MIDDLESEX UNIVERSITY DRUG AND ALCOHOL RESEARCH GROUP

THE ALCOHOL CONCERN SMART RECOVERY PILOT PROJECT FINAL EVALUATION REPORT

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MAY 2010

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BACKGROUND

THE PILOT PROJECT

The idea for this pilot project began in 2006 with Professors Nick Heather and Keith Humphreys (a leading US addiction specialist and author of the key text *Circles of Recovery)* agreeing to collaborate on a project for England[1]. Their interest as scientists and professionals was in reducing the harm caused by alcohol consumption and was prompted by awareness that the formal treatment system would never have the capacity to meet the needs of all people with problems relating to alcohol. They agreed there was good evidence about the value of peer-led support and they were aware of the benefits and achievements of AA. But they felt, in an increasingly secular society, not all people would feel suited to AA and there was a need for an alternative. They put together a proposal to DH in 2006 which was not successful but tried again in 2008 and this time were successful in getting Section 64 money.

Alcohol Concern's interest stemmed from their general interest in promoting self-help groups and from having had earlier contact with SMART when they were approached by its UK representative. At the time, they had money from DH and from The Tudor Trust[2] around activities to do with self-help but had not heard about SMART before then. They learnt about their work in prisons and found this very interesting and thought it could be promoted in England. A bid was made to NOMS to run SMART groups in London prisons, which was funded. It was called a befriending scheme - essentially using SMART UK methods and tools. At the same time, DH were beginning to think about interventions for people with alcohol problems and self-help was one aspect, which was eventually mentioned in policy documents.

So when approached by Nick Heather with the representative of SMART Recovery UK, Alcohol Concern were happy to be involved in putting together a bid – it felt like a good partnership. Alcohol Concern's mission statement has two tenets – to campaign for effective policy change to reduce alcohol harms – and to ensure support and treatment for people affected by alcohol misuse – so the proposal fitted with their goals.

The SMART Recovery UK Group Development Director at this time was Fraser Ross and he became a member of the steering group and delivered the training. He had become involved in SMART in 2000 through his work in Inverness prison where he had developed groups based on these methods. Later he was invited onto the Board of SMART Recovery US – he was the first non-US person to be on the board and at the time of writing remains a member. In 2005, he developed SMART Recovery groups in Inverness, working with the DAT team as a volunteer. Most of his spare time and holidays were spent developing SMART Recovery. He then wrote to the Robertson Trust and from September 2006 was funded to work on developing SMART Recovery UK full-time. About this time, he also met up with Nick Heather and the partnership developed from there.

[1] Originally it was expected that Keith Humphreys would be associated at a distance with the steering group but his appointment to the US Obama Administration's Office of Drug Control led to his resigning from this role although he maintains a close interest

[2] *How to start and run a self-help group : DIY with support for people overcoming alcohol misuse* Alcohol Concern April 2007

The pilot project was thus a partnership between Alcohol Concern (the leading national agency on alcohol misuse, campaigning for effective alcohol policy and improved services for people whose lives are affected by alcohol-related problems), SMART Recovery UK (a network of groups coordinated from a centre in Inverness, which supports individuals who want to abstain from any type of addictive behaviour or activity) independent experts and scientists, recovery advocates, host agencies, facilitators and members of groups in six selected sites. It was funded by the Department of Health for a limited two year period. Thus a key element of the design involved working in partnership, including working with alcohol service providers.

The focus for the project would be alcohol (even though SMART Recovery® overall deals with a range of addictive behaviours). There was an underlying assumption that recruitment to the groups would be mainly through services in the six areas. Recruitment would be encouraged by the host agency and the groups would most likely act as a form of after-care following formal treatment programmes.

The Alcohol Concern/ SMART Recovery pilot project was funded by the Department of Health for a two year period from April 2008 to end of March 2010. Its aims (as set out in the grant proposal and other documents) were:

- To establish six new sites where mutual aid can flourish and become self-sustaining[3]
- To develop training, manuals and resources to enable local champions to develop and promote new groups
- To establish standard referral protocols in line with MOCAM from all tiers to newly established mutual aid groups[4]
- To facilitate a national roll-out of non-12-step mutual aid groups throughout England after the project has ended.

The intended outputs were:

- SMART Recovery mutual aid groups set up in six sites in England
- Establishment of local Champions in each area to promote and develop groups and ensure further sustainability
- The development of a Champions' Manual and an adaptation of existing mutual aid materials for use in England

[3] 'Mutual help organisations are voluntary associations operated by peers who share a problematic status, rely upon experiential knowledge, value reciprocal helping, do not charge fees, and include personal change among their organisational goals' (Humphreys 2004: 177).

[4] *Models of care for alcohol misusers* (MoCAM) provides best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers. Page 73 notes 'Mutual aid and self-help groups are often a useful local resource, particularly for aftercare. Alcoholics Anonymous (AA) offers a model of support and continuing care for alcohol misusers, using the 12-step approach, and has the benefit of being available nationally. Other complementary mutual aid services may need to be specifically commissioned in each area to offer choice and an appropriate range of provision'.

- An evaluation report on project successes and learning points
- A guidance document for commissioners and alcohol services
- A national conference to disseminate good practice and share learning from the project.

The longer term outcomes envisaged by those proposing these developments were that, as a result of mutual aid groups being established, local areas would see improved outcomes across health and social care for participants; that these local areas would see improved models of care; and that more commissioners would adopt mutual aid approaches in their locality.

The problem which the pilot project aimed to address was identified as:

- lack of provision for after-care for people who graduate successfully from alcohol treatment programmes
- lack of an alternative to AA - the principal form of mutual aid available in England
- lack of provision for relapse prevention or recovery from relapse
- lack of paths to recovery for those not wishing to enter formal treatment.

The population in need was seen as:

- principally people with problems relating to use of alcohol
- other groups such as people with problems relating to other substances or other forms of addictive behaviour (though these would not be targeted in this pilot)
- people who have received some form of treatment and would benefit from less formal ongoing support
- people who are not comfortable with aspects of the AA form of mutual aid.

The solution was seen as SMART Recovery. This was broadly constructed as the use of well-evidenced cognitive behavioural approaches to addiction, delivered through mutual aid groups, which have been seen as playing a key role in any long lasting recovery process (Humphreys 2004).[5]

It was assumed that there is good evidence for the effectiveness of cognitive behavioural interventions in addiction treatment ('these are the treatments that tend to be best supported by research evidence' - Raistrick et al 2006: 103). The issue was whether these interventions could be delivered through a mutual aid support system as developed by SMART Recovery® in USA adapted to UK conditions. Raistrick et al's comprehensive review of the effectiveness of treatment for alcohol problems also noted as one of its key themes that 'the majority of people, including dependent drinkers, move into and out of different patterns of drinking without recourse to professional treatment. Unassisted or natural recovery is often mediated through self-help, family and friends, and mutual aid groups'.

[5] 'Participation in addiction-related mutual help organizations seems, on average, to reduce substance use and associated problems with psychological, physical and social functioning' (Humphreys 2004: 179).

One element in the design of the pilot rested on the idea of speeding up or condensing the time frame for the development of groups and roll out of SMART Recovery nationally by providing start up training in six identified locations in different parts of England.

SMART RECOVERY®

SMART is an acronym for Self Management and Recovery Training.

'SMART Recovery is the only addiction-related self-help organisation that explicitly acknowledges science as the ultimate authority,' (Humphreys 2004: 85).[6] It recommends abstinence and uses a four point programme focusing on:

1) building and maintaining motivation to abstain
2) coping with urges
3) managing thoughts, feelings and behaviour, and
4) balancing momentary and enduring satisfactions (Humphreys 2004: 85).

SMART Recovery® became a not-for-profit organisation in USA in 1994 and relies on donations, sale of materials and grants from foundations for financial support. It now claims meetings around the world (in California, New York City, Washington, Australia, Canada, Iran and UK) with a further 16+ online meetings per week. The founding president Joe Gerstein sees the key to SMART Recovery as 'self-management'[7]. The belief that 'you can do it' is the most important factor in making progress. 'The belief that you have the capability to overcome your addiction and that you can get back to living a normal life and will not always have to be "in recovery"'. Choice is the key. There are various approaches to recovery and SMART Recovery is just one. 'What is important is to find the one that suits you, fits you best'. In his view, the SMART programme can be used in therapy but SMART Recovery meetings are a form of self-help and mutual aid. Now there are 500 meetings per week world-wide, he claims. The Handbook has been translated into many languages. Now the Board in USA is composed half and half of professionals and alumni of SMART Recovery meetings. It is a slim organisation with only two full-time employees in the headquarters. The aim is to promote peer-led meetings but in the early stages professionals may facilitate meetings, in his view. After six to eight months they should hand them over to group members. 'Professional involvement helps to feed in the science'. The approach adopted may vary depending on the context, including differences in health services in different countries.[8]

A SMART Recovery Therapy manual has been developed recently which can be used by treatment professionals. In Australia treatment professionals play a role and there has also emerged there a group of peer support facilitators who have a para-professional role – as expert facilitators. There are thus a number of variations within the SMART Recovery model and only one approach is to emphasise that groups must be independent and peer-led from inception. However Bill White (who, like Nick Heather, is a member of the SMART Recovery international advisory board and who

[6] Humphreys notes that SMART Recovery views substance abuse as 'simply an unhealthy behavioural habit' (2004:2).

[7] Speaking at final conference on the pilot March 2010 London

[8] Humphreys notes that 'each SMART Recovery group has a voluntary coordinator who has access to a mental health professional advisor between meetings… the professional advisor is also a volunteer, because like all self help organisations, SMART charges no fees' (2004:85).

has become influential within the recovery movement in Scotland) places much more stress on autonomy and independence. His recent influential monograph points out that 'the history of addiction treatment and recovery in the United States contains a rich "wounded healer" tradition. For more than 275 years, individuals and families recovering from severe alcohol and other drug problems have provided peer-based recovery support (P-BRS) to sustain one another and to help those still suffering. Formal peer-based recovery support services (P-BRSS) are now being delivered through diverse organizations and roles' (White 2009). He notes also that 'the organizing principle for providing care for people with alcohol and other drug problems is shifting from pathology and intervention paradigms to a long-term recovery paradigm' (2009:9).[9]

Groups developed in Scotland initially with support from the Scottish Executive and later from the Robertson Trust. Groups within the SMART Recovery UK network are now running in seven Scottish towns and cities. A report on the members of some SMART Recovery groups and their experience of training has recently been written by Laura Graham, an independent evaluator (Graham 2010). Groups in Manchester also developed. The Manchester groups initially focused on drugs rather than alcohol. Meetings are now held in several locations in England (in addition to those relating to the Alcohol Concern pilot), for example in Bolton, Bury and West London (Graham 2010: 4).

Addaction received a contract to deliver a pilot SMART Recovery service from three Ayrshire local authorities and NHS Ayrshire and Arran.[10] Their view was that social workers in local

[9] White also notes that 'peer-based recovery support (P-BRS) is the process of giving and receiving non-professional, non-clinical assistance to achieve long-term recovery from alcohol and/or other drug-related problems. Peer-based recovery support is provided by people who are experientially credentialed. There are substantial differences between models of peer recovery support and models of professionally directed addiction treatment. P-BRS can be delivered through a variety of organizational venues and a variety of service roles (including paid and volunteer recovery support specialists)' (2009: 15). His arguments support a more assertive and independent network of recovery advocates: for example 'People in recovery have been cyclically included and excluded from leadership and service roles within addiction treatment and the broader arena of recovery support services. Recovering people are awakening politically and culturally and are generating new recovery support institutions that complement and, in some circumstances, compete with professionally directed addiction treatment.' (2009: 32). He includes SMART Recovery within the category of secular recovery support societies in the United States which there have included the Washingtonians (1840), multiple fraternal temperance societies (1840s to 1890s), the Dashaway Association (1859), the Ribbon Reform Clubs (1870s), the Business Men's Moderation Society (1879), Women for Sobriety (1975), Secular Organization for Sobriety (1985), Rational Recovery (1986), Men for Sobriety (1988), SMART Recovery® (1994), Moderation Management (1994), and LifeRing Secular Recovery (1999). He notes that such secular recovery groups have grown in number since 1975, but the availability of face-to-face meetings continues to be geographically limited. This limitation is balanced by the rapid growth in Internet based secular recovery support meetings (2009: 37).

[10] The Addaction pilot SMART Recovery programme in Ayrshire was implemented from July 2006 and evaluated in 2008. The evaluation report concluded *inter alia* that Addaction had successfully developed an open door service that clients could access rapidly and SMART Recovery offered an important and effective alternative to existing treatment and recovery services in Ayrshire. Most participants were able to quickly grasp the tools and techniques and enjoyed the learning and changes they experienced both in one to one sessions and group meetings. However the development of autonomous groups was slow and in 2008 no such groups were running. Facilitator training was still very much in the hands of professionals. Many referring agencies did not understand the underlying values of SMART Recovery. It recommended moving forward with facilitator training and supporting individuals to facilitate their own groups. (Opit 2008: Executive Summary). Currently the Addaction SMART Recovery website in west of Scotland says **'**SMART Recovery is a self-help programme *(footnote continued)*

community teams could lead the development of groups and that this was preferable as members might be endangered if non-trained people were leading groups. From the beginning of the pilot, there was a tense relationship between SMART Recovery UK and Addaction Scotland about what constituted the SMART Recovery approach (Opit 2008 describes differences between SMART meetings and SMART therapy). The SMART Recovery ® website lists treatment providers and programs. However it notes that 'SMART Recovery® does not endorse or approve health care providers. SMART Recovery® Affiliated Professionals are addiction treatment professionals or facilities who recognize and support the SMART Recovery® program. Being a SMART Recovery® Affiliated Professional means that 1) in the Affiliate's opinion the Affiliate's philosophy of addiction treatment is similar to SMART Recovery's philosophy, 2) the Affiliate has requested to be listed here in support of SMART Recovery, and 3) the Affiliate regularly suggests SMART Recovery participation to clients/patients'. Some members of the network were relaxed about these issues while others took the view that there were 'correct' and 'incorrect' approaches. This tension grew over time and produced strains within the movement in UK and also in USA.

SMART Recovery offers a response to any type of addictive behaviour either to do with substances or activities.

It is based on a set of tools which include:
• Change plan worksheet • ABCs of REBT for emotional upsets[11] • Cost Benefit analysis • Brainstorming • ABCs of REBT for urge coping • Role playing and rehearsals • Hierarchy of values • DISARM (destructive images, self awareness and refusal methods).

for people with drug and alcohol problems. People take part in one-to-one and group meetings that are led by themselves and their peers. All Addaction ask is that those attending consider becoming drug and alcohol free.'

[11] REBT: Rational emotive behavior therapy (REBT), previously called rational therapy and rational emotive therapy, is a comprehensive, active-directive, philosophically and empirically based psychotherapy which focuses on resolving emotional and behavioral problems and disturbances and enabling people to lead happier and more fulfilling lives. REBT was created and developed by the American psychotherapist and psychologist Albert Ellis who was inspired by many of the teachings of Asian, Greek, Roman and modern philosophers. REBT is one of the first and foremost forms of cognitive behavior therapy (CBT) and was first expounded by Ellis in the mid-1950s and continues its development to this day, (from Wikipedia accessed 14 October 2009).

Facilitators can be provided with a starter package (via the US website http://www.smartrecovery.org) which includes:

- The handbook
- The hat
- 5 DVDs and 4 videos
- Who we are
- Facilitating a SMART meeting
- Facilitating an advanced SMART meeting
- 4 point programme
- SMART for life DVD.

SMART Recovery has thus had a presence in UK for some time.

A number of key principles have been emphasised (as outlined in the various manuals adapted for a UK audience by SMART Recovery UK which have been distributed to interested persons and through training):

- Being non-hierarchical
- Being non-religious
- Being relaxed
- Being a practical approach to self-regulation
- Stress on self-responsibility to maintain abstinence
- Partnership between professionals and groups
- Valuing the opinions of all members of a group
- Facilitator style – approach and attitude
- Being forward looking
- Focus on recovery - being powerful not helpless
- Exploring individual challenges in a group setting
- Using the tools
- Brainstorming possibilities and solutions.

Over time the Development Director at SMART Recovery UK came to stress the value of separating groups from professional involvement, influenced by the ideas of Bill White and the emerging recovery movement in Scotland. This separation he saw as encouraging:

- Group autonomy
- Empowerment
- Independence
- Ownership

Some members of the SMART network fear that recovery groups can be hi-jacked by professionals, turning them into a service mechanism within an acute care model of addiction treatment.[12] A tension remains around this and related perspectives within the network associated with SMART Recovery UK. Some other individuals and groups who are also associated with SMART Recovery ® do not place as much emphasis on this separation, considering it possible for professionals to play a role in setting up groups and facilitating them initially, although the ultimate aim might be for such groups to become self-sustaining and autonomous in time. Some groups and 'SMART Recovery affiliated professionals' also argue that the tools may be used and taught in one to one sessions between a professional and a client or service user. [13]

EVALUATION AIMS AND METHODS

The research described in this report was carried out mainly using qualitative research methods. The aim of such research is to capture the experiences of participants and to see how they give meaning to the activities in which they are engaged. As social researchers we also place emphasis on considering the context within which participants' accounts are located and the inter-relationship between the perceptions of participants and the social world in which they arise. In the alcohol field, part of that social world is the system of treatment and service provision which aims to improve the health of people affected by alcohol consumption. Qualitative accounts look not only at 'objective' measures of outcomes, costs and benefits but include also reference to emotions, ideas and values. As an *evaluation* project, this research was not purely of academic interest but aimed to improve knowledge and assist in the improvement of services and activities focusing on alcohol problems.

The key questions for those developing the pilot project and for the evaluation centred on *feasibility* and *acceptability*: was it feasible to start up new mutual aid groups in six areas through the processes initiated by the steering group? Would these new arrangements be acceptable to services and potential group members?

The methods of research adopted were those of a *process evaluation*. It would have been unrealistic to attempt an outcome evaluation at this early stage to ascertain the effectiveness of the pilot projects. This would have required the collection of systematic data on behavioural changes at the individual level and on health system outcomes and changes. An important feature of the setting in which this research was conducted was the need to respect the desire for confidentiality and autonomy among group participants. Conventional intrusive data collection methods were not appropriate as they could disrupt the very process of developing groups, which was our main object of study as well as generally being resisted by participants at all levels in this pilot project.

[12] Humphreys notes that 'many professionals lack knowledge about self-help organisations' (2004:3).

[13] Humphreys points out that many self-help organisations establish supportive roles for professionals. Professionals may perform an advisory role, and may be invited to speak to groups, asked to help secure meeting space, and refer patients to the groups. Some self help organisations are openly hostile to treatment professionals though Humphreys notes this is more prevalent among organisations for serious mental illness than for substance abuse. Groups may be described as 'peer led' when in fact peer control is trivial. He adds 'buzzwords are far less important in differentiating self help organisations from professional interventions than is the bread and butter reality of who has power within the organisation' (2004: 20).

Ethical approval was given by the Middlesex University School of Health and Social Sciences Ethics Committee. Information sheets and consent forms were produced and used where appropriate. The research aimed to contribute to policy and practice discussions by helping to provide information on the needs of self-help organizations such as SMART Recovery. It hoped to draw together the evaluations/ views of participants in the process of developing SMART groups in the pilot sites, ranging across group members and facilitators, and other stakeholders such as the host agencies, other service providers and service users, and other activists as represented on the steering group and in Alcohol Concern. The research aimed to look for evidence on the *planning*, *delivery* and *receipt* of the pilot overall and in each of the six chosen sites. Quantitative and qualitative data were sought out on the extent of delivery, coverage of target groups and levels of satisfaction.

The main sources of information were:

- Routine monitoring data [to be collated by the project coordinator]
- Documents [from websites, manuals, grant application, project applications, and progress reports to DH and steering committee]
- Interviews [with steering committee members]
- Focus groups [two were held with facilitators attending networking events organized by the project coordinator in September and December 2009]
- Questionnaires [to contact persons in the host agencies on two occasions, to group members in Autumn 2009 and to participants in the final conference March 2010]
- Observation [of steering committee meetings, networking events, training sessions and the final conference].

Questions addressed using the above listed sources of information were:

- What is the SMART Recovery model?
- How did the idea for the pilot come about?
- How was the proposal developed into action?
- How and why were the six sites selected?
- Who were the key players in developing this pilot?
- What were the characteristics of each host site?
- Did an influential champion develop in each site? And who were they?
- What resources were needed to support the groups?
- What aspects of the local policy and practice environment were influential in each area?
- Were local stakeholders mobilized to support the groups?
- Were stakeholders mobilized nationally to support the pilot?
- How were facilitators and group members recruited?
- How many groups were established in each site?
- How many people attended?
- What were the characteristics of group members?
- Did networks develop between groups?
- What were the expressed needs of group members? Were these met by group membership?
- What did group members think about the model/ SMART Recovery approach?
- Did group members feel empowered by participation?

Not all these questions were amenable to full answers in the process of carrying out this research. It proved impossible to collect standardized routine monitoring data mainly because of the importance of not disrupting the delicate process of establishing new groups. Contact between the project coordinator and the host agencies proved more difficult than anticipated as the contact persons at each site were very busy people who could rarely be contacted by phone or email. The researchers found it most useful to base information collection around naturally occurring events such as the networking meetings or the final conference. Facilitators were especially helpful in negotiating access to group members and encouraging them to complete the questionnaire distributed in Autumn 2009.

FINDINGS

PLANNING

EXPECTATIONS

The original expectations of those involved in planning the project can be deduced from an analysis of documents and from interviews and observation.

Key participants

It was expected that the key participants would be the Department of Health, Alcohol Concern, SMART Recovery UK, the steering committee, the project coordinator, the host agencies in the six sites, the facilitators and the group members. These were thought to have various roles which were briefly:

- Department of Health would provide funds over a two year period and monitor developments through observation of steering committee meetings, and receipt of regular financial and administrative reports

- Alcohol Concern would organize free access to SMART Recovery® facilitator training, literature, practice and techniques; assist with capacity building for service providers and service users; support the creation and development of a network of mutual aid champions; and provide support to commissioners for service expansion and development of access to after-care and peer-based support for long-term recovery

- SMART Recovery UK would offer advice through membership of the steering committee

- The steering committee would meet quarterly and guide the development of the project

- A project coordinator would lead the development of the project and be responsible for ongoing development, operation and evaluation; and would in particular provide support for the facilitators by bringing people together from different sites through networking meetings

- The host agencies would offer support and guidance for any of their clients who wanted to start a meeting and offer rooms to hold meetings in; would assist service users in setting up SMART Recovery groups; provide a room for the training to take place in and promote the idea to their service users; and offer support to the facilitators

- The facilitators would lead, develop and coordinate meetings, having been trained; they would access materials and maintain adherence in meetings to the SMART agenda and guidance, and maintain focus; they would function as a leader within a peer-group, self-help setting rather than being expected to provide an answer to every question. After

training, it was envisaged that individuals identified as facilitators would be ready to set up meetings. As the groups should operate with a relatively flat structure, there might not be just one facilitator in a group but any or all group members could take turns in facilitating.

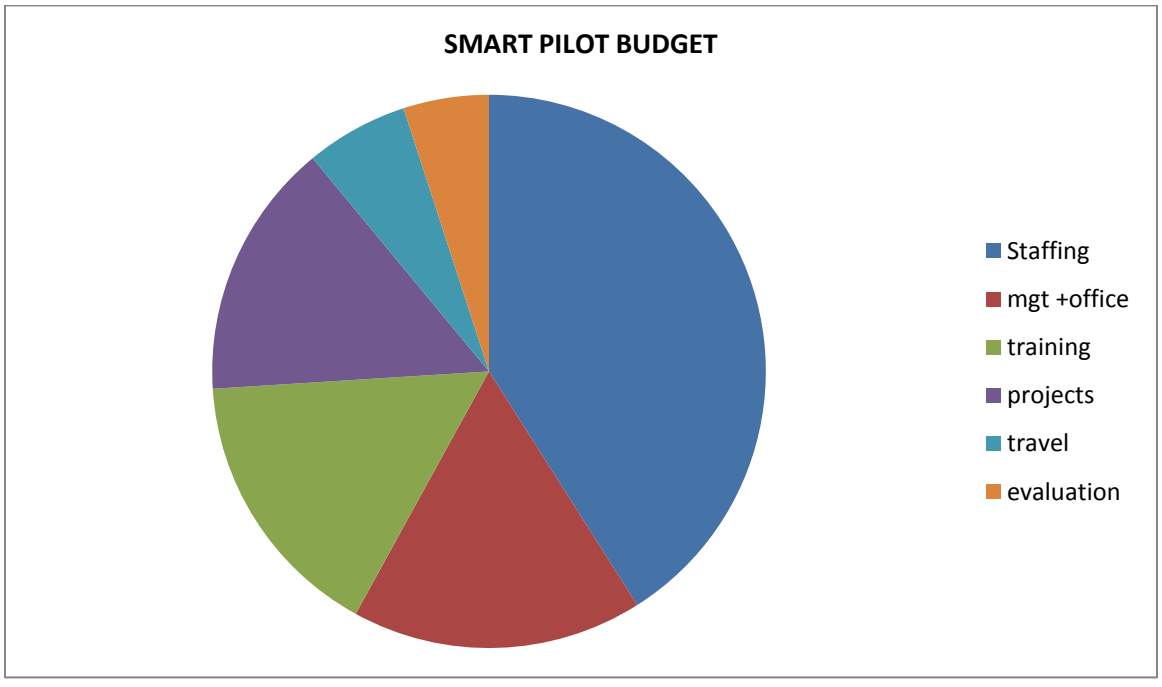
DEVELOPMENT AND DELIVERY

EXPECTATIONS

How was it anticipated resources would be distributed?

Resources:

The total budget allocated by DH over a fixed two year period April 2008 to end March 2010 was £100,000.The projected expenditure divided into a number of heads allocated as in the diagram below.



What did stakeholders define as the core ingredients of the model?

Core elements were *training, support, and champions*.

Training

The design assumed that one initial period of training in each site would be sufficient to jump start/condense the process of developing groups. Host agencies would nominate people to take part in the training and the DH project budget would pay the travel and related expenses of those delivering the training.

Support

It was assumed by those writing the project grant application and on the steering group that pilot sites would ensure that a room was available for at least one meeting per week, that they would refer service users to the meeting as appropriate and provide access to photocopier, paper, telephone and email internet as needed. These would be provided as part of the general expenditure of the host agency and no additional funds would be required. It was also expected that they would advocate locally among fellow services to raise awareness and ask them to encourage their clients to try the SMART Recovery meetings.

It was also assumed that support would be provided to both host agencies and groups by the Project Coordinator acting in a developmental role and that the wider SMART Recovery UK network and website would provide additional ongoing support for groups as they developed over time.

It was also expected that support would be offered by the host agencies through one named person (usually the person whose name was on the project application) who would also become the champion for these groups in the agency and more widely in the local area.

Champions

The emergence of champions in each area to take up the cause of promoting and developing SMART Recovery groups was seen as important for longer-term sustainability. It was assumed these would emerge from the active interest expressed by agencies in applying to take part in the pilot and through experience of the benefits of the existence of groups.

In the Facilitator Training Resource Manual (February 2009 version) it is stated that SMART Recovery® local champions are volunteers – 'the person who helps with local organising and promoting SMART Recovery. Ideally there will be a team of local champions who form a steering group to run and support groups locally. These groups will be joined up by the Central Office and brought together for mutual support and learning' (p8). Elsewhere in a handout to those attending facilitator training there is a section 'how to identify a SMART Recovery champion' with the answer:

'an individual who has demonstrated or is demonstrating recovery responsibly and capably; an individual who has sustained abstinence; or an appropriate service user that may wish to start up a mutual aid group'. Others involved in the process of developing the pilot programme envisaged service providers, treatment professionals or other independent supporters and experts as the main champions who might in particular fulfil a key function by referring people to the groups and encouraging support for SMART in the broader local community.

EXPERIENCES

Steering committee

The steering committee was chaired by a distinguished Emeritus Professor and member of the International Advisory Board of SMART Recovery® USA. Other members were the Director of Policy and Communications at Alcohol Concern, the Development Director at SMART Recovery UK, and two recovery advocates from SMART Recovery in Manchester. The meetings were also attended by a representative from the Department of Health, the independent evaluator and the project coordinator. Meetings were held quarterly.

The representative of SMART Recovery on the steering committee was involved in the appointment of the first project coordinator and suggested new members to represent recovery advocates. He also delivered much of the training.

Training

Training was offered over two days in each site and covered principles used in SMART Recovery® and how to facilitate a meeting. Alcohol Concern also committed to provide one day of training for professionals.

Training covered the following topics:

- what is SMART Recovery
- how does SMART Recovery work
- staff support
- evaluation and monitoring
- basic REBT theory
- actively listening
- brainstorming
- how to introduce a meeting
- dealing with challenging situations
- work time
- basic skills
- role play
- patterns of interaction, and
- facilitator styles.

How did the distribution of resources match original expectations and why were there changes?

Staffing covered the costs of the project coordinator salaries, insurance and other related costs. Management and office costs included staff overheads and stationery. Training involved the costs of contracts to provide training. Project activity covered marketing and publicity, national conference costs, networking events and publications. Travel included costs of accommodation and covered attendance at networking meetings and visits to projects. Evaluation covered the cost of contract to independent evaluation team.

The cost of the trainer's expenses was not adequately covered in the original budget. Networking events were not in the original budget either. Both these activities emerged as important. Other items not covered or covered insufficiently in the original budget included visits to local sites by the project coordinator or by the evaluation team. There was no money for any follow up to the initial formal training – future training would have to be done by the volunteers and costs met by host agencies. It was agreed that a further application for funds to support more training would be useful and one was drafted but not in the event taken forward. There was also some uncertainty for a time about the time period over which the contract would run. Since the pilot had to end by March 31 2010, it emerged that there would be a project under-spend on salary costs. It was also found that some reallocation towards travel would be needed. Other activities which might benefit from more expenditure emerged also as the pilot developed: these included an end of project conference, further travel costs and more networking events.

As it emerged that costs were becoming a barrier to groups' development in some local areas, the issue of costs and expenses for facilitators was discussed at a steering committee meeting (June 2009). It was agreed that reasonable costs related to training were acceptable but that other costs could not come out of the project budget. The reasoning here was that to provide such support would encourage dependency on the centre and that this would store up problems for the future when such support would inevitably have to be withdrawn.

How did developments take place over time?

The early stages involved a series of tasks including:- identifying the pilot sites; drawing up service level agreements; appointing an independent evaluation team; mobilising SMART Recovery information, training tools and manuals[14]; distributing information and manuals to the pilot sites; producing promotional materials; compiling training packs; organising the steering committee; agreeing terminology and approach; understanding the needs of host sites; and agreeing the appropriate form of evaluation. The time required for these early stages was probably underestimated in the original design.

It emerged that there were two competing requirements in the project coordinator role: one was for the personal skills to be able to network effectively with group members and agencies; the other was for the administrative and communication skills required in organising steering committees

[14] A body of materials were made available including: *Facilitator Manual; Members' Handbook; Guide for Professionals and Commissioners; Alcohol Concern Pilot Site Information Book; Facilitator Guide Book; Facilitator Training Resource Manual; newsletters; posters; card handouts; briefings for pilot sites.*

(preparation of agendas, minute taking etc) and production of written promotional materials. The person appointed as Project Coordinator initially had the first set of skills but not the second: the administrative demands placed on the Project Coordinator were probably underestimated in the original design.

After the second Project Coordinator had been appointed, a variety of tasks were completed including:- the production of an information sheet; explanatory information about the project was put on the Alcohol Concern website; a visit was made to Cornwall to discuss problems that had arisen there and the decision was made to end the agreement with that agency (Addaction Cornwall) and a replacement rural site was selected – Cumbria; training events were organised and training was delivered at all sites; professionals were trained at four sites; facilitator networking meetings were organised; a progress report was submitted to DH; visits were made to host agencies; a peer support briefing and a Champions Resource Manual were prepared[15]; liaison with the evaluation team continued; steering committee meetings were organised and minuted; and an application was drafted to DH for funds for a related follow on project. A grand final conference was successfully organised.

MONTH	***KEY ACTIVITIES***
APRIL 2008	Grant begins.
MAY 2008	1st Steering Group meeting.
JUNE 2008	
JULY 2008	1st project coordinator appointed.
AUGUST 2008	Advertisement for applications to be one of six host sites.
SEPTEMBER 2008	Selection of six sites.
OCTOBER 2008	Contracts issued by Alcohol Concern to six sites
NOVEMBER 2008	Contracts completed by six sites.
	Evaluation begins.
	Materials on training and promotion developed.
	Steering group meeting.
	Addaction Cornwall indicate wish to withdraw from the pilot.
	Cumbria identified as replacement location.
DECEMBER 2008	1st project coordinator leaves post.

[15] *Developing choice in peer support: how alcohol services can support SMART Recovery* Liz Ainsworth Alcohol Concern 2010; *Peer Support Briefing : the SMART Recovery Project* Alcohol Concern 2010.

JANUARY 2009	2nd project coordinator appointed(temporary)
FEBRUARY 2009	2nd project coordinator appointment confirmed.
	1st training event Birmingham.
MARCH 2009	2nd training event Sheffield
	3rd training event Norwich
	Birmingham groups meet for first time.
	Norwich groups begin to meet.
	4th training event Croydon
APRIL 2009	Sheffield group starts to meet.
	5th training event Gateshead
	Croydon group begins to meet
MAY 2009	
JUNE 2009	1st networking meeting of facilitators at Alcohol Concern.
	6th training event Cumbria
	Steering committee meeting.
JULY 2009	Cumbria groups begin to meet
AUGUST 2009	
SEPTEMBER 2009	2nd facilitators networking meeting in Manchester
	Steering committee meeting
	Alcohol Concern 25th birthday party
OCTOBER 2009	Peer support briefing paper written
NOVEMBER 2009	Alcohol Concern annual conference
	Steering committee meeting
DECEMBER 2009	NORCAS formally withdraw from the pilot.
	Networking meeting, London.

JANUARY 2010	Conference planning
	Champions Manual written
FEBRUARY 2010	Conference planning
	Steering committee meeting
MARCH 2010	Final end of pilot project Conference London
	Article in the Guardian by Denis Campbell

Issues discussed at steering committee meetings

The ambition of the pilot was that it would lead to a national roll-out of SMART Recovery groups. It was always the view of the Chair that groups would be user-led not depending on professionals. At an early meeting (November 2008), it was agreed that the champion would be an advocate or a supporter who would disseminate the idea of SMART Recovery. Ideally there would be at least one in each area, perhaps more. At this meeting it was noted that a key issue emerging was that of the *relation between professionals and members of groups*.[16] Important questions to consider throughout would be how much professional involvement (and of what type) was most helpful. At each site it would be important to consider what would be the best relationship between service providers and the mutual aid groups and how would the arrangement of local services in an area affect the development of groups. This might vary by area. It was thought that SMART Recovery groups could be after-care, could be a precursor or an alternative to treatment, or might even run in parallel with treatment. The Chair however was clear that in his view SMART Recovery was pure self-help or after care. Alcohol Concern too were emphatic that SMART Recovery was about mutual aid and should be peer-led. Fear that groups would be taken over by the services was a concern for the SMART UK member of the steering group.

Members of the steering group were aware that a key issue was *how much flexibility could be allowed within the model*. There were two key influences on thinking within the steering committee: the work of Keith Humphreys whose book is a comprehensive discussion of issues; and the work of Bill White who emphasises the importance of simplicity and that attempts by outsiders to control the development of groups is a hindrance to their development (White 2009).

Another issue discussed was *the right balance of financial support to offer to local areas*. One view was that if financial help was given then the groups would no longer be self-help groups. The other view was that, in the development stage, some financial support was required. Most members of the committee were against providing funds. They recognised that some areas had expressed their frustration at the lack of seed-corn money but nothing had been put in the original budget to cover

[16] These discussions mirrored those noted by Humphreys where he refers to the fact that many professionals fear losing status if self-help groups are successful while self help groups sometimes fear being controlled by professionals (2004:165).

this. Ideas were discussed about how local groups could raise money. One member thought that group members ought to be able to contribute as they had spare money now they were not spending money on drink. However in this pilot it seemed difficult to raise money solely from contributions from group members themselves (perhaps because so few were employed full-time).

Communications were an issue discussed periodically by the steering group. It was hoped that a website might help to link members of the network effectively. Better use of the Alcohol Concern website and development of the SMART Recovery UK website were discussed and encouraged. How to increase use of the websites was identified as an issue but not fully resolved.

The identification of Champions was discussed. The formal list of champions consisted of the people who had applied to be part of the pilot and were named on the forms submitted to Alcohol Concern. Their role had been to advertise the training, inform their staff, and meet regularly with the facilitators. They were not necessarily the people who might actually be involved in referring people to the groups. One view was that it was important to get clinicians to use the groups and refer people to them as after care. While this was mentioned, little was done by the steering committee to encourage this to happen – whether or not it did depended on the actions of the host agencies and sometimes of the facilitators themselves. The Chair recognised that champions were important people for the future of the project after the pilot phase had ended. It was recognised that spreading the word beyond the one individual in each host agency who was the named contact and beyond to the local service agencies and professionals should be a key function but it was not clear who should do this. A Champions' Manual written by the project coordinator would assist and would be one contribution from the pilot to this process.

The *referral process* emerged as a key issue for the viability and development of groups. One view was the importance of developing an 'assertive' role in referring someone to a group – perhaps accompanying them to the meeting on the first occasion rather than just giving them the time and place to attend.

Some discussion took place on the role of champions also in helping groups with small funds. It was recognised that *commissioners might have a role to play* but no one was sure how this could be developed and this specific issue did not receive much attention. That a briefing document might be prepared was mentioned at one point –this became merged later with what became known as the Champion's Manual (*Developing choice in peer support: how alcohol services can support SMART Recovery 2010)*. It is worth noting that SMART Recovery is now specifically mentioned in the DH guide to commissioners (DH 2009).

The *role of the key activists* was recognised and members of the committee were aware of the danger of overloading individuals or of investing too heavily in one person in each area.

The *future development of SMART Recovery UK* and how to support the development of a network in England became a pressing topic as the end of the pilot phase approached. Sources of future funding to support a central infrastructure were discussed but this was thought not to be a matter for this steering committee but for SMART Recovery itself.

The organisation of *the final conference* was discussed along with how to access financial support for this. AERC were approached and support secured. The Chair saw the key role for the conference being to disseminate information about SMART Recovery, including to commissioners and practitioners. The question of how to promote SMART Recovery nationally was discussed and attendance and presentations at conferences was viewed as one way – and committee members did

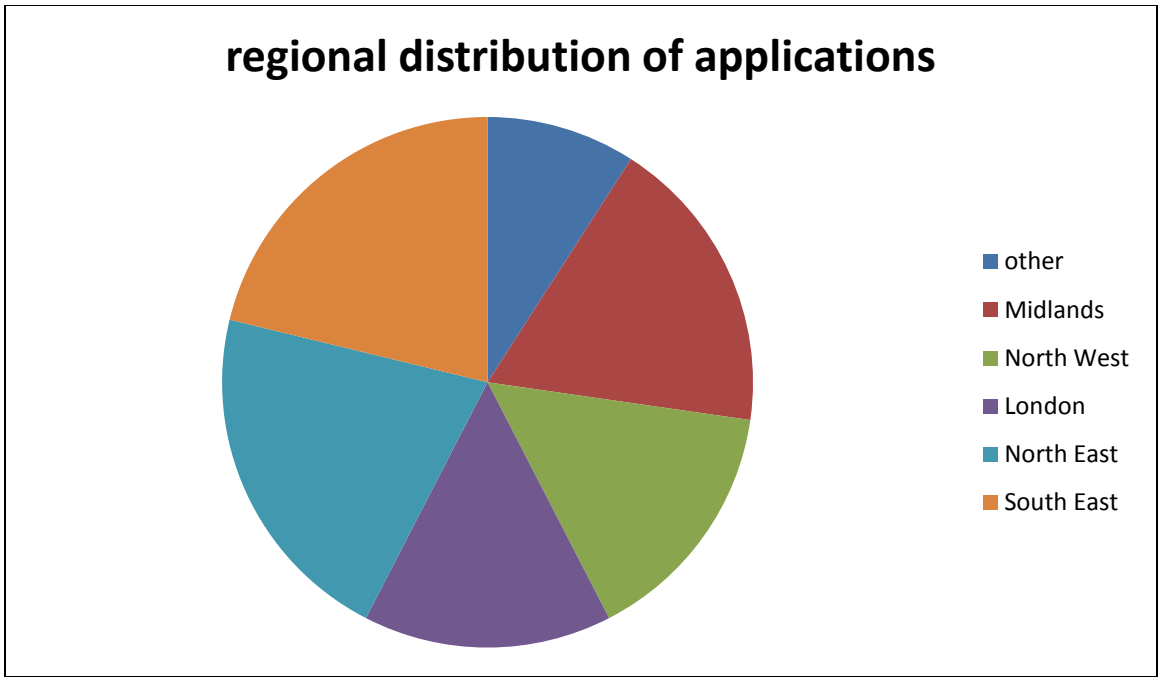
contribute to several conferences over these years to this effect. It was decided to withdraw the application to DH for a follow-on training programme, influenced by the fact of disputes within SMART Recovery UK and some disagreement as to how important training actually was in the development of peer led groups. There were differing views on whether in future the focus should be purely on alcohol or whether to cover the range of addictive behaviours that SMART Recovery addresses. The problems in SMART Recovery nationally led to a renewed discussion of the degree of professional involvement in SMART Recovery and recognition of the fact that internationally there were various views and differing practices.

Developing the host sites

For about half of the host agencies, the pilot served to introduce them to SMART: some had not heard of it before - they said they knew nothing at all about SMART Recovery previously; what they knew they had gained from looking at the website when considering whether to apply to be a pilot site. Some knew a little about it – that it was cognitive in approach and involved structured group work. However there were others who were already well informed about it: 'through Addaction Scotland who had run SMART Recovery for the past two years' or 'we had a detailed knowledge of SMART and the concepts behind it having run these groups in other of our projects'.

33 applications were received, indicating quite extensive interest in developing peer support options in England.[17] There was no financial incentive for agencies to become involved. Applications came from all areas of England as illustrated in the diagram below. In the event only six could be selected but it is worth noting that there are therefore at least 27 other agencies in England who might be amenable to becoming involved in future in developing mutual aid peer support groups of the kind represented by SMART Recovery.

[17] Humphreys notes that 'referring treatment providers should present self help group attendance options to the patient along with a recommendation reflecting their best clinical judgement (2004:169).



Agencies responded to the invitation to apply to be a host site for the following reasons:

- *service expansion* - to add another service to the range available to their clients, as an additional abstinence-based service, to add to or complement existing services, as it was a low cost additional treatment option, to provide more choice for their clients or as an alternative treatment pathway for clients
- *staff development* - to provide CBT training for staff
- *attraction of the model* - because they liked the SMART model and its philosophy and ethics, being secular, being peer led and more flexible in mode of delivery (particularly useful in rural areas)
- *supporting clients* - to be able to support clients in recovery, helping them maintain abstinence, as a next step once structured programmes or other interventions had ended or to provide a pathway of skills for existing clients who were developing the role of facilitator.

The key characteristics that appealed were that the groups were peer -led and focused on abstinence:

- 'a client led group that could own and develop their own methods of recovery, where ex users would facilitate the groups themselves'
- 'an additional peer led group with a focus on alcohol'
- 'as additional abstinence-based support, as a non AA service, alternative to AA'
- 'an independent service distinct from the statutory services with people having the freedom to join or leave, community based'
- 'as an option either before or after other interventions'
- 'offering clients something to work towards'
- 'offering an option in a new location'.

The criteria for selection of the six pilot sites were:

- geographical location (distribution across regions of England)
- urban-rural coverage
- range of different service providers, and
- indications of commitment and resources available.

Project agreements and protocols were drawn up between Alcohol Concern and the host agencies.

Once agencies had been selected, liaison with the host sites was required, prior to arranging training events. Host agencies recruited suitable people to attend the training sessions. As well as the main SMART Recovery UK trainer, others involved in delivering training included an expert on REBT and two experienced facilitators from Manchester (who were steering group members). The project coordinator also attended some of the sessions.

The key person delivering training was emphatic that training had only a limited role. Self-help was what had to be encouraged.[18] It was important not to tell people what to do as they have always been told they have deficits. A huge amount of material was made available to those attending, including detailed advice on operations (c.f. facilitator manual): for example, there is practical advice on finding a meeting location and on publicity. The facilitator guide book and a training resource manual had been developed by the Development Director of SMART Recovery UK, adapting US material to make it suitable for a UK audience.

The training and materials provided details on how to organise a meeting, how to develop and help to set up new groups, how to support and provide ongoing training, how to deal with challenging situations, and on principles, practices and key skills.

[18] The self-help ethos places the individuals who have the problem or status in charge of the organisation (Katz 1981).

Referring to the Facilitator Guide Book, key aspects of the programme were highlighted such as the link between a person's thinking and their behaviour and that irrational thinking is one of the major causes of addiction and addictive behaviour. It was stressed that meetings are confidential ('what is said here stays here') and people do not have to give their names. Meetings were expected to last between 60 and 90 minutes. An agenda was suggested covering welcome and introductions, check in, agenda setting, working time, donations and check out. It was explained that the focus in discussions should be on the here and now and how to change and not the past ('you don't drive a car constantly looking in the mirror and not looking at the road ahead'). It was useful for group members to identify homework to try out between meetings. Examples of the tools were explained and tried out such as: urge log; priority list; action plan; cost/benefit analysis; ABCs – activating event, beliefs, consequences; dispute, effect of disputing; coping with urges; self acceptance – problem solving; and lifestyle balance.

The resource manual included a code of conduct. The code is lengthy and lists key principles. These include reference to the importance of confidentiality and the right to privacy of group members. Other key statements are that 'professional involvement is not an element of mutual aid and over involvement stifles group development' (p7). 'A meeting run by a worker, paid or voluntary, of a professional organisation as part of its business is not a mutual aid meeting and should not be called a SMART Recovery Group' (p8).

Host agencies

Host agencies were not very clear about the role expected of them. One imagined 'I would be planning training, bringing it all together, advertising it and supporting'. Most host sites respected the principle of self-help and expected to play a support role only in the process of setting up the groups. They did not expect to have to make much input into the pilot. They expected their role to be minimal - 'help with set up and then support at hands length'. However they expected to help in promoting the project, supporting facilitators, providing a room and refreshments and generally encouraging clients.

There was a range of expectations about levels of involvement among host agencies, from emphasising the hands off approach to expecting to play a role in support and mentoring, as well as providing materials, staff hours, resources and help with marketing.

There was one host site which expected to play a fuller part in the process however and this led to their withdrawing from the pilot because of a disagreement about how best to develop these groups. This project in Cornwall saw potential for SMART to be an addition to their existing six support groups, alcohol day programme and counselling provided in 78 GP practices. They saw their role as helping to coordinate the process and that they would train with the service users to deliver SMART groups. They preferred a system where all groups would be set up with either two Addaction staff or one Addaction staff member and one service user, depending on the availability of service users in the early phases. They were prepared also to provide or assist in finding suitable premises, carrying out health and safety reviews etc. 'We felt that the most important role other than co-facilitating would be providing support and supervision to service user facilitators, to help them feel supported and safe and [have] a place to take issues to if they were not clear'.

RECEPTION

EXPERIENCES

Profile of people attending training events

In total, 63 people participated in the training events for potential facilitators with between 9 and 13 attending on each occasion. Of these, about two thirds were men and one third women (68% m; 32% f). They ranged in age from 29 years to 63 years with an average age of 45 years. The vast majority categorised themselves as White British, and about seven in ten were presently unemployed with the remainder retired, full-time or part-time employed or self-employed. About one third were single, one quarter were divorced, and one quarter married or cohabiting (with 10 no replies).

In most areas, most people lived in rented accommodation, although there were a number of owner occupiers in Birmingham. A few were living in rehab. and some in hostels, particularly in south London where the host agency was a housing service. Almost nine in ten had received some specialist treatment for their addictive behaviour. One quarter were currently in treatment. The remainder were most commonly not in treatment currently but had received treatment in the past year, with others having left treatment two or three or more years previously. About six in ten had attended AA at some time, with at least about a quarter currently attending AA.

The majority had last had a drink over three months ago, with almost four in ten having been abstinent for more than one year. Only two in ten had had a drink within the past three months. Of those who completed the Leeds Dependence Questionnaire, with reference to previous drinking patterns, almost six in ten scored above 25 (a score of 21-30 shows high dependence).[19]

Thus most of the people who attended the training appeared to approach SMART Recovery groups as a form of after-care following on from treatment and it appeared that the group members would most likely have previously had quite serious drinking problems with marked physical, psychological and social effects.

Developing the groups locally

In Birmingham, training took place in February 2009 and 15 people attended day one and 13 day two. Seven people were keen to be involved in setting up meetings, a number of whom were already attending an abstinence group at Aquarius. Some of those who attended training were worried about how confident they might be in facilitating a meeting. Another worry was what to do if people attended who had been drinking.

In Birmingham initially there was a hardcore of four people who attended group meetings and who spent time getting to grips with the tools and techniques of SMART Recovery. Two made a visit to a SMART meeting in Manchester which was found very helpful.

In North Birmingham, a group set up there after some time decided not to continue. This may have been partly because it was held in a church hall rather than in the Aquarius building. It also

[19] It has been observed that AA members typically have a high prevalence of physical dependence symptoms and histories of in-patient treatment (Edwards et al 1966; Robinson 1979).

reflected some conflict developing between group members and also some members relapsing or stopping being associated with the partner agency (SIFA).

In Solihull, the local manager was very supportive and easy access to her was a factor that helped in developing the group. This group were interesting as they preferred not to stick religiously to the tools although they did do the check in. They tended to focus their discussions on 'issues'. They said they use the structure but are not so strict about using the tools as other groups. This group disagreed with members of other groups, such as those in Sheffield and Manchester, who were more committed adherents to what they saw as the SMART approach. The local champion in Solihull (different from the higher level person named as the formal contact) had played a significant role in supporting the group and she used some funds from her own social work budget to help the group with incidental expenditures.

In Sheffield a key facilitator emerged who had attended SMART meetings previously in Manchester and was in close contact with members of SMART Recovery UK. He aimed to do one presentation a week to staff and clients at various agencies and had very positive feedback. He answered the phone when people enquired about the groups and this personal contact was helpful. The groups were publicised well in the network of alcohol and drugs agencies. Agency workers recommended the SMART group as a step on from counselling and clients then attended. A lot of attendees came from health services and community drugs and alcohol services. This group was also supported by visits from and contact with keen activists in Manchester where a lively network of SMART Recovery groups was developing independently of the pilot. No other pilot areas received this level of attention.

In Norfolk, from the beginning group members thought that 'setting up SMART Norwich seemed like it would be a challenge'. After a time the key facilitator at Norwich, who had done a lot of work in getting the meeting up and running, chose not to continue. A meeting was also considered for Lowestoft after the training but this did not develop. In this area, there was competition from a range of other alcohol focused interventions, including one for people who had been warned about alcohol related disorder offences who were required to attend an alcohol awareness group. These groups too were peer led and facilitated by experienced people who had skills in engaging the groups and were flexible and sensitive in their approach.

Similarly, setting up SMART in south London proved to be challenging. Initially a lot of effort went into finding a venue to meet in and marketing SMART to the public and local organisations. At first they were holding their meeting on a Wednesday but this clashed with another peer-led user group in the same area. After trying out meeting in a church hall and searching for other venues, the group went back to holding the meeting in one of the YMCA lounges.

In Gateshead immediately some problems were encountered. 25 people turned up for training but half walked out on the first day due to miscommunication – they thought they were coming to a general facilitator training not one specific to SMART and felt misled. (These were all service users). 12 attended on day two. But none was interested in becoming a facilitator. In Gateshead two facilitators were eventually identified but the group there never really got off the ground. This was in spite of trying to sell SMART, putting up posters all over Gateshead and meeting with people in a range of different agencies who might refer people to the group.

In Cumbria, the last area to join the project, clients who attended the SMART training met up in Kendal, Carlisle and Workington to discuss ways forward, practicalities and arrangements for advertising meetings and engaging new members. Access to stationery supplies, telephone etc were

given by the NHS team and ADS to help this along. Presentations were made by core activists to various agencies to try to get known and encourage referrals.

Overall *the activities of the people who participated in the groups in local areas were a vital element in the development of groups*. From the start, those involved gave a lot of time and attention to trying to establish groups. They thought about how best to market the group, how to produce leaflets and distribute them. They thought about how to recruit members to the group and discussed being proactive, going to places like drop-in centres and treatment settings and talking about SMART Recovery to people there to encourage them to attend. Two women in Solihull, for example, spent time going into local hospitals to tell people about the group. They recognised that referral itself was not enough - 'people need help to get through the door'. The *lack of money and lack of basic finance* to support them was often a problem. They needed help with simple things like access to a phone line so that someone would be there to answer the phone if a person responded to an advert about a meeting. Having someone available to answer queries about SMART Recovery from agencies or potential members made a difference as to whether a group could take off. In Sheffield, for example, the agency eventually provided the main facilitator with a phone, after he had contributed his own money for some time to the cost of a phone. Most members contributed their own resources as well as their own time to the projects.

Whether or not there were *competitor peer support groups* in the area also influenced how much they could do. While some thought that people spoke more freely if the group met outside a treatment setting, the problem of paying for hire of a room elsewhere was a major handicap. Once the group had established credibility with the local agencies they found it easier but these first stages were very challenging. They felt the *need for back up support* as they met these challenges and those who did make contact with SMART Recovery UK found this useful but not all were aware of this possibility or made use of the offer. Group members were also aware that the *stage that individuals were at themselves* was a factor in how much contribution they could make to the development of the group. Some thought it might be only after at least ten months of being a group member that a person would be ready to become a facilitator. In this sense the pilot was compressing the time required and in some cases perhaps putting a lot of pressure on individuals. One lesson learnt might be to allow time for groups to grow and develop more slowly than expected by the pilot. (This would of course also be an argument for continuing developmental support from a central infrastructure and from host agencies).

Group members identified the *need for publicity and establishing credibility* as key factors in the development of groups. The umbrella of a local host agency offering support was thought to be important in helping to give them credibility. Alcohol Concern was also recognised to play a role nationally in raising the profile of SMART Recovery. But group members also knew they had to play an active role themselves and so they did – making contact with services, meeting practitioners face to face, advertising meetings. At times they distrusted the pilot, being afraid that they might be being used as 'guinea pigs'. There was sensitivity about the evaluation especially rejection of being viewed as 'specimens'. There was some concern about what would happen once the pilot phase was over: and a worry that the final conference would be 'about them' not 'for them'.

Benefits of group involvement

The key element of SMART Recovery that appealed was that it was *non-hierarchical* and that there was an *emphasis on moving on* not repeating 'war stories'. They thought it important that a group should establish its own ground rules and then own them. There might be a difference between the people who pioneer the development of a group and those who join later but these groups had not been

around long enough to tell. The group members were pleased when on one occasion SMART Recovery got mentioned on the Jeremy Kyle show and then had a mention in Hollyoaks. They also got encouragement from seeing attention to recovery in the work of the NTA and more generally in the alcohol field – there was a feeling that perhaps their time had come. Members had different opinions on how far they could go to be independent of service providers, While the recovery agenda was seen as an opportunity, some thought it would be naïve to think that they could be completely independent and autonomous and that support from the host agency remained very important to them.

Being with people who had had similar experiences was very important for group members: 'you can make a statement and you don't have to paint the picture [in long and tiring detail] because others have been in same situation – you don't have to spend half an hour explaining - people automatically understand so then you can go on to address the problem'. Role models were valuable also: 'having people in the group who have not drunk for some time – is a really powerful role model thing – you get people who have been arrested and they come to the group - for them to sit in a room and actually see someone who stopped drinking 20 years ago (or even two years ago) and now has a life – this is impressive'. 'In the early stages of recovery, the majority of people in groups are probably not working – SMART is teaching people to go on and live a normal life'.

Peer comparisons

'having people in the group who have not drunk for some time is a really powerful role model thing – to sit in a room and see someone who stopped drinking 20 years ago and now has a life – or even two years'

'to see people only recently sober – I can look back – you see people where you have come from – I find that helpful'

Benefit of SMART Recovery group as seen by members

'I wish I had joined a group like this before. It is good to meet people in the same situation as me. It has taught me that I am not unique'

'you don't have to spend half an hour explaining'

'I find that SMART is very focused on the practical which is very important to me'

'SMART tools have helped me in my whole life (not just my recovery)'

'we don't tell anyone what to do – we allow people to make their own decisions'

Value and distinctiveness of SMART Recovery
'with SMART you are in control – you are responsible for yourself'
'Focus on the here and now'
'SMART is teaching people to go on and live a normal life'
'the whole aim of the group is to be a safety net so people can come back and maybe just sit quietly'
'Sharing with others'
'Gives confidence'
'You can see people change'

Role of host agencies

Host agencies in general respected the wishes of the group members in terms of how much involvement they had with the groups. One host agency had clear views on this issue: 'it is not in the spirit or the right approach for professionals to attend SMART meetings regularly, this should not happen and one hopes that people who say [they do] could be re-educated into this model. Professionals are very powerful and prevent the group members developing their own approach to fulfilled living'.

Another host agency held similar views: 'I do not attend meetings as I am not in recovery myself and I do not think it would be appropriate for me to attend'. Professional staff in one case attended the initial set-up meetings when requested. But they would leave the decision to attend down to whether the clients wanted or needed them to be there. In another case, the group meetings took place in the same building where staff worked so the key contact would 'pop into the group at the end of the session' or before it if there seemed to be no-one turning up – keeping an eye on how things were going. At the other extreme, in one area contact was difficult because the key staff contact was often not around but 'when I can I do pop into the group to say hello and am always made to feel welcome'.

Most hosts tried to be available so groups would know who to contact should they need to speak with one of them or needed further support. Correspondence was usually by telephone (sometimes by text messaging to remind of meetings or other activities) or email with the facilitators – not with the group as a whole - but in one case it was proving difficult as none of the group members there had an email address and telephone contact was problematic. In one case, regular informal contact occurred face to face in the same building. There were regular contact meetings fortnightly in another area and at least twice a week in another as facilitators were in the same building doing SMART or engaged in other work: similarly in another case there was regular informal contact daily with two key group members as they came into the office to use the computer. In another, the key staff contact did take part in the training to comment on the model and arranged for another staff member to watch the facilitator to give feedback twice – so here, although emphasising the importance of the independence of groups, this area saw a key role of support in the early development phase of groups setting up.

PROFILE OF GROUP MEMBERS

A 'snap shot' of SMART Recovery pilot group members

A questionnaire was distributed to groups in Autumn 2009. 65 completed questionnaires were returned (percentages are rounded to the nearest point). This was reported to be an almost complete response from members attending at that time.

Of those attending the SMART Recovery groups at this time, 68% were men and 32% were women.[20] They ranged in age from 27 – 69 years (mean 47 years).[21] 83% had received treatment for alcohol/drug use in the past and 28% were currently receiving treatment. 12 % had never received treatment. The length of time since the respondent had last had a drink (or consumed drugs) varied considerably from that day to 20 years, with most having last had a drink within the past 3 months (55 %) although for 20% this was over a year ago and 8% over 5 years ago.[22] In general, most members had previously had severe problems with alcohol, including serious physical complications. They had had experience of being in rehab. or in hospital as a consequence of drinking. They mostly were committed to abstinence, believing that attempts at moderate drinking did not work for them. The change in their condition with abstinence was remarkable and noted by group members themselves.

Group members were a remarkable body of people.

'One thing that sticks out for me is the confidence you get from the group - a lot of people in alcohol services are very damaged - quite often they may have had say a liver function test – they have serious problems – they come in and then next time you see them they have had a shave, have enrolled on that computer course – they come back changed into different people'.

'We have had two people who are moving on to courses or work directions'.

'One woman completely inspired me - blew me away – she said she was always very negative – had always been on something to keep her high all her life - she came to meetings and started talking – this was the first time in her whole life she had never been on anything - now she is starting to enjoy life - moving on - keeping herself busy – she has learnt from other people in the group'.

'I have learnt a lot from other people in the group'. [23]

[20] According to the NTA figures for 2008/09 - of those in treatment 64% were men and 36% women - which is similar to the SMART groups. Median age was 41 (younger than SMART). Most clients were white British (87%) with no other ethnic group accounting for >2% of clients. See report at http://www.nta.nhs.uk/areas/alcohol/docs/NATMS_Annual_Statistics_Report_2008_2009.pdf

[21] Humphreys notes that SMART Recovery self help groups had not at the time he wrote his book (2004) been the subject of scientific study so their membership characteristics are unknown. However he speculated that given that its roots were in RR he suspected that the characteristics of SMART members would be similar to those of RR members (ie primarily white, educated, socially stable people) (2004:86).

[22] There is a contrast here with people who attended the training sessions with group members being more recent abstainers it seems.

[23] One group member had written a letter: 'SMART Recovery - this group has been a life saver for me – I have had counselling for the last three years – I have moved on more in the last three months than in the whole of

(footnote continued)

77% said that their problems were mostly related to alcohol. For 11% problems were mostly related to both alcohol and drug use and for 9% problems related to both alcohol and other behaviours.

For 1.5% their problems were mostly related to drugs and for 1.5% their problems were mostly related to other behaviours.

Finding out about SMART

66% had heard about SMART from an alcohol worker. 9% from another SMART member, 5% from a friend, 3% from a drugs worker, 3% from their GP, 5% from other sources, 6% from a social worker and 1.5% heard about SMART from both their GP and an alcohol worker. No one reported hearing about SMART from a flyer/poster.

Most people (63%) had first attended SMART within the past 3 months, 20% 3-6 months ago, 17 % over 6 months ago.

Most (63%) attended meetings weekly, 29% twice or more a week, 6% 1-2 times a month and 1.5% less than once a month.

95% intended to continue attending meetings during the next 3 months, whilst 1.5% reported that they would not.

80% of respondents had used self-help groups previously: 60% had attended AA; 28% a voluntary/community group; 17% a NHS group; 8% NA and 23% other groups (respondents could tick more than one option).

The majority (79%) found SMART Recovery very helpful and 21% quite helpful, with no one reporting that it was unhelpful. When compared with other self-help groups, SMART Recovery was reported to be either much more useful (33%) or more useful (39%), with 19% stating it was about as useful as other self-help groups. Only 2% thought it was less useful than alternative self-help groups.

The benefits of being in a group for members were that they had support in not drinking. This helped them to achieve stability and then move on to improve their situation with regard to housing, employment and social integration. Their self esteem and confidence improved and they enjoyed being able to think about becoming involved in new activities or rediscovering old activities.

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the past three years – I can speak openly and not be judged – it has improved my self esteem and made me feel proud of myself – the beauty of the group is that we are all in the same boat – we want to achieve the same goals – there is always someone with advice which is helpful – I have met people through the group who understand where I am coming from - my future is becoming more positive – I can now look forward to what is round the corner.'

Use of services in past three months

Service	*Percentage who have used/made contact in past 3 months*
General Practitioner	77
JobCentre Plus	32
Accident and Emergency department	25
Hospital inpatient department	20
Rehabilitation project	17
Advice centre	17
Hospital Outpatient department	15
Daycare or programme	5
Probation	3
LA social services	2
Prison	0

Current worries or difficulties

Worry or difficulty	*Percentage experiencing*
Money	51
Employment	39
Marriage/relationship	23
Housing	20
Custody/access to children	11
Other	9
Court case	8

Thus group members come from a wide variety of backgrounds and include a good proportion of women. [24] They were mainly adults in middle years and some felt younger people might not fit in with the groups, although some groups did include younger people. The majority had had treatment but there were some who had not. What they liked about involvement was the focus on problem solving and the practical approach to recovery. Most groups had developed via a close link with services, and this was an important referral route into groups. However one in five came through other routes and it might be that over time, as groups became more established, the non-service referral route might increase in importance as groups became better known. Group members were certainly not hostile to AA: they simply preferred SMART Recovery – it worked for them. For most group members, involvement with the group is currently a regular part of their life and a core group of longer term members appears to be building up. There is also another inner core who are very

[24] Recent data on individuals in contact with structured alcohol treatment in the North West of England shows that the majority of individuals were male (62%) and stated their ethnicity as White (98%). The median age was 40 years (Hurst et al 2010). One study has found that compared to men, women were more likely to participate in treatment and AA, and to experience better alcohol-related and life context outcomes. In general, women and men who participated in treatment and/or AA for a longer duration were more likely to achieve remission. However, women benefited somewhat more than men from extended participation in AA (Moos et al 2006).

committed to SMART Recovery and who might contribute to developing a national network. The key benefit of group attendance was thought by most to be being able to talk to people who have 'been there' and who understand. Respect for each other, personal autonomy and group independence were very important to these group members. They accept that relapse may be part of the recovery journey and see the availability of groups as an important factor in helping people get over relapse.

VARIATIONS BETWEEN SITES

A group member in Croydon commented that 'it is good to have something different from other types of meetings. Meetings are always friendly and leave me feeling more positive and relaxed'. Another member of this group said 'I find the meetings more useful and appropriate than say AA or NA – more personal but more interesting and more relevant to my addiction'. Another commented that s/he would be 'willing to help with administration work and help develop SMART groups in other areas and that s/he had attended a group at a rehab centre previously'.

In Sheffield, a group member reported that s/he 'feels very comfortable at SMART meetings – nobody criticises anybody else - everybody gets a chance to talk about their problems without interruption which is very good'. Another member of this group thought that it would be good to 'have some group activities for the group to do together' and another suggested they might get involved in carting, paintball, swimming, gym, badminton, ice skating, music concerts, eating in a restaurant, bowling, or the pictures'. Another reported that 'SMART tools have helped me in my whole life (not just my recovery) by using the problem solving to help me make every-day decisions – and I now go to the gym with other group members'. Someone else said 'I find people in the group very friendly and a pleasure to talk to – I find the group very relaxed and always get something useful from them'. One reported that ' I have started voluntary work – a SMART member arranged it'.

'During my attendance I have found it helpful to be placed in an environment with people in the same or similar situation as myself and find it helpful' said one group member here, while another commented that 'it is just enjoyable to discuss or listen or talk to people who have been in similar situations and who understand'. The same emphasis on being with people with shared experiences occurred in other comments such as 'the group of people do understand other people's problems'.

Although the Gateshead groups did not become established, in Autumn 2009 some people were trying to get them going and one commented that ' the SMART Recovery group is better than AA'.

Groups in Birmingham were established quite early on and continued to meet regularly. One person said 'I find being in SMART is very beneficial and is helping in maintaining and improving my recovery – I do SMART alongside AA meetings – I am a SMART facilitator and am helping make [people] aware of it in Birmingham'. Another said s/he was involved because s/he wanted to 'share and guide other people to help and motivate them and give them hope and faith in themselves'. Other comments from Birmingham group members included that 'it is good to have a weekly meeting with other people in the same situation as myself (ie recovering alcoholic)'. Another told us that 'after attending SMART for two months I had a relapse which resulted in being in hospital – drink lasted for three weeks and was not a failure of the SMART group – SMART was fully supportive and kept in touch by phone when I wasn't well enough to attend the group after drinking'. One group member thought that ' if you have been in rehab or hospital and just started the process of not drinking it is best to come to SMART when advised to do so'. One person here was

very precise about the length of time since the last drink – '14 months, 19 days and 3 hours'. Another said 'I wish that I had joined a group like this before. It is very good to meet people in the same situation as me. It has taught me that I am not unique'.

In Cumbria a group member told us ' The practical aspects of AA worked for me to a certain extent, the spiritual/ steps aspect did not. I find that SMART is very focused on the practical which is extremely important to me. It is also a very open minded programme which some AA meetings are not and this is also important to me'.

Acceptance of centrality of mutual aid

The Cornwall host agency withdrew quite soon after becoming involved as a dispute arose between them and the representative of SMART Recovery UK. This position was supported after discussion by the Steering Committee. It was agreed that in this pilot there would be no place for supervision or the kind of co-facilitation that Addaction Cornwall wanted to offer.

Addaction Cornwall felt as an agency that this was an integral part of the programme as delivered in the USA, Australia and in parts of Scotland notably in Glasgow: 'without the support to service user facilitators, we felt both service user facilitators could be put at risk if not supported properly'. Addaction regretted having to withdraw since, as Cornwall is a very rural area, they felt it would have been ideal to set up groups across Cornwall, firstly as co-facilitated groups between service users and Addaction (or other agencies within Cornwall) but with the goal of becoming service user- led groups with proper support from Addaction.

For members, the group aspect is the part that distinguishes it from professional treatment or services, where counselling is on a one to one basis. The self-help aspect of SMART Recovery is the most important element for them. There was value in 'knowing there is a group there I can sit down and discuss with'. It is useful to share in a group 'how we have dealt with our experiences and how we have moved forward'. The focus on experiences stands out as important as well as the sharing: 'we are still learning how to deal with different situations – we are all taking from the group'. Some thought having a relaxed atmosphere and not putting pressure on people helped them to move on.

In Solihull members of the group also met outside meetings, for example they might go together for nights out or meet during the day at cafes and also text and telephone each other.

DISSEMINATION

A Peer Support briefing document was developed and a Champions' Manual written by the Project Coordinator was distributed to all attending the final conference and made available from the Alcohol Concern website. This was also publicized through DrugScope's Daily News email. These briefings were informative, clearly written and well-presented.

A key activity to disseminate learning from the pilot project was the final conference organized by the Project Coordinator and other staff from Alcohol Concern in March 2010. 109 delegates were registered. Delegates came from a wide variety of regions covering most areas of England. 22% represented the statutory sector and 78% the non-statutory. Statutory sector delegates came from such agencies as Substance Misuse Services, Drug and Alcohol Teams, Primary Care Trusts, Primary Care Alcohol Services, local authorities, NTA, Foundation Trusts and Drugs Services. Of the non-statutory delegates, 45% came from Addaction and 16% from SMART Recovery. Other non-

statutory agencies included Lifeline, St Mungo's, CRI, Vaughan House Project, Cranstoun Drug Services, Project 6, and St Edmunds Charity.

Entitled '*Developing choice in peer support: the SMART Recovery model*' the conference included presentations in the morning by Professor Nick Heather, Chair of the Steering Committee, Joe Gerstein, Founding President of SMART Recovery ®, Fraser Ross previously of SMART Recovery UK, Nicolay Sorenson of Alcohol Concern, Nicola Smith, Director of SAAS, and Carl Cundall of Sheffield SMART Recovery, and David Ford of south London SMART Recovery. In the afternoon, workshops were held and presentations given on the evaluation, on DH policy, and others by the Chair of the Trustees of SMART Recovery UK and by a recovery advocate and steering committee member, Kevin Malthouse from Manchester.

Nicola Smith, describing the pilot in Sheffield, pointed out that SAAS had been established for thirty years and that the training and involvement of volunteers was a key part of their ethos. They already had peer support services when they became involved in the pilot and the new groups were able to build on their experience and on their existing provision. What was important was to recognize that peers could be 'inspirational role models' and that involvement in these groups helped to build confidence and skills. A shared belief in the value of CBT and in the role of volunteering as part of recovery on the part of the service provider was critical. She felt it was important to get paid staff on board to encourage them to see groups as complementary to their work. It was important also not to put all the work on one person but to develop a number of facilitators. Collaboration was the key in Sheffield.

Carl Cundall describing the SMART Recovery groups in Sheffield said that referrals came from GPs, from community health projects, from treatment providers and from prescribing services (ie including problem drug users). Involvement with SAAS 'gave them credibility'. He had met 'brilliant people' through involvement in groups in Manchester and was glad to spread the activity to Sheffield. What was good about SMART Recovery groups was the emphasis on the positive not overly concentrating on relapse and deaths. Hope was the key as well as a stress on problem solving and being solution focused.

David Ford talked about his experiences in south London and thanked the Project Coordinator at Alcohol Concern for her contribution – she was 'an unsung hero'. He had been to many different meetings and what was different about SMART Recovery he thought was its attitude. Again he stressed the value of not focusing always on the negatives from the past and on using the tools to focus on the positive. This gave a different dynamic to a group. People do not want to be told what to do – this is why mutual aid and ownership of the group by its members is so important. However he recognized the value of support from service providers in his case from south London YMCA and Phoenix: 'I have to say in my experience service provider support can make the difference between success and failure'.

These presentations along with another in the afternoon from the recovery advocate from Manchester gave energy and dynamism to the conference and lifted it above conventional discussions. Workshops in the afternoon allowed conference participants to make their contributions and there was good time for questions and answers after formal presentations too. The conference was followed up with articles in the *Guardian a*nd *Addiction Today*.

PROJECT SUCCESSES

WHAT WENT WELL

- Networking meetings – these were a reward, an incentive and an encouragement to group facilitators, giving some recognition of their efforts
- Training – these jump-started the whole process and condensed the time- frame for action
- Collaboration between committed activists and supportive practitioners in host agencies
- Dissemination of learning via briefings, manuals and successful final conference and links on Alcohol Concern website
- General guidance from steering committee working together
- Careful management of DH budget by Alcohol Concern

LEARNING POINTS

Host agencies involved in this project reported the following observations about what they had learned from their experiences.

SMART group values are

- groups should be run fairly
- everyone should be encouraged to have a voice
- everyone should feel they are in a safe place so they can express themselves

With regard to groups achieving these goals and values

- the group should be able to manage its own resources
- the group needs to be well trained
- the group needs to address ethical questions
- facilitators must not be over stressed

With regard to setting up groups, key initial inputs are

- adequate resources for room and photocopying
- encouragement from others
- successes should be celebrated
- being in a suitable environment i.e. an agency with contacts already

Ongoing development requires

- further additional and refresher training
- more training for recruitment of more facilitators
- more training for continuous learning by existing facilitators

Key learning points included

- do not be over ambitious
- it takes time to establish new groups
- it takes time for groups to gain new members
- make it clear early on that this is their group not one which is owned by the agency
- agencies have to be willing to step back – this can be difficult for people who are used to organising
- group members have to be willing to make the effort to own the group
- the agency must continue to demonstrate enthusiasm for SMART and support for group members
- the agency has to put in more time than was perhaps originally expected - more professional support than anticipated has been needed
- more financial input is needed at first stages until funds have been built up

In practice, some of the problems encountered included:

- it is hard to keep the group together
- it requires a lot of dedication from facilitators
- facilitators need support to keep the group together
- it can be difficult to maintain the enthusiasm of facilitators
- clients are initially keen but then get a bit worried about their responsibilities
- inadequate funding
- some resistance in some areas to mixing those recovering from alcohol and those recovering from drug addiction.

What should be done differently if starting similar projects again or elsewhere

funding and resource issues

- secure sufficient initial funds
- provide adequate funding
- make sure everyone is fully aware of the commitments involved

organisational issues

- locate meeting venue before initial training
- ensure posters and advertising ready before training conducted
- quality checks should be made to ensure that facilitators are following guidelines
- better funding of a central SMART Recovery office to manage and monitor training

training issues

- more training required
- have local trainers
- make training available for trained facilitators to become trainers
- provide training in the delivery of learning
- get trainers together
- get expressions of interest in different towns at same time for training

networking issues

- give advice to new groups from existing groups

WHAT WENT LESS WELL

It was thought essential to the longer term development of the programme that champions of some sort should emerge. It was generally hoped that in time local champions would develop and that they would form steering groups to support future growth. There was a tension between developing champions in host agencies and encouraging recovery advocates among group members to act as champions. Where they worked in partnership as in Sheffield this model worked best. Developing partnerships is not however an easy task.

Getting host agencies to act as champions was the original intention. The steering committee, while deciding it would be best if a senior person at each host agency acted as champion, did little to encourage them to act in this way. It would be worth considering what kinds of actions might have led to a closer link developing between the steering committee and these agencies. The involvement of a senior person is needed to put the issue on the agenda at higher policy levels, extract resources and make links to other agencies in local agreements. However, on the ground, practitioners are also needed to link to groups directly, deal with day to day issues, link into referral and care networks and give personal support.

There was some lack of clarity about who was the key actor responsible for carrying out the decisions of the steering committee – the Steering Committee itself, Alcohol Concern, the Project Coordinator or another person? There was also some confusion about who should play the main developmental role – the project coordinator or the SMART Recovery UK Development Director following up on training.

Meetings held outside the location of the host agency found it hard to become established – in Birmingham a third group which met in a church hall ceased to continue and the same thing happened in Norwich and in Croydon.

If the original membership of a group is based on a short-term identification, it is unlikely that the group will continue. When group members move on, particularly if they move out of residential accommodation and disperse into varying locations, it is difficult to keep the group together.

Funding was the number one issue and most agencies asked for more support to help provide purchase of mobile phone, to print more professional leaflets and publicity or to advertise in local papers and publications. 'They had promised us support to do the marketing originally but this has not happened other than A4 posters and business cards. They said they would help with funding applications and this has not materialised.'

There does appear also to be a need for more training for new groups as they are propagated in an area.

Relations between the centre – ie the project coordinator and members of the steering committee – and host agencies did not develop into close partnerships: there was 'some contact in the beginning, setting up the training and talking to us about the pilot and also some after the training to see how the groups were developing' but this contact tailed off over time mainly because it was difficult to communicate. However one agency said it was 'good to know they are on hand to offer advice and guidance' and another that the contact helps 'to keep us motivated too.'

RECONCILING DIFFERING EXPECTATIONS

RELATIONS BETWEEN PROFESSIONALS AND GROUP MEMBERS

From the outset, a key issue was that of the right balance in relations between professionals and group members. On this there was not total agreement. Cornwall Addaction had different views on the way groups should develop and be supported from those held by the Development Director at SMART Recovery UK, the latter being supported at this point by the steering group and by Alcohol Concern. The Birmingham host agency also requested advice on how much involvement was expected, for example is supervision or debriefing allowed? Would it not be useful, another asked, if a member of the host agency were to attend the training session to explain how they saw themselves fitting into the project and to answer questions or concerns. The first project coordinator noted early on 'I have become acutely aware of how SMART Recovery can challenge professionals and create some opposition to really empowering the service user in recovery and allow the process of genuine mutual aid, self-help and community involvement to take place. There remains uncertainty about what are the limits or boundaries of professional involvement in groups'. At a steering committee meeting in June 2009, it was agreed that professionals could be involved in meetings but should not be facilitating them.

There are some disputes within the SMART Recovery international network about what is the right approach and within UK there are groups and practitioners who take a different view on what is the right relationship between group members and professionals ie how autonomous and independent groups should aim to become over time and whether SMART tools can be utilised by professionals as a form of intervention. [25]

[25] Humphreys notes that there is an American cultural emphasis on individual autonomy from social and cultural bonds citing Bellah 1985 in support. We could take from this that it might be that one difference between US and UK lies in where the culture falls on the individualism – social solidarity continuum. Transferring ideas from US recovery movements directly to UK may be difficult unless a process of accommodation to these differences is allowed for.

SUMMARY - KEY POINTS

What seems to influence success?
Training and refresher training
Core of keen and able activists
Right amount and kind of support from main host agency – '*agencies have to be willing to step back'*
Patience and perseverance from both groups and agencies – '*agency has to continue to demonstrate enthusiasm and support'*
Central office support and small seed corn grants
Supportive environment of services locally into which SMART groups can be linked
Links to wider social movement of recovery advocates

Key conclusions
Facilitators are to be congratulated
Evidence of gaps in services
Expressed need for alternative to AA
Great value for money
Mutual aid element seems most appealing aspect
Importance of training – in tools and group work but also in development
Value of umbrella support from host agency and centre
Need to continue to promote the brand
Questions around what happens now?

CONCLUSIONS

RESEARCH AND POLICY CONTEXT

Alcohol misuse is finally being recognized as a key public health concern in UK (*Alcohol harm reduction strategy for England* 2004; *Alcohol misuse interventions: guidance on developing a local programme of improvement* 2005; *Review of the effectiveness of treatment for alcohol problems* 2006 and *Alcohol treatment pathways* 2006.). The view is now emerging that addiction is best viewed as a chronic health problem comparable to diabetes or hypertension. Acute care interventions are important for immediate medical needs and stabilization but are not a cure. Self-help groups can provide an important enduring support for recovery, complementing rather than competing with acute care interventions. Clinical, agency and governmental procedures and policies can help or hinder the development of self-help groups, (Humphreys 2005; Humphreys et al 2004). The effectiveness of a self-help organization can be judged in a number of ways, including how it grows, how it handles change, and membership satisfaction. Some of these issues have been described in this report. For policy makers, the primary interest may be in whether self-help 'works', what it costs, and are there any other benefits for the individual or society? More research is needed to address these questions. What research has been conducted in this area indicates that self-help groups are best seen as a form of continuing care rather than as a substitute for acute treatment services. Involvement with them can improve social functioning, increase the likelihood of abstinence and increase self-efficacy. Involvement in these groups may reduce use of health care services thus relieving demand on the system.

Evidence from studies which have been reviewed concludes that self-help groups may assist in preventing relapse or dealing with relapse, complementing professional interventions. Policy makers can play a role in supporting self-help organizations without compromising their traditions or independence (Humphreys 2005: 5). Practitioners can assist self-help groups by drawing attention to the range of options available among groups and referring patients to these groups. The infrastructural support for an array of self- help organizations might include provision of information on websites and on helplines, encouraging use of public spaces for meetings and assistance in supporting training on recovery and peer support, consideration of what might be needed to expand the attractiveness and suitability of self-help groups for presently under-represented groups and increasing provision in criminal justice establishments. Self-help organizations themselves will aid the process of expansion of a network of such organizations by seeing themselves as allies rather than competitors of treatment agencies. They could work as partners with researchers to develop the knowledge base on self-help. Reviews of the evidence conclude that 'we have much more to learn about how they work and how they can be supported' (Humphreys 2005).

FEASIBILITY

As in many pilot programmes, the time it takes to institute change was underestimated. The project developed very slowly and, for example, almost a year had passed before training was complete and groups were beginning to get going (in most areas). Where groups developed relatively quickly as in Sheffield, this was largely because work had already begun at local level.

There is evidence from this pilot of the feasibility of developing mutual aid groups through partnerships between people in recovery and host agencies. Groups got off the ground where there were energetic activists ready to take on the tasks required to develop a new group. But a lot is expected of group members. What is needed to sustain their commitment over time? A key challenging moment for groups is when should they try to move from being a small core inner group to recruiting new members?

Factors that seem to help in the development and consolidation of groups are
• encouragement of networking between group members in different locations • having a central point of coordination which can provide ongoing information, resources and guidance • celebration of successes locally and nationally • recognition of the emotional labour involved and some input of resources to replenish this.

Two areas could be seen as completely successful, Sheffield and the Midlands (Birmingham and Solihull) with two others (Cumbria and south London) still at a relatively early stage in the process and with some doubts about their future, given that this pilot has now ended. Overall, the impression is that for most of these sites, there remains a need for the umbrella of a host agency within which to operate as a self-help group, at least to give it credibility until SMART becomes better known.

It appears that the resources needed to support development were underestimated. The evidence of this pilot is that the idea that an independent and autonomous social movement of people in recovery could develop without support from host agencies seems misconceived. Too much would be expected of people who are often in quite early stages of recovery, whose social circumstances may be uncertain and fragile and who do not have substantial financial resources of their own to draw upon. While it is important to respect autonomy and to support the ideal of not encouraging dependence, adopting too puritan a view with too robust expectations of group members and host agencies seems a risky policy. This dilemma could be presented as the *Goldilocks problem* - how to offer not too much and not too little – just the right amount of support. The key questions are:

- What is the right amount of support?
- When does the 'hands off' approach become neglect?
- When does encouragement become control? [26]

A key gap in this pilot was that insufficient attention was devoted to encouraging the development of local champions, who would promote the brand and would encourage an ongoing system of referrals to groups. Where champions are present, as in Sheffield, groups have a much better chance of thriving. Attention could be given to considering what more could be done centrally to help to develop a network of champions among professionals, practitioners and commissioners.

The steering committee might have played a more active role here. But by meeting only quarterly it was not able to be directly involved in steering and tended to act more like an advisory body. The

[26] Humphreys notes that the task for agencies is to support groups without co-opting or harming them (2004:158).

centre was not as proactive as might be thought desirable in what was in essence a development programme. Most attention was devoted to developing the groups. Developing new groups and networks always takes longer than anticipated and requires continuing input from initiators, albeit acting in a supportive rather than controlling role. This left less time to devote to links with the host agencies and with a wider body of professionals and commissioners. It may be therefore that the original aims were overoptimistic about what could be achieved in the time available and with the resources provided.

The final conference went some way to develop such links and to promoting the brand nationally and to developing a network of champions nationally.

At local level, the extension of provision to include mutual aid is possible but what is needed is the right environment into which to plant the seed of a new group or network. Before embarking on similar developments, thought should be given to the question what is a nurturing environment in which groups can become embedded and grow? The experience of these pilot projects points to the importance of having in place a suitable infrastructure of services, including links to services built on CBT principles so that there is a fit between prior treatment service experience and SMART. Also important is the presence of an understanding and diplomatic approach from contacts at the host agency to the groups, as well as sufficient resources and experience of working with volunteers and peer support groups.

A suitable environment is one in which:

- there are local service providers who understand and sympathise with the SMART approach
- services are ready to provide just the right amount of encouragement and practical support without taking over
- an established partnership of appropriate agencies concerned with substance misuse issues is willing to include the new groups within their ambit
- recruitment to groups is encouraged by host agencies along with their partners.

ACCEPTABILITY

There is evidence of a demand for mutual aid provision and a gap in services was indicated by the lively response from services to the call to be involved in this pilot programme. Evidence of a need among some service users for an alternative to AA was voiced in these applications and in the comments of group members.

There are some differences of opinion about which elements of SMART are most acceptable. Overall, the mutual aid element seemed most appealing among the facilitators. But the self-help dimension - working with the tools between meetings, absorbing this way of thinking or accessing the web for support – also played a part. The specific 'science' aspect of SMART, as distinct from mutual aid, presents an inherent tension which has not been resolved. There is an argument that the religious element in AA is important in holding groups together and that secular groups struggle without the cohesive bonds provided by a common belief system. It would be interesting to consider whether the use of the tools and the common structure have a key function in serving as rituals, helping to establish group solidarity, identity, cohesion and a sense of belonging, at least as much if not more than by acting upon individual cognition to influence behaviours.

The emphasis on the value of training which was highlighted in many of the responses is interesting. This may raise the question of how far training is itself a form of intervention, one which helps to shape and support groups as they develop, since it provides ongoing learning and aids new ways of thinking. There was a lot of reference to 'issues' in the vocabulary of group members, which indicates the acceptability of the model - in particular the focus on current problems and ways to find solutions.

Some differences emerged about the future direction of SMART Recovery® in the UK which came to a head in 2010. The Trustees moved to review the financial situation and developed a new business plan. A statement about the future was issued and a consultation organized. These disputes within the organization impacted on this pilot programme, not least in leading to the withdrawal of an application to DH for a follow on project to develop further training – an idea which had some merit and reflected the expressed wishes of host agencies and group members. They also led to some commissioners holding back from committing to support SMART groups in their area at least until the disagreements had been sorted out.

These matters are for the wider SMART Recovery network to resolve themselves. However the evidence of this pilot is that, while the radical desire to develop a wider social movement and link into the developing recovery agenda is laudable, it also involves substantial risks. A less ambitious agenda, encouraging the development of mutual aid groups using the SMART tools, encouraging local treatment providers to refer people to groups but not expecting too early a move towards total separation and independence might be more likely to be successful. Groups cannot be expected to run before they can walk and most of the groups developed through this pilot will continue to need some emotional and material support if they are to be sustained into the future.

In conclusion, key lessons learnt are that developing groups is the core focus of activity in promoting SMART Recovery but this takes time and groups need support in these early stages: where that support comes from is less important than the form it takes – best being non-intrusive, respectful and helpful in providing basic infrastructural resources. If group development is to be

condensed into a shorter time frame, as was one intention of this pilot, then support through training is useful but one session is not enough and repeat visits are beneficial, boosting morale and helping to deal with questions that arise that can be answered by more experienced members.

A supportive environment is important for groups to flourish in, that is, one where the network of services and groups already focusing on alcohol have recognized the value of self-help and mutual aid and see value in use of CBT approaches. New groups seem to develop best, in the early stages at least, if linked to a specialist alcohol provider rather than a generalist service, as these agencies are better versed in knowing what resources are helpful to developing peer support groups and importantly are in a position to refer people to the groups.

Encouraging systems change within service networks towards such attitudes and activities was also an ambition of this pilot but as yet little has been achieved, mainly because the focus of attention was perhaps justifiably on developing the groups. To effect systems change, champions are viewed by many people as the way forward - people who will promote such groups at different levels from ground to strategic. An obstacle to developing champions in this pilot came partly from some uncertainty about who made the best champions – graduates of recovery programmes or treatment professionals or both. This issue needs further discussion within the network. Overall the main lesson of this pilot is that groups develop more rapidly where nurtured through *partnerships* between group members and recovery advocates, professionals, practitioners and service providers, including commissioners.

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ACKNOWLEDGEMENTS

Carrying out qualitative research is as much a partnership as is the action involved in developmental pilot programmes. A key ambition of such research is to capture the experiences of those involved. We could not have carried out this research without the help and support of a number of people: principally we should thank the facilitators and group members who participated in focus groups and completed questionnaires; members of the Steering Committee, the Chair Nick Heather, and Nicolay Sorensen, Fraser Ross, Dan Davidson and Kevin Malthouse who actively assisted with the research; contact people at host agencies Aquarius, SAAS, NORCAS, SLYMCA, ADS/CCDAS and Turning Point as well as contacts at Addaction; and Don Lavoie and the Department of Health for financing the evaluation. All views expressed here are those of the researchers and not necessarily of Alcohol Concern, SMART Recovery UK or the Department of Health. And finally and most especially we should like to thank the Project Coordinator Liz Ainsworth who quietly and efficiently got on with the job and as well as helping to develop the pilot programme, assisted us in numerous ways in carrying out the monitoring and evaluation work.