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The History of SMART Recovery in the UK: An Interview with Richard Phillips

Introduction

Addiction recovery mutual aid organizations have a long and rich international history, but the rate of growth and diversification of philosophy and methods of these organizations in recent decades is without historical precedent. What is emerging is an ever-growing network of secular, spiritual, and religious recovery mutual aid groups adapted to diverse cultural, political, and religious contexts yet increasingly connected into a larger global community of recovery via the power of the Internet. In the early weeks of 2013, I had the opportunity to interview Richard Phillips, one of the leaders of SMART Recovery in the UK. The interview provided the opportunity to touch on a wide variety of issues related to the history and future of SMART Recovery in the UK and to discuss SMART Recovery's relationship with the larger recovery movement and the UK treatment system. Please join us in this engaging conversation.

History of Personal Involvement in SMART Recovery

Bill White: Richard, how and when does your personal story intersect with the story of SMART Recovery in the UK?

Richard Phillips: Hi, Bill, and firstly thanks for inviting me to do this interview – a slightly daunting prospect, but I'm curious to see where we go.

My path to involvement with SMART Recovery was a long and winding one. A part of my own back story was a minor drug problem and serious mental health problem by my early twenties. I narrowly avoided homelessness and flunked several efforts to get professional help, but had enough luck and got a few key decisions right to figure out the natural recovery thing for myself. My own community as method or 'social cure' if you like was lots of voluntary work, five years living in a Quaker influenced Commune, some good friends, holding down work long enough that it became a career, and a couple of stints in a Zen Buddhist monastery in Japan. So not a conventional path, but hey it worked for me!

My first job, off the back of volunteering with a drugs / HIV charity, was in a street agency doing needle exchange, methadone, and outreach. It was the days of hard core HIV prevention and we did things you would not be allowed to do today, like delivering bulk supplies of needles, syringes, and disposal bins directly to the homes of local dealers!

I still think methadone and needle exchange are incredibly important; facing a heroin epidemic without harm reduction is to my eyes deeply immoral, barbaric even. In the UK, I sometimes think there is a 'generational' side to this debate – you have either worked in the field long enough to have seen dozens of people die of AIDS or you have not. Not many people who have sat at that particular bedside will argue against needle exchange.

Where we were deeply mistaken was falling into the trap of thinking of harm reduction as an end in itself; we did well at preventing HIV spread but were completely rubbish at helping people get out the other end of treatment.

So we needed change, but it does trouble me how divided the field became on this in the UK – it was a dumb thing to fall out about because the evidence was *always* that we needed harm reduction interventions *as well as* greater ambition for sustained recovery. Being pro harm reduction and deeply committed to abstinence is not common here, but I proudly swing from both sides of this argument! Over twenty years ago, I wrote some computer software to print drug prescriptions so that we could handle bigger caseloads and get more people off injecting street drugs –it is still used today, so I do still have some connection to the harm reduction side of things.

Later in my career, I was Operations Director at Phoenix and spent a lot of time with the therapeutic community model rehabs. It was a huge eye opener; the insight and wisdom of many rehab graduates was deeply moving, and it really shifted my understanding about treatment and recovery. In a sense, that is when I 'got' what recovery was really about.

There was also a strong personal connection – it seemed to me that therapeutic communities helped people in fundamentally similar ways that living in a commune and even the monastery helped me. This is not a trite point, the similarities are extremely strong and I really do think they 'work' in similar ways – maybe someday I will write a paper on monasticism, communes, and the TC movement! Extending the thought a little, I think *all* recovery communities are to some extent 'intentional communities'; even when they have looser bonds and rules than residential communities, they still answer to our need to *belong*. The human animal is fundamentally *social* and for most of us, emotional wellbeing depends on reciprocity.

Getting back on topic, working with the therapeutic communities put some passion back into my work and got me really interested in the recovery agenda and SMART Recovery. At the end of the day, most treatment in the UK is not 12-step based, yet pretty much the only available recovery mutual support was the 12-step fellowships. It seemed obvious there was a place for SMART Recovery.

In previous jobs, I did some work at a national policy level so am always keen to work out where things 'fit in', big picture. At the moment, I co-chair the Recovery Committee on the Advisory Council on the Misuse of Drugs (a scientific advisory group to government), which scratches that itch to keep involved with the recovery agenda outside of SMART Recovery.

Bill White: What roles have you served since your involvement in SMART Recovery?

Richard Phillips: I'm not sure my role has changed as much as the organization has changed under my feet! In spring 2010, I was asked by the board to help them figure out how to deal with the crisis that enveloped the organization at the time. SMART Recovery UK was almost bankrupt and had no foreseeable source of income; with no money left for his salary, Fraser Ross, who had set up the charity, had recently been made redundant. There were also competing visions of what direction the organization should go in. I'm sure we will get into that a bit later, but it was a small, broke organization in the middle of a *big* identity crisis.

So initially this was as a consultant; I'm sure you have seen the picture before – you go in to do a few days' work, realize it will take weeks or months of commitment and there is no money in the bank to pay you – but by that time you are in love and can't put it down! The thing was, however deep the difficulty in 2010, it was *blindingly* obvious that SMART Recovery could be a very big deal in the UK, it could help tens of thousands of people a year. I wanted to do what I could to help make that happen, and I was truly inspired by people I met in SMART –

every last one of them believed in it with passion. The in-fighting and disagreements were heated *because* people cared what happened to SMART.

It was also obvious that the political winds were in the right direction to support SMART; I'm not exaggerating to say that this was a once in a generation opportunity to really make this happen. So I started as a Consultant, then Interim Director, and a year or so later became Director.

The UK Context

Bill White: What cultural and political differences between the UK and the US have influenced the evolution of SMART Recovery UK?

Richard Phillips: The biggest cultural difference between the US and UK when it comes to a response to addictions is that the 12-step model is not dominant here; in the public imagination, you mention addiction and they think of AA, but probably 90% or more of treatment services are not 12-step based, nor are most researchers, academics, or psychiatrists of influence.

Our addictions treatment system has been built up within a socialized healthcare system, with money being poured in because of high level *political* goals such as reducing the spread of HIV or reducing crime and so on – so harm reduction has been a big influence because that was a government priority. Also, in our National Health Service, addictions tended to sit within psychiatry, with some influence from clinical psychology and these professional groups do not lean toward 12-step models over here.

From the late 1970s, we had a massive epidemic of mostly white, working class men using heroin, especially in northern towns, which were falling apart as big steel and brawn industries collapsed. It was a complete mess and then to scare everyone stupid, along came HIV. Plug these things together and the most sensible response was needle exchange plus methadone – where there were psychological therapies – and there was not much – it was mostly CBT-based.

The upside is we contained the heroin and HIV epidemic; the downside was massive methadone prescribing and not many people leaving treatment with fulfilling, stable lives. Because of this, many people in the UK recovery movement are very anti-methadone – personally I am not, as I said earlier I saw it save too many lives; can I recommend a wonderful monograph Bill, '*Recovery oriented methadone maintenance*', you might have heard of it!!

There is a big 'but' though…so much effort went into harm reduction here that it is only in the last few years that a strong 'recovery agenda' has emerged. If you are really keen to support sustained, long-term recovery, you need mutual aid, but here the other big cultural difference matters.

Compared to the US, we are a pretty godless lot, I think it is about one in twenty people who regularly attend a place of worship and a slim majority says they have no religion at all. Of course many people without religion are comfortable in the fellowships, but others are not. Shouting at them that they *should* make it work isn't really a reasonable response, though a few people – including at the NTA – still seem to think that is all that is needed.

So SMART putting forward the argument that there needs to be choice in mutual aid is, as you say in the US, a no-brainer. Talking to SMARTies in the US, they have much more of an up-hill struggle, they often run into people and officials who think the very existence of SMART is putting people's recovery at risk – we hardly ever hear that view here.

I don't have evidence to prove this, but it seems blindingly obvious that *more* people in the UK compared to the US want a non-religion based approach to mutual aid. I don't mean to set this up as an either / or argument here, as many people want both, but offering choice is better than just saying someone is 'in denial' because they prefer one kind of meeting to another.

I don't have a strong grasp of the evolution of the position in the US, but I do think the relative religiosity, insurance driven healthcare, and plain lack of specialist provision for lots of people accounts for some of the differences. I hope that doesn't sound harsh, but we Brits tend to defend our NHS (National Health Service) – did you *see* the Olympics opening ceremony!

Bill White: What overall trends do you see related to the operation of recovery support groups in the UK and how they perceive and relate to each other?

Richard Phillips: There is such a diversity of recovery groups that I think it is very difficult to generalize; the big issue that affects everyone is the shift in government policy to focus more on recovery, which means that commissioners and treatment providers are keen to get all sorts of recovery initiatives going.

Lots of recovery groups now get financial support that would have been pretty unimaginable a few years ago – I think this is great, but it of course introduces some local tensions where different groups see themselves as in competition for the same pot of money. It is forcing lots of grassroots organizations to have a long hard think about whether to go for a core of paid staff or stay entirely voluntary. Of course if you become a commissioned service, you might need to start doing what you are told by your paymaster – so there are tradeoffs and dilemmas all round.

Bill White: There have been recent efforts to launch a grassroots recovery movement in the UK. What are your perspectives on this movement and the sometimes fractious politics that have accompanied it?

Richard Phillips: If I can pick at your words a little, I don't think the grassroots recovery movement has been *launched* – the heart of this is an emerging cultural movement that has no leaders or many leaders, depending on how you look at it. Like many cultural changes, you can put your finger on trends and common threads, but it will always be a bit elusive – it is many things not one thing; organic, messy, and sometimes contradictory.

I try to keep out… and keep SMART out… of the more fractious politics. I would not pretend to understand most of it, but a few thoughts.

I think that problems arise *because* some people assume that the recovery movement should be consistent, unified, and coordinated. As soon as two people take that line, you end up with debates about who are the true believers, who have the authority to define things, and what to do about people who disagree. That is the path of squabbles, competing claims, and arguments about ideological purity.

It is such a tempting idea, that everyone in recovery and everyone supporting recovery can share a unified vision and common fraternity – but it isn't going to happen any time soon and I don't think this is an important enough goal to fight over! My preference is to accept that there are many paths to recovery and many definitions of what recovery is; if we can agree on a general direction, it is probably best to encourage a messy, organic, and rich network of different models and approaches.

The other damaging factor is the perception that this is a zero sum game, so if one recovery group is getting well established, then *my* favored approach will lose out – so there can be old fashioned competitiveness.

Overall, we have managed to avoid the worst of the problems and have avoided taking sides on some of the distressing falling outs in the last year. That said, we have not exactly been ignored by pot stirrers either. There was a pretty extraordinary misinformation campaign by a journalist, pseudonyms and fake accounts on social media to spread rumors, attempts to try and split the organization – all sorts of antics, almost entirely from people who have not actually used SMART Recovery as part of their own recovery.

Big picture though, these problems are more than compensated for by the overwhelming goodwill and sense of fraternity in the UK Recovery Community – so I would not want the occasional problems to color the picture too much.

Bill White: What influences do you see this larger movement exerting on SMART Recovery and other recovery mutual aid organizations?

Richard Phillips: There have been two related things going on; one is the grassroots, emergent recovery movement, and the other is the sea change in government policy toward recovery.

The shift in government policy made a huge difference to SMART Recovery because it nudged professionals to become our allies in spreading SMART. We get commissioners phoning us up and saying 'what can I do to help you get SMART Recovery available in my area'; of course there are risks, but the right thing to do was to make sure we had figured out what we wanted them to do that would actually help peer led SMART meetings spread.

One of the other things that has happened is that some of the very local recovery communities have wanted to see SMART as part of the local picture, so we have meetings in recovery cafes and emerging from user groups, recovery forums, and so on. This has been really rewarding to see.

Bill White: How would you characterize the relationship between SMART Recovery and newly emerging recovery support organizations –from new recovery community organizations and new recovery support institutions such as recovery cafes?

Richard Phillips: With the local recovery communities, I would describe it as 'walk beside but not compete with'; so I would love it if most recovery cafes hosted a couple of SMART meetings per week, but it would be peers involved in those café's wanting to run a meeting – it is not SMART 'parachuting in' as a service – that isn't how we work. All recovery is local – people pick it up and start meetings because it works for them. Oh and I would add that the thing I love even more is to see these cafés with Fellowship meetings and all sorts of other groups *as well*; there is strength in diversity and choice.

Bill White: You have raised concerns about the potential exploitation of self-identified people within some new government-funded recovery support efforts. Could you elaborate on this concern?

Richard Phillips: The government's drug strategy has made 'Recovery Champions' the fashion of the day; actually I think it is a good thing in principle and the overall impact has been positive, but there are all sorts of risks and problems that are only just being talked about.

The problem is that no one knows what a recovery champion *is*…or actually everyone knows what one is but everyone has a different idea! To my mind, one measure of whether a particular model of recovery champion is working is whether it helps the individual champion *themselves* change their lifestyle, self-image, and place in society in a healthy, balanced, and recovery supporting way. In many places this is happening, while in others it seems to be a way of adding free labor to the treatment sector workforce; the expectations are simply too high and it becomes exploitative. No one should be a few months into abstinence and feel pressured to spend dozens of hours a week, unpaid, propping up a creaking treatment system and being told they are the main source of support for even more vulnerable people.

From a SMART point of view, it is all about lifestyle balance – becoming a recovery champion should be a *part* of developing a balanced lifestyle. Each week, putting something back in and helping others can be a wonderful and transformative thing, but so are a new hobby, getting some exercise, and spending more time with your mum.

Sorry this is a bit of a rant, but many people in the UK are worried that *some* versions of the recovery champion model are actually undermining peoples' recovery. Of course we have reflected on this in SMART Recovery and we try and encourage our meeting Facilitators to work this into their own 'lifestyle balance'. If they spend a few hours a week promoting SMART and running their meeting, this is likely to enhance their recovery *if* they are doing lots of other life enhancing things as well.

The SMART Recovery Program

Bill White: What do you think distinguishes the SMART Recovery approach to recovery from other recovery support programs available in the UK?

Richard Phillips: I think the rigor of our focus on the science is pretty unusual, so having a process of renewal that updates the program as the science changes. Other defining characteristics are the degree to which our meetings are structured and the role of the Facilitators. The meetings themselves are discussion focused, so participants help each other use the SMART 'tools' in the room; we discourage 'war stories' and try and keep the focus on finding solutions. None of these ingredients is unique in itself, though the overall recipe is very much distinctive!

Bill White: Because of the size and international dispersion of 12-Step programs, many of the leaders of alternatives to such programs often took a defensive anti-12-Step stance during their early histories. Was that true of SMART Recovery and, if so, has that stance changed through the history of SMART Recovery?

Richard Phillips: The origins of SMART Recovery in the US go back to Rational Recovery and certainly you cannot read Jack Trimpey without thinking he had a bit of an 'issue' with the Fellowships – so I do understand where you are coming from here.

When SMART Recovery was formed in the USA, it moved away from this critical approach very quickly, so there may have been some individuals who were critical of the 12 steps but the organization's position was robustly that there are many paths to recovery. I have

not been around long and am not part of the US organization, but my impression is that as SMART Recovery has become more established, it has also become less defensive.

In the UK, I don't think SMART has ever been defensive about this – it is less loaded as an issue than in the US – though of course some people pass through our doors who are anti-fellowship and we have to deal with that in a constructive way.

Bill White: Although 12-Step programs and secular alternatives are often portrayed as polar opposites in their approaches, there is growing evidence of a substantial level of co-participation across the boundaries of these organizations. Is that the case with SMART Recovery members in the UK?

Richard Phillips: As I say, *some* SMART Recovery participants are vehemently opposed to the fellowships, whether on ideological grounds of secularism or because of bad experiences. Others are huge fans of the Fellowships but use SMART Recovery as well. It's a really mixed picture, but what is very clear is that there is considerable overlap; *lots* of people attend both.

I think part of my role is to try and make sure we welcome all of these people – there are a few people with strong feelings, but we simply ask them to take their debate elsewhere. It is also not a good idea to define SMART 'in contrast to' other organizations; our approach should stand on its own merits.

The guidelines for meetings and our Facilitator training ask that they prevent bashing of the fellowships in our meetings, but also that we stick to the SMART Recovery model. Most of the time this works well, SMART meetings maintain their distinct approach and people who also spend time with the fellowships can still feel welcome in SMART.

This isn't a pretense that there are no big differences between SMART and the fellowships – there are many and in some ways they represent very different world views – but maybe we can encourage people to see that diversity of beliefs can be a source of learning rather than an excuse to get all shouty!

Bill White: Does the expected length of participation in SMART Recovery differ from the expected duration of participation in 12-step programs?

Richard Phillips: We hope that people will use SMART Recovery as long as they find it valuable in supporting their recovery – which might be anything from one meeting to many years; it's individual and not really for us to say what each person should do. We certainly don't take the view that attending meetings is a lifetime commitment – if someone makes a sufficiently radical change to the way they live and the way they think about themselves, maybe yet more meetings would actually be counterproductive. At the end of the day, each person needs to figure this out for themselves.

Bill White: There is growing respect for the legitimacy of multiple pathways of long-term recovery in the US. Is that also the case within SMART Recovery in the UK?

Richard Phillips: Yes, very much so. There are as many pathways to recovery as there are individuals; for some people attending lots of meetings might be the best way, for others it might be a new hobby, rebuilding family life, joining a club – that is what multiple pathways really looks like, the long-term solution for you might not be our program – it *might* not even be any

program at all. There should be many options on the table and it is for each person to figure out what works for them.

Bill White: There seems to be less of a focus on identity transformation in SMART Recovery than one often finds in other recovery programs. Could you comment on this?

Richard Phillips: Ah, I think I'm going to go straight for the full strength rebuttal on this one! I think you are completely wrong on this, Bill; SMART is radically ambitious about identity transformation!

People glance at SMART and think the program is 'just' a few CBT-based tools, a look at cognition and lifestyle issues and that is about as 'deep' as it goes. In fact, SMART Recovery is profoundly ambitious about the shift in identity necessary for long-term recovery; the key to this is that we are not primarily interested in people changing their *thoughts*; it is their *beliefs* that matter more, and core beliefs or *values* most of all. Some of the things recommended by SMART, such as changing your lifestyle, are important *because* they transform the way you think about yourself and change your core values.

SMART has a strong philosophical underpinning, drawing on the Stoics and Skeptics of ancient Greece by way of Albert Ellis who developed Rational Emotive Behaviour Therapy. Because of the influence of rational skepticism, we do not tell participants what their new belief system should be, but we can give them the tools to figure out *for themselves* their own version of the 'Good Life'.

There is a place in SMART for your core values and beliefs, and we think many people can transform their identity to an extent they don't need SMART any more. Life can be so rich – why would you *want* to live the rest of your days looking through the lens of 'being in recovery'? It might be who you are right now, but maybe one day it will not frame your life. That is the shift in identity SMART believes possible!

SMART Recovery doesn't really have a set position on this for the simple reason that we leave it to the individual to work out how best to describe their identity or recovery journey; in our literature, we do tend to use the term 'in recovery' as a short-hand – but some people describe themselves as recovered or previously in recovery.

A very personal view – to be a little provocative – is that people wanting to be 'in recovery' for the rest of their lives lack ambition! If you can work out what your life would be like if you were 'fully recovered' and no longer needed this label to get through the day without addictive behaviour – then that is the goal to work towards. Live that life; that is a *real* shift in identity.

Bill White: I know you avoid labels such as 'addict' or 'alcoholic' in SMART, can you explain why this is?

Richard Phillips: Someone posted a quote to our online forum a couple of weeks ago; *'I am' are potent words; be careful what you hitch them to. The thing you're claiming has a way of reaching back and claiming you.* This really speaks to me; labels are laden with meaning and have consequences, apply them to yourself and it changes the way you think about yourself. I don't think this is always a bad thing, so moving from being a chaotic drug user to thinking of yourself as 'in recovery' might be motivating to keep things on track; identifying as a

'SMARTIE', as some participants affectionately describe themselves, is normal and healthy social identification.

We have a specific problem with the labels 'addict' and 'alcoholic' because they are implicitly 12-step terms and carry with them assumptions about the nature of addictive behaviour that are different from the approach of SMART Recovery. Other labels such as 'druggie' are just pejorative and negative. So as a general rule, we discourage use of labels in our meetings.

This works just fine even for most people who also attend the fellowships as well; it is *normal* to follow different social conventions in different places so most people are fine if we just explain 'this is how we do things here but you might decide that outside the meeting you prefer to think of yourself as an addict'. For some people, SMART allows them to 'try out' different ways of thinking – just for the next hour, see what difference it would make if you choose not to use that label.

The bottom line though is we encourage people to reflect on what is helping them in their recovery. If a label is helping, great, if it stops being helpful, better to drop it!

The History of SMART Recovery UK

Bill White: Could you briefly share how SMART Recovery began in the UK?

Richard Phillips: We can append a history of SMART Recovery UK (see Appendix) when we write this up – and it is also worth pointing out to readers that you helped write a history of SMART Recovery in the USA so maybe we can put a link in to that as well (see http://www.williamwhitepapers.com/pr/2012%20A%20Chronology%20of%20SMART%20Recovery.pdf). So maybe just a couple of highlights at this point:

SMART Recovery was effectively brought to the UK by a prison officer named Fraser Ross who was working in a Scottish prison; in 1998, he arranged for Joe Gerstein to come over to speak at a couple of prisons. It took a couple of years, but a group-work program based on SMART Recovery was approved for use in Scottish Prisons and in 2005, the first community meeting was started. The actual charity was started in 2006 with Fraser as a full-time employee – which was the point things started moving more quickly.

Bill White: What are the most significant milestones of SMART Recovery since that early period?

Richard Phillips: I guess getting the program going in Inverness prison was the first milestone, then the first community meeting in 2005, along with setting up the charity in 2006. Also in 2006, a large treatment provider 'Addaction' was given permission to train staff and run SMART Recovery meetings within their service.

Because of this and the programs in the Scottish prisons, most SMART meetings for a number of years were in some way in partnership with professionals. I think this is important historically, as some people think this partnership stuff came later – not so, in different forms, it was there from the start.

For the next four years, SMART Recovery tried to find an approach that would help groups to flourish and grow. We got grants for various projects and employed a couple more staff and of course like any startup, some things worked and some did not.

The growth of peer led meetings was slow for several years and most SMART Recovery was within Addaction, so by the end of 2008, there were about 11 peer led meetings and more than 20 with Addaction.

The "Big Breakthrough" was when Keith Humphreys and Nick Heather came up with a proposal to the Department of Health (DoH) for a SMART Recovery pilot with alcohol treatment services. I have already talked about this so won't go into more detail here – other than to say this was a *huge big deal!* During the two years of the pilot scheme, the number of peer led meetings tripled and for the first time exceeded the Partnership meetings run by Addaction. In my view, this was the biggest milestone since Fraser set up the charity.

The next big milestone was toward the end of the pilot scheme. It had been very successful and by then had about 35 peer led meetings – but the charity had completely and utterly run out of money. The board scrabbled around to get some unrestricted grants – gifts, to be frank – just to prevent bankruptcy. Fraser had been employed by the charity for several years, but his post could not be sustained and he was made redundant to prevent the charity going under; so by 2010, they had a part-time administrator, an office but no money.

The organization then had a bit of a crisis. It was complicated and controversial, so best to read the history for the detail – but basically there was the basis of a model to spread meetings from the DoH pilot but no source of income to enable us to put this into place. I was brought in at that point and worked with the Board to turn this into the partnership scheme that we are still running.

The next milestone was getting the partnership scheme actually running in early 2011 along with the setting up of an e-learning platform for Facilitators and Champions. A great deal of our energy since then has been trying to control the monster we created – we still only had the same number of staff but interest in SMART went through the roof!

You may have heard of the National Institute for Health and Clinical Excellence (NICE) who effectively advise our National Health Service on what treatments should be available – they publish things like clinical guidelines and have looked at addictions several times. It was a big deal for us when they recommended SMART alongside Fellowships, the wording is really good – in effect, *every* state-funded addictions treatment service should be working to engage service users with SMART Recovery *as well as* 12-step mutual aid.

There have been lots of other smaller milestones since then; it doesn't sound like much, but writing our own Facilitator Manual was a lot of work and a big deal; getting online meetings started; an online social community platform running, lots of things like that.

In terms of our work with Partners, we got the five largest treatment providers involved as partners in the first year. I think that was a big milestone. Since then, we have also gotten a number of local Commissioners to ask *all* of their local providers to make SMART Recovery available within their services.

Bill White: What has been the growth profile of SMART Recovery since its founding in the UK?

Richard Phillips: I will add a graph to the history we can include at the end – it will be a very steep line going from the bottom left to top right! If we leave partnerships to one side, it took five years to get the first meeting, another four years to add another 10 – and then over 120 in the following four years.

It seems likely we will continue to add at least one additional peer led meeting per week for the next few years. In some ways, it is getting easier to support this many meetings as we have more volunteers and resources to improve materials, online services, and so on.

Some people say that growing fast is a bad thing; I don't agree with this, but of course there are risks. One of the differences I see with the US is that most people involved in SMART Recovery here have only been involved a year or so – in the US, they have dozens of volunteers who have been with SMART for a decade or more. That gives them a stronger core – our Facilitators are not as experienced and they are newer to recovery than most in the US – which does carry risks. One thing we are wary of is that this leaves us more dependent on the paid staff, so over the next few years we have to make a real effort to widen involvement and share more responsibilities and decision making across the volunteer team.

Bill White: What are the factors that have affected and will affect the growth of SMART Recovery in the UK?

Richard Phillips: I think it is pretty clear the Partnership approach has worked and it seems likely it will carry on working – and by 'working', we mean that it helps us spread peer led meetings. As long as we can convince professionals to introduce people to SMART Recovery 'early in their treatment journey', SMART will keep growing for some time yet.

Let me give a specific example. Our Prisons are very keen on SMART Recovery. They report to us that many, as many as half, of prisoners are not comfortable with the Fellowships, and they are desperate for alternatives. There are many challenges to getting SMART into prisons, but in many places, the Partnership model is working well and news is spreading. At the time of writing, almost half of all prisons in the UK are in the process of getting involved with SMART Recovery. If we pull this off, tens of thousands of prisoners with addiction problems will be exposed to SMART Recovery during their time inside and many – we hope – will want to use peer led meetings on release.

Bill White: Is there a typical profile of a SMART Recovery participant? Do you think this profile would differ from those involved in AA, NA, or other recovery support groups in the UK?

Richard Phillips: I am not totally sure about this because there isn't a source of reliable data, though I think there are some differences. At least at the moment, so many people are coming to SMART UK through the partnership scheme they tend to reflect the treatment population. So the average is probably a little younger than in AA and more drug users than drinkers overall. The differences are probably small and will change over time as SMART 'beds in' and conversely as there is more twelve step facilitation building stronger links between treatment and the fellowships.

Some people have suggested that SMART is for people with less severe addictions and that – to quote in terms I would not use myself – 'real' addicts need the 12 steps. I certainly see no evidence to support this view at all; people with very serious addiction problems seem to gain great benefit from SMART. Looking at the research literature, there are *hints* that people with certain patterns of problems or personality traits might do better with one approach over another, but to my reading, these are not particularly significant findings. As of now, this particular argument against SMART Recovery *cannot* be justified by the evidence.

Operational Issues

Bill White: How is SMART Recovery UK governed?

Richard Phillips: SMART Recovery UK is a charity and in terms of the big picture has the same governance structure of almost every other charity in the UK. Charities have to be on a register here and come under charity law, which makes sure what we do is consistent with the charitable purpose it was set up for.

So we have a board of Trustees who are themselves volunteers; their role is to oversee the work of the charity. Our Trustees have a range of backgrounds, including personal experience of addiction, professional experience in the addictions sector, and a Peer Facilitator. We have board meetings where they give us a bit of a grilling – in a good way – about how things are going.

All our meeting Facilitators are volunteers of the organization – we try and keep in touch and consult with them on changes and developments, though to be honest, it is an area we are still trying to up our game. Most Facilitators run their meetings but are not more closely involved than that, though there are a handful who have been a huge help to our work on a national scale.

In particular, we have a number of 'Volunteer Regional Coordinators' who help keep things organized and moving forwards on the ground. One of our volunteers did several months work helping rewrite manuals and another puts in many dozens of hours per month helping organize the online training.

We want to build up this group of our core team of volunteers, who we describe as the 'Big Team', and get them more involved in the running of the organization. It is taking a long time to get in place, but we will have monthly meetings and in time begin to spin off 'working groups' and committees where individual volunteers are empowered to lead in certain areas and report back to the Big Team meeting.

It's all evolving in the direction of more volunteer involvement; I might talk later about how this works in the USA – which has an amazing culture of volunteer involvement and is something of a template of where we would like to get in the next five years or so.

Bill White: Recovery support structures have often been depicted in opposing models of professional support and peer support, but SMART Recovery seems to represent something of a hybrid of these models.

Richard Phillips: The way I would prefer to put it is that we offer peer led mutual aid, but *also* work closely with treatment. It is this second bit that is a hybrid approach; the first is not.

Big picture, I think it has been a mistake to treat professional support and peer support as opposing models; a huge mistake – they are in many ways fundamentally different, but should be complimentary, two sides of the same coin.

Peer to peer recovery support can be incredibly effective. But I don't think it follows from this that professionals are somehow the enemy; this isn't a zero sum game where using treatment takes something away from peer support. The flip side is that professionals often underestimate the value and effectiveness of peer support structures and sometimes see this as a threat to their status or job security.

It is almost like some professionals and recovery groups have colluded on this idea that their activities are opposing and before long, everyone starts to believe it! For years, this has undermined participation in mutual aid and arguably the effectiveness of treatment. It seems pretty obvious to me that there should be *more* overlap between peer / recovery groups and treatment services not less; some blurring of the edges and interventions like Twelve Step Facilitation or the SMART Partnership model benefit everyone.

In the UK, there was for a time this idea being promoted that we needed a 'bridge' from the land of treatment to the land of 'recovery', suggesting firstly that recovery did not take place in treatment and secondly that mutual aid should be entirely separate and distinct. I argued against this model because it pushed mutual aid to a far distant land of aftercare support: complete treatment and *then* pop down the road to sit in a church hall for mutual aid. To my mind, there is absolutely no reason why you should not benefit from mutual aid whilst you are in treatment, in fact the earlier the better.

Our partnership model with treatment services has similarities with Twelve Step Facilitation; it provides *within treatment* interventions to engage service users with mutual aid. The main difference is that TSF is delivered without any involvement of the Fellowships themselves. Our model is to provide training, license our materials, and provide a template or road map for how services can introduce SMART. We also provide ongoing support to help their staff initiate meetings and hopefully service users to take these over.

So I am comfortable describing our approach as a hybrid model, but question whether we really are any *more* hybrid than the 12-step movement, which has independent fellowships but also 12-step based providers doing Twelve Step Facilitation and similar. There are differences, but the similarities are also strong, it is not obvious to me that one should be described as hybrid and the other not.

Bill White: Can you explain how the Partnership model works?

Richard Phillips: Sure; so the core focus of SMART Recovery UK is developing and supporting the network of mutual aid groups led by peer volunteers. At the time of writing, we have 150 open peer led meetings per week, which is up about 200% in two years – so small fry compared to the fellowships, but growing...

We also have a Partnership scheme with care and treatment services. The way this works is that they sign a partnership agreement and then we train usually two members of staff as what we call 'SMART Recovery Champions'; they do the same training as our peer facilitators and are then able to start SMART meetings within their services. We do not describe these as mutual aid, and some Champions are in recovery and some not, though at best the meetings are *almost* the same as peer led meetings in the community.

A key bit of the model is that the Partner is committed to help participants begin to co-facilitate and help identify future peer facilitators, who we then train up. In some cases, the peer facilitator takes over the running of the meeting; in other cases they start a new meeting down the road. The Champions provide some long-arm support until the peers are ready to become more independent, at which point the meeting becomes part of our national network of peer led meetings.

Treatment professionals have been using SMART in the UK since 2006, though this did not always benefit the growth of SMART. The new partnership model aimed to help us start more peer led meetings, which is what has happened.

Bill White: How have inevitable tensions between professional and peer influences been resolved within SMART Recovery?

Richard Phillips: SMART Recovery was founded by a group of addictions professionals along with people in sustained recovery who wanted to see more choice in mutual aid. It has *always* been a partnership between professionals and people in recovery.

The SMART program itself is science-based, so we need some way of reflecting upon and understanding the emerging science of addiction *within the context* of mutual aid. The way this works is as a dialogue between a large group – roughly 200 – of Facilitators and a smaller group of psychologists and other professionals with the grounding in the science such as researchers and clinical psychologists. What we are looking for is a sweet spot of evidenced tools and methods that actually make sense within a self-help / mutual aid approach. It is a blend of expertise by experience and expertise by academic authority – and it works.

The board of trustees in both the US and UK include a mix of people in recovery and people with professional backgrounds in addictions – and some with both kinds of experience. Just to pause on this for a moment, this is actually something we have in common with AA. Both organizations have a mix of people in recovery and professionals on their boards, both employ staff to keep the trains running, and both are charities that own copyrighted materials – there are also differences, but these similarities get overlooked by people who question the legitimacy of SMART Recovery – a bit of a pet peeve!

Back on your question, there *are* some inherent tensions around the Partnership scheme that we need to handle with some care. We have treatment professionals trained as SMART Recovery 'Champions' running meetings within services, and there is often a perception that these are not 'as good' as a peer led meeting. The line I tend to take is that this is fair enough, a good peer led meeting offers something special that a meeting led by a professional may not – so let's work together to get more peer led meetings up and running as well. Occasionally there will be a Champion who feels threatened by this and doesn't support their service users to get more involved, but the vast majority are great and really believe in mutual aid.

In a sense, we have found a model that gets professionals 'on our side' to help grow peer led mutual aid – they are not the enemy and the antagonism from some in the recovery community toward professionals is I think hugely counterproductive – and not helping people recover.

I have been really long winded here…your question was how to overcome the 'inevitable tensions' – simple really, encourage professionals to treat mutual aid respectfully and as an important option and encourage people in recovery to treat treatment respectfully and as an important option – don't be antagonistic or rude and this supposedly inevitable tension seems to evaporate!

Bill White: Do you think participant volunteers will play an increasingly important role in the leadership of SMART Recovery in the future?

Richard Phillips: I think they will – but just to be clear, volunteer participants are hugely involved already – more so in the USA than the UK, but the direction of travel is pretty clear.

The original board of SMART Recovery in the USA was mostly professionals; today it is mostly people in recovery, with some of these also being professionals. They have a small paid

staff team at a central office and an amazing range of committees, working groups, and other structures largely handled by volunteers who are in recovery. Some of these committees report directly to the board, others to the Executive Director. Most of these committees are entirely volunteer led, with staff and Board support where needed.

I think the best way of describing this in historical terms is that SMART Recovery was founded as a partnership between people in recovery and a team of professionals – with the balance of involvement evolving over time in the direction of more 'peer' involvement, responsibility, and leadership.

In the UK, we hope to follow the example from the US – though it is very early days. Just to give a sense of scale, the US has a team of 70 volunteers supporting their online community; in the UK, we have over one hundred volunteer facilitators, but only half a dozen volunteers who are helping with national projects. This is a big priority this year, to 'broaden the base' of involvement in the running of the organization.

Bill White: SMART Recovery has used a trained facilitator model. How are these facilitators trained, supervised, and monitored?

Richard Phillips: Our meetings follow a pretty set format, so the main role of the facilitator is simply to keep things to this structure. They introduce the meeting, read an opening statement, and track time for each section of the meeting. They also make sure everyone gets a chance to talk and may introduce the 'Tools' to help newer participants learn how to make the best use of the meeting.

I should stress, they are not being a therapist – to be technical about it, the locus of therapeutic interaction is *between* the participants of the meeting, not between them and the facilitator. So SMART Facilitation is not quite as complicated as it first sounds, but to do it well does require some training.

The best way to become a facilitator is to attend lots of meetings, learn how things work, and slowly take on more 'co-facilitation' tasks. At that point, we have an online training course that takes about 20 hours to complete. This has lots of video, some reading, and also questionnaires and other learning materials. You get a certificate and a nice professionally printed Facilitator's Manual at the end of it.

We have various ways of supporting facilitators, though in the UK, we certainly have a way to go before we will be happy. This includes peer supervision meetings and in some areas face to face events. We also run 'meeting startup seminars' and are creating mentoring structure to help new facilitators get their meetings established; even though we are getting lots of meetings running, there is quite a high dropout rate between completing the training and starting meetings.

There is a balance to find here; these are peer led mutual aid meetings, so we don't want some heavy handed, top down system. On the other hand, we have strong laws about 'safeguarding vulnerable adults' in the UK that make the charity responsible (legally, as well as morally) for what goes on in our meetings. I would not say that we have a way of 'monitoring' facilitators – but a strong, organic local community of recovery will pick up problems quite quickly. This good support, good complaints process and things like that helps keep SMART safe and effective.

We *can* directly intervene if we get a complaint about a meeting. We have never had to close a meeting down, but on a couple of occasions we have asked Facilitators to vacate that chair, or for example, go to a different meeting than their love interest.

Bill White: What percentage of the facilitators are persons in recovery? Is there a trend toward either greater professional or greater peer facilitation?

Richard Phillips: In the UK, the distinction we make is between peer led meetings and Partnership meetings. The main list of meetings on our website is all peer led mutual aid, to which anyone struggling with addictions is free to attend. These are *always* led by volunteers who describe themselves as in recovery. This is our core activity, the network of open, peer led, free mutual aid meetings – we have just hit 152 meetings per week and are adding four to six more per month.

Partnership meetings are run within treatment services by members of staff we describe as 'SMART Recovery Champions'. Some of these are also in recovery, but they are not required to say either way; we don't have precise figures but from a survey, I think it is about 60% with some prior personal experience of addiction. In terms of the balance between peers and professionals, it has evolved over the years but not in quite the way most people think.

SMART was first brought to the UK by Fraser, who worked in a Scottish prison, initially using a group-work program that was *not* peer led. For several years until 2009, the majority of meetings in the UK were run by professionals within Addaction, a large treatment provider. The real breakthrough in peer led meetings was the Department of Health Pilot scheme – which I will talk about more later – so by 2010, a majority of the meetings were finally peer led.

We have maintained this position since then. The number of Partnership meetings has increased, but so has the number of peer led meetings. Indeed, most of our peer led meetings 'emerge from' the Partnership scheme, so clients introduced to SMART whilst in treatment take the initiative to create new peer led meetings. It is absolutely clear now that the Partnership scheme helps us spread peer led SMART.

The ratio between the two has been fairly stable over the last three years, though we will probably see a short period where there are more Partnership meetings than peer led meetings. The main reason for this is that the prisons are taking up the Partnership baton at an amazing rate but find it hard to get peer led meetings running. We are trying to find ways of getting prisoners trained as peer facilitators, but even where we get that right, there is often a high turnover. Lots of prisons without peer led meetings will skew the balance between peer led and Partnership meetings.

In the long run, we expect there will be, as there is now, more peer led meetings than Champion led meetings.

Bill White: There is always the potential for a local group leader to radically divert from program philosophy and take a group in potentially destructive directions. Is there any mechanism in SMART Recovery to ensure fidelity to the SMART Recovery approach?

Richard Phillips: In the long run, Facilitators are part of the discussion about the direction of SMART. That doesn't mean we are content for them to take things in a completely different direction on a whim – so we are fairly hard-nosed about insisting that Facilitators stick to the

standard meeting structure and approach. Keep the core intact and the meeting participants feel safe to share.

When Fraser left, we no longer had training capacity, so there were Facilitators with a few hours training inducting other facilitators – there was a huge risk of SMART getting watered down – and we could see this beginning to happen. We wrote a new course and decided to make training mandatory: no one could Facilitate a SMART Recovery meeting without doing the approved course. There was some resistance, but an important milestone was crossed when one of the 'resistors' did the course and then told everyone how much they benefited from it!

So in the last couple of years, the main approach has been training and a good Facilitator's Manual. In the long-term though, it will be the 'organic' and deeply embedded cultural understanding of what SMART Recovery *is* that will keep things on track. At this point, not many people around the country have years of SMART experience – as these numbers build up, I think paradoxically there will be even less need for central oversight; the local SMART community will be self-correcting and organically reinforce the integrity of the program.

We do get some complaints about meetings that are not following the model, but this is getting easier to sort out.

Bill White: How is SMART Recovery financially supported in the UK? Could you describe the license fee arrangement that SMART Recovery has with some UK treatment programs?

Richard Phillips: For the first few years after registering as a charity in 2006, nearly all the money for SMART Recovery UK came from various grants. This worked well for a time and allowed the charity to employ several members of staff to build things up.

There is a trade-off to grant income though, which is that funders don't like funding ongoing activity or running costs. So you end up with money that helps you run, but gets you doing things that are a distraction from the core task of setting up and supporting meetings. So SRUK was funded to run a suicide helpline and things like that, worthwhile but distracting. The other problem with grants is that they expire – so as the funded projects came to an end, the money ran out.

It was pretty obvious that there was no way, in the UK, of running a central office just on pass the hat donations. All the money coming in from pass the hat in a year would not cover a single electricity bill – so keeping a member of staff employed that way was not going to happen anytime soon.

The approach we set upon was to charge the treatment providers for involvement with the Partnership scheme. We are effectively selling them training and a 'license' to use all our materials; they sign a partnership agreement so they agree to play nice and encourage service users to start their own peer led meetings. It's a win – win, they get better treatment outcomes by getting service users engaged with SMART Recovery; we get a source of income and many thousands of people introduced to SMART whilst they are in treatment.

The wonderful thing about the model is that it keeps us afloat financially without distracting us too much from the core mission of getting peer led meetings running; everything we do to promote and support the partnership will in time lead to more peer led meetings.

Bill White: What is the relationship between SMARK Recovery UK and SMART Recovery in other countries?

Richard Phillips: We have a very close relationship with SMART in the USA because they are the 'upstream' owner of SMART Recovery – in a sense, we operate under license from them. It is all very friendly and supportive though; we have a representative on each other's boards and I have contact with my counterpart in the US a couple of times a week. There is a lot of cross fertilization of ideas. We have less contact with other countries, though do speak to Australia once in a while.

Bill White: I have observed that those in the most visible leadership positions in recovery support organizations are in a quite vulnerable role in terms of internal scapegoating or external attack. What are your experiences and thoughts about such vulnerability and how it can best be managed at program and personal levels?

Richard Phillips: An interesting observation, though I am not sure this is a single phenomenon – there are a number of angles to this and probably different solutions.

Grassroots recovery activism is pretty new in the UK and so are many of the support groups, community interest companies, peer mentoring services, recovery cafes, and so on. These will take time to bed in and learn to work together. Things get a bit fractious if any one group or individual believes it has found the 'one true path' and sees others as a threat. We are also in a time of austerity and some groups have gotten used to a funding stream that now looks under threat – again this can encourage tensions.

Fairly young grassroots organizations are almost by definition not going to have well established governance structures; in some ways, that can be a strength – that they are directed by passion not business plans – but it can leave them vulnerable when there are personality differences and falling outs. Give it a couple more years, and I think it will settle down a bit!

Relationship between SMART Recovery and Treatment Sector

Bill White: How does SMART Recovery relate to addiction treatment programs in the UK?

Richard Phillips: I've explained the Partnership scheme – so we work pretty closely with the treatment system. We believe strongly that it is beneficial to introduce people to mutual aid early in their treatment journey and treatment providers can help make that happen. They increasingly see the benefit of having a network of peer led SMART – and other mutual aid groups – in their local areas. Of course part of this is that from their point of view, this is free aftercare! I don't mind if they want to see it that way, from their point of view it is true!

Overall I would say we have a good relationship with most treatment providers – we now work with most of the medium and large providers in the country who are almost without exception supportive.

Bill White: What do you see as the potentials and pitfalls of such collaborations?

Richard Phillips: The potential is pretty obvious; introducing lots of people who pass through the treatment system to SMART Recovery based mutual aid will help SMART Recovery grow. It seems abundantly clear that this is what is happening.

Of course there are pitfalls, but I think we need to keep them in perspective. At every stage of developing partnership with the treatment sector, there have been dark warnings that

disaster was just around the corner, that we were about to destroy SMART Recovery forever. If you were a gambling man, you could have lost yourself a great deal of money by backing the naysayers!

I don't mean to sound complacent – there *are* risks – but without risk there is little opportunity so the real question is whether risks are acceptable and can be managed. We listened carefully to the doubters, who had made some good points as well as bad points, and found a way forward that minimized the risks.

The main risk was that providers would simply use SMART Recovery as an adjunct to treatment, rip off the program, and not encourage peer led meetings. Historically, we also had examples of agencies selling Facilitator training in our name and without our permission, running meetings without training; misusing copyrighted material and all sorts of things that would make your hair stand on end.

Our solution was to get agencies to sign a legal partnership agreement that commits them to various things – including to actively encourage service users to get involved with peer led SMART, do the proper training and so on. This has worked, and we now get very few problems. I can quite honestly say that 99% of partner agencies are helping SMART Recovery in a way that is consistent with our values and aims.

Bottom line, treatment is not the enemy of mutual aid; our interests are not quite the same but they *do* overlap a great deal. Working in the space where interests overlap is a pretty good definition of partnership.

Bill White: Does SMART Recovery have what could be thought of as a counterpart to the 12 Traditions of 12-step programs that would govern how it relates to outside organizations?

Richard Phillips: Certainly there are shared values underpinning the organizational culture and direction of travel, which will no doubt evolve over time. We have no equivalent to the traditions, just like many other successful organizations!

Bill White: 12-Step program traditions prohibit local groups from taking a stand on alcohol and other drug-related policy issues. That does not seem to be the case with SMART Recovery. Could you comment on this difference?

Richard Phillips: As an organization we are able if we wish to take a position or publish opinions; in the UK, we will, for example, make submissions to government consultations on policies that will impact mutual aid, or liaise directly with officials, commissioners, and pretty much anyone else who can help get mutual aid more available.

If I can again be slightly pedantic about your wording – the 12-step *Fellowships* of course avoid taking a stand on policy issues – but 12-step programs certainly do not. 12-step programs and champions are an active lobbying force and routinely fight the corner for what *they* see as the interests of themselves or the Fellowships.

I must stress that I don't have a problem with this – all forms of mutual aid need their advocates – but we must be clear that the voice for *choice* in mutual aid is a very small one compared to the advocacy of 12-step approaches – and this is overwhelmingly the case in the USA.

As an aside, we are often in the position of working *with* 12-step groups on areas of policy that affect mutual aid as a whole – our interests substantially overlap so we often work together when we find ourselves sitting on the same committees.

Final Reflections

Bill White: What is your vision for the future of SMART Recovery in the UK?

Richard Phillips: Everyone in the UK will have the option of attending several SMART Recovery meetings per week if they find this useful to their recovery. Everyone going through treatment will be introduced to SMART Recovery. Our meetings will continue to evolve as the scientific understanding of addictive behaviour evolves and we will get world class materials into the hands of meeting participants. We will have a vibrant national network of peer volunteers involved at every level of how we run the organization.

Bill White: Looking back over your years of involvement with SMART Recovery, what have been the greatest challenges and greatest rewards you have experienced?

Richard Phillips: That we have moved so far, so quickly toward the vision I have just set out. That has been the greatest challenge. The greatest reward has been to share this journey with such a wonderful group of people.

Bill White: Richard, thank you for taking this time to share your experience and knowledge with us.

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Appendix - History of SMART Recovery UK

Context - USA

SMART Recovery was started as a not-for-profit organisation in the USA back in 1994, with roots back to the mid-1980s and a group called 'Rational Recovery'. SMART Recovery was founded out of a partnership between people in recovery and professionals, though evolving in the direction of greater peer involvement and responsibility over time. By the late 1990s SMART Recovery was well established in the USA, with a growing number of meetings, on-line support and a thriving training programme for new facilitators. SMART Recovery also worked alongside a commercial company 'Inflexxion' to secure a government grant and develop a group-work programme for prisons, InsideOut. More recently, work on a family support programme based on both SMART Recovery and the evidence based CRAFT approach has been developed.

1998 – 2000

Fraser Ross, a prison officer in HMP Inverness in Scotland, became interested in SMART Recovery and approached the US charity. Joe and Barbara Gerstein visited the UK in 1998 and made a presentation at Inverness prison. These initial attempts to get a meeting started were not successful, though another visit by Joe in 2000 helped Fraser build momentum. This visit included presentations at two prisons and also at a prison service conference.

2001

In 2001, Fraser persuaded Nick Royle, Head of Addictions at the Scottish Prison Service (SPS) to back a proposal for the InsideOut group-work programme to become an approved activity within SPS. Inside Out is a professionally delivered psycho-educational group-work programme based on SMART Recovery.

The SPS Accreditation Services scrutinised the application and granted approved status of the programme throughout the Scottish Public Prisons. The programme manuals were slightly amended to comply with SPS requirements and to fit better within the Scottish treatment and criminal justice system. This process was handled within SPS by David McCue, who many years later became a trustee of SMART Recovery UK. Inside Out was established within Inverness prison.

In 2001, Fraser also attended a face to face training session on meeting Facilitation in Newark, New Jersey – making him the first person in the UK to do this training.

2005

Due to other pressures, it was not until 2005 that the first meeting was established in the community, at Beechwood House in Inverness.

2006

- Received £25k from the Robertson Trust to underwrite running costs and support the creation of new meetings.

Fraser registered the charity 'SMART Recovery UK' with the purpose of helping the network of meetings grow and became the first paid employee, from August 2006.

Also in 2006, Addaction (a large voluntary sector addictions treatment provider) received permission from the USA to use SMART Recovery in all their services. A member of their staff team, Tom Macintosh attended the Facilitator Training in Boston in 2006 and later attended the US annual conferences in 2007 and 2008.

2007

- Received £41k from the Scottish Executive for Prison internet project
- Received £27k from NHS Highlands for Prison internet project
- Received £75k from the Robertson Trust to support creation of new meetings
- Received £22k from NHS Highlands for Choose Life Project.

A focus of activity in 2007 was trying to strengthen the funding base of the organisation, primarily through grant applications. Two additional members of staff were taken on, in order to build administrative capacity and work on the new initiatives.

The Prison internet project aimed to develop an on-line 'Distance Therapy' platform to support prisoners and ex-prisoners and link them into peer support on release. This would also be offered to other organisations, so partner agencies such as treatment services would use this to work with prisoners over the internet.

The Choose Life or 'Internet Crisis Intervention Project' aimed to create a range of evidence based on-line interventions targeted at suicidal behaviour using the same distance therapy platform. The intention was to work in partnership with treatment services, which would use the chat rooms to support their clients remotely.

A partner organisation, 'Mackay Ross International' (MRI) was established as a Community Interest Company, with Fraser Ross, Shirley Ross, Chris Darge and Kathryn Darge as Directors. This was intended as vehicle for business initiatives, such as website design, on-line toolkits, needs assessments and consultancy that would build a sustainable source of income for SMART Recovery UK. MRI was funded to provide project management support for the Choose Life project.

The first UK Facilitator Training took place in Inverness, supported by guest speakers Jonathon von Breton and Tom Litwicki from the USA. The event was attended by 40 delegates, combining service users and treatment service professionals.

The first face to face SMART Recovery meeting in England was started in Manchester in 2007, after the National Treatment Agency for Substance Misuse (NTA) provided funds for Fraser to travel down and deliver some training.

Also in May 2007, a conference was organised in Glasgow, with several high profile speakers from the SMART Recovery movement and supportive academics, such as Dr Linda Sobell.

Toward the end of the year there was insufficient funds to continue with the additional staffing, so for a period we returned to having a single paid position.

- Ian Smillie was appointed as a board member in October.
- Chris Durge was appointed as a board member in December.

2008

- Received £15k from the Scottish Executive and Police and Community Safety Directorate for the prison internet project.
- Received £6k for work and expenses on the DoH pilot scheme
- Received £50k from the Robertson Trust to support creation of new meetings.

In 2008, Fraser arranged for the President of SMART Recovery, Dr. Tom Horvath and also Dr. Linda Sobell to present to the Scotland Futures Forum.

Although there was a great deal of interest, at the start of 2008 SMART Recovery was still very small. The majority of meetings were professionally led, within Addaction and there were fewer than a dozen peer led meetings in the community.

The breakthrough came when Professor Nick Heather and Keith Humphreys successfully applied for Department of Health funding for a pilot scheme to work with alcohol treatment providers to spread SMART Recovery. The idea behind the project was that many people using alcohol treatment services did not, for whatever reason, engage with the existing mutual aid organisations and that SMART Recovery looked to be a viable alternative.

The scheme was hosted by Alcohol Concern, which dedicated a staff member to the project for a year, and overseen by a steering group chaired by Nick Heather and including Fraser and two other SMART Recovery Facilitators, Dan and Kevin. After sifting through 40 applications, they identified 6 sites to host pilot meetings. Training and support was provided by Fraser to interested service users at these sites to help them get meetings running.

The scheme was evaluated by Susan McGregor of Middlesex University (McGregor 2010). The report concluded that further rollout of SMART Recovery was both 'Acceptable and Feasible', though further development would depend on:

- Proactive development of activities such as provision of training and start up resources

- Presence of a supportive environment in local agencies, involving an agreed approach to mutual aid, experience with peer support and knowledge about SMART Recovery
- A national infrastructure with a clear identity and strong and stable central office, able to provide support with communications, networking and encouragement.

The pilot scheme certainly seemed to trigger a broader interest in SMART Recovery. In particular, some of the new Facilitators became very effective ambassadors and pioneers, getting even more new meetings started in a fairly short period of time. This was especially true around Manchester.

- The Directors of Mackay Ross International applied to have the company dissolved in December.
- Carol Hammond began working as Administrator and became company secretary in December.

2009

- Received £4k from Alcohol Concern for expenses of pilot scheme.
- Received £2k survival money from NHS Highland
- Received £2.6k survival money from Alcohol Concern
- Received £9k survival money from SMART Recovery USA

Toward the conclusion of the Alcohol Concern pilot however, the charity SMART Recovery UK faced an imminent threat to its survival. The organisation had two members of staff but no meaningful source of income on the horizon. The small number of funders that had supported the organisation to date were unwilling to put in further funds, applications to other funders were not successful and the commercial enterprises through MRI had not made a profit.

Faced with the risk of the charity going bankrupt within a few months, the Trustees brought in David McCue to carry out a review of the financial viability of the charity. The Board concluded that there was no alternative but to make the Development Coordinator redundant, which is what happened in November 2009. David also accepted an invitation to become a member of the Board of Trustees.

The 'survival money' described above was secured to ensure that the charity did not have to fold immediately, since committed expenditure such as redundancy costs and an office lease significantly exceeded existing funds.

- Carol Hammond became Company Secretary in February.
- David McCue became a Trustee in May

2010

- Roxbury Foundation £7k survival money
- NHS Highland 6K – survival money
- SMART Recovery USA £3k – survival money

By February 2010, the organisation had roughly 30 peer led meetings, plus another 20 or so being run within Addaction and facilitated by paid staff. Carol Hammond was still employed part time to run the central office though there was little money in the bank and no income. With the loss of Fraser, there was also no training available for new Facilitators and without further funding the future of the organisation was uncertain.

In April a conference was held as the final conclusion of the Alcohol Concern pilot scheme. This event revealed deep differences within the SMART Recovery Community. The Board was keenly aware of the precarious finances, but also felt we could not move forward without staff. They talked about the need for income and suggested we build on the partnership with providers. Fraser (now attending and contributing as a volunteer) offered an alternative vision, that SMART Recovery UK should become entirely peer and volunteer led and undertake no partnership work with treatment providers. This, it was suggested, would remove the need for income. Others opposed this idea, believing that trying to run the organisation entirely with volunteers was unlikely to work.

The trustees thought that the model proposed by Fraser did not meet the success criteria set out (and quoted above) in the Alcohol Concern pilot evaluation report and essentially ignored the key lessons of the pilot. They did however recognise that there were very strong feelings around these issues.

The board brought in Richard Phillips to help them work up an outline plan, based on a variation of the DoH Pilot, that would enable the charity to survive and secure the future growth of meetings. This would then go out to wide consultation over the summer of 2010. Richard remained involved to run the consultation.

The consultation itself was very broad, including four events, an on-line survey and the involvement of over 100 people in several months of passionate debate. Some parts of the proposals were almost universally unpopular, so changes were made to reflect these concerns. A clear majority accepted the need for the organisation to work in partnership with treatment providers in some way and also to have some paid staff.

The conclusion was that we should keep our primary focus on building a network of peer led mutual aid meetings, but also develop a partnership scheme with providers that would help our meetings grow more quickly across the country and provide a source of income. The main difference to the Alcohol Concern pilot was that we would train staff as well as peers – but ask the provider to sign an agreement that committed them to helping service-users start their own meetings.

The Board also decided to abandon the previous funding model, based on grant funding for projects only tangentially related to the core task of running and supporting meetings.

The Board asked Richard to remain involved as 'Interim Director' and implement the new development plan. The remainder of 2010 was spent on two projects, building an on-line e-learning platform to train SMART Recovery Facilitators and also working out the detail of the partnership scheme.

The Board of Trustees was further strengthened in 2010 with the addition of:

- Dr Joe Gerstein, the co-founder and first President of SMART Recovery.
- Carl Cundal, an experienced facilitator who was involved in the Alcohol Concern pilots.
- Charles Steel, a leading figure in the Scottish recovery community.
- Terrie Semple, a leading figure in the Scottish recovery community.

2011

- Received total of £100k from the new partnership scheme

The partnership scheme was launched in February 2011 and grew to roughly 80 organisations over the following year. Most of the major treatment providers in the UK signed up, including CRI, Turning Point, Phoenix Futures, Lifeline and Compass. Addaction also signed the agreement and was asked to begin transitioning more of their meetings to become peer led.

A 'whole area' partnership was agreed with commissioners in Bristol to bring all their local services into partnership and train both staff and peers across the city. A similar partnership was set up in the Lothians region of Scotland; aiming to build a strong network of SMART meetings, with strong links to treatment services. This included a full time post for a year, to which Jardine Simpson was recruited.

NICE published clinical and commissioning guidance encouraging engagement with SMART Recovery. (NICE February 2011) (NICE August 2011)

In November 2011 we published a UK re-write of the SMART Recovery Facilitators manual, which is sent free in professionally printed hard copy to everyone who completes the facilitator training.

By the end of 2011, the organisation was no longer at risk of going bankrupt and the number of meetings was again rising.

2012

- Received total of £230k from the partnership scheme

We entered into partnership with Waypoint, a voluntary sector training agency, helping us develop a face to face training program. A plan is in place to train a team of peer trainers early in 2013.

We launched a new website and on-line community on which over 2,000 people registered in the first 8 months. This also supports weekly on-line meetings using a voice chat system.

New poster and participant leaflets were published and mailed to all Facilitators.

Support for the Lothians project continued into a second year and Jardine's post was re-configured to become the National Coordinator for Scotland. Steve Crawley was recruited as National Co-ordinator for England and Richard Phillips, previously Interim Director, was confirmed as Director.

NICE Quality Standards aimed at all NHS interventions for people with drug problems explicitly state that people in drug treatment should be offered support to access mutual aid, and specifically mentions SMART Recovery along with the Fellowships. (NICE 2012)

By the end of the year, this brought us up to 4 paid members of staff, with 120 peer led meetings, 60 partnership meetings and > 250 partnership sites signed up. The number of both peer led and partnership meetings continued to grow strongly, with roughly 200% growth over the previous two years. Over 1,500 people had applied for training, 750 enrolled and 200 completers. Roughly half of these were people in recovery and the rest Champions.

2013

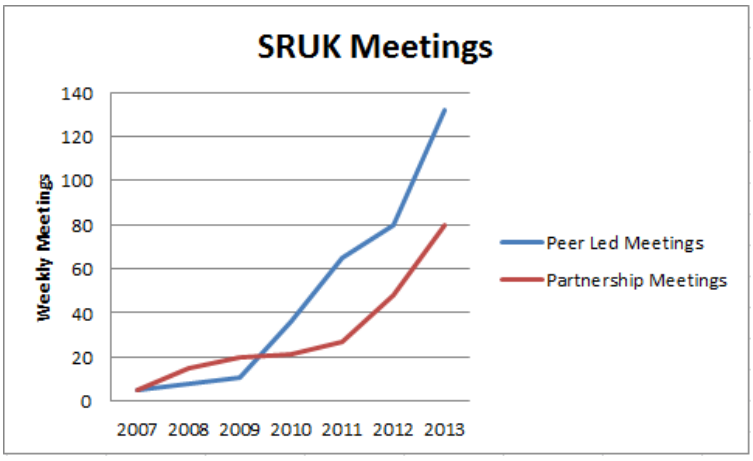
Going into 2013, the charity is fast growing, has stable finances and is focused on an ambitious plan to make SMART Recovery even stronger and more widely available in the coming years. Highlights include a new Handbook and training up a team of peer Facilitators.

The focus of work this year is

- To broaden the base of peer involvement in how the organisation runs
- Improve how we support Facilitators and in particular new facilitators
- Publish several manuals and improve other materials.
- Consolidate the partnership scheme and in particular strengthen our work in Prisons

Finances and meeting activity by financial year

For simplicity, the main narrative of this report is provided by calendar year. The most reliable information on the number of meetings has been recorded by financial year.



There are also a small number of additional closed partnership meetings not shown here, for example some prisons. Earlier historical records of the numbers of meetings are not entirely consistent and are probably not entirely accurate, though reflect the best available data and are included here in good faith.

The financial position of the organisation is also best judged against financial year so the following table is offered as a quick overview of how things have evolved in relation to both meetings and finances. Figures are at March 31st.

	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13
Peer meetings	~ 5	~ 8	11	36	65	80	132
Partnership meetings	~5	~ 15	20	21	27	48	80
Turnover £k	-	140	84	25	27	185	235
Net position £k	-	1	24	-21	4	44	79
Carried forwards £k	-	1	25	5	9	52	132

All financial figures are £ thousands, rounded for clarity. Net position and carried forwards are provided as a rough indication of the financial strength or vulnerability of the organisation. Please see accounts available from Companies House website for more detailed information. 2012/13 Finances are approximate and accounts have not been finalised.

Additional notes

There are three possible dates to describe the appointment of directors: when the decision was minutes at a board meeting, when the application was made to Companies House and the date on which this was approved. Dates shown are mostly the dates of application but this has not been checked in detail.

During the drafting of this document we sought comment and input from a number of people. We are deeply grateful for the insights, recollections and corrections of everyone who contributed though responsibility for the accuracy of final version rests with SMART Recovery UK. If you know of any inaccuracies, please contact central office and we will do what we can to verify and then update this document on our website.

References

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NICE (February 2011) Clinical Guidelines: Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence: http://goo.gl/EnGsj

NICE (November 2012) Quality standard for drug use disorders: http://goo.gl/gc5Wu5

Updates of this history will be available at

http://cdn.smartrecovery.org.uk/doc/history-smart-recovery-uk.pdf