THE AMSTERDAM INSTITUTE FOR ADDICTION RESEARCH

Final Activity Report

Project "Evaluation and Implementation of the Self-Control Information Programme for Drug Abusers"

(= EU-SCIP project)

Report period 01-01-2002 to 30-06-2004
Agreement: No SI2.328246 (2001CVG2-217)

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Introduction

This report describes the activities of the Amsterdam Institute for Addiction Research regarding the project "Evaluation and Implementation of the Self-Control Information Programme for Drug Abusers (= EU-SCIP project)" during the period of 1 January 2002 to 30 June 2004. As such this report is composed to inform the European Commission in the framework of the Grant Agreement, contract number SI2.328246 (2001CVG2-217).

Looking back upon this period, we may conclude that the members of the EU-SCIP project staff and their partners in Belgium, Germany, Greece and Wales were able to execute almost all of the planned activities according to the 30 months schedule, that contract partners agreed upon.

This report presents an overview of preparatory, implementory, and evaluation activities performed in the report period, as well as a description of plans for the future. Further, an overview is given of the collaborating centers and their co-workers in the participating Member States (§ 2), a timeline (Annex 1), a list of EU-SCIP materials as well as of publications around the project (Annex 2), a list of presentations, training sessions, workshops and symposia delivered and organised during the report period (Annex 3), a brief description of an EU-SCIP training (Annex 4), and the contents of the EU-SCIP Survey Questionnaire (Annex 5).

1. Aims and background of EU-SCIP project

The aim of the EU-SCIP project is to facilitate the implementation and to evaluate a self-control intervention for reducing the harmful effects of drug use in the European Community. The intervention, originated in the Netherlands, is called Self-Control Information Programme (SCIP) and contains the use of motivation-to-change enhancing materials in four guided sessions with drug-abusing clients. It aims to accelerate drug users natural recovery processes by (1) Helping drug users to realistically assess both the advantages and disadvantages of drug use and those of 'kicking the habit'; (2) Helping them to view 'kicking the habit' as a process that can be gradual, rather than all-or-none; (3) Helping drug users to view controlled use that is integrated within the context of a conventional lifestyle as a success in the right direction; (4) Helping them to assess the present quality of their life and compare it with the life that they are striving for; and (5) Helping them to formulate a step-by-step strategy for attaining the quality of life for which they are striving.

The SCIP consists of the following components: 1) an information booklet entitled "Kicking the Habit: An upward Spiral", 2) a client workbook entitled “In An Upward Spiral. Workbook for greater self-control over drug use “, and 3) a facilitator’s guide for counsellors who want to use these materials in interaction with their clients.

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The programme (used in a four-session format) has originally been pilot tested in Dutch out-patient treatment centres, as well as in Dutch prison settings (Cramer and Schippers 1994; 1996). Results were promising. Accordingly, SCIP became widely used in the Netherlands and, in consequence, attracted the attention of helping professionals in other countries. This is the reason why the European Community in 2001 has decided that this groundswell of interest in SCIP needed to be consolidated into a concerted course of action consisting of (1) the establishment of a Steering Committee with the task to identify groups interested in SCIP and link and synergise their efforts, and of (2) implementation and evaluation of SCIP model projects in Belgium, Germany, Greece, Wales, and the Netherlands, and of (3) a feasibility study on facilitating and inhibiting factors in implementing SCIP in various countries.

2. Partners: EU-SCIP project teams in the five participating countries

Countries / sites	Supervisors / co-ordinator	Members
Belgium Participating Drug prevention/treatment organisation: - MSOC Free Clinic in Antwerp	Prof. dr. Tom Decorte University of Ghent Dept. of Criminology Universiteitstraat 4 B-9000 Gent Phone: +32.9.264.6962 Fax: +32.9.264.6988 E-mail: Tom.Decorte@rug.ac.be	1) Tom Decorte 2) Sarah Slock (researcher) 3) Derkje Van der Elst 4) Frauke Van Goethem 5) Tino Ruyters (Free Clinic) 6) Heidi Holvoet (Free Clinic)
Germany Participating Drug prevention/treatment organisations: - Sleep Inn in Oberneuland - Verein Kommunale Drogenpolitik für akzeptierende Drogenarbeit in Bremen	Dr. Heino Stöver University of Bremen FB 08 – ARCHIDO Postfach 33 04 40 D-28334 Bremen Phone: +49.421.218.3173 E-mail: heino.stoever@uni-bremen.de	1) Heino Stöver 2) Birgitta Kolte (researcher) 3) Stefan Huß (La Campagne) 4) Irmtraut Kuzyk (Mobile)
Greece Participating Drug prevention/treatment organisation: - Kethea Therapy Center for Dependent Individuals in Athens	Dr. Anna Tsiboukli Kethea: Therapy Center for Dependent Individuals 24, Sorvolou Str. 116 36 Athens, Greece Phone: +30.21.0924.1993-7 Fax: +30.1.0924.1986-7 E-mail: Anna@kethea.gr	1) Anna Tsiboukli 2) Gerassimos Papanastasatos (Head Kethea Research Department) 3) Petros Triantos 4) Ioannis Tentis (Kethea Multiple Intervention Center) 5) Remos Armaos
The Netherlands Participating Drug prevention/treatment organisations: - The Jellinek Centre in Amsterdam - Bouman Addiction Care in Rotterdam	Prof. dr. Gerard M. Schippers AIAR Overschiestraat 65 1062 XD Amsterdam Phone 1: +31.20.408.7870 Phone 2: +31.626.538.750 Fax: +31.20.408.7862 E-mail: schippers@aiar.nl Mr. Edith A.S.M. Cramer AIAR (see above) Phone 1:+31.20.408.7869 Phone 2: +31.6.5337.6339 Fax: +31.20.408.7862 E-mail: cramer@aiar.nl	1) Gerard Schippers 2) Edith Cramer 3) Femke Mager 4) Hans Kronemeijer 5) Gijs Visser 6) Andrea v/d Pouw

Wales Participating Drug prevention/treatment organisation: - Cnygor Alcohol and Drug Agency (CAIS)	Prof. W. Miles Cox School of Psychology Brigantia Building Penrallt Road University of Wales Bangor LL57 2AS North Wales, United Kingdom Phone: +44.1248.383774 Fax: +44.1248.382599 E-mail: m.cox@bangor.ac.uk	1) W. Miles Cox 2) Aneurin Owen (General Manager CAIS) 3) Pauline Powell (researcher) 4) Gaynor Jones 5) Mary McIntyre 6) Jody Mardula 7) Irsha Sidiqi 8) Marc Kristian

3. Co-operation between EU-SCIP partners: Three Steering Committee Meetings

3.1 First Steering Committee Meeting

The first meeting of the EU-SCIP Steering Committee was held in Amsterdam on the 22nd and 23rd of February 2002, hosted by the AIAR research team. For the partners from Belgium, Germany, Greece, and Wales the aim of this meeting was to get acquainted with each other and to become familiar with the EU-SCIP materials as well as its background philosophy and to discuss a first design of the EU-SCIP research project. During this meeting all partners also presented the state of the art on drug policy and drug treatment in their country. They outlined their country approach, its features, and the problems that currently exist.

The introduction to the background, development, evaluation and implementation of SCIP was given by its originators. On the basis of a sheet presentation they focused on the following issues:

- The goal and research questions of the original Dutch project: "Self-control for drug users"
- The development of its background philosophy
- The comparison of three influential models on addiction and kicking the habit: the moral model, the disease model and the self-control model
- The question to what extent these models are supported by empirical data from epidemiologists (i.e. from long-term follow up studies), sociologists and psychologists
- The stages of change model of Prochaska & DiClemente (from cognitive-behaviour therapy) and its relationship with the spiral upward model
- Description of SCIP's background philosophy as process oriented, pragmatic, realistic, non-moralistic as well as emancipative, as giving priority to quality of life over complete abstinence, and as demystifying of drug addiction
- The development and use of SCIP illustrations
- First implementation and evaluation of SCIP in the Netherlands: design, methods and results
- Translation of SCIP materials in other languages: English, German, Spanish
- Adaptation of SCIP materials to application in other cultures

After this first Steering Committee Meeting, each team was expected to make a feasible plan for the implementation of the EU-SCIP in their own country.

3.2 Second Steering Committee Meeting

Items on the agenda of the Second Steering Committee Meeting on the 28th and 29th of June 2002 (venue again the AIAR office in Amsterdam) were comparison, discussion, and adaptation of the first English and German versions of the EU-SCIP educational and research materials, presentation and discussion of the EU-SCIP country plans, and training in recruitment of participant drug abusers as well as in EU-SCIP delivery.
The presentation and discussion of the respective country plans appeared to be one of the main topics. Belgium presented their plan to invite 50 clients from the low-threshold facility Free Clinic in Antwerp to take part in the SCIP intervention, Greece their plan to pilot test SCIP with 25 clients from the Off Club, a drop-in centre from Kethea in Athens. Germany unfolded their

intention to target clients from a Sleep Inn in Oberneuland as well as from various centres from the Verein Kommunale Drogenpolitik für akzeptierende Drogenarbeit in Bremen (N = 45). In Wales SCIP was adopted by Cnygor Alcohol and Drug Agency (CAIS), the largest drug treatment organisation in the Northern part of Wales. Their research team had planned to include 140 clients from a large gamut of treatment settings: 70 in an experimental and 70 in a comparison group. In turn the Dutch had made agreements with the Jellinek Centre in Amsterdam and the Bouman Addiction Care Centre in Rotterdam to include 84 of their clients in an experimental group as well as 84 clients in a comparison group.

In discussing the feasibility of the various plans it became obvious that on the one hand almost all teams were particularly interested in the observation of the impact, that SCIP would have on clients from low-threshold facilities, but on the other hand expected a large number of drop out during implementation of SCIP in these facilities, because of the chaotic lifestyles most of their clients live and the numerous problems they see themselves confronted with day after day. So beforehand each team carefully had considered the number of clients, that should be involved in pre-assessment in order to be able to collect enough reliable data at post-assessment.

The EU-SCIP training given during the second day of the meeting consisted of the following components:

- All facilitators were invited to give a short description of the setting, that they work in and the methods and techniques that they use in order to deliver treatment as usual;
- Discussion with facilitators about their own attitudes towards the following issues:
  - the various models of addiction and kicking the habit
  - the relationship between quality of life and complete abstinence
  - the relationship between quality of life and a controlled use of substances
  - willpower;
- How to introduce SCIP to research participants, other clients or colleagues?
- How to set group rules?
- How to work with the SCIP materials?
- How to structure a series of four SCIP sessions?
  Structure of sessions (in principal):
  - Welcome. Explanation of group rules. Short review of the previous session.
  - Introduction of session theme. Explanation exercise in group.
  - Exercise
  - Discussion exercise results.
  - Closing. Assignment of homework if feasible!
- How to make a kicking the habit biography? How to draw a graph about one's use through the years?
- How to use the List Self-control rules?
- How to approach drop-out?
- Any other issues that were not yet covered in the training, but that participants would like to discuss?
- Short evaluation of the training.

After this second Steering Committee Meeting, each team was expected to start preparations for carrying out their own EU-SCIP model project plans in the course of 2003.

3.3 Third Steering Committee Meeting

At the Third Steering Committee on Kea Island in Greece (11th to 13th of May 2004) experiences with the implementation and the evaluation of SCIP in the various countries were shared and discussed.
Round table discussions were held on following issues:

- How went the implementation of SCIP in each country?
- Description and comparison of participating location(s)
- Recruitment, compliance and drop-out of clients
- Integrity of SCIP delivery
- Satisfaction of clients and deliverers with SCIP
- Strength and weaknesses of SCIP
- Match of planned SCIP activity to actual delivery of the intervention
- What conditions facilitate or inhibit SCIP intervention effects?
- What comments can be made on other issues that affected inplementation?
- What lessons were learned?
- What recommendations can be made to improve SCIP?
- What recommendations can be made to improve implementation of SCIP in general?

At the end of the meeting conclusions were drawn regarding the feasibility of implementation of SCIP in general and recommendations were formulated in order to improve future implementation processes.

4. EU-SCIP feasibility and effectiveness studies

The experiences and data that were discussed during the Third Steering Committee Meeting were the preliminary results of the EU-SCIP feasibility and effectiveness studies. These results are presented in this paragraph (see 4.3)

4.1 Research questions

Feasibility:

(1) What changes in cognitions, attitude, and quality of life do the participants of the SCIP undergo during the intervention?
(2) What is the satisfaction of clients and service providers with the SCIP?
(3) What (other) conditions help or inhibit SCIP-intervention effects?

Effectiveness:

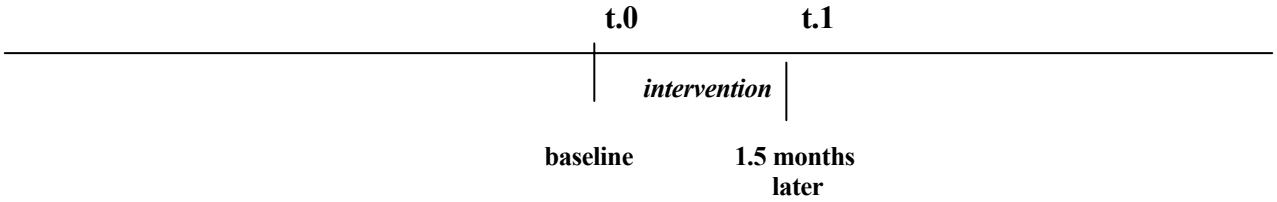
(4) Does exposure to the SCIP intervention (as stand alone, or add-on to treatment as usual) leads to more positive changes in cognitions, attitude, drug use and use related behavior, and quality of life than no treatment or treatment as usual during a three month follow-up period?
(5) Are any baseline characteristics predictive for changes at follow-up?

4.2 Methods

4.2.1 Designs and timelines

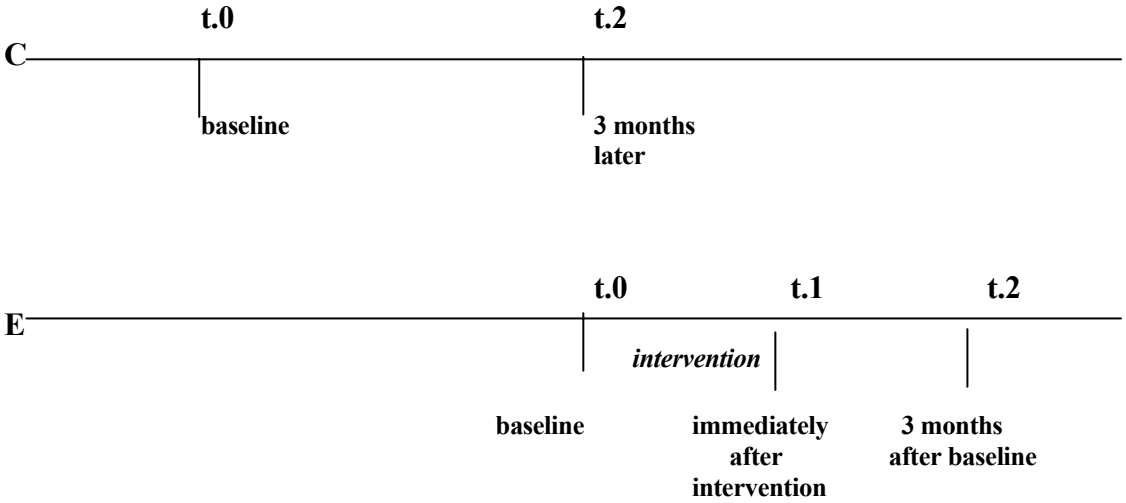
Design and timeline in Belgium, Germany, and Greece

A pre- and post intervention design without comparison group:



Design and timeline in Wales and The Netherlands

A sequential comparison / experimental group design with repeated measures at two points of time (baseline- and follow-up assessment):



4.2.3 Participants

Possible target groups

- Hard drug using clients of low-threshold drop-in, methadone maintenance or out-patient treatment facilities
- Hard drug using clients in residential treatment facilities
- Hard drug using offenders under custody of the police
- Hard drug using inmates in remand houses or prisons

Target number of participants

- Belgium: N = 50
- Germany: N = 45
- Greece: N = 25
- Wales: N = 140: 70 in experimental group and 70 in comparison group
- The Netherlands: N = 168: 84 in experimental group and 84 in comparison group

4.2.4 Inclusion- and exclusion criteria

Inclusion criteria

- A history of DSM-IV or ICD-10 dependency of at least the past one year
- Written informed consent

Exclusion criteria

- Not meeting all inclusion criteria
- Severe medical, psychiatric or psychosocial problems which constitute a contra-indication for participation in SCIP
- Unwilling or unable to attend SCIP
- Inability to read and write own language

4.2.5 Procedures

Experimental groups	**Comparison groups**
- Invitation to participate - Signing letter of informed consent - Selection - Baseline-assessment: t.0 - SCIP intervention - Post-assessment: t1 - Follow-up: t.2	- Invitation to participate - Signing letter of informed consent - Selection - Baseline-assessment: t.0 - Follow-up: t.2

4.2.6 Assessment and Follow-up

1. Recruitment through organizations involved and other means of contacts.
2. Invitation to participate: providing information and getting informed consent
3. COMPARISON: Individual assessment of baseline instruments to the participants of the comparison group.
4. COMPARISON: Individual assessment of follow-up instruments after 3 months to the participants of the comparison group.
5. EXP: Individual assessment of baseline instruments to the participants of the experimental group.
6. EXP: Delivery of SCIP.
7. EXP: Monitoring the intervention.
8. EXP: Exit interview
9. EXP: Individual assessment of follow-up instruments after 3 months to the participants of the experimental group. Interviews with the service providers as to the conditions that helped or inhibited intervention effects.
10. COMPARISON: Invitation to participate in SCIP intervention as well.

4.2.7 Assessment battery

- Demographic Information Sheet
- Lehman Quality of Life Scale
- Maudsley Addiction Profile (= MAP)
- EuroQol
- Readiness to Change Questionnaire (= RCQ-D)
- Self-efficacy List for Drug users (SELD)
- Statements on Kicking the Habit (SKH)
- List Self-Control Rules
- Self-Anchoring Striving Scale (= SASS) (short version)
- Questionnaires on Satisfaction with SCIP materials
- Questionnaires on Satisfaction with SCIP sessions

4.3 Results

As can be seen in table 1, row 1 and 2 all project teams have been able to offer the programme to one or more organisations, as they intended to, and a substantial number of them could be involved in the implementation itself. The majority of the settings that were involved, can be described as low-threshold.
In table 2, row 1, one can find how many people in each country were trained in the delivery of SCIP: 22 staff members and research(ers) assistants from Belgium, 6 from Germany as well as from Greece, 14 from Wales and 100 from the Netherlands. In total 148 persons.
In table 2, row 2, the number of clients, that were recruited across the various countries, is presented: 35 clients from Belgium, 39 from Germany, 25 from Greece, 42 from Wales and 95 from the Netherlands participated in one or more SCIP sessions. In total 236 persons.
Furthermore, another 150 clients (66 in Wales and 84 in the Netherlands) participated in the comparison groups.

All project teams also have been able to carefully monitor how accepting staff members and clients were of SCIP. That commitment to the EU-SCIP project across the various organisations was quite satifactory, can be learned from table 2, row 3. In row 4 is described to what extent translation and adaptation of SCIP materials was necessary across countries.

That translating and adapting the texts of the Dutch EU-SCIP materials (see Annex 2) has been successful and that they indeed did become useful tools for drug users in Belgium, Germany, Greece, and Wales can be concluded from table 3, row 1. The same is true for the characteristic illustrations of the SCIP-materials: they have proven themselves to be nice and helpful in illustrating the process of kicking the habit and regaining self-control. The Dutch origin of the SCIP does not seem to be a problem for the large majority of clients and staff members in Belgium, Germany, Greece, and Wales. Only one staff member in Wales clearly suffered from a so called “not invented here syndrome”. At the other hand drug users in Belgium and Wales explicitly said that the fact that SCIP was coming from Amsterdam added to its credibility.

As was expected, drop-out during implementation turned out to be high, but according to the explanations, presented in table 3, this high percentage seems to be not so much a reflection of the dissatisfaction of clients with the programme, as it seems to be a reflection of the difficult, strenuous circumstances, which they are living in.

Finally, strengths and weaknesses of SCIP, as perceived by SCIP participants in each country are summarized in table 4, and SCIP implementation facilitating or inhibiting factors, as identified by the various project teams, in table 5.

Table 1. Overview data regarding EU-SCIP studies

Countries	Belgium	Germany	Greece	Wales	The Netherlands
Number of organisations involved	1 organisation: - MSOC Free Clinic in Antwerp	2 organisations: - Sleep Inn in Oberneuland - Verein Kommunale Drogenpolitik für akzeptierende Drogenarbeit in Bremen 7 settings approached 5 settings participated	1 organisation: - Kethea Therapy Centre for Dependent Individuals in Athens 1 setting: Off Club	4 organisations: - Cnygor Alcohol and Drug Agency (CAIS) in Llandudno, Colwyn Bay, Bangor, Rhyl and Wrexham - Community Drug and Alcohol Services in Rhyl and Wrexham - North Wales Probation Services in Llandudno, Rhyl, Wrexham, Bangor and Deeside - Dewi Sant centre in Rhyl Group sessions in 5 settings	2 organisations: - The Jellinek Centre in Amsterdam - Bouman Addiction Care in Rotterdam and Dordrecht 7 settings were approached: 5 participated in the comparison study, 2 participated in pilot tests regarding further development of the EU-SCIP training
Description of organisation(s) involved	- Low-threshold medical facility centre for methadone maintenance, medical and social assistance	- 2 low-threshold shelters for homeless men - 1 guided housing project for men and 1 for women - 1 methadone programme for women - 2 (meeting point and) care projects for methadone clients	- Low-threshold drop-in centre	- Outpatient treatment and probation services - Detoxification unit - Rehabilitation unit - Drop-in centre	- Women shelter and crisis centre - Addiction care unit in Remand House (VBA) - 2 methadone maintenance facilities - Activity and reintegration facility - Inter cultural Motivation Centre (IMC) - Work and education facility

Table 2. Overview data regarding EU-SCIP studies (continuation)

Countries	Belgium	Germany	Greece	Wales	The Netherlands
Number of people trained	4 research(ers) assistants 18 staff members	2 research(ers) assistants 4 staff members	2 research(ers) assistants 4 staff members	2 research(ers) assistants 12 staff members	2 research assistants 98 staff members
Number of clients involved	50 invited 49 T-1 35 attended one or more sessions 17 completed 4 sessions 16 T-2	45 invited 39 T-1 39 attended one or more sessions 15 completed 4 sessions + T-2	10 invited to pilot testing first Greek version of EU-SCIP questionnaire and first translations of SCIP materials 25 invited to sessions 25 T-1 and one or more sessions 8 T-2	T-1 comparison group: 66 T-2 comparison group: 49 After T-2 one or more sessions: 8 T-1 experimental group: 70 One or more sessions: 34 T-2 experimental group: 24	T-1 comparison group: 84 T-2 comparison group: 72 After T-2 one or more sessions: 13 T-1 experimental group: 84 One or more sessions: 82 T-2 experimental group: 69
Commitment to EU-SCIP project across organisations	Staff commitment was from top to bottom. Some were more enthusiastic than others but overall SCIP was very well accepted.	Organisations were mostly open minded and supportive. Others were keen but had no time, but thought it a good idea and wanted to have the booklets. Some considered it totally different to current practice and thought it wouldn't fit in.	There were some problems in conveying the message, but when the aims were explained this became easier.		Management and a large part of the staff of both organisations were already familiar with SCIP materials. They were keen to take part and to get as many staff members trained in delivering SCIP as possible.
To what extent translation and adaptation of SCIP-materials necessary	Dutch information booklet was adapted to Flemish language and situation.	Information booklet was already translated and adapted before start of project, but workbook needed translation and adaptation to German situation.	Information booklet as well as workbook needed thorough translation and adaptation to Greek situation.	Information booklet was already translated and adapted before start of project, but workbook needed translation and adaptation to Welsh situation.	SCIP materials were ready for use at the start of the project.

Table 3. Overview regarding explanation EU-SCIP drop-out across countries

Countries	Belgium	Germany	Greece	Wales	The Netherlands
Drop-out	Many of the clients are stuck in structural social problems: some still need to serve a prison sentence, some are still wanted by the police for theft or other petty crimes, others are infected with HIV or Hepatitis. Many have permanently lost contact with their families. Not to mention refugees or people without official documents or visa, or people who have Belgian nationality but whose administration is not finalised. Many are not entitled to a disablement allowance or unemployment allowance, yet are unable to go to work at the same time. Others are homeless and still refused at a night shelter because of their drug use …An important barrier for treatment of drug users is the difficulty for them to adhere to agreements, because of their chaotic lifestyle and the fact they are hard to reach (they often have no phone or voice mail). The fact that many Free Clinic clients encounter successive problems and that most clients have trouble with keeping appointments may explain the large dropout after the T-1measurement.	Drop-out c/should for a large part be attributed to life-style of clients. The life of the drug users that were reached, is extremely difficult and strenuous. One man died. They have many problems with money (debts), family, police, other people and some are missing an own flat etc. So they forgot sometimes the meetings or just skipped their participation because of their circumstances of life.	High drop-out rate should be attributed to the "fluid" status of the Off Club members: many of them regularly interrupt without prior notice and are not contactable.	One main issue affecting group work was attendance. This was beyond the control of any individuals involved in the arrangements, rather down to the participants themselves and how they were on the day. Some participants were predictable and attendance was almost guaranteed. Some were extremely proactive during the group and yet would not show the next week. This could be attributed to the chaotic lifestyle some drug users lead. Others on a DTTO order have many commitments and occasionally found the group clashed with other activities planned for them by probation. One participant on parole, needed to sign on each day at the time of the group commencement. So workers need to be aware of the unpredictable / unreliable nature of some of this client group and should be prepared to have wasted sessions.	

Table 4. Overview regarding strengths and weaknesses of SCIP

Countries	Belgium	Germany	Greece	Wales	The Netherlands
Strengths of SCIP	The quality of SCIP is that it combines different insights on drug use - and kicking the habit- and therefore makes it possible to discuss those insides in a clear and structured manner.	The kind of intervention (new approach, no classical therapy) The view of acceptance and new philosophy (change of drug consumption is possible, control over the drug habit is possible) The win of consciousness about someone's own life circumstances and possibility to concentrate on things he/she would like to change (possibility to visualise real drug consumption, possibility to set own rules - The easy way of implementation: low-threshold. - The language - Talking about own experiences No pressure The structure of the programme (the programme gives structure) The programme is a result of the cooperation with (former) drug users.	SCIP produced good interaction between clients and provided them with an opportunity for self-assessment and exchange of ideas. They could compare their experiences with others. It was supportive.	SCIP materials provide useful, manageable, relevant information.	SCIP materials provide food for thought, and for exchange and discussion of own experiences. SCIP materials can be used as self-help guidelines, as basis for individual or group treatment aiming at self-control, as instruments/tools to inform parents, relatives and friends of drug users, and as instruments to educate personnel in -for example- prisons. Kicking the habit / regaining self-control is a process – so eventually people will get through it on their own but it could take 20 years. SCIP can be used as a catalyst to motivate and change earlier and go to the stages earlier or get them to the process more quickly. In terms of effectiveness / efficiency, one could say that SCIP maximises the window of opportunity. People are often in and out cycles. With SCIP it seems they return earlier to go through the cycle again.
Weaknesses of SCIP	Facilitators would have liked more guidelines and more training in the delivery of SCIP in an one-to-one situation.	Number of sessions. Clients would have liked more sessions. Certainly one after one or two months.		Number of sessions. In general clients would have liked more sessions.	

Table 5. Overview identification facilitating and inhibiting factors across countries

Countries	Belgium	Germany	Greece	Wales	The Netherlands
Identification of factors facilitating implementation	Commitment of staff members from top to bottom.	Commitment of and support from the staff of the various settings.	In Greece drug users motivated to change their behaviour generally go to Therapeutic Communities. This leads them to all kinds of practical help. Before the start of the project staff members had noticed that some of the visitors of the Off Club were gradually making changes in their behaviour, although they were not prepared to go to a Therapeutic Community. Staff members thought that SCIP could be especially helpful to this category of drug users. The EU-SCIP questionnaire, with its questions on how clients feel about the quality of their lives turned out to be a good starting point for discussing behaviour change or changes in lifestyle.	Cultural similarities between drug treatment practices in Wales and the Netherlands. All but one of the deliverers (9 out of 10) appeared to be committed to the SCIP project and expressed enjoyment and fulfilment from doing the groups. Good group work skills and knowledge of motivational interviewing on the side of the facilitators. Flexibility in the delivery of SCIP. Adaptation of the delivery of SCIP to the pace and the lifestyle of the clients.	The Dutch people were already familiar with and accepting of SCIP background philosophy. Good group work skills on the side of the facilitators. Adaptation of the delivery of SCIP to the lifestyle of the clients. For instance: scheduling of sessions just before or just after clients are used to come in for a meal.
Identification of factors inhibiting implementation	Time resources: facilitators would have liked more months time for the implementation of SCIP. Lack of time because of long waiting list and because of the need to defend the existence of the organisation.	Lack of time of staff members. Two staff members clearly suffered from feelings of uncertainty about own capabilities to deliver SCIP.	At one hand illiteracy of some clients slowed down the pace of the group, but at the other hand started the group members to help each other.	Resistance of one middle manager and some of his co-workers. He felt the project was imposed upon him. One deliverer (out of 10) started to change SCIP and to deliver it according to her own ideas. Some deliverers from a nursing background felt to be inadequately prepared to deliver SCIP.	

	Lack of group work practice in organisation. Inflexibility in the delivery of SCIP because of existing house rules.			Rural area: facilitators and clients sometimes had to travel long distances. Clients did not always had the money to pay bus or train fares.	

4.4 Conclusions and recommendations

Conclusions

- Although drop-out was high, all project teams have been able to collect enough reliable data in order to report on :

    a. The changes in cognition, attitude, behaviour, and quality of life the SCIP-participants undergo during and after the implementation of the intervention (data on effectiveness of SCIP will be presented later on in an article in a peer-reviewed scientific journal);
    b. The satisfaction of clients and service providers with the SCIP;
    c. Any other conditions that help or inhibit SCIP intervention effects.

- Although further in-depth analysis of qualitative and quantitative data is still needed, from comparison and evaluation of experiences across the five participating countries it can be concluded that implementation of SCIP in other countries than the Netherlands is feasible.

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- Furthermore, in carefully monitoring and evaluating the entire implementation process in each of the participating countries, all project teams have been able to collect valuable feedback in order to improve the EU-SCIP questionnaires, materials, facilitator's guidelines and training as well as the implementation of SCIP in general.

Recommendations

In carefully analysing and balancing the perceived facilitating and inhibiting factors, following recommendations can be formulated in order to improve future implementation of SCIP:

- Involve personnel from top to bottom in the decision taking concerning the implementation of SCIP
- Take ample time for implementation
- Good group work skills of deliverers facilitate implementation
- Good motivational interviewing skills of deliverers facilitate implementation
- Be flexible while delivering SCIP
- View, approach, treat clients as experts on the subject of their own drug use
- Go through materials / the programme at the pace of the client
- Adapt delivery of SCIP to the life-style of the clients. For instance: schedule sessions just before or just after clients are used to come in for a meal.
- Learn deliverers to accept that occasionally they come in and nobody shows up
- Be also flexible in the delivery of the number of SCIP sessions
- During implementation it is sometimes useful to invite an outside group leader - experienced in delivering SCIP- to come into the organisation for a while and train the regular workers in SCIP. Since this helps to identify (client) personal development that is going on which is not picked up by the regular workers.
- Staff personnel, who would like to become SCIP facilitators, but are hesitating about their own abilities to become capable ones, can be best reassured by inviting them to join a SCIP group as auditors and discover for themselves how SCIP works.

5. EU-SCIP Survey

According to the project proposal 150 copies of the EU-SCIP Survey Questionnaire (see annex 5) together with the English information booklet "Kicking the Habit" and a black and white version of the English workbook were send out in the winter of 2003 to a selection of key organisations in addiction care all over Europe. Immediate response turned out to be disappointingly low. In making telephonic inquiries with some of the non responders why they had not replied, the following reasons were discovered:

- Language barriers: researchers in most of the Member States were able to understand, read and write English, but drug workers often are not.

- Some of the non responders were of the opinion that the questionnaire was send out to early. They advised us to first finish the whole project, wait for the final versions of the EU-SCIP materials in the various languages, add some information about process evaluative issues and outcome results to the survey packages and then send them out again. Furthermore they also recommended us to take care of translation of the materials in French and Russian.

Nevertheless, 40 groups interested in SCIP originating from 12 different countries could be identified:

- Two treatment agencies as well as the National Board on Treatment Agencies (VAD) in Belgium
- Around 20 treatment agencies and one prison in Germany
- One organisation in Switzerland
- Four organisations in Wales
- Two organisations as well as the National Probation Board in the United Kingdom
- One organisation in Stockholm, Sweden as well as the Swedish National Probation Board
- One organisation in Copenhagen, Denmark and also one in Skieen, Norway
- One in Greece, one in Barcelona, Spain, one in Ljubljana, Slovenia and one in Russia

6. EU-SCIP continuing development and future

Since the official closure of the EU-SCIP project on the 30th of September 2004 more work has been done to improve the experimental versions of the EU-SCIP materials, which were used during the project period and to produce and print its final versions.
Revising the EU-SCIP Questionnaires and EU-SCIP Facilitator's Guidelines in order to improve them according to the qualitative feedback, that was collected during the official project period, will be next steps in the ongoing process of the implementation of SCIP and the dissemination of SCIP materials in other European countries.Qualitative and quantitative data will be analysed and results will be published in peer-reviewed scientific journals.

There are indications that SCIP has been accepted for regular use in the various sites. The Welsh facilitators extended it to use with their alcohol clients. The Kethea team will continue piloting the materials. Not only at the Off Club, but also at the Kethea Induction Centre. In Belgium facilitators of the Free Clinic are still using SCIP materials too. They want the materials to be at hand when occasion arises.

Current developments in Germany are perhaps the most impressive: In September 2004 BINAD in Münster offered drug treatment centres in the region of Westfalen-Lippe the opportunity to take part in a SCIP training.14 facilitators from 7 drug treatment centers in Bielefeld, Castrop-Rauxel, Dortmund, Hamm, Rheine, Steinfurt, and Viersen accepted this kind offer. They received their training in Münster in the beginning of November and returned in February 2005 for a booster session. From the sharing of their experiences it could be concluded that most of them were quite pleased with what was achieved with their clients in just one round of SCIP, so they decided to do another round of SCIP before June 2005. Furthermore between February and June 2005 training of staff members and pilot testing of SCIP materials is also taking place in a prison in Bremen.

Last but not least, a team of drug workers from a drug treatment agency in Skieen (Norway) is currently busy with the translation of the EU-SCIP materials in Norwegian. They intent to visit the Netherlands in April in order to get proper training and then start pilot testing in September 2005.

A first presentation of the final versions of the EU-SCIP materials will take place at the 10th European Conference on Rehabilitation and Drug Policy in Heraklion, Crete (10th -14th of May 2005). On the 9th of June 2005 a presentation around the development and use of the final versions of the German EU-SCIP materials is scheduled to be held at BINAD offices in Münster. Later on in this same year symposia around the EU-SCIP project also will be organised in Belgium, Greece, the Netherlands, and Wales. The Welsh are in favour of a two day event with one presentation in the University setting and one in Services. The Greek will organise a day in October 2005.

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SASS	www.atsqol.org > American Thoracic Society (Q.of L. resource) www.qolid.org > Overview 1000 Q. of L. instruments	Cantril, H. (1965). The pattern of human concerns. New Brunswick (NJ): Rutgers University Press. Cramer, E.A.S.M., & Schippers, G.M. (1994;1996). Zelfcontrole en ontwenning van harddrugs. Eindrapport van een onderzoek naar de ontwikkeling en evaluatie van een zelfcontrole-programma voor druggebruikers. [Self-control and kicking the drug habit. Final report on development and evaluation of a self-control programme for drug users]. Nijmegen: University of Nijmegen Research Group on Addictive Behaviors (UNRAB).
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Annex 1: EU-SCIP timeline and overview of activities

Activities and phases were planned according to the following timeline:

Jan'02 - Feb.'02:	Preparation of first Steering Committee Meeting
Feb'02:	First Steering Committee Meeting
Mar.'02 - Jun.'02:	Preparation of survey, pilot and comparison studies
Jun.'02:	Second Steering Committee and Training Meeting
Oct.'02 - Nov.'02:	Start collection of comparison study data in the Netherlands and Wales
Jan.'03 - Feb.'03:	Start model projects and collection of pilot data in Belgium and Germany
May '03 - Jun.'03:	Start model projects and collection of pilot data in the Netherlands and Wales
Sep. '03 – Oct.'03:	Start model project and collection of pilot data in Greece
Nov.'03 - Dec.'03:	Start collection of survey data
Jan.'04- May' 04:	Computer entry, cleaning and analyzing of first part of study data
Jan.'04 - May.'04:	Continuation collection of data in Greece, the Netherlands and Wales
11-13 May'04:	Last Steering Committee Meeting
13-16 May'04:	Presentation and discussion of preliminary process evaluative results at EASAR symposium
Jun.'04 - Sep.'04:	Further data analyses and production of final country evaluations
30 Sep.'04:	Closure of project

Overview of activities

The EU-SCIP project started on 1 January 2002. Activities since then:

- January '02 – February '02: Start project and preparation of first Steering Committee Meeting;

- 22-23 February '02: First Steering Committee Meeting in Amsterdam (11 participants representing all collaborating institutions). Agenda: getting acquainted, introduction to EU-SCIP research project and to use of EU-SCIP materials;

- February '02– June '02: Preparation of details of research design, research instruments, and educational materials in all needed languages (English, German and Greek, and adapting the Dutch versions to produce Flemish versions as well); preparation of a second Steering Committee and Training meeting;

- 28-29 June '02: Second Steering Committee and Training Meeting in Amsterdam (14 participants representing all collaborating institutions). Agenda: adapting and correcting of research and educational materials, discussion of country plans, training in recruitment of participant drug abusers, in collecting data in comparison group conditions (for the Welsh and Dutch research assistants) as well as in EU-SCIP delivery;

- June '02 – October '02: Recruitment and instruction of addiction care sites participating in the comparison study in Wales and in the Netherlands. Finalizing the research instruments in Dutch and English;

- June ‘02 – December ‘02: Finalizing the educational materials (information booklets, client workbooks and facilitator’s guides) and research instruments in English, German and Greek;

- 23 October ’02: Official start of the implementation of the EU-SCIP research project in Wales with the arrival of consent of the Welsh Ethical Medical Committee;

- November ‘02 – June ‘03: Collecting data in comparison groups in Wales and in Amsterdam, Dordrecht and Rotterdam in the Netherlands. As to June ’03, 66 participants have been interviewed in Wales, of which 49 have been re-interviewed after three months. 84 participants have been interviewed in Amsterdam, Dordrecht and Rotterdam, of which 70 have been re-interviewed;

- 29 – 30 January ’03: Training session in Amsterdam with the deliverers of the SCIP intervention in Wales (attendance: 2 deliverers), and with the Welsh researchers (attendance: 2);

- January ’03 – June ’03: Training of deliverers of the SCIP in Antwerp (Belgium), Bremen (Germany), Athens (Greece) and in Amsterdam and Rotterdam;

- February ’03: Start of delivering SCIP in the Free Clinic in Antwerp and in two Sleep-in centres and one guided housing project in Bremen. In Belgium 45 drug users have been interviewed and 16 re-interviewed after a period of at least 6 weeks, in Bremen 39 participants have been interviewed and 15 re-interviewed also after a period of at least 6 weeks.

- May ’03 – September ‘03: Start delivering of SCIP in Wales at locations of Cnygor Drug & Alcohol Agency (CAIS) in Colwyn Bay, Bangor, Rhyl and Wrexham and in Amsterdam (one outpatient treatment centre and one work and rehabilitation centre) and Rotterdam (one shelter and crisis centre for women and one addiction care unit in prison). 84 experimental group participants have been recruited in The Netherlands, of which 69 have been re-interviewed after a period of three months. In Wales 70 experimental group participants have been recruited, of which 24 have been re-interviewed.

- June ’03: Drafting survey questionnaire that has been sent out in December ’03 and start computer entry, cleaning and analysing of first part of process evaluative study data.

- 12 June ’03: Welsh EU-SCIP Symposium: Introduction to EU-SCIP project 2002-2004, Dawn Centre, Colwyn Bay, Wales.

- September ’03: Visit project coordinator and German research assistant to Greek site. Sharing with Greek partners information about Belgian and German experiences with implementing SCIP.

- Oktober’03: Start pilot testing Greek materials and start recruitment of 25 Greek participants, of which 8 could be re-interviewed after a period of three months.

- 11-16 May ’04: Final Steering Committee Meeting and EASAR symposium in Kea (Greece)

- 3 June ’04: EU-SCIP workshop, Suchttherapietage, Hamburg (Germany).

Annex 2: EU-SCIP project publications

EU-SCIP Questionnaires (available in Dutch, English, German and Greek):

- Demographic Information Sheet
- EuroQol
- Kicking the Habit Biography
- Lehman Quality of Life Scale
- List Self-Control Rules
- Maudsley Addiction Profile
- Questionnaires on Satisfaction with EU-SCIP Materials and EU-SCIP Sessions
- Readiness to Change Questionnaire for Drug users (RCQ-D)
- Self-Anchoring Striving Scale (SASS)
- Self-Efficacy List for Drug users (SELD)
- Statements on Changing the Drug Habit
- Statements on Kicking the Habit

EU-SCIP materials:

- Information booklets:

  - Posma, R., Cramer, E., & Schippers, G.M. (2003) *In een spiraal naar boven. Naar meer zelfcontrole over druggebruik* [heruitgave van: Het Afkickproces. In een spiraal naar boven (1994; 1996) Nijmegen: University of Nijmegen Research Group on Addictive Behaviors (UNRAB)]. Nijmegen: SPIRUP.
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- Workbooks in Dutch, English, German and Greek:

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- Facilitator's guidelines in Dutch, English and German

EU-SCIP publications:

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Annex 4: EU-SCIP training

An EU-SCIP training consists of the following components:

1) Getting acquainted;

2) Participating facilitators are asked to fill out the Self-Anchoring Striving Scale and the list Statements on Kicking the Habit;

3) An introduction on the background, development, evaluation and implementation of SCIP until now (sheet presentation of around 45 minutes):

    - The Dutch project "Self-control for drug users"
    - Goal of project
    - Research questions
    - Comparison of three influential models on addiction and kicking the habit: the moral modal, the disease model and the self-control model
    - The question to what extent these models are supported by empirical data from epidemiologists (i.e. from long-term follow up studies), sociologists and psychologists
    - The stages of change model of Prochaska & DiClemente (from cognitive-behaviour therapy) and its relation with the spiral upward model
    - Description of SCIP's background philosophy as process oriented, pragmatic, realistic, non-moralistic as well as emancipative, as giving high priority to quality of life, and as demystifying of drug addiction
    - The development and use of SCIP illustrations
    - First implementation and evaluation of SCIP in the Netherlands: design, methods and results
    - Translation of SCIP materials in other languages: English, German, Spanish and Greek
    - Adaptation of SCIP materials to application in other cultures

4) The answers of the research participants in the original Dutch study on the three questions of the SASS and the 16 questions of the List Statements on Kicking the Habit are discussed and compared with the answers that the participating facilitators have given themselves at the start of the training;

5) All facilitators are invited to give a short description of the setting, that they work in and the methods and techniques that they use in order to deliver treatment as usual;

6) Discussion with facilitators about their own attitudes towards the following issues:

    - the various models of addiction and kicking the habit
    - the relationship between quality of life and complete abstinence
    - the relationship between quality of life and controlled use
    - willpower;

7) How to introduce SCIP to research participants, other clients or colleagues?

8) How to set group rules?

9) How to work with the SCIP materials?

10) How to structure a series of four SCIP sessions?
Structure of sessions (in principal):

- Welcome. Explanation of group rules. Short review of the previous session.
- Introduction of session theme. Explanation exercise in group.
- Exercise
- Discussion exercise results.
- Closing. Assignment of homework if feasible!

11) How to make a kicking the habit biography? How to draw a graph about one's use through the years?

12) How to use the List Self-control rules?

13) How to approach drop-out?

14) Any other issues that were not yet covered in the training, but that participants would like to discuss?

15) Short evaluation of the training.

Annex 5: EU-SCIP Survey Questionnaire

1) What is your involvement in the treatment of drug use and abuse?

2) What is your general opinion on the *quality* of the SCIP "In a spiral upward"? Please, comment on the content, message, structure, clarity, logic, intelligibility, size, lay-out, etc of the materials.

3) What is your general opinion on the *usefulness in your country* of the SCIP "In a spiral upward". Please, comment on the possible interest, attractiveness, feasibility, costs, applicability, etc.

4) What elements of SCIP do you consider positive?

5) What elements of SCIP do you consider negative?

6) Are there any kinds of preventive-educational or recovery-facilitating materials available for drug users in your country that resemble the "In a spiral upward materials"?
If so, please provide us with the references for these materials?

7) How well are these materials disseminated in your country?

8) Do you think that there are sub-groups of drug users in your country, who could profit from using SCIP materials? If so, please describe them?

9) Would you be interested in implementing SCIP in your country? If so, in what way?

10) Through which persons, agencies or institutions could interested groups be reached?

11) In your opinion, what factors will facilitate or inhibit this dissemination?

12) Do you have any other suggestions about SCIP or its dissemination?

13) Would you be interested in attending a conference where the results of the evaluation project will be presented?

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