRANADA
- HUELVA
- JAÉN
- JEREZ
- LA RIOJA
- LEÓN
- MADRID
- MÁLAGA
- MURCIA
- NAVARRA
- SALAMANCA
- SEVILLA
- VALLADOLID

Proyecto Hombre Network is composed of more than two 200 centers, 1.200 employees (physicians, psychologists, social workers, teachers, instructors, therapists…) and 2.500 volunteers. The variety of programmes that have been gradually incorporated, to respond to the needs of the target population detected by each center, shows the effort made by the organization to adapt itself to social needs and changes in the reality of the addictive phenomenon.

The centers are an observatory of the reality, the place from which they carry out an integral treatment given to drug users. Proyecto Hombre Association is the central node of this Network structure. At the same time, it represents the centers nationally and internationally, and provides a permanent work from its Departments (Training, Administration, national and international Projects, Communication, R&D…).

The Association pursues common goals, as reflected in the following chart:

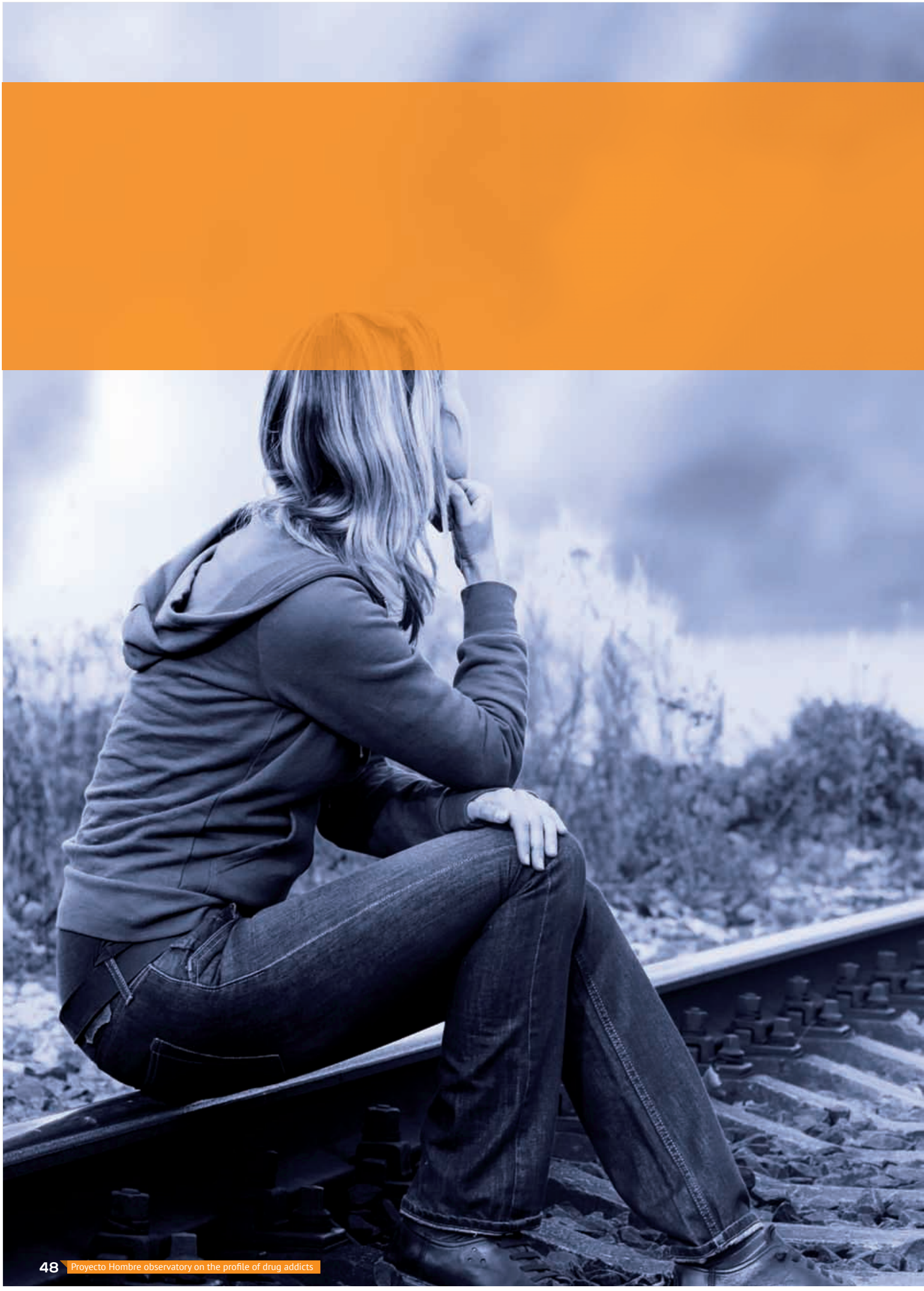


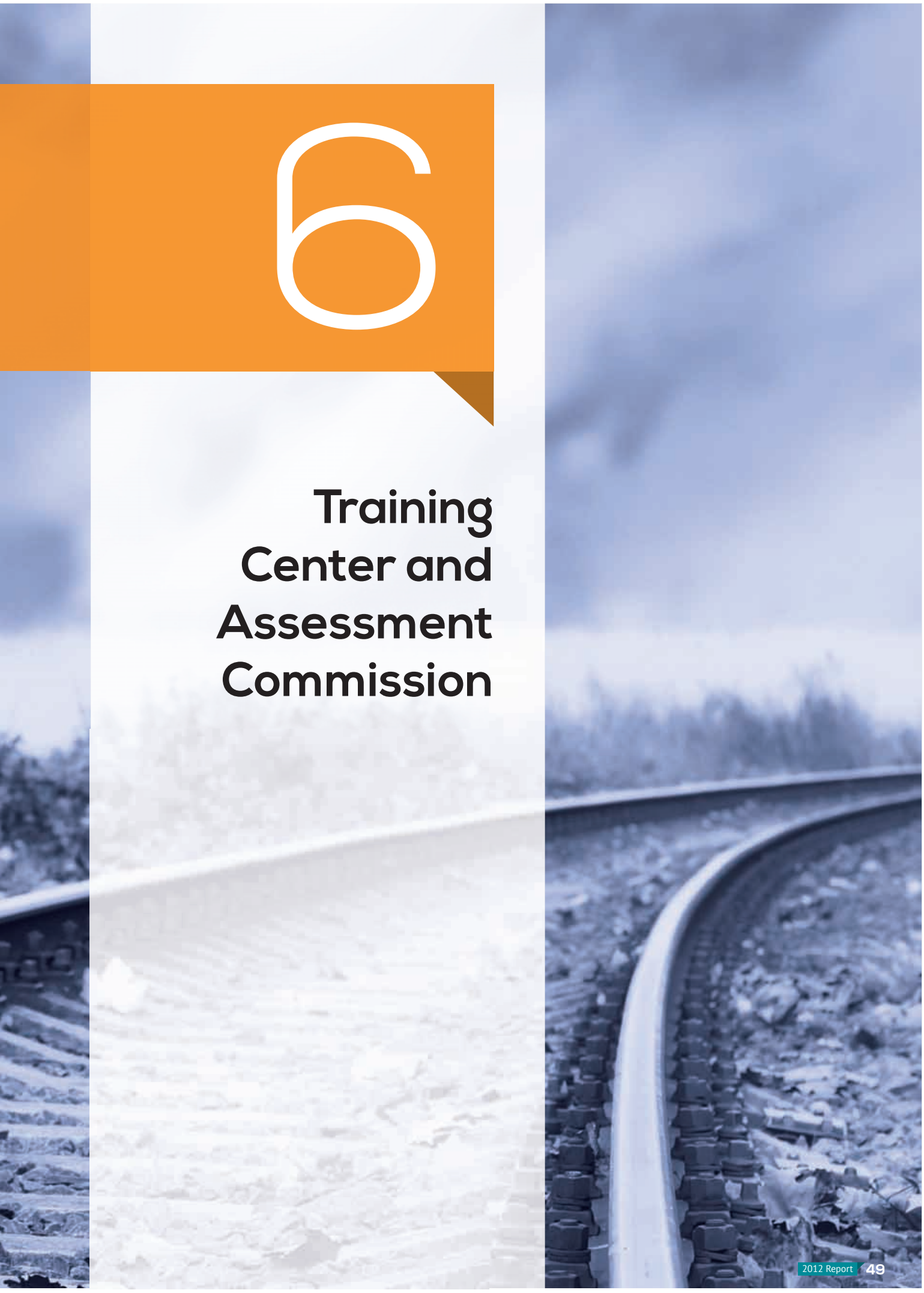
Theoretical models and practical programmes based on genuine prevention are those that help the whole person to discover the sense of self-respect and respect for others, the sense of freedom and responsibility, the value of ethical life (truthfulness, honesty, etc.), communication and meeting with others, real pleasure and real suffering, etc. Otherwise, prevention is insufficient not only to face addiction problems, but other difficulties. (Cañas, 2004)

Since its inception in Spain in 1984, Proyecto Hombre has developed its work in the field of care and rehabilitation of drug addicts. The experience gained in this area, along with the adaptation to the different realities that have gradually emerged in the field of addiction along these twenty eight years, has enabled Proyecto Hombre Association to give different answers to the needs posed by the evolving social reality of drug dependence and addiction.

This global and flexible style has progressively allowed for the classical methodological line to adopt innovative elements that have favored a significant improvement in the Quality of intervention programmes, seeking an increase in the results related to the social reintegration of users, as well as a driving force from different Prevention Programmes.

The work in the various areas in which Proyecto Hombre operates is carried out in diverse Commissions consisting of Proyecto Hombre specialists and external advisors. Later we shall explain the essential task that the Assessment Commission has carried out in Knowledge Management of Proyecto Hombre, especially in the preparation of this 2012 Report.





6

Training Center and Assessment Commission

During 2011, more than 17.000 people were attended in the centers that Proyecto Hombre Association has throughout Spain. The personal and social characteristics of these people have changed during the twenty eight years in which Proyecto Hombre has been working in Prevention, Rehabilitation and Reinsertion of drug dependence problems. The evolution in the profiles of the people under treatment has been evident since the late 80s: from the heroin user by injection, which characterized the profile attended at that time, we have reached the current polydrug profiles usually found in the treatments. The establishment of defined profiles, especially the clarification of their sociodemographic and psychosocial variables, will allow the adaptation of the treatments to be increasingly effective and personalized, especially from a comprehensive approach based on the biopsychosocial model.

"This kind of organization of care response to drug dependence matches the predominance of the explanatory theoretical model of drug dependence called biopsychosocial. After unsuccessful attempts to formulate reductionist or partial explanations of drug addiction, it is necessary for professionals in this area to impose a basic consensus on the multicasual nature of drug dependences, to its multidetermination" (Mayor, 1995).

We assume that there are psychosocial and sociodemographic factors affecting addictions, and in doing so, we try to avoid stereotypes and preconfigured ideas and make a radiography of the social reality of the "drug addiction" phenomenon, with the aim of converting that radiography in a succession of images that can oppose one another, and comparing the true evolution of the people attended by Proyecto Hombre.

> This project, in its technical development, has been put together around three essential axis: Proyecto Hombre Training Center, the Assessment Commission and the Association's R&D Department.

Periodically, the National Drug Plan makes surveys on the attitudes and use of substances in Spain. Known are "The State Survey on Drug Use in Secondary Education" (ESTUDES), and the "Domiciliary Survey on Alcohol and other Drugs in Spain" (EDADES). International entities such as the European Observatory on Drugs (EMCDDA) and the United Nations Office on Drugs and Crime (UNODC) carry out similar studies. Proyecto Hombre Association, in the line of this project, aims to help in complementing the information in these studies with the data and characteristics of people under treatment, that is, we add two achieved values:

- Using data of people under treatment that were not collected with surveys but personal interviews; and
- The information extracted comes from people that only do use substances but recognize the use of drugs as a problem.

This Project has a comprehensive and integrative intention (House, 1994): in our methodology and development we seek to group sanitary/psychological and social models, using as data collecting tool the EuropASI (quantitative instrument internationally accepted as Addiction Index) as a source of information in the different categories, thus carrying out a multifactorial analysis (McLellan, Luborsky et al., 1980; 1985; Kokkevi and Hartgers, 1995; Blanken, Pozzi, et al., 1996; Bobes, González, et al. 1996).

In this way, we have tried to generate a valid and reliable report that can simultaneously be corroborated and refuted, in order to be able to offer useful conclusions in the improvement of treatment conditions, both for people with drug addiction problems and for their families.

This project, in its technical development, has been put together around three essential axis: Proyecto Hombre Training Center, the Assessment Commission and the Association's R&D Department.

6.1. TRAINING CENTER

Proyecto Hombre Association's Training School for Therapists was created in 1991 for the training and professional improvement of the educational and therapeutic staff (professional and volunteer) that participates in Treatment and Prevention programmes of Proyecto Hombre, both in Spain and in Portugal. Its main objective was and is to train all those people under a common perspective, that of the founding Letter and its treatment philosophy. During these years, more than 3.700 participants have taken some of these educational courses.

Proyecto Hombre's Training Center project was born with the main purpose to become an Observatory on the reality of drug addictions in Spain in order to favor the adaptation of PH programmes to these new realities and thus improve the quality of our services, centers and programmes.

In addition, and relying on the previous experience of Proyecto Hombre Association, we seek to offer to society the Knowledge Management ("expertise" or "background") in order to generate an opening to the outside world and a feedback circuit between Proyecto Hombre Association and the civil society in regards to the fight against drug dependence and addictions. This process is being carried out by showing a firm commitment to create strategic alliances with other entities, by way of encouraging collaboration agreements related to drug dependence with other Training, Research and/or Social Action entities, either public or private.

On top of this, we need to respond to the internal and external requests about which role Proyecto Hombre Association must have, always referring to Treatment, Rehabilitation and Prevention of drug addicts nationally and internationally (essentially Europe and Latin America). Thus, we try for educational actions to be open to the outside, to people that do not necessarily belong to Proyecto Hombre centers but to all those that want to learn about matters related to treatment of drug dependence and other addictions.

To achieve these objectives, it is our intention to generate a stream of motivation to actively participate, including all political and social entities possible. Every idea and proposal will be welcome. To that aim, we have created a series of agreement and collaboration dynamics both with public and private entities.

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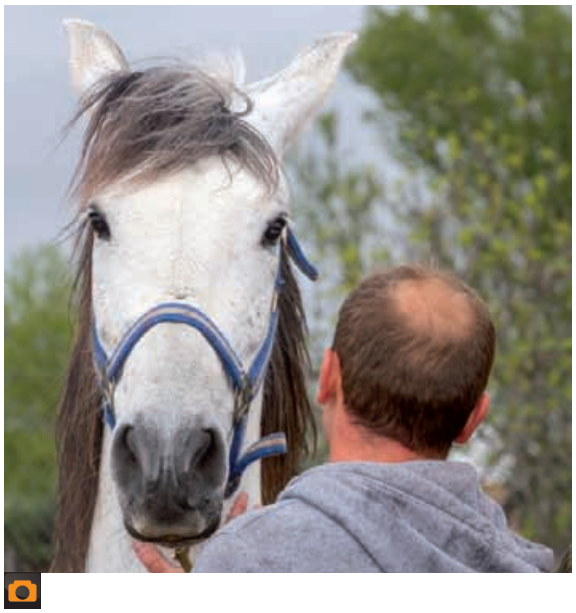
The "Knowledge Management" in Proyecto hombre refers to the ability of this association to capture, to organise and accumulate acquired knowledge to transform it in an intellectual asset, in a common benefit for all the people involved. This Knowledge Management generates in our institution a commitment of openness to the outside and a responsibility to share our knowledge.

Within the context of the Training Center project, one of the fundamental core ideas is to elaborate materials bearing the "PH signature". Both the materials transferred from previous experiences (coming from this "Knowledge Management") as the new activities we are developing, should be recognized for their quality, innovation, adaptation to new realities and public visibility, without ever forgetting our commitment of respect for all participants and our comprehensive view of the phenomenon of drug dependence and addiction. This report is an example of these PH materials.



6. 2. ASSESSMENT COMMISSION

In 2000 Proyecto Hombre Association decided to include the assessment of its treatment programmes within its Strategic Plan. The abundance of programmes, the diversity of work methodologies and the very different styles when it comes to presenting the results, force us to plan a series of common and standardized evaluation systems to the extent possible. To this end, we developed some proposals aimed at training a group of professionals in order for them to become a team with the task of implementing an evaluation methodology.

To do this, we contacted the Complutense University of Madrid, and in collaboration with the Evaluation Unit team of the Center of Management Studies, Analysis and Evaluation, formed by María Bustelo (responsible), Juan Andrés Ligero and Marta Martinez, a training course on evaluation was organised with the objective for each center to have, at least, an evaluation technician. Subsequently, we created an Assessment Commission, consisting of a selection of professionals from different centers that would help teams overcome their initial resistance against evaluation and encourage the establishment and maintenance of an evaluation practice, within twenty six programmes that are part of the Association.

Currently, the functions of the members of this group are focused on implementing assessment projects commissioned by Proyecto Hombre, based on the priority criteria established by the assembled presidents. Once defined, they work in groups, following the methodology that is valued as most appropriate for each project: search for and collect information, organise meetings, analyze the collected information, select and evaluate different options for meeting the objectives (identify and know what you want to evaluate, define criteria and indicators that are to be answered and instruments that allow us to obtain and gather information, analyze data and prepare the relevant assessment reports), make decisions about the group's objectives and disseminate the results (publications, interventions in forums , etc.).

The Assessment Commission is based on the definition of assessment given to us by Ligero (2006): **"To collect and analyze information systematically to be able to understand and give meaning to what occurs in a programme, from which some specific judgements will be deduced that will allow us to give an account of it and take decision about its improvement"**.

The **functions or intentions** of the Evaluation **in Proyecto Hombre** have been:

- To improve and/or transform professional practice.
- To share our knowledge with other similar experiences that allows us to participate in national and international forums. The Evaluation is a tool for institutional Visibility, an especial key factor in PH development from 2000.
- To help enrich the theory of social intervention based on the contribution of a specific methodology in the evaluation of drug addiction treatment.
- To strengthen the institutional capacity of transformation of reality. Evaluation in Proyecto Hombre has meant a commitment of institutional Transparency in the presentation of their Reports and results.
- To provide a model of systematization of the experience for the first time within Proyecto Hombre Association.
- To achieve the development of the evaluative culture and practice in all programmes carried out in the Association centers, thus:
  - Improving and progressing in our interventions.
  - Generating institutional learning methods based on feedback.
  - Encouraging prospective analysis of which and how future interventions can be.
- To establish control mechanisms of social and political responsibilities.

6.3. R&D COMMISSION AND THE PH NEMOS APPLICATION

During the last years, Proyecto Hombre Association has been developing a therapeutical management application based on the ICT with the intention of modernizing and upgrading collection and use of therapeutic data.

> The functions of the members of this group are focused on implementing assessment projects commissioned by Proyecto Hombre.

This was a necessity of Proyecto Hombre "towards" society and "from" Proyecto Hombre, as 1.200 employees and 2.500 volunteers that are part of the institution were demanding new working tools that allowed them to access and collect, in real time, information on the people we attended. And "towards" society, the ultimate beneficiary of all our work, based on a demand for transparency, quality and professionalism in which public administrations are also fully engaged (Vedung, 1997: Ballart, 1998).

In response to these demands, this project has improved the methods of data collection and management (Stufflebeam and Shinkfield, 1987; León and Montero, 2002), given the growing and very diversified high amount of people attended by PH Network.

Our location, covering almost all the National territory, the group of people treated annually, as well as the families attended and the beneficiaries of our Prevention programmes represent a significant annual amount of information and a very important and meaningful sample size. The development of this project involves the creation of one of the largest Spanish databases in our area of social action: intervention on addictions.

In 2007, Proyecto Hombre Association began to develop the TIC application of therapeutic management PHNemos (González, Trecet and Molina, 2012). It is an online application, to which all Proyecto Hombre centers have Access, and is being used every day for storage and subsequent processing of all the information generated in treatment programmes.

Having a tool like PHNemos solves two problems that exist in our organization: the collection of information and its scientific exploitation. This project has developed a technological tool that allows multiple studies on different aspects of the people we treat. In conclusion: a bank of updated information that provides indicators of the problems related to drug use and other addictions. The choice of this technology has been the result of a profound reflection on work processes of the Association, and it has been contrasted by external experts who have agreed to value the Web Platform as the most appropriate technological answer for the purpose of this project.

The decision to opt for a centralized web server will lower costs of production, implementation and maintenance of the final product that will ensure the preservation of investment and its profitability. Regarding the management of high confidentiality data, the adaptation of our information systems to the regulations of the Organic Law on Protection of Personal Data requires a huge investment for non-profit organizations like ours,

> Having a tool like PHNemos solves two problems that exist in our organization: the collection of information and its scientific exploitation.

so that with this project, any deficiency that might exist with respect to the law would be solved globally and permanently.

This tool will enable the collection of information with respect to many precise aspects that constitute the situation of our Users. These records will have a dual functionality:

- Providing professionals in the various areas with the appropriate tools for the improvement of their work.

- Creating the "log book" of all this work, which will lead to very specific studies of each area and which can be related to the rest of variables in the data model.

6.4. PREVIOUS EXPERIENCES OF THE PHA

Earlier we have mentioned the projects of Evaluation programmes being carried out continuously in Proyecto Hombre Association since 2004. These activities have generated a background that has enabled us to tackle this current project of "Proyecto Hombre Annual Report 2012" with assurance and credibility.

In addition to these above mentioned projects, this report is based on diverse previous experiences, in which Proyecto Hombre Association has participated, Above all in two research works with some similar characteristics.

- 2004: two studies were developed on the "Psychosocial profile of users" in Heroin (200 users: 150 men and 50 women) and Cocaine programmes (200 users: 150 men and 50 women). This work was carried out by the Addictive Behaviours group of the University of Oviedo, in particular by the team of Professor Roberto Secades, with the Assessment Commission participating in the technical process of the project. The study was published, among others, within the 2004 Proyecto Hombre Association Report (PHA, 2004). Both reports have used the EuropASI as information collection tool.

- 2008: Proyecto Hombre Association elaborated a "Psychosocial Profile of teenagers treated in Proyecto Hombre programmes" to be included in the "2009 Report". This profile included different psychosocial and sociodemographic indicators. This work was also published within the PHA Report corresponding to 2008 (2008 PHA).

Also systematically since 2004, in the reports on evaluation studies of different programmes we have included a section for the analysis of the psychosocial characteristics of the people treated in each of the different treatment modalities.

7

Final notes

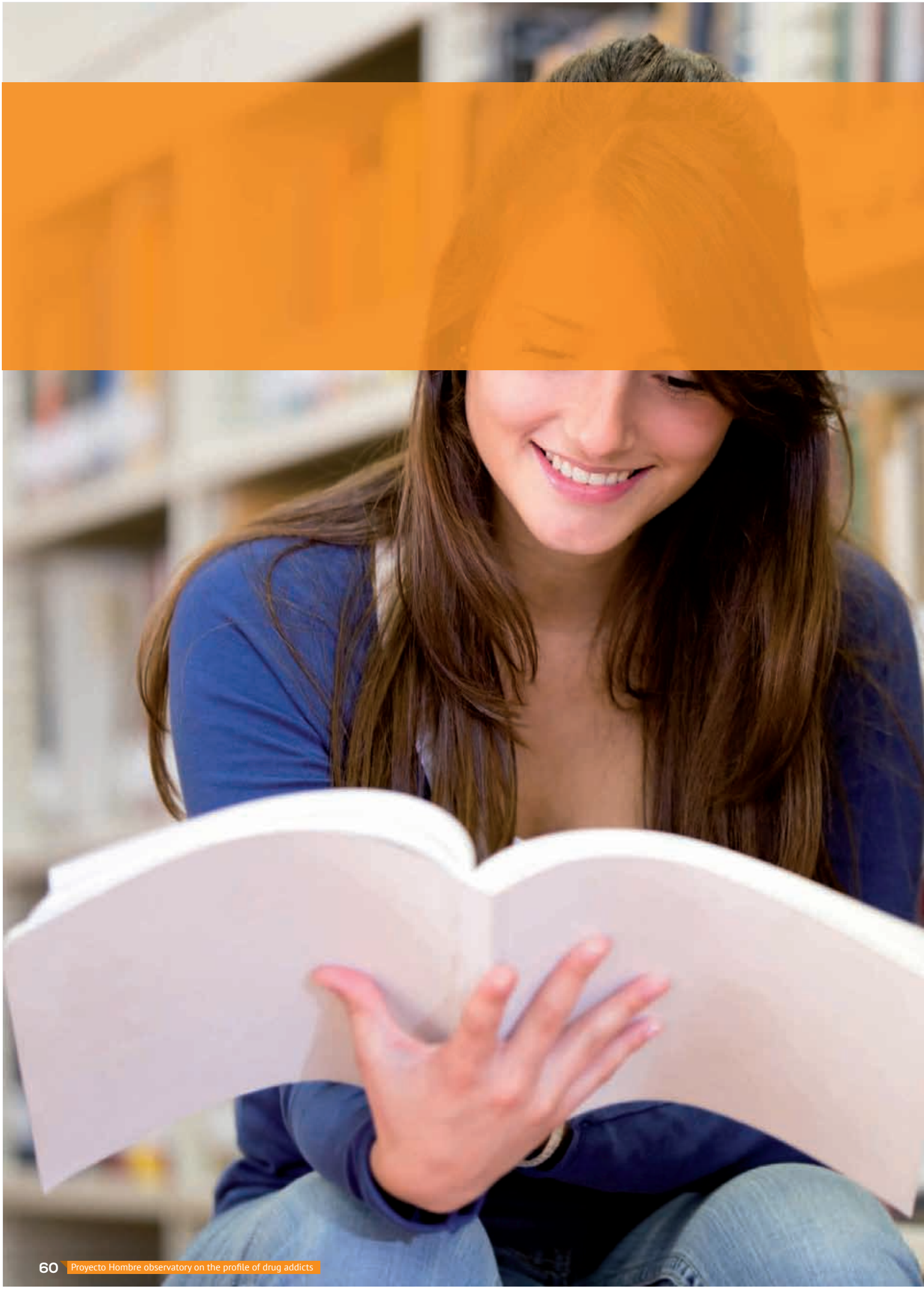
- Having created a strategic alliance for the project with public and private entities (PNSD, Obra social La Caixa and Complutense University of Madrid) seems to us an added value to the results of this project. At the moment, the coalition of diverse interests and needs appear to be a way to generate projects that can be effective, useful and visible to our groups of action. The "Public Administrations+Private entities+Civil Society" combination is an example of commitment by all sectors involved in social change.

- In these difficult times, to invest on Evaluation and Innovation becomes profitable, not only in economic terms but in human resources, material costs, motivation, creation of activities, search for new answers and financial sources, etc. In the long term, the return is much higher than the costs of the activity.

> "Investment is not an expense.
> Innovation is not an expense.
> Innovation is investing."

"Practical problems are not solved
when I know the solution
but when I put it into practice,
which usually is the hardest part..."

José Antonio Marina



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WEB SITES

- Virtual Training Classroom of Proyecto Hombre:

  http://www.formacionph.es/

- Family School:

  http://www.escueladefamiliasph.org/

- European Monitoring Centre for Drugs and Drug Addiction (EMCDDA):

  http://www.emcdda.europa.eu/

- National Drug Plan, Ministry of Health, Social Services and Equality:

  http://www.pnsd.msc.es/

- Proyecto Hombre:

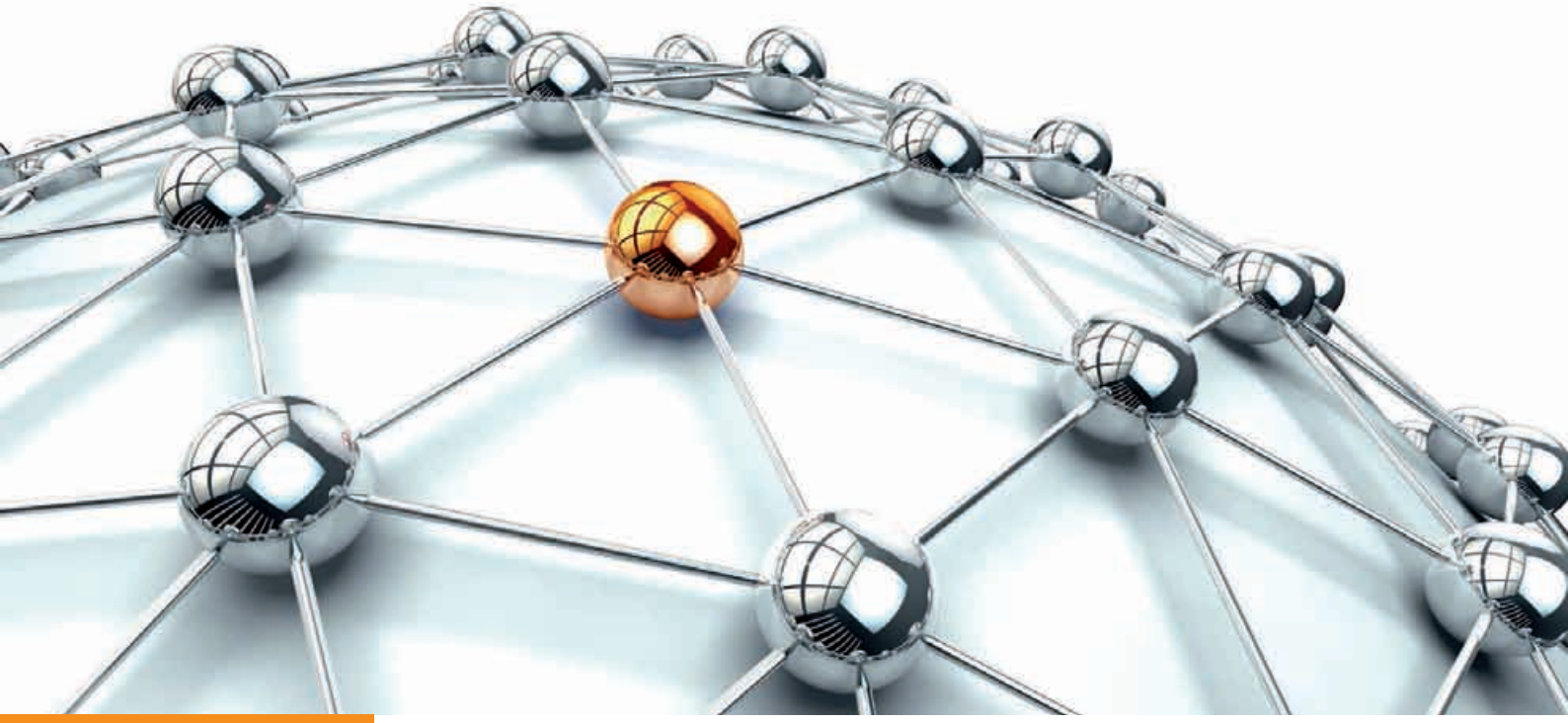
  http://proyectohombre.es/

- World Health Organization (WHO):

  http://www.who.int/substance_abuse/en/

- Obra Social La Caixa:

  http://obrasocial.lacaixa.es/



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Proyecto Hombre observatory
on the profile
of drug addicts

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