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▶ The Alcohol Concern Smart Recovery Pilot Project final evaluation report.

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Macgregor S, Herring R.
Middlesex University, 2010.

Austerity plus recovery plus curtailed treat equals more mutual aid is the formula for ways out of dependence in the post-credit crunch 2010s. But with only 12-step groups, the offer is limited. What will it take for a cognitive-behavioural alternative to flourish in England was the question for this pilot project.

Summary The SMART Recovery pilot project was funded by the English Department of Health for two years from April 2008. SMART is an acronym for 'Self Management and Recovery Training'. As applied to drinking, it offers a recovery and relapse prevention aid which like Alcoholics Anonymous (AA) relies on mutual support in small groups of people recovering from drink problems, but instead of being based on the 12 steps, sees addiction as a learned behaviour which it seeks to unlearn using cognitive-behavioural principles. The US-originated system focuses on:

- building and maintaining motivation to abstain;
- coping with urges;
- managing thoughts, feelings and behaviour; and
- balancing momentary and enduring satisfactions.

SMART Recovery UK (see web site) and the national charity Alcohol Concern joined together to establish the SMART Recovery project to pilot the model at six sites in England. It aimed to test whether non 12-step mutual aid can flourish and become self-sustaining with a view to facilitating take-up by areas across England. Such a development would in particular redress the lack of aftercare following formal treatment for patients uncomfortable with AA, but might also offer a recovery and relapse prevention option in its own right.

The featured evaluation report (for full report click title of this entry; for summary click here) was one of the project's outputs. It was not intended to quantify drinking outcomes but to determine whether the project's methods had proved a feasible way to establish

new mutual aid groups of these kinds in the six areas, and whether these developments were acceptable to alcohol treatment/help services and potential group members. The researchers relied largely on analysing documents related to the project, observing its work, and on the views of those involved, gathered via interviews, focus groups, and questionnaires.

Main findings

In response to the call for pilot sites, 33 applications were received, suggesting quite extensive interest in developing peer support options focused on abstinence.

At the six selected sites, the key dilemma in developing groups was the degree to which services and the central SMART office should support them, or leave them to make their own way. Project leaders were concerned that external funding would undermine SMART's mutual aid/self-help ethos, and a preoccupying issue was the degree to which the groups would involve or rely on services and professionals as opposed to being entirely user-led and operated. For its US originator, a period of professional facilitation was acceptable as long as within a few months operational control was relinquished to group members. Project leaders in England saw the groups as potentially working with treatment services (as a precursor to treatment, support during treatment, or aftercare) but were adamant that groups should be user-led rather than becoming an arm of treatment services. Group members themselves differed on this issue. Some thought it naïve to think groups could function completely independently of treatment services, and support from the host agency remained very important to them. While trying to be available if needed, host agencies generally respected the wishes of group members in terms of how much involvement they had with the group.

Though the risks of co-option might be minimised by financial and operational distance from services, this also created problems. The attempt to set up a group at one site foundered when the local host agency wanted to co-facilitate the groups for an initial period, a strategy rejected by the project's national leadership. On the financial side, perhaps because so few group members were employed full time, it proved difficult to fund the work solely from their contributions.

In the event, 63 people attended for training to facilitate SMART groups, of whom nearly nine in ten had been or were (a quarter) in addiction treatment. About six in ten had attended AA and despite commonly severe dependence, most had been abstinent for several months.

Nearly all SMART group members the pilot areas responded to a survey. Of those responding, only 1 in 8 had never been treated for alcohol/drug problems, over a quarter were currently in treatment, and 80% had used self-help groups previously, mainly AA. Severe past problems with alcohol were the norm – for many, not far in the past; just over half had drunk within the past three months. Finding moderation did not suit them, most were committed to abstinence. Demonstrating how critical was referral from treatment services, two thirds had heard about SMART from an alcohol worker, reflecting the fact that most groups had developed via a close link with services. If groups become more widely established and better known, non-service referral routes might become more important.

Involvement with the group was a regular part of the life of most members, and a core

group of longer term members appeared to developing. About two thirds attended meetings weekly, and all but a few intended to continue attending. All found the meetings helpful, generally more so than other types of self-help groups. The groups appealed to them because of their non-hierarchical structure, they could readily be understood by others with similar experiences, and other members acted as role models who had overcome their dependence and forged a 'normal' life. SMART Recovery in particular emphasised 'moving on', not repeating 'war stories'. Members liked the focus on problem solving and the practical approach to recovery. Support not to drink helped them stabilise and then move on to improve housing, employment and social integration. However, they accepted that relapse may be part of the recovery journey and saw the availability of groups as important in helping people get back on track. They felt their self esteem and confidence improved and enjoyed being able to think about new activities or rediscovering old ones. They were not hostile to AA – simply preferred SMART Recovery; it worked for them.

The authors' conclusions

SMART groups addressed gaps in services and the need for an alternative to AA while offering great value for money. Overall, the mutual aid element seemed most appealing to facilitators, but self-help – working with the tools between meetings, absorbing this way of thinking, or accessing the web for support – also played its part. Training and refresher training (in use of therapeutic tools, group work and project development) were valuable, as was the right amount and kind of support from the host agency, which ideally remained a steadfast and enthusiastic supporter, but one willing to 'step back'. Successful implementation was aided by a core of keen and able activists, central office support and small seed-corn grants, a supportive environment of services locally into which SMART groups can be linked, and links to the wider social movement of recovery advocacy. It is important not to underestimate the support groups initially need from services nor to expect too much too quickly.

Practical lessons from the pilot include: secure sufficient initial and ongoing funding and make sure everyone is fully aware of the commitments involved; locate meeting venues before initial training and ensure posters and advertising are ready before training starts; check whether facilitators are following guidelines; better funding of a central SMART Recovery office to manage and monitor training; offer more training including for facilitators to themselves become trainers; have local trainers but enable them to meet and network; make advice available to new groups from existing groups. Further details below.

The project showed that it is feasible to develop mutual aid groups through partnerships between people in recovery and host agencies. Two of the six local projects could be seen as having been completely successful. Two others were still in the early stages and their development was in doubt after the pilot has ended. Most still needed a host agency within which to operate, at least to give them credibility until SMART becomes better known.

Groups got off the ground where there were energetic activists ready to take on the required tasks. A key question is what is needed to sustain this considerable commitment. In the pilot the required resources were underestimated. In particular, the idea that an autonomous recovery movement could develop without support from host agencies seems misconceived. Too much would be asked of people often in early recovery, whose social circumstances may be uncertain and fragile, and who do not have substantial financial resources. If group development is to be condensed into a short time frame, then support through training is useful, but one

session is not enough; repeat visits boost morale and help deal with questions that arise. Funding was the number one issue and most agencies asked for more support to help purchase mobile phone, print more professional leaflets and publicity, or advertise in local papers and publications. While it is important to respect autonomy and to avoid dependence on services, adopting too puritan a view and having fixed and high expectations of group members and host agencies seems risky. A less ambitious agenda – encouraging mutual aid groups using the SMART tools and encouraging treatment providers to refer people to groups but not expecting too early a move towards total independence – might be more successful. Groups cannot be expected to run before they can walk, and most of the groups developed through this pilot will continue to need emotional and material support.

Factors that seemed to help sustain the activists included:
- the encouragement derived from networking between group members in different locations;
- a central coordination point offering information, resources and guidance;
- celebration of successes locally and nationally;
- recognition of the emotional labour involved and some input of resources to replenish this.

The steering committee might have played a more active development role but – meeting infrequently – it tended to act more like an advisory body. Most attention was paid to developing the groups but this always takes longer than anticipated and requires continuing supportive input from initiators, leaving less time for linking with host agencies and the wider body of professionals and commissioners. Though the final project conference helped redress this deficit, insufficient attention was devoted to encouraging the development of local champions, who would promote the brand and encourage referrals to groups. With such champions, groups have a much better chance of thriving.

At local level, thought should be given to what constitutes a nurturing environment and infrastructure of services in which groups can become embedded and grow. Such an environment features:
- service providers who understand and sympathise with the SMART approach, and in particular which offer services based on the same cognitive-behavioural principles so there is a fit between prior treatment and SMART;
- services ready to provide just the right amount of encouragement and practical support without taking over, and which have sufficient resources and experience of working with volunteers and peer support groups;
- an established partnership of appropriate agencies concerned with substance misuse willing to include the new groups within their ambit;
- recruitment to groups is encouraged by host agencies along with their partners;
- these conditions seem most likely to met through links to specialist alcohol rather than generalist services; they are more aware of the resources needed to develop peer support groups and are in a position to refer people to the groups.

Encouraging system-wide change in service networks to help create a conducive environment was one ambition of the pilot, but little was achieved, mainly because the focus was perhaps justifiably on developing the groups. Champions are commonly seen as the main change agents – people who will promote such groups at levels from ground to strategic. Uncertainty about who made the best champions – graduates of recovery programmes or treatment professionals or both – obstructing this development and needs clarification.

FINDINGS After being relatively ignored in policy circles, in recent years mutual aid has received a multi-pronged policy boost in Britain. The rise of the new "recovery" agenda has brought with it a greater emphasis on sustained and extensive life change including abstinence, and a greater role for the lived experience and contributions of recovering addicts and alcoholics. At the same time as treatment services are being expected to do much more, their resources are no longer increasing and probably diminishing overall. One way policymakers seek to square this circle is to move the stress

from retaining patients in treatment to getting them out the other end, if possible sustainably free of dependence. Long-term, 24-hour access, frequent support meetings, offering a new social circle and a new way of life, yet free or low cost to the service – mutual aid groups seem tailor made for this new environment. It comes therefore as no surprise that they feature in recent commissioning guidance from England's National Treatment Agency for Substance Misuse, which sees SMART Recovery groups among others as providing "valuable support and positive social networks for individuals who are addressing their dependency through treatment". The advice to services is that "Details of how clients can access local recovery networks should be made available throughout their treatment journey. Services may wish to consider more active engagement with local mutual aid groups, for example making rooms within the treatment service or prisons available for meetings". The agency now sees (see annual reports for 2009–10 and 2010–11) promoting mutual aid networks as a key way to achieve its objectives. Local service commissioners are being called on to ensure that the treatment system is better integrated with wider supportive services, among which mutual aid organisations are seen as the most prominent.

The featured project has in particular kick-started the development of SMART groups in England. According to the UK organisation's interim director, as of June 2011 it had spawned 25 groups, and agreements with local services and commissioners would soon see SMART active at 40 sites. In the same month the UK organisation's web site also listed 15 meetings in Scotland. Centrally organised growth is possible because the organisation works in partnership with services and commissioners to create groups which are not necessarily peer led, rather than waiting for groups to mushroom 'bottom-up' from the uncoordinated initiatives of local drinkers and drug users. Though the featured project was focused on alcohol, drug services too are fostering the development of mutual aid groups, including SMART groups.

Fostering and supporting SMART groups is one way services can extend the support made available to their clients, and also support more problem substance users than services can manage or attract on their own. A degree of independence from services (or a mixture of independent and non-independent groups) is however desirable if groups are not to be limited to (ex)service users, are not to duplicate the work of service user groups or therapy/aftercare groups, and are to fulfil their potential to offer a recovery route to people who do not want to be associated with formal treatment.

The argument has been made that mutual aid is too valuable a resource to leave to chance. Though findings are far from definitive, studies suggest that group involvement reduces substance use and health care costs, and has additional benefits relating to self-efficacy, social support, depression, anxiety, and coping with stress. Without 'throwing out the baby' by co-opting groups, services can offer practical support and in particular act as a referral route. Advocates recommend validated methods (such as 12-step facilitation counselling or motivational enhancement) to ensure appropriate patients are referred to appropriate groups, and are more likely to act on that referral than after simply being told about their existence. The great advantage of adding SMART or similar groups to the mutual aid menu is to open the door to this type of support to people who would not be attracted to or not do well in 12-step groups – in particular, to open the door and enable a smooth transition from time-limited cognitive-behavioural type treatment to long-term, cognitive-behavioural support from compatible groups. Details

below.

Even in an environment like the USA, where 12-step groups are widely known and accepted, a study found that systematic, persistent and practical referral efforts by substance use counsellors can modestly strengthen post-treatment involvement and improve outcomes. One simple and effective tactic is to offer to host mutual aid meetings for your patients at the treatment site, found in the featured study to also help groups avoid succumbing to the practical burden of finding a home. In a US study of patients who had generally not attended 12-step meetings in the past year, going to an intensive day programme with rather than without meetings on site increased during and post-treatment attendance and (partly because of increased participation in groups) post-treatment drug and alcohol abstinence rates.

Research has focused almost exclusively on 12-step approaches, and specifically on 12-step based treatments, rather than autonomous non 12-step approaches like SMART recovery groups. A unique US study compared the two approaches by alternately allocating 112 patients suffering serious mental illness and substance use problems to 12-step or to SMART Recovery groups. These were not autonomous groups, but run by counsellors at two separate intensive day treatment/partial hospitalisation programmes. The results suggested that these two types of groups might differ (but not dramatically) in their impacts. The 12-step intervention was better at quickly curbing self-reported drinking (though urinalysis results did not differ), there was a fleeting extra reduction in urinalysis-confirmed cannabis use, and the 12-step patients saw more of their friends or family. These improvements seemed to have been gained at the cost of a worsening of medical problems, health status, and employment, and more psychiatric admissions, while positive changes in health and employment were associated with the SMART intervention. How satisfied patients were with their lives was not differentially affected by the two types of groups. The implication is that substance use is more radically controlled in the short-term by 12-step's greater emphasis on abstinence, but that the cognitive-behavioural strategies and perhaps too the more empowering ethos of the SMART groups helped patients more with the rest of their lives.

That outcomes were generally similar in the two groups fits with indications that 12-step groups work in much the same way as can be expected of SMART and other mutual aid groups. Recent reviews (1 2) of how Alcoholics Anonymous works have highlighted non-specific mechanisms including self-efficacy, motivation for abstinence and commitment to recovery, coping strategies such as avoiding high-risk situations, the provision of clear goals and a coherently structured route for achieving these, abstinence-oriented norms and role models, involvement in alternative rewarding activities, and social support. Particular importance was placed on "perhaps its most potent influence" – social group dynamics in the AA meeting, the broader fellowship, and social support. In contrast to these generic mechanisms found in other approaches, there was less support for spirituality, adherence to AA beliefs and philosophy, or following recommended AA practices.

Differences in outcomes are probably minor and insignificant compared to the potential benefits of being able to point patients to some kind of support group which suits them and which they might join. What SMART offers is (in ethos and therapeutic approach terms) a potentially seamless transition from cognitive-behaviourally based treatments to a similarly based aftercare option, or a parallel supportive social environment which does not compete with but reinforces the treatment. In the USA, 12-step based services widely enjoy this kind of compatible mutual aid ally, with the result that continuing abstinence in particular (the shared target of both) is bolstered, while those exiting cognitive-behavioural programmes gain less (still some) from participating in 12-step groups (1 2 3). It seems likely that if cognitive-behavioural mutual aid were as widely available as 12-step groups, patients from cognitive-behavioural treatments too would better be able to sustain the behaviour changes targeted by the prior treatment, with resultant health care cost savings.

What type of mutual aid is most suitable is of course not just a function of prior or parallel treatment but of the individuals's preferences. Those alienated by what they see as the religious or spiritual overtones of AA and NA can find a compatible home in SMART recovery groups, without this compatibility at the same time deterring the more spiritual or religious. In contrast, the appeal of 12-step groups may be more limited to participants sufficiently spiritual or religious to accept submission to a higher power. It may also be that people who prefer

to see themselves as in control of their drinking will prefer SMART's ethos.

In one US study, the more deeply religious someone was the less (but only slightly and not statistically significantly) they participated in SMART groups, but the more they participated in 12-step groups (a substantial and statistically significant relationship). What made this important was that 'clean and sober' time increased with participation, suggesting it is beneficial to match patients to groups on the spirituality dimension.

In this study any deterrent effect of the SMART ethos on religious members was at most slight, showing that it can appeal across this dimension. That seemed confirmed in another US study comparing the views of recovering alcoholics in AA as opposed to SMART groups. About half the SMART members believed in a higher power, suggesting no incompatibility with SMART's ethos. However, the AA groups were able to attract only a few dissenters from this view, and members were on average much more spiritual or religious in their beliefs. They were also more prone to see their drinking as subject to forces over which they had little control rather than as something whose control lay in their own hands.

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