Turning Point

TREATMENT · RESEARCH · EDUCATION

Embedding SMART Recovery in Alcohol and Other Drug treatment: A pilot study

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Contents

EXECUTIVE SUMMARY

Background

Research suggests mutual aid in the form of peer support groups such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) is widely available and cost-effective and can amplify and extend treatment effects and enhance long-term recovery from Alcohol and Other Drug problems (Humphreys et al, 2020; Kelly et al, 2020; Manning et al, 2020). However, in the Victorian AOD treatment system, peer support groups are largely restricted to residential treatment services which represent only 16% of treatment episodes (AIHW, 2019). As such there is a missed opportunity for peer-to-peer learning, where clients share their experiences, knowledge and encouragement and provide social, emotional and practical support to one another. Peer support groups provide opportunities to build recovery capital by increasing connection to others and strengthening positive pro-recovery social networks (Hennessy, 2017; Kelly et al, 2011). By offering peer support groups as part of AOD treatment, clients can be introduced to a free and widely available form of aftercare in the community for as long as they need.

Opportunity

Turning Point was commissioned by the Victorian Department of Health and Human Services (DHHS) to conduct a demonstration (pilot) project to address the question *"How can AOD providers support the provision of mutual aid?"*. Research suggests that the different types of mutual aid groups are equally effective (Penn & Brooks 2000; Zemore et. al 2018; Atkins & Hawdon, 2007). Twelve-step groups such as AA and NA are the most established and widely available forms of mutual aid, and offer non-professional, peer-to-peer support worldwide with an abstinence-based philosophy based on powerlessness over their addiction and the need to relinquish control to a 'higher power'. The 12-step program aims to improve psychological well-being and the capacity to transition and maintain a life free of substance use. However, as an evidence-based alternative to the dominant 12-step groups, Self-Management and Recovery Training (SMART Recovery©) offers a person-centred, strengths-based approach and in Australia adopts a harm-reduction philosophy. SMART Recovery was established 25 years ago, and is now available in 25 countries with approximately 3500

meetings run each week. It offers a form of self-empowering mutual aid that aims to stop problematic addictive behaviour. Based on the above, SMART Recovery was considered to be more compatible with that of the Victorian Government funded AOD treatment system. As such, to achieve the aims of this project, Turning Point piloted the running of SMART Recovery groups in three AOD treatment services in Victoria.

Research Objectives (phases)

(i) To examine how SMART Recovery could fit into existing AOD service-delivery models by identifying which Drug Treatment Activity Units (DTAU) allocations could be used to run groups.

(ii) To determine sector-wide interest in participating in a pilot study incorporating SMART Recovery within existing AOD services and identify suitable pilot sites;

(iii) To consult with existing SMART Recovery facilitators in the community to identify strategies for successfully implementing SMART Recovery groups;

(iv) To provide SMART Recovery training to identified peers and clinicians and provide support to services as they implement SMART Recovery groups, and track participant uptake, attendance and benefits;

(v) To examine experiences of SMART Recovery from a consumer, group facilitator and service manager perspective; &

(vi) To develop a list outlining the key facilitators to, and recommended actions for, the implementation of SMART Recovery into AOD treatment services.

Methodology

The multifaceted aims of the project necessitated a mixed-methods approach with phases developed and implemented independently, whilst at times running in parallel. This project was approved by Monash University Human Research Ethics Committee (Project ID. 2020-23632-42409). The project used a predominantly qualitative approach to address the above research questions and develop insights to inform how SMART Recovery can be embedded in AOD treatment.

Phase 1: Identification of options within the existing funding framework

The options identified were based on the treatment Drug Treatment Activity Units described in the Victorian AOD Program Guidelines (2018), the VADC Data Specification (2020-21), as well as the DTAU Derivation Rules (2019-20). It is recommended that services utilise the existing service stream of Brief Intervention (code 21) and Funding Source Brief Intervention Counselling (code 136) or use the existing Service Stream of Brief Intervention with a *new* Funding Source code to reflect the program.

Phase 2: Canvassing sector-wide interest and recruitment of AOD services

Twenty AOD services across Victoria expressed interest in participating in the pilot of which three services were selected as pilot sites (two metro and one regional) based on criteria indicating their commitment to running peer support groups, resources (staff that could be trained), location etc). The selected sites were Kickstart program (site one) delivered as part of the Eastern Consortium of Alcohol and Drug Services (ECADS) (partnership) designed specifically for men involved in the justice system, providing a *forensic population*. Site two was Ballarat Community Health Centre (BCHC), providing a *regional population.* Site three was Odyssey House (OH) Footscray, part of an established and wide-reaching AOD treatment service, providing a *multicultural, metropolitan Melbourne population.* Finally, as a result of a trained facilitator moving to another related service, a fourth site was established at Turning Point (TP), constituting a second *inner-urban population*.

Phase 3: To consult with existing SMART Recovery facilitators in the community to identify strategies for successfully implementing SMART Recovery groups

Researchers conducted semi-structured interviews with six existing SMART Recovery facilitators (three clinician and three peer facilitators) running groups in community health services with AOD treatment programs to explore barriers and facilitators and practical considerations that could be adopted in the pilot sites to optimise success. The themes (and subthemes) emerging from the interviews are listed in Table 1.

Table 1: Overview of themes

1. Referrals	2. Logistical/practical considerations	3. Its role in AOD treatment pathways	4. Facilitators
1.1 Lack of knowledge among clinicians (treatment)	2.1 Time, place, space	3.1 Bridging support versus aftercare	4.1 Optimal number and clinician/peer composition
1.2 Lack of knowledge in health, social & welfare organisations	2.2 Managerial support (legitimate activity , resources, admin etc)	3.2 Connection with the service	4.2 Better support for peer facilitators
1.3 Lack of community awareness & need for better promotion /dissemination			

Several facilitators identified the challenge of attracting group participants and the importance of **referrals (theme 1)** due to a lack of understanding about what SMART Recovery is among those working in AOD services and other health, social and welfare services. Education and awareness raising among workers and better promotion/advertising to communities were considered critical were strongly recommended.

> "*Clinicians and people who are supposed to refer don't really understand what SMART Recovery is or how it works, so they may be hesitant to refer their clients there. There needs to be more education for clinicians around SMART Recovery." (Christian).*

Others described barriers to ongoing participation, noting the importance of **logistics and practical issues (theme 2)**, with recommendations that groups are run at venues close to public transport, at convenient times, catering for the needs of clients regarding childcare and employment and the need for managerial support regarding facilities to run groups (e.g., an allocated room, administrative support etc.) and recognised that it needs to be a funded activity (e.g., recognised a legitimate element of service delivery).

> *"It's just clinician time.. it needs to be integrated as a work role – someone needs to have responsibility for it or it won't happen...The main challenge for the clinicians is*

time- they don't have time in their roles to organise SMART Recovery and advertise and train referrers and monitor emails" (Sarah).

Facilitators also recognised SMART Recovery's potential role in terms of **treatment pathways (theme 3),** where it could support clients wait-listed for treatment episodes (e.g., inpatient withdrawal), serve as a form of post-treatment aftercare or as way of keeping them connected to the service. Finally, **facilitator composition and needs (theme 4)** centred around needing two facilitators so that one can continue guiding group discussion whilst the other manages disruptive, drug-affected or distressed participants and recognition of the value of both peers and clinicians as facilitators. Several recognised the need to attract, support, supervise and financially reimburse peers as facilitators to support their continued involvement.

"There are no peers. Most people who really benefit go on to get jobs and live their lives and so don't really get put through training to become a facilitator- they need money to live." (Henry)

Phase 4: To provide SMART Recovery training to identified peers and clinicians and provide support to services as they implement SMART Recovery groups, and track participant uptake, attendance and benefits

Eight clinical staff and two peer workers were trained as SMART Recovery facilitators and the sites were running weekly groups by December 2019. In March 2020 all in-person treatment was ceased due to the COVID-19 pandemic and associated Government social-distancing measures. To maintain momentum, groups were transitioned online via the SMART Recovery Australia Zoom platform. To explore the impact of SMART Recovery, AOD participants were asked to complete a brief anonymous survey at the end of each group on their reasons for attending, experiences with facilitators and other group members, as well as health (mental and physical) and wellbeing. Semi-structured qualitative interviews were also undertaken with participants, facilitators and site mangers.

Key Findings:

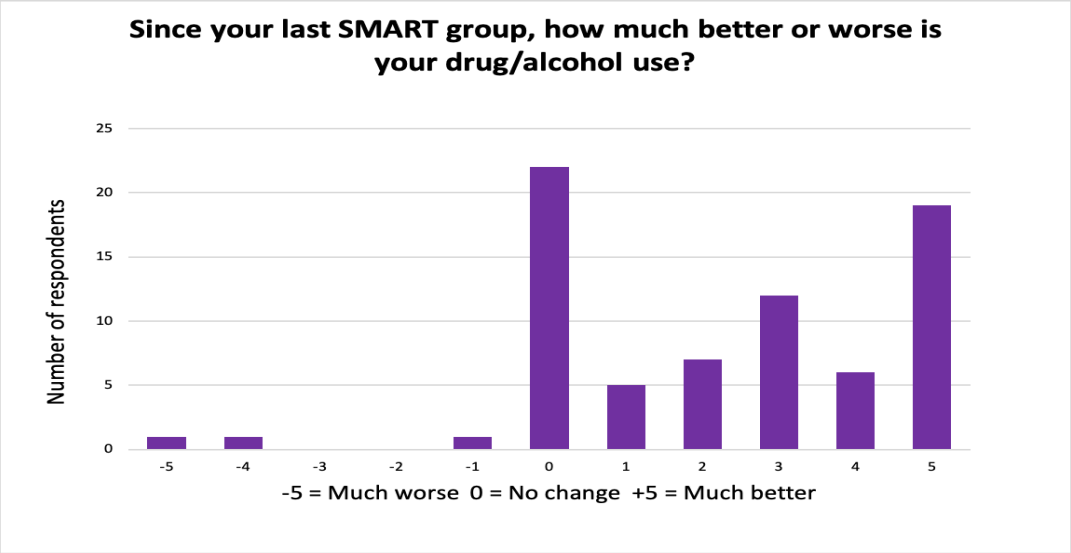
Attendance rates: Between December 2019 and August 2020 **78 SMART Recovery groups** were delivered by the pilot sites, with a total of **486 attendances** (138 in person and 348 online). After April 2020 there was a steady increase in both regular and new participants each month, demonstrating a substantial demand for SMART Recovery. Participation rates and group size was relatively consistent across sites, though the Saturday group had the highest number of participants. The pilot study clearly demonstrated that it is feasible for AOD services to offer SMART Recovery groups as part of their program. Uptake and participation are testament to the demand for peer support in addition to the one-on-one counselling clients receive, and also to the commitment of clinicians and peers to offer this form of recovery support in addition to their usual roles and duties.

Survey responses on the Treatment Effectiveness Assessment (TEA)

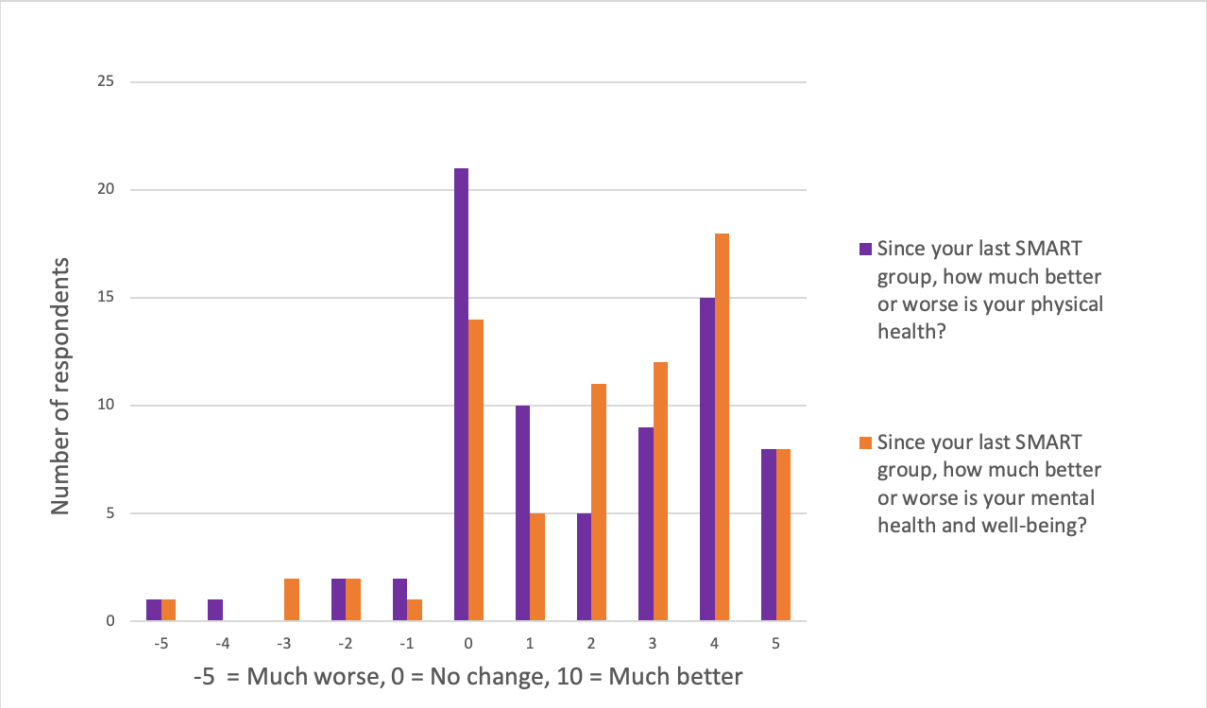
Since the previous SMART Recovery meeting:

- 66% reported a positive change (reduction) in use of their primary drug of concern
- 63% reported a positive change in their physical health
- 73% reported a positive change in their mental health and wellbeing
- 73% reported being better at taking care of their personal responsibilities
- 86% reported feeling better connected with others

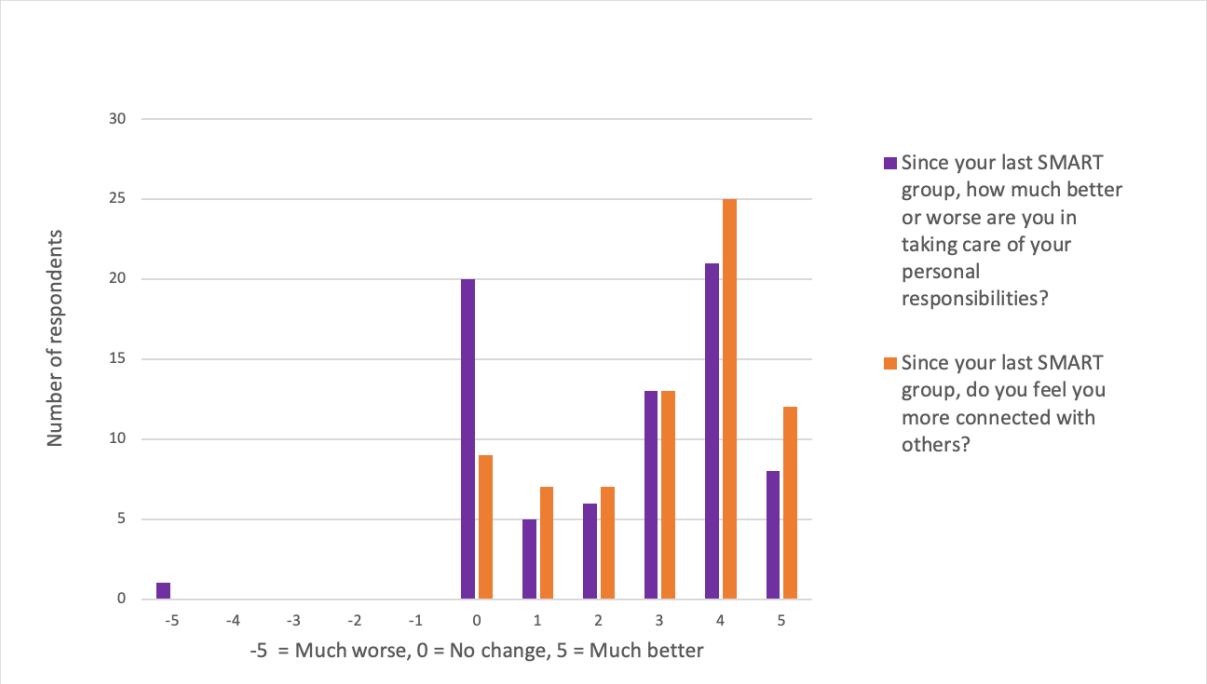
Reported changes in AOD use since attending SMART Recovery groups (n=74)



***Reported changes in physical and mental health and wellbeing* (TEA)**



Reported changes in personal responsibilities and connectedness (TEA)

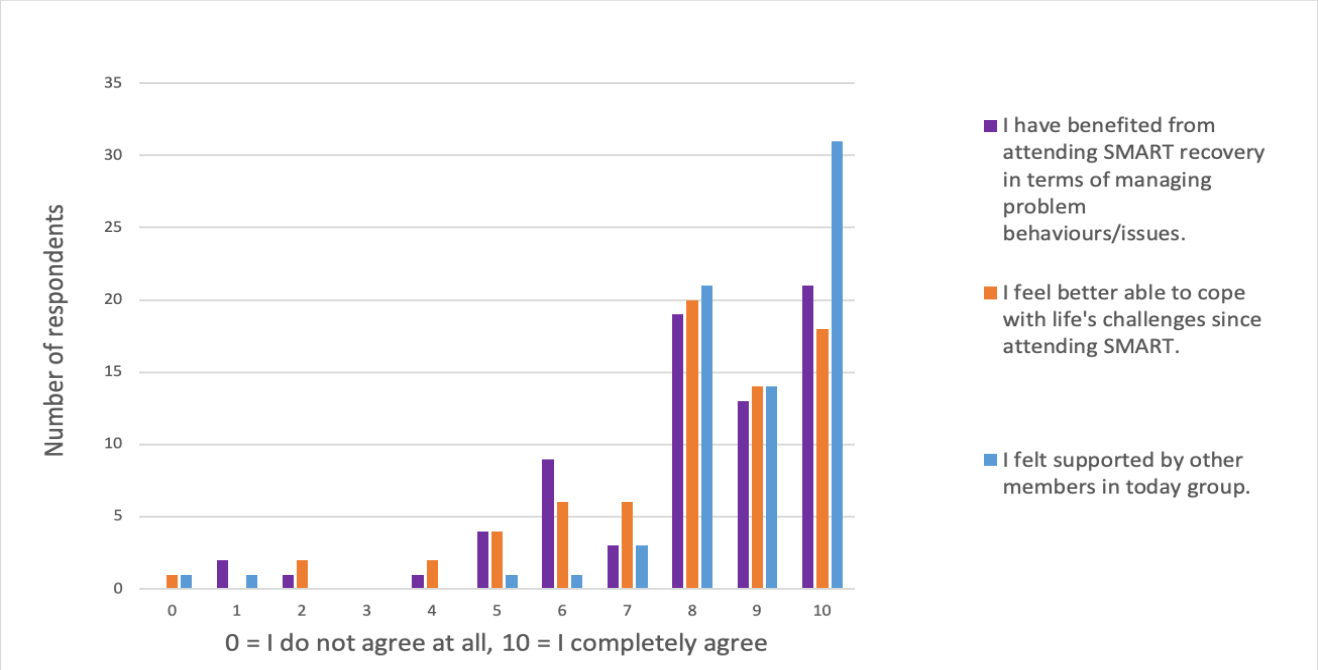


Benefits of attending SMART Recovery

Survey respondents responded to three statements on the benefits of attending groups on a Likert scale where '0' = 'completely disagree' through to '10' = 'completely agree' and:

- 72% indicated that they could better manage problematic substance use
- 71% that they were better able to cope with life's challenges
- 90% that they felt supported by members of the group during the meetings

Participants level of agreement with post meeting statements



Several participants completed multiple surveys, however, few participants attended every group consistently and completed the post-group survey. There were however four who attended seven groups and completed post-group surveys, facilitating 'case studies' where changes could be examined over time. Scores on the TEA domains indicated continued improvements or sustained improvements over time (over the seven meetings), none showed any deterioration in their substance use during their engagement with SMART Recovery, and only one reported a decline one showed a mild decline on two other domains (mental health and wellbeing and personal responsibilities).

Survey response to online groups

Of the 32 participants who completed a post-meeting survey on zoom, all but two participants 'agreed or strongly agreed' with the statements 'they found the meeting helpful', 'left the meeting with a 7-day plan', and all participants 'agreed or strongly agreed' that they intend to continue attending SMART Recovery groups.

SMART Recovery Australia brief online survey

Following the implementation of online meetings, SMART Recovery Australia conducted their own post-meeting surveys to assess the transition to the online format (for survey questions see Appendix G). Access to data pertaining to the meetings run by pilot sites was made available for analysis of 30 participants aged 18-55 years (16 female, 15 male) attending most frequently for alcohol problems. Overall, participants 'agreed/strongly agreed' that they felt welcomed (93%), supported (93%), and able to contribute (93%) at the meeting attended prior to completing the survey. All participants 'agreed/strongly agreed' that the meeting had been helpful (83%) and that their intention was to continue attending (96%).

QUALITATIVE INTERVIEWS

Participant interviews

As illustrated in Table 2, participants were **motivated** to attend SMART Recovery **(theme 1)** for a number of different reasons. Some felt that formal treatment was no longer relevant to them (e.g, their AOD use had stabilised), they viewed SMART Recovery as an informal support that they could use, and a 'safety-net' if needed. SMART recovery was both an extension of and an **adjunct to formal treatment (theme 3).** Others felt that the program provided them with the opportunity to focus on the 'bigger picture'. The **practical application (theme 5)** provided participants with an opportunity to actively engage in their recovery, supported self-efficacy and was a welcome alternative to 12-step programs.

> *"I think for me, it's about life now, you have to learn how to live your entire life now... So every week I think we learn how to live life." (Esme)*

Table 2: Overview of themes from participant interviews

1. Motivation to attend SMART Recovery	**2. Peer to peer learning opportunities**	**3. SMART Recovery as an adjunct to formal treatment**	**4. Connecting with others**
1.1 Maintenance of treatment gains, and a safety-net if required	2.1 Collective expertise	3.1 Informal support post treatment	4.1 Avoiding isolation
1.2 Sense of purpose and direction	2.2 Interactive process	3.2 Transcends formal AOD treatment	4.2 Establishing social connections
1.3 An alternative to 12-Step models	2.3 Giving back as a tool of recovery	3.2 Tailored to the individual needs	4.3 Shared circumstances and experiences
5. Practical application and 7-day focus	**6. Perceptions of SMART Recovery run by AOD services**	**7. Perceptions of facilitators**	**8. Future considerations for SMART Recovery groups**
5.1 Active agents in their own recovery	6.1 Quality assurance	7.1 Facilitators as guides not directors	8.1 Number of participants per group
5.2 Supporting self-efficacy throughout recovery	6.2 Maintain connections with AOD services	7.2 (non) Differentiation between peer and clinical facilitators	8.2 Characteristics of participants
5.3 Future focused			8.3 Online and in person meetings

Of particular importance to participants was the opportunity for **mutual aid (theme 2)** and to build **social connections (theme 4).**

> *"I have benefited hugely. It's beneficial enough for me for my own recovery but I've also found it beneficial to be able to help other people." (Elizabeth)*

> *"I like sharing with the other people, and it's nice seeing people in the first stages of their recovery and helping them, because I'm 15 months clean now, so it's awesome to give back because I would have loved to have received that when I was in that position." (Kayla)*

> *"It is peer support and you can bounce off each other it's made it so much easier because there are so many people who can relate to my situation and it's just been heart-warming and just such a good experience." (Tayla)*

Several participants noted the importance of working with others in similar circumstances or with similar experiences and learning from each other. Others felt that it was less about learning, and, noting the isolation of addiction, identified the importance of the social connections they had developed as part of the group for their ongoing recovery.

> *"Generally speaking I find people very accepting and I find people have things to contribute to one another- even if not, enough people go away feeling accepted and nurtured and cared about by other group members, and I think that at different times people may take away different things they may try for themselves." (Joshua)*

Finally, participants provided their thoughts on the pilot and the impact of having the SMART recovery program embedded in AOD treatment services. Participants **perceptions of it being run by AOD services (theme 6)** this to provide a level of quality assurance for the program and allowed them to maintain the supportive connections that had built during earlier stages of treatment.

> *"It's the best thing I've seen apart from my psychologist, it's the best thing, it's really good, I'm really impressed." (Anton)*

> *"I've been a client of [Site 4] for years and also given consumer feedback so…I know the kind of high-quality organisation it is, which adds a great deal of weight to their meeting. It's like a guarantee almost, of quality." (Elizabeth)*

No preference was expressed for either peer or clinical facilitators, but the significant issue pertinent to participants was that **facilitators remained as guides (theme 7)**. On a **practical level (theme 8),** participants were open to the dual modality of the SMART groups run during the pilot (in-person and online) and recommended that both were continued into the future.
"I also think just having that short-term goal and planning for the week ahead and then coming back and talking about how you went and what you can do differently. Like it's really easy to make small adjustments and move forward." (Gregory)

"I like the fact that if I'm abstaining, I get support, but if I change my mind and I want to try and manage my drinking, I get support - I'm not left alone." (Joshua)

Facilitator interviews

As illustrated in Table 3, facilitators noted that without **support (theme 1)** the SMART Recovery program would not be successful. Support was required from participants, AOD treatment service staff and managers. The primary method for enlisting support from these groups was via **education (theme 2).**

> *"We're all really busy and delivering a group it's not just the delivery time, there's prep and there's you know the work to do afterwards so being able to manage that and the support of your extended team is important." (Amy)*

Table 3: Overview of themes from facilitator interviews

1. Support	**2. Education**	**3. Program Integrity**
1.1 Of service managers	2.1 Education of treatment staff re SMART Recovery program	3.1 Consistent implementation of the manualised program.
1.2 Of AOD treatment staff	2.2 Managing (potential) participants pre-conceived notions of mutual aid programs	3.2 Maintaining role as facilitator, not clinician
1.3 Of group members		3.3 Ensuring inclusivity of groups
4. Facilitator responsibilities	**5. Integration with current treatment offerings**	**6. Implementation considerations**
4.1 Maintaining a safe space for participants	5.1 Provision of oversight	6.1 Logistical factors (time/day of the week/location)
4.2 Encouraging self-efficacy	5.2 Aligns with service philosophies (evidenced based program with harm minimisation focus)	6.2 Group characteristics
4.3 Supporting mutual aid	5.3 Flexibility of implementation	6.3 Peer or Clinician facilitators

Facilitators were passionate about the SMART Recovery program and were cognisant that maintaining the **integrity of the program (theme 3)** was one of their **primary responsibilities (theme 4).**

> *"We don't want to tell the client what to do, we want them to come up with their own plan …. I think as long as we stick to that philosophy of them being the leads of their own life." (Stuart)*

Facilitators also provided their thoughts pertaining to the ongoing implementation of the SMART Recovery program within the AOD treatment service. Facilitators were unanimous in their belief that the program could be **integrated (theme 5)** within their service, and noted several suggestions pertaining to the **practicalities (theme 6)** of such.

> *"It aligns [with our treatment philosophy] really well, it fits in really good – it's really small and achievable and it fits into the harm minimisation perspective to help people with whatever they need help with. It complemented our services as well." (Lucy)*

Service Manager interviews

In contrast to the participants and the facilitators, service managers were more inclined to discuss the "bigger picture" issues pertaining to the implementation of SMART recovery into their existing AOD service. As illustrated in Table 4, three key themes emerged.

Table 4: Overview of themes from service managers interviews

1. Managing risk	**2. Managing Resources**	**3. Managing the needs of stakeholders**
1.1 Maintaining therapeutic oversight of high-risk patients post treatment	1.1 Funding new (additional) programs	3.1 Staff needs and requirements
1.2 Managing risk of harm to service and staff	1.2 Managing staff numbers and activities	3.2 Client needs
1.3 Implementation of evidence-based practice		3.3 Reporting obligations (DHHS)
1.4 Responding to jurisdictional cross over		

The first was **managing risk (theme 1),** which encompassed risk to their clients, staff and to the agency itself.

> *"It's an opportunity for people to undertake and provide more, you know, peer support but within a therapeutic and safe space… although, it's you know, client-directed, the facilitators are still there to be able to identify anybody who might be struggling and checking in with them later." (Elaine)*

The management of resources (theme 2) was also important to managers, notably they expressed concerns regarding the funding of any new program and the impact on staffing capacity. Finally, managers were required to **balance the needs (theme 3)** and wants of their staff (e.g., flexibility and professional development) and clients (e.g., treatment needs), and reconcile these with their legal and reporting obligations.

> *"We're not technically funded to do a group, although you know, it does fit into the guidelines, but you know we are just doing the work in a different way I guess, so if there were stand-alone funding, funded treatment type that would be great, it would be much more straightforward that way." (Elaine)*

The final objective was to consolidate all the recommendations for the successful implementation of SMART Recovery from the earlier phases of the project in to a **table outlining the key challenges and recommended action/solution** (see main report **Table 8**). This provides a useful summary of the key considerations as well as practical guidance for services wishing to offer SMART Recovery as part of their program.

Conclusion

In conclusion, the pilot study demonstrated that it was feasible to deliver SMART Recovery within AOD treatment services. Furthermore, results suggest that participants had positive experiences of both online and in-person SMART Recovery groups (e.g., connection with others and support). Responses also demonstrated the multiple benefits of attending in terms of positive impacts on attendees substance use, health and wellbeing and lifestyle. In summary, the findings elicited from the brief surveys clearly illustrate the multiple ways in which AOD clients benefited from attending SMART Recovery on top of their usual treatment.

It is important to acknowledge that with the absence of a control group (e.,g, people not attending SMART Recovery), the aforementioned improvements cannot be directly attributed to SMART Recovery attendance itself and thus cannot be disentangled from treatment effects and other factors impacting on substance use, health and wellbeing. Nonetheless the data illustrate the multiple ways in which AOD clients benefited from attending SMART Recovery

and future research should investigate the effectiveness of SMART Recovery against a control group.

Despite this study limitation, the perspectives of the participants, facilitators and managers elicited in the qualitative interviews provide much optimism for the role of SMART Recovery in the broader Victorian AOD treatment system. Moving from participant, to facilitator to manager, the focus shifts from the individual, to the group, and on to the broader treatment system. Thus, from the perspective of each stakeholder group, SMART Recovery carries different benefits and challenges. As such, it is important to consider all three perspectives in the planning its wider implementation of SMART Recovery in the future.

It is likely that SMART Recovery offers a cost-effective model for supporting multiple clients with minimal staffing requirements. Whilst there are training costs for facilitators and subscription fees, these would be quickly offset by savings in clinician time given the facilitator to client ratio. It is important to note that whilst the project demonstrates the feasibility of embedding an established peer support group like SMART Recovery, there may be alternative peer groups that work equally well.

It is important to acknowledge that whilst the four pilot sites successfully demonstrated that SMART Recovery can be delivered as part of their AOD treatment program, this provides much optimism for, but in no way guarantees its successful replication in other AOD services. Much of its success can be attributed to the dedication, passion and commitment of service managers, facilitators and researchers involved, as well as the provision of training via this project. This was evidenced by the determination to continue offering SMART Recovery groups despite seismic shifts in the way in which AOD care was delivered during COVID-19 restrictions. It many ways it was fortuitous that pilot sites could pivot to online groups and provide ongoing care for both their clients and others in the community to meet the increased demand for online recovery support as AOD issues were compounded by unemployment, lack of social support, and isolation during lockdown. As such, there is hope that the findings and recommendations from this pilot study will pave the way for extending recovery support to clients throughout the Victorian AOD treatment system.

Recommendations

- **Recommendation 1a: Services could use the Brief Intervention- Group DTAU unless a new funding source can be identified.**
- **Recommendation 1b: DHHS consult with AOD providers in regards to the impact SMART Recovery program may have to existing targets and performance challenges (e.g., over and underperformance).**
- **Recommendation 2: Given the extent of interest in running SMART Recovery and the demonstrated implementation success of the pilot, the wider roll-out of SMART Recovery should not be delayed.**
- **Recommendation 3a: Services should ensure all their staff and partner-organisations are familiar with the SMART Recovery model and promote their meetings and refer suitable clients.**
- **Recommendation 3b: Services must consider the specific needs of their clients when scheduling meetings.**
- **Recommendation 3c: Service managers need to allocate sufficient resources (e.g., SMART Recovery trained facilitators and a physical space to run groups).**
- **Recommendation 4a: Based on the uptake, attendance rates of both regular and new participants and the reported benefits of attending across all pilot sites, SMART Recovery should be rolled-out across the sector.**
- **Recommendation 4b: Given the clear benefits for clients in terms of improved substance use, health and wellbeing and social connections, services should continue to monitor client outcomes.**
- **Recommendation 5a: Given the multiple ways in which clients benefit from SMART Recovery, all services should aim to offer SMART Recovery as part of the program or refer clients to SMART Recovery meetings run in the community.**

- **Recommendation 5b: Services should aim to run enough groups oand have enough facilitators to maintain an optimal group size of 8-10 participants.**
- **Recommendation 5c: Services should consider offering both in-person and online SMART Recovery groups as a form of stepped-down aftercare.**
- **Recommendation 5d: Services should consider running groups for specific populations (e.g., women-only or forensic-only).**
- **Recommendation 5e: Services need to create a forum (e.g., Community of Practice) to allow facilitators to engage in regular debriefing, supervision and foster opportunities for collaboration and reflection (between other facilitators at their service as well as between services).**
- **Recommendation 5f: Services need to find ways of identifying and attracting peers as facilitators and exploring reimbursement models to maximise sustainability.**
- **Recommendation 5g: Managers must adopt flexibility in staff working hours and load, so that facilitators can run groups when there is greatest demand (e.g., outside of office hours) and must consider it a legitimate part of their role.**
- **Recommendation 5h: Managers should allocate at least 2 facilitators and 0.1 EFT per group.**
- **Recommendation 5i: Services wanting to run online groups (e.g. to cater for regional/remote clients) should consider running these as closed-groups (e.g., attended only by clients of the service) so that facilitators are better-placed to manage group dynamics. This this will require investment of use of the services own video-conferencing (e.g., not using the SMART Recovery Australia platform).**
- **Recommendation 5j: Managers will need to undertake further risk-assessment when catering for forensic clients to maintain participant safety (e.g., consider offending behaviour, Apprehended Violence Order's and group composition).**

1. BACKGROUND

1.1 Recovery and social networks

Mutual aid (peer support) is the process of giving and receiving non-professional, non-clinical assistance from individuals with similar conditions or circumstances and has been shown to support the achievement of long-term recovery from psychiatric, alcohol, and/or other drug-related (AOD) problems (Tracy & Wallace, 2016). Mutual aid peer support groups such as AA can help maintain treatment gains, are widely available and cost-effective (Kelly et al, 2020). In the Victorian Alcohol and Other Drug (AOD) treatment system, opportunities to engage in peer support groups are largely restricted to residential treatment services, which represented only 16% of treatment episodes in 2017-2018 (AIHW, 2019). AOD treatment generally comprises one-to-one counselling with an AOD worker/clinician, for a maximum of 15 sessions. By offering peer support groups as part of the suite of treatment modalities, clients can share experiences, knowledge and encouragement with others who have a lived experience of AOD problems, providing social, emotional and practical support to one another. Importantly, peer support groups offers members a form of aftercare that is free and easily accessible for as long as needed (i.e., with no restrictions on duration of attendance).

1.2 Peer support groups

The most well-known peer support group is that of the 12-step program. Used extensively under the auspice of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), the aim of the 12-step program is lifelong abstinence (Donovan et al, 2013). Twelve-step groups are guided by principles which include powerlessness over addiction and relinquishing control to a 'higher power'. Whilst the 12-step model has been adapted to a multitude of substances and behaviours, AA appears to have the highest rate of participation worldwide. At present there are over approximately 118,000 AA groups registered across 180 countries, including Australia (Alcoholics Anonymous World Services Inc., 2020).

A recent Cochrane review (Kelly et al, 2020). concluded that AA groups run according to 12-step guidelines (manualised groups) may be *more* effective than clinician administered treatments such as Cognitive Behaviour Therapy (CBT) in increasing rates of abstinence from alcohol (Kelly et al, 2020). In addition, both manualised and non-manualised groups were found to be equally effective when compared to clinician administered treatments in increasing other alcohol-related outcomes (i.e., drinking intensity) and alcohol-related consequences (i.e., physical, interpersonal, social consequences). The reviewers concluded that AA groups were an important and cost-effective alternative to clinician-administered interventions.

Further to the recent Cochrane review, Humphrey's et al, (2020) reviewed the role of 12-step programs in recovery of substances other than alcohol. This review pooled the findings from six randomised control trials examining the effectiveness of 12-step attendance for people with drug use disorders. Whilst engagement/uptake was more challenging than with clients for whom alcohol was the substance of concern, greater attendance still predicted reduced illicit drug use and associated problems (Humphreys et al, 2020).

Notwithstanding the findings of these recent studies (Kelly et al, 2020; Humphreys et al, 2020), several studies have reported on the limitations of the 12-step model. The spiritual content of the 12-step philosophy (with references to God or a higher power in several steps) is a recognised by many as a barrier to attendance (Harris et al, 2003). Other research suggests that the underlying principle of powerlessness over addiction, conflict with key concepts such as self-reliance, personal goals, desires, and identity (Kingston et al, 2003) and may be problematic for already marginalised individuals. Finally, the specification of drug-specific groups such as 'cocaine anonymous' may discourage engagement among the vast majority of whom have poly-drug issues.

In response to the some of the noted barriers and limitations of 12-step groups, a variety of alternative peer support models have emerged (Manning et al, 2020a). Broadly, these groups place less emphasis on abstinence and spirituality, and focus on promoting harm-reduction, problem-solving, goal-setting, personal responsibility, agency and self-reliance. For example,

LifeRing (*Secular Recovery*) approaches recovery from the perspective that attendees are the best authority in determining their recovery journey (Nicolaus, 2009). *Secular Organizations for Sobriety* encourages abstinence, however, disengages from the spiritual focus (Connors & Dermen, 2009). At present, the efficacy of these alternative forms of peer support is yet to be rigorously assessed.

Another more established alternative to the 12-step model, is *Self-Management and Recovery Training* (SMART Recovery®) which draws on evidence-based principles of CBT and Motivational Interviewing (MI) to stop problematic addictive behaviour (Horvath, 2000). Established 25 years ago, it is now available in 25 countries and offers around 3500 meetings each week. SMART Recovery is a four-point program (Figure 1), centered around self-initiated, recovery-oriented behaviour change. It offers a form of self-empowerment in that the focus is on what the individual themselves can do (as opposed to a sponsor or external higher power). Unlike other mutual aid groups, SMART Recovery meetings are facilitated by either (or both) a clinician or peer worker. At each meeting, participants set goals for themselves - and with the help of others in the group - develop plans and strategies for achieving these goals. One of the key distinctions between SMART Recovery and 12-step groups is that SMART Recovery Australia adopts a strengths-based, and in Australia is committed to the philosophy and practice of harm minimisation (prioritising and advancing the safety, health and wellbeing of SMART participants). In SMART Recovery people set their own goals, which may, or may not include abstinence. Since most AOD treatment in Australia, and Victoria, are underpinned by a harm minimisation approach, SMART Recovery aligns closely with the predominant client-centered approach of individualised goals. In contrast to the lifelong commitment of 12-step programs, the SMART Recovery model has been developed to support participants on a needs basis.

Whilst traditional forms of peer support focus on story-sharing such as the downward spiral to hitting '*rock-bottom*', SMART Recovery focuses on the 'here and now', and the changes people can make to their lives to better manage their addictive behaviour, irrespective of its cause. Another distinction between SMART Recovery and 12-step is the extent and nature of active participation during group meetings. Typically in AA/NA meetings, a handful of people

will speak, with most members only listening. Other features include the serenity prayer, and references to the AA/NA literature. As such, meetings are arguably more passive in terms of engagement. In contrast, SMART Recovery requires active participation from all of its members.

Groups are run weekly, held for 90-minutes and are structured. An initial 'check in' is undertaken, where each member in turn states what brings them to SMART Recovery and what they want to work on during the meeting. This is followed by 'work time', where participants review their success with the goal they set for themselves for the previous week, problem-solve an issue with the assistance of other group members, and then set a goal for the forthcoming week (e.g., have at least two non-drinking days, only use on the weekend). The discussion in this 'work-time' section centres around four key points with the facilitator drawing on common themes using MI and CBT techniques. The key points relate to (1) maintaining motivation, (2) managing craving and urges, (3) examining the relationship between thinking patterns and behaviour, and (4) establishing a healthier lifestyle balance (e.g., by focussing on stress management, exercise, diet, sleep, social connection etc.).

Work time is followed by the 'check out', where each member reflects on what they got out of the meeting and re-states their goal for the next week. In this way, individual goals are cemented. Members hold each other accountable to their goals, and can assist one another in revising their goals or adapting them over time. Group members acknowledge and celebrate each other's achievements, provide encouragement and share ideas, strategies, resources, tips and tools that may help others in managing their addictive behaviours. Finally, participants' conduct during groups is underpinned by an agreed set of guidelines and principles which include being respectful, inclusive, non-judgemental, supportive and maintaining and protecting confidentiality.

Figure 1. ***Core tenets of SMART Recovery***

Unlike other alternatives to the 12-step model, SMART Recovery has grown significantly since its inception, yet, little research has been conducted into its effectiveness. The limited research to date suggests SMART Recovery is equally as effective as other mutual help groups effective (Penn & Brooks 2000; Zemore et. al 2018; Atkins & Hawdon, 2007). Twelve studies evaluating various aspects of SMART Recovery in relation to alcohol-related outcomes were included in a recent systematic review (Beck et al, 2017). Although positive effects were reported, modest sample sizes and inconsistent methods prevented the researchers from drawing firm conclusions about the effectiveness of SMART Recovery. The only randomized controlled trial investigating the efficacy of the SMART Recovery program to date (Hester et al, 2013), compared the effectiveness of *overcoming addictions* (a web-delivered SMART Recovery program) to face-to-face SMART Recovery. The researchers found that participants in both groups significantly increased their percentage of days abstinent, and that those participants who were not abstinent significantly decreased their average drinks per day.

The qualitative research reporting on the experiences of those participating in non-12-step programs also presents promising results. Sanger et al, (2019) interviewed participants of non 12-step, online alcohol support groups in the USA and in the UK. Participants reported engaging with others in similar circumstances, engaging in support without the requirement of belief and having authority over their own experiences were key perceived benefits of these groups (Sanger et al, 2019). A recent study by Gray et al, (2020) focused specifically on SMART Recovery participation. Interviews with participants attending SMART Recovery groups across Australia highlighted that participants value the mutual support fostered in the group and felt that exchanges between group members provided for an atmosphere which increased self-esteem and reduced social isolation (Gray et al, 2020).

1.3 Sector support for peer support groups

Unlike traditional clinician-delivered AOD treatment programs, attendance at peer support groups is typically based on informal referral processes (i.e., self-referral, encouragement from a friend or family member). Research has demonstrated the benefit of active encouragement/referral to peer support groups by addiction treatment services with

approaches such as twelve-step facilitation (TSF) (Kelly et al, 2020). Indeed, the positive impact of assertive linkage to peer support groups (12-step) in terms of subsequent attendance and outcomes is long established (Sisson & Mallams, 1981; Timko et al, 2007; Manning et al, 2012), yet remains rarely implemented. Research including studies of Victorian AOD clinicians suggests that this may reflect negative or ambivalent attitudes to 12-step groups, which can influence client attitudes and thereby deter engagement and attendance (Day et al, 2005; Gaston-Lopez et al, 2010; Best et al, 2016). Indeed, 'Patient Pathways', Australia's largest treatment outcome study (n=800) showed that people seeking treatment for alcohol use disorder in WA and VIC were significantly more likely to have reduced or ceased drinking if they attended peer support groups in the year after their treatment episode, with higher rates of treatment success reported the more frequently they attended peer support groups (Manning et al, 2017). As such, the authors recommend that *"Specialist AOD services should develop and promote interventions and pathways to aftercare such as supportive community groups, including but not restricted to mutual aid groups (p. XVII)."*

Despite the potential utility of peer support groups, the above research suggests that engagement is to some extent dependent on the support and encouragement of those working in the AOD treatment system. Clinicians working in specialist AOD services are well placed to link clients with peer support groups and since SMART Recovery is a "good fit" in terms of peer support group philosophies, there is immense potential to enhance the uptake of this free and widely available form of peer support. However, the integration of SMART Recovery into Victorian AOD treatment has been overlooked to date. As such, there is a need to explore how SMART Recovery can be offered by AOD services. The current pilot project aims to determine clinician and peer interest and capacity to facilitate SMART Recovery groups, ascertain where it could sit within current funding models (Drug Treatment Activity Units, DTAU's), and explore the uptake and benefits from a consumer, group facilitator and service manager perspective. This work is both pertinent and timely, not only are peer support groups recommended in the next edition of the Australian Government Department of Health and Aging *National Alcohol Treatment Guidelines* (Manning et al, 2020b), recovery-orientated treatment – defined as treatment which is tailored to the individual, and takes into consideration their individual strengths, goals, preferences, needs, experiences, values and

cultural background - accords with the *Victorian Alcohol and Drug Treatment Principles* (Department of Health, 2013).

1.4 The current project

The overarching research question was '*can SMART Recovery be integrated with formal AOD treatment?*' To answer this, it was necessary to conduct a pilot project to determine the feasibility of running groups, assess uptake, attendance rates and benefits for stakeholders and identify necessary resources and key considerations for its future, wider implementation, should it be proven successful.

SMART Recovery offers an evidence-based alternative to 12-step groups. This model of recovery support aligns with the Victorian Government's harm reduction focus, and as such was identified as the most suitable peer support group for this project. The current project seeks to facilitate the uptake of peer support group participation in the Victorian context, by integrating SMART Recover within existing AOD treatment services. Whilst AOD clients have always been able to self-refer to SMART Recover groups in the community, to date there have been a limited number of groups available in Victoria, with many independent groups losing traction over time and eventually terminating. The sustainability of groups that run independently of treatment services and which depend on the "goodwill" of peer(s) is a major challenge. By systematically integrating SMART Recovery into treatment services and within pre-existing treatment offerings groups may be more likely run consistently as a result of dedicated referrals and resources (e.g., multiple clinicians and peers). In addition, clinicians can become better acquainted with the nature and process of SMART Recovery, and may be more inclined to refer their clients to such groups in the future. Likewise, clients may be more likely to attend SMART Recovery groups endorsed by, and run within the context of an AOD treatment service. Ultimately, the pilot project aims to support the process of embedding SMART Recovery groups into treatment, to provide ongoing accessible, sustainable and cost-effective recovery support to those wanting to reduce harm from substance use and other addictive behaviours.

1.5 Research objectives

At the commencement of this pilot six specific research objectives were identified:

(vii) To examine how SMART Recovery could fit into existing AOD service-delivery models by identifying which DTAU allocations could be used for running groups.

(viii) To determine sector-wide interest in participating in a pilot study incorporating SMART Recovery within existing AOD services and identify suitable pilot sites;

(ix) To consult with existing SMART Recovery facilitators in the community to identify strategies for successfully implementing SMART Recovery groups;

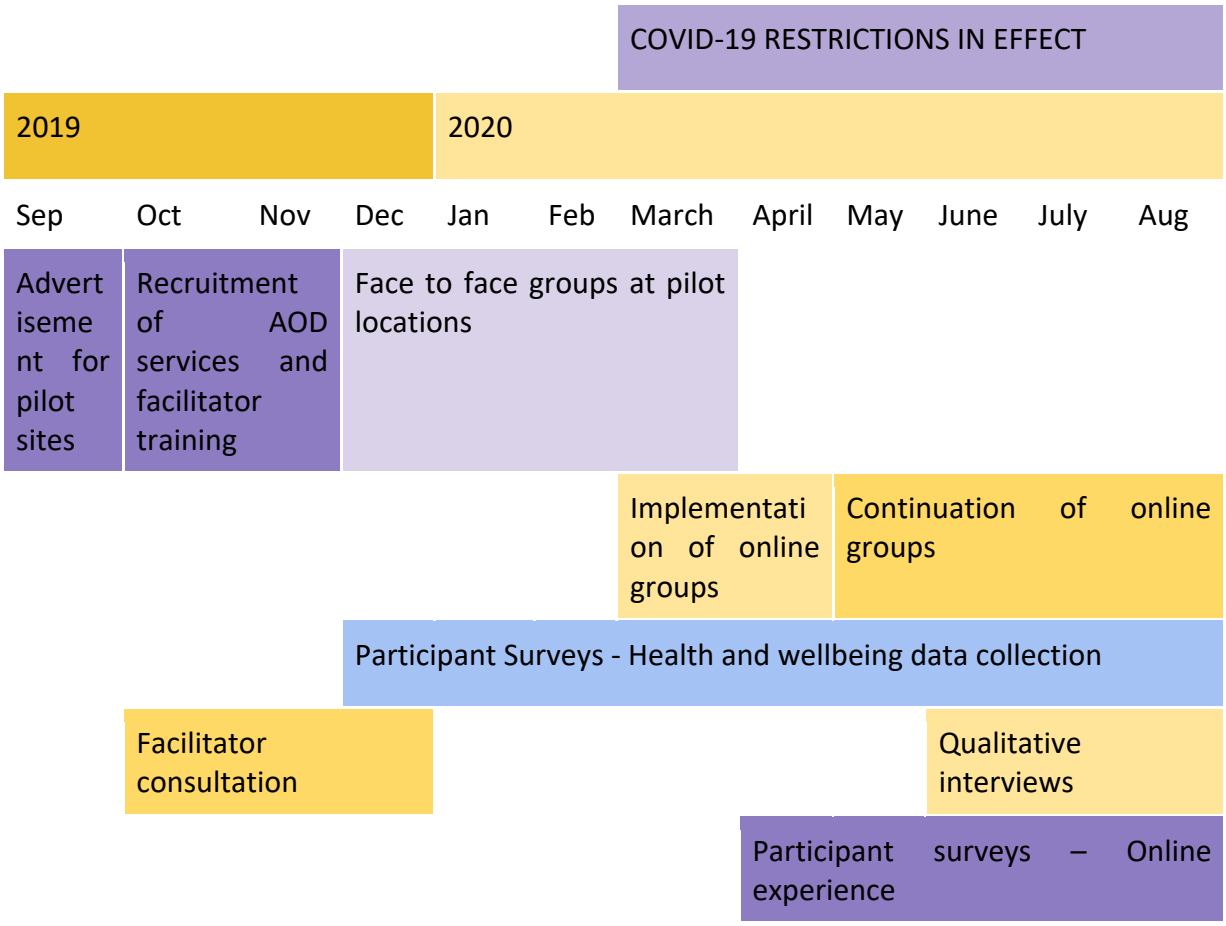
(x) To provide SMART Recovery training to identified peers and clinicians and provide support to services as they implement SMART Recovery groups, and track participant uptake, attendance and benefits;

(xi) To examine experiences of SMART Recovery from a consumer, group facilitator and service manager perspective; &

(xii) To develop a list outlining the key facilitators to, and recommended actions for, the implementation of SMART Recovery into AOD treatment services.

The multifaceted aims of the project required that implementation be a stepped process. As such, the project progressed in several phases. Phases were developed and implemented independently, however several ran in parallel (Figure 2). This project was reviewed and approved by Monash University Human Research Ethics Committee (Project ID. 2020-23632-42409).

Figure 2. ***Pilot project timeline***



2. RESEARCH OBJECTIVE ONE: Exploring service stream and funding source options

2.1 Identification of options within the existing funding framework

One of the first aims of the project was to examine how SMART Recovery could be supported by services within the existing funding framework and within current funding levels. To maximise the sustainability of SMART Recovery in specialist AOD treatment it was necessary to explore ways in which Victorian government-funded services could use their Drug Treatment Activity Unit (DTAU) allocations for running groups (i.e., when acquitting to treatment delivery targets). The options identified follows the treatment DTAUs described in the Victorian AOD Program Guidelines (2018), the VADC Data Specification (2020-21), as well as the Drug Treatment Activity Unit DTAU Derivation Rules (2019-20) (See, Appendix A).

Pilot sites were encouraged to use the 'Brief Intervention- Group DTAU' in the counselling service stream which allows for one-off attendance, with an AOD treatment price (2019-20) of $106.73 per treatment per client, plus loading for forensic and indigenous clients (see Table 1). Brief interventions are defined as 'education and advice that aims to achieve a short-term reduction in harm associated with AOD include crisis intervention, harm reduction measures, relapse prevention planning, and support for co-occurring issues such as mental health'.

Table 1. ***DTAU service code with forensic and ATSI loading***

Service Stream	Service Stream Code	DTAU (FY19/20 $820.99)	DTAU+15% forensic loading	DTAU+30% ATSI loading
Brief intervention	21	0.130	0.150	0.169
Price ($)	-	$106.73	$122.74	$138.75

There is an assumption that the referral paths would utilise the existing Intake and Assessment streams and the Funded Agency Channel Activity and Code would be Counselling 34301.

Proposed Service Stream and Funding Source Options

Proposed combination of the Service Stream and Funding Source code could be as follows:
a) Utilise the existing service stream of Brief Intervention 21 and Funding Source Brief Intervention – Counselling 136; or b) Utilise the existing Service Stream of Brief Intervention 21 and new Funding Source code to reflect the new Program (akin to Kickstart and Choices).

Table 2. ***Proposed funding option***

If funding source:	**AND**	If contact type:	**AND**	If contact method:	**AND**	DTAU base:
136 – Brief intervention – counselling (or new Funding Source XXX – Brief Intervention Smart		2 – group		1 – in person 2 – telephone 5 – teleconference/ video link		0.130

3. RESEARCH OBJECTIVE TWO: Canvassing sector-wide interest and recruitment of AOD services

3.1 Recruitment of services

An expression of interest to participate in the pilot was promoted to government funded AOD services via the Victorian Alcohol and Drug Association (VAADA) eNewsletter on 17 September 2019 (Appendix B). The aim was to include two metro and one regional AOD service with one serving a complex population (i.e., forensic clients). Services interested in participating were asked to provide a brief summary of their service and to answer some questions that would indicate their suitability as a pilot site (see Appendix C).

3.2 Identification and selection of pilot sites

Twenty organisations from across metro and rural/regional Victoria submitted an expression of interest in response to the pilot study promotion in VADDA eNews. This included services in metropolitan and regional Victoria, services situated within primary health networks and specialist AOD services as well as those focussed on LBGTIAQ+. Those selected for participation in the pilot are detailed below in Table 3.

Table 3. ***Description of pilot services***

Agency	
Service location (referral catchment)	**Brief description of the service and AOD services offered**
Odyssey House	
Footscray (North West Melbourne)	Odyssey House is a state-wide AOD treatment organisation for people experiencing problems from their substance use, as well as their children and other family members. Odyssey House provides the following AOD treatment services: – residential rehabilitation – case management (care and recovery coordination) – counselling (individual, group and family) – drink and drug driver behaviour change programs – education and training

Ballarat Community Health	
Ballarat (Grampians)	Ballarat Community Health has six locations across Ballarat and the Western Region providing a range of health and community services. Ballarat Community Health provides the following AOD services: – counselling – care and recovery coordination – naloxone services – smoking cessation – Drink Drive, Drug Drive program – needle and syringe exchange program – withdrawal services – hepatitis C prevention – Making a Change program – pharmacotherapy network – youth outreach – nurse practitioner services
Kickstart, Turning Point Eastern Treatment Services	
Ringwood (East Melbourne)	Turning Point Eastern Treatment Services (TPETS) is part of the Inner East & Eastern of Alcohol and Drug Services (ECADS) which provides AOD treatment and interventions services for individuals living in Melbourne's inner and outer eastern Suburbs. The Kickstart program is one part of suite of community programs run by TPETS. The is an eight-week therapeutic group specifically for men involved with corrections services. The group is based on CBT and supports men to reduce substance use and substance related offending through a holistic approach to behaviour change.

The sites chosen met all the selection criteria (i.e., demonstrated commitment, capacity and were funded to deliver the relevant DTAU) and enabled the exploration of barriers and facilitators to successful SMART Recovery implementation across diverse populations. The Kickstart program (site one) delivered as part of the ECADS consortium (partnership) of Victorian Eastern service providers is designed specifically for men involved in the justice system, providing a forensic population. Staff from this service included two clinicians and one peer worker. Following training, one of the clinicians from this program transferred from the program to Turning Point, an affiliated service. The clinician chose to continue with the pilot program, and as such, a further group (site four) was established. This group is referred to as

the Turning Point (TP) group. This group is based in Richmond, characterised by an inner urban, mixed socioeconomic and demographic population.

Site two was Ballarat Community Health Centre (BCHC) selected as it enabled exploration of barriers and facilitators that might arise in a regional setting. BCHC staff included three clinicians and one peer worker. Site three was Odyssey House (OH), part of an established and wide-reaching AOD treatment service which offers a full suite of treatment and recovery options. The inclusion of the Footscray location provided for access to a service located within a highly multicultural, lower socioeconomic area of Melbourne. Three OH clinicians were included in the training. At the commencement of the pilot program none of the above services had previously implemented SMART Recovery; similarly, none of the ten staff members (eight clinicians and two peers) had previously undergone SMART Recovery facilitator training.

5. RESEARCH OBJECTIVE THREE: Consultation with existing SMART Recovery facilitators to identify strategies for successfully implementing SMART Recovery groups

Several existing SMART Recovery groups operating in Victoria were identified and contacted by SMART Recovery Australia staff. Facilitators who provided consent to be contacted by the research team were invited to participate in interviews. Interviews were undertaken between October and December 2019 (for interview schedule, see Appendix D). The aim was to elicit information regarding considerations, practical resources and other tips for running groups that could then be adopted in the pilot to optimise success. Interviews were analysed using framework analysis (Smith & Firth, 2011). This process involves two levels of analysis. Inductive, or 'bottom up' analysis aims to extract the underlying thoughts and feelings from the words of the participant and identify themes regarding the context under consideration. In contrast, deductive analysis provides for the analysis of interviews with a specific question or questions in mind. This method of analysis was selected as it has previously been used effectively in multi-disciplinary health research (Gale et al, 2013). Three clinician and three peer facilitators, running six community SMART Recovery groups were interviewed (Table 4). Of the six facilitators, four were based at community services, who offered AOD treatment as

part of their suite of services. All facilitators had been engaged in SMART Recovery groups for a minimum of 12 months. Pseudonyms are used throughout to protect participant anonymity.

Table 4. ***Details of existing SMART Recovery groups and facilitators***

Service /Location	Located within a community service centre?	Service centre provides AOD treatment?	Peer or clinician facilitator?	Duration running SMART (at time of interview)
1	Yes	Yes	Clinician	3 years
2	Yes	Yes	Peer	3 years
3	Yes	Yes	Clinician	1 year
4	Yes	Yes	Clinician	1 year
5	No	N/A	Peer	1 year
6	No	N/A	Peer	4 years

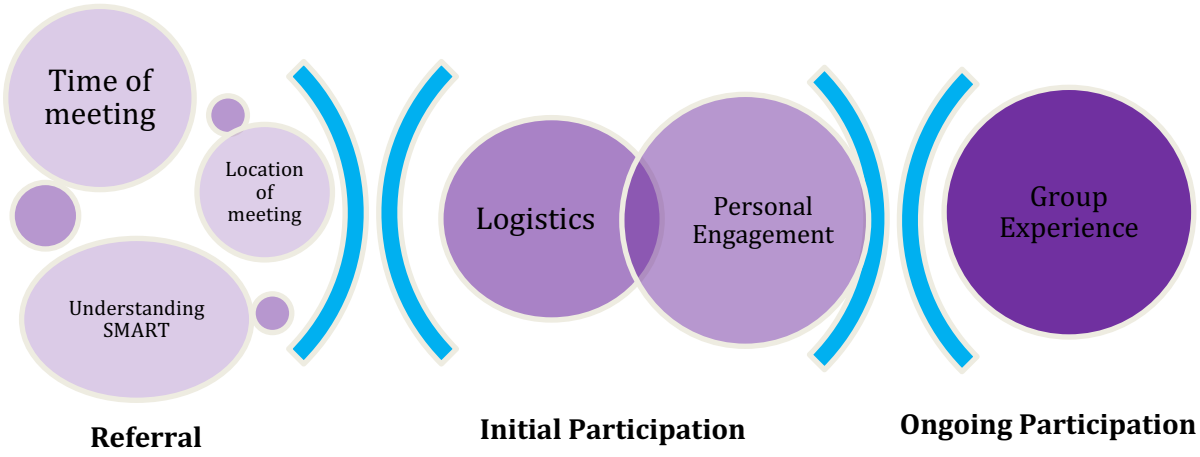
4.1 Analysis of active SMART Recovery facilitator interviews

Semi-structured interviews explored challenges facilitators encountered while running SMART Recovery groups, elements they believed made for successful meetings, as well as strategies used to recruit group members and promote ongoing attendance. The analysis, of these interviews resulted in the identification of two themes: (1) referral, and (2) participation.

4.1.1 Referral and participation

Referral to, and participation in, SMART Recovery were not independent events, but rather existed on a continuum. Factors which influenced referral, by extension affected (both initial and continued) participation. In figure 3, referral is placed to the far left, and participation to the right. The factors discussed below affect both processes to varying degrees. Factors were both practical and experiential. Practical factors like the time, day and location of the meeting influence likelihood of initial referral, and to a lesser extent continued attendance. In contrast participants' experience during the referral process and at their initial contact with the group was a significant factor influencing their longer-term engagement.

Figure 3. ***Factors along the process of referral to participation***



Referral

Most facilitators agreed that the primary challenge associated with running SMART Recovery was a lack of referrals to their group. Referral and initial attendance were heavily contingent on logistical aspects of groups. If the meeting was not easily accessible people would not attend. Whilst there was no consensus on the best time to run a group, several suggested that groups should run after hours to accommodate group members who were employed or had other commitments. In contrast, others noted the benefit of scheduling groups during school-hours for those with childcare responsibilities (i.e., a group held after school drop-off or before pick-up). Whilst the ideal time was debated, the location was not. Facilitators agreed that the site of the meeting had to be readily accessible, particularly in terms of public transport. Importantly, facilitators capacity to manage such practicalities were noted to be reflective of the level of support received from their employing service:

> *"The project won't succeed unless management are invested in the project and willing to dedicate some time and money." (Michael)*

In comparison with 12-step groups such as AA or NA, facilitators commented that the SMART Recovery model was poorly understood among clinicians and members of the community. Even if the term was recognised, facilitators noted that its structure and core tenets were

often misunderstood. Continuous engagement, information dissemination and education was deemed essential to facilitating referrals from community members, organisations and clinicians, as well as dispelling misconceptions about SMART Recovery groups:

> *"Clinicians and people who are supposed to refer don't really understand what SMART Recovery is or how it works, so they may be hesitant to refer their clients there. There needs to be more education for clinicians around* SMART Recovery*." (Christian)*

Participant's limited understanding of mutual aid groups often made recruiting group members challenging. As one facilitator noted:

> *"People come in with misconceptions about what the group is going to be like – they think it's going to be like AA/NA and sometimes they're looking for a spiritual connection." (Alan)*

Whether the initial referral was successful appeared to rely on two factors, how readily the day, time and location of the group could be incorporated into participants lifestyle, as well as their understanding of the SMART Recovery program. Thus, when individuals are referred to a SMART Recovery group, their capacity to attend the meeting and previous experiences with 12-step and/or expectations regarding mutual aid may discourage initial attendance.

Participation

In addition to issues of meeting time and place, there were additional practical issues which could affect the longevity of the group. This included ensuring there was adequate space to run groups week-to-week and negotiating access to important resources (i.e., ordering SMART Recovery manuals, printing activity sheets). Again, facilitators capacity to manage such practicalities were noted to be reflective of the level of support received from their employing service:

> *"The only reason they don't have a group after hours - which they recognise would be much better and boost attendance - is because of lack of funding – there needs to be money to pay staff." (Henry)*

"It's just clinician time.. it needs to be integrated as a work role – someone needs to have responsibility for it or it won't happen...There needs to be someone responsible for this – maybe if they had a peer, they could do that- or maybe there could be some funding for a casual but for whatever reason that hasn't happened." (Sarah)

Whilst practical concerns became less of an issue as the group became established, maintaining group member participation became an increasing concern for facilitators. A number of interpersonal and experiential factors were identified by facilitators during this discussion. One of these factors concerned how the facilitators functioned within the group:

"The facilitator shouldn't be framed as an expert- they're just guiding the conversation." (Henry)

Facilitators believed that participants were more inclined to continue attending if they felt an affinity with the group. This could be based on the demographics of the group:

"They have separate groups for women who have been experiencing domestic violence (that's a women's only group – they found more women would come to those) and one that is mixed gender." (Henry)

Or more generally, on inherent group dynamics:

"The groups need to be a positive thing. People need to see it as a longer-term part of their lives, or they'll feel like they don't belong." (Sam)

"This is a great opportunity for them [group members] to verbalise their achievements and get acknowledgement from others who, by their recognition, encourages them to keep coming back." (Alan)

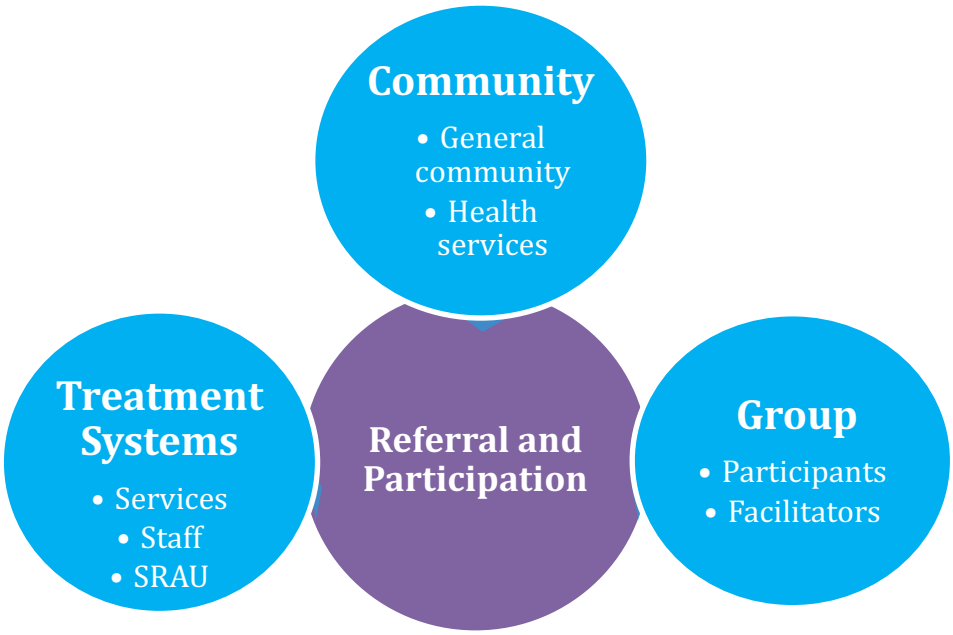
A final factor noted by facilitators as a means of maintaining attendance was the focus of the group. Focus on the *present* (i.e., achievements, a plan for the next 7 days) rather than the *past* encouraged ongoing participation:

> *"I help people put a plan in place for the next week, between groups, and people seem motivated to come back if they have enacted that plan – they are encouraged by it and proud of it." (Henry)*

4.1.2 Barriers and facilitators to running SMART Recovery groups

The process of deductive analysis was undertaken in the context of the following questions; " *"What factors influence (facilitate and hinder) the implementation of a SMART Recovery group?* The success (establishment and longevity) of any group - understood as participants referral to, and engagement in SMART Recovery required interaction with, and support from, the wider community, the AOD treatment system and from within the group. Figure four provides an overview of this process; referral and participation are independently linked to the wider community, the AOD service and the SMART Recovery group. These three groups however are not independent, with support flowing bidirectionally across and through groups.

Figure 4. ***Factors influencing the implementation and sustainability of SMART Recovery***



The role of the wider community

Individuals experiencing addiction face a myriad of social and health concerns and will often engage the assistance of community and ancillary services outside of the AOD treatment system. This can include, but is not limited to, generalist physical and mental health services, or more specialist housing and financial services, community legal services or child and maternal support services. Facilitators noted that, especially in the initial stages of group establishment, they tried to engage with workers at these services to bolster referrals to their group:

> *"We spoke to the Magistrates Court and asked them to refer, Vic Gov, most community centres, we were talking to everyone and anyone we could- but we haven't done that since and I think that's why new people aren't coming." (Sarah)*

Facilitators at Thorne Harbour took a more targeted approach to engaging community members for their LGBTQI+ specific SMART Recovery group, advertising in LGBTQI+ spaces and services:

> *"We used an advertising campaign, using flyers, posters, going to places we know our clients are and put up posters there." (Michael)*

Notably, facilitators agreed that it was not just a matter of dropping flyers or hanging posters, community support is contingent on community members and stakeholders understanding SMART Recovery, becoming familiar with the model and its effectiveness. As one facilitator noted:

> *"AA may be more entrenched in this area, and the community doesn't really know what SMART is. I used to run groups for many years in St Kilda, and the community there really knew what SMART was because it was advertised extensively, and many services would refer to that group." (Sam)*

Engaging the community was of particular importance to facilitators who ran independent groups. These individuals could not rely on service affiliation for support or referrals therefore relied heavily on community participation.

The role of AOD treatment systems

Facilitators who ran independent groups experienced limited *direct* (i.e., resources) or *indirect* (i.e., referrals) support from services. In contrast, those who ran groups connected to an existing community service suggested that to different degrees they had received both direct and indirect support. At the organisational level, support required *buy-in* from team managers and other clinicians. This provided for the provision of resources to sufficiently implement, manage, and run SMART Recovery groups such as the space within the service to hold groups, and undertake administrative tasks associated with the group process (i.e., corresponding with group members, engaging with the community and potential referrers):

> *"The main challenge for the clinicians is time- they don't have time in their roles to organise SMART and advertise and train referrers and monitor emails." (Sarah)*

Facilitators noted that despite the importance of clinicians and allied health staff explaining SMART Recovery to their clients and making referrals, this was not usual practice. One facilitator reported:

> *"I was really shocked at the low numbers- they have around 200 people with AOD issues in the service – so I don't understand why people aren't engaging in SMART Recovery more – I think that clinicians and people who are supposed to refer don't really understand what SMART Recovery is or how it works, so they may be hesitant to refer their clients there." (Christian)*

Facilitators understood this hesitation as a by-product of clinicians misunderstanding SMART Recovery and what it could offer clients. Education of clinical staff and encouragement to discuss Smart Recovery with clients was seen as integral to facilitating referrals:

"There needs to be more education for clinicians around SMART Recovery - he (facilitator) really wants some key personnel to come and observe a group sometime so that they understand." (Christian)

"Clinicians (referring to clinician facilitators) need to be taught how to sell the groups." (Michael)

Facilitators linked to AOD services noted the benefit of having the program structurally integrated within existing treatment pathways. This allowed for treatment seekers who may have disengaged from services whilst waitlisted or following the conclusion of formal treatment to maintain a connection with the service:

"We have a really interesting and effective system whereby SMART is offered to people at the intake/assessment stage- it's almost a "bridging service." (Henry)

"They had an 8-week CBT based therapeutic group which then transitioned after it finished into SMART Recovery*, with many people who graduated that group becoming peer facilitators." (Alan)*

However, commentary suggested that long-term organisational support was often contingent on demonstrating outcomes. Facilitator's highlighted the *quid pro quo* of organisation support:

"The managers can see the data, the benefit, and that's why they support it. If they had more data, manager support would be even better." (Henry)

Ongoing support for the program may therefore be reliant on being able to demonstrate its effectiveness. Despite this, it was unclear whether organisations have processes in place to measure and monitor the outcomes of SMART Recovery groups or individual participants.

As the governing/overseeing body for individual groups in Australia, and registered training providers for SMART Recovery facilitators, SMART Recovery Australia appears to be well regarded amongst facilitators. Facilitators found the current *ad-hoc* support provided by this group useful but noted that a more formalised system of contact with SMART Recovery Australia and other facilitators would be beneficial:

> *"Talking to [the* SMART Recovery] *representative and trainer was really useful- I wish there was a network setup for facilitators to talk to one another." (Christian)*

In addition, several facilitators noted that they benefit from continuous training and reinforcement of their SMART Recovery facilitation skills:

> *"Fundamentally, continuous training is really important." (Alan)*

The role of the group

All facilitators spoke extensively about the group process, which included the role of the facilitator, the experiences of the participants, and group member interactions. At a practical level it was noted that whilst groups could run with just one facilitator, two facilitators was preferred. If a group member became disruptive or required extra care, one facilitator could provide support while the other could continue overseeing group discussion:

> *"Two people is best especially if an incident occurs – if someone shows up to the group intoxicated it's important to have back up." (Sam)*

There was also consensus in respect to the role of facilitators. As part of the aforementioned conceptualisation of their role, facilitators felt responsible for maintaining the group dynamics and ensuring that participants felt safe to engage in conversations:

> *"They should make sure the group dynamics are positive and everyone feels safe and supported." (Alan)*

"[Facilitators should] acknowledge people's anxieties about group work – note that this is a common thing, and everyone is feeling that way." (Henry)

Finally, facilitators were cognisant that part of their role was to support the processes of peer support and mutual aid:

"The facilitator should be aware that they're trying to build a good group dynamic between the group members." (Henry)

Whilst there was consensus as to the role of the facilitator, whether this facilitator was a peer or clinician remained a topic of conjecture. Facilitators interviewed appeared to be in their role as a result of philosophical and practical considerations. One service used only peer facilitators, which aligned with their peer-led philosophy and structure. Other groups were run by clinical staff, a ready supply of clinicians and the lack of peers within the AOD workforce limiting options for these services. Interestingly, whilst some facilitators saw peers as increasing group sustainability, there was no mention of payment:

"There are no peers. Most people who really benefit go on to get jobs and live their lives and so don't really get put through training to become a facilitator- they need money to live." (Henry)

Issues of power and hierarchy were raised. One facilitator noted his experience in a group that was run by one peer and one clinician, in this case the peer facilitator felt an imbalance of power when relating to his clinician co-facilitator:

"It was awkward and ____ found that there was power imbalance." (Michael)

Furthermore, it was noted that issues may arise in the instance that a facilitator is both a clinician and a SMART Recovery facilitator at a particular service. Clinician facilitators who refer their own clients to SMART Recovery may encounter difficulties in maintaining confidentiality and may even rupture the therapeutic relationship:

"Group members found it uncomfortable/awkward when their AOD clinician was there." (Michael)

Power imbalance on any level is in direct conflict with the aim and process of peer support and as such remains an important area of consideration.

4.2 Conclusion

Interviews with current SMART Recovery facilitators suggest that the implementation and management of successful SMART Recovery groups is complex and multifaceted. Understanding the complex processes and interactions between facilitators, group members and between groups and treatment services was an important first step in the pilot project. Informed by the above analysis, table five summarises the potential challenges to the implementation of SMART Recovery groups and the proposed actions to mitigate these, many of which were adopted in the pilot study.

Table 5. ***Active facilitator consultation conclusions and recommendations***

Identified challenge	Recommended action
Management and related challenges	
Support from managers/directors	● Identify how SMART Recovery accords with the philosophies/current operating program of the service ● Identify potential performance indicators and methods of capturing uptake and benefit of SMART Recovery ● Ensure managers agree to 'release' clinicians from their normal duties for a minimum of 3 hours a week to facilitate groups and complete related administrative tasks (e.g., attendance paperwork for court-mandated clients, supervision, outcome measurement etc.).

Service level challenges	
Limited resources available to support the proper implementation and management of the group	● Allocate appropriate monetary resources to staff (i.e., purchase of facilitator manuals and participant material) ● Make service-based resources available to staff (i.e., rooms, chairs, tea/coffee, potentially even after-hours support, childcare facilities for group participants with children)
Outcome reporting	● Establish appropriate processes to facilitate data collection, analysis and outcome reporting to managers/directors
Embedding SMART Recovery groups within existing service structure	● Offer it as a waitlist option and refer clients to SMART Recovery at intake ● Integrate it within current treatment offerings (i.e., detox, rehab) ● Offer it as a form of post-treatment support
Limited number of referrals from within the service / service support	● Engage with staff within the service (i.e., other clinicians, reception, management) ● Clarify internal referral pathways ● Ensure potential referrers have a sufficient understanding of the model to explain and promote it to clients
Ongoing facilitator training	● Engage SMART Recovery Australia in the ongoing training of facilitators, for example, organise workshops and refresher training ● Implement facilitator support/debriefing both within and between services
Number and arrangement of facilitators	● Allocate sufficient staff for two facilitators per group ● Train a sizeable team of facilitators to manage absences, workload, potential burnout ● Provide incentives for staff to transition to facilitation roles ● Support/encourage peer facilitation ● Provide clear pathways for transitioning participants to peer facilitators
Group and participant level challenges	
Management of relational issues between facilitators	● Provide a space/opportunity for facilitators to debrief and reflect (facilitator-facilitator feedback) ● Ensure that there isn't a hierarchy established between clinician or peer facilitators

Management of relational issues between facilitators and participants	• Invite facilitators who are external to the service to run groups • Hire peer facilitators or allocate group-specific clinicians • Establish at least two independent groups and ensure group members are not referred to groups run by their direct clinician(s) OR explain to relevant (i.e., internally referred) group members that their clinicians may run-groups and ensure confidentiality measures are maintained
Management of relational issues between participants	• Facilitators should attempt to manage group size to provide all group members a chance to participate, • Establish closed groups for certain high-risk or vulnerable groups (i.e., women who have experienced violence)
Supporting participants to engage in groups	• Promote group agreement and confidentiality of all members • Acknowledge anxieties regarding the process of group work • Focus on the development of a safe, respectful space to facilitate group engagement
Engaging participants in the process of mutual aid	• Ensure relevant questions are referred back to group members, rather than purely answered by facilitators • Draw upon the participants experiences when engaging in MI or CBT discussions, and when developing 7-day plans • Engage experienced/long term participants in group facilitation
Encouraging ongoing participation	• Schedule groups in a location and at a time/day that is convenient for your target demographic/potential attendees • Educate participants on purpose/aims of SMART Recovery • Provide/create a welcoming and engaging space for the group

5. RESEARCH OBJECTIVE FOUR: Facilitator training and pilot implementation

5.1 Facilitator training

Peers and clinicians chosen to participate in the pilot completed in-person SMART Recovery facilitator training (see table 6 for facilitator demographics). In November 2019, trainees attended either the scheduled (bi-monthly) 2-day training event run by a SMART Recovery Australia trainer in Melbourne, or a training event held by a SMART Recovery Australia trainer at Turning Point specifically for those involved in the pilot. Following training, facilitators returned to their location and were supported by members of the research team to

implement the SMART Recovery program within their service. This support involved regular consultation and refresher training prior to program implementation. Pilot implementation (i.e., the specific start-time of the SMART Recovery group and how this group was integrated within the service) was at the discretion of each service. Using the information garnered from interviews with active facilitators (see table 5) services were provided with recommendations on how to acquit their time running SMART Recovery groups within existing funding agreements with respect to DTAU's.

Table 6. ***Pilot site facilitator demographics***

Service	**Number of facilitators**	**Clinician*/Peers**	**Gender identification**
Site 1	4	3 clinicians, 1 peer	4 females, 1 male
Site 2	3	3 clinicians	2 females, 1 male
Site 3	2	1 Clinician, 1 peer	1 female, 1 male
Site 4	1	clinician	female
TOTAL	10	8 clinicians, 2 peers	8 females, 3 males

***Note:** *Several clinicians noted that in addition to their formal training, they had lived experience, and therefore felt that they facilitated in both a clinician and peer role.*

5.2 Pilot implementation

By February 2020, all services involved in the pilot had commenced offering SMART Recovery groups to their clients. However, in March, the COVID-19 pandemic and associated Government social-distancing measures necessitated the cessation of all face-to-face groups. It was decided that rather than postpone groups indefinitely, the momentum could be maintained by transitioning groups to an online format. To do so efficiently and smoothly and with no additional cost to the services the SMART Recovery Australia Zoom platform was used. This meant groups transitioned from being 'closed' groups (i.e., available only to clients of

each pilot site) to open-groups where others could attend as well as clients of the pilot sites. By April 2020, all groups involved in the pilot successfully transitioned online, and continue to be run in this format as of September 2020.

Table 7 outlines the schedule and number of meetings undertaken by each service as part of the pilot project. Whilst the number of online meetings is similar, it is noted that OH and BCHC conducted more in person face-to-face groups. Each service ran only one group at any one time.

Table 7. ***SMART Recovery meetings at pilot sites***

	Meetings (face-to-face)	**Date/time of face-to-face meeting**	**Meetings (online)**	**Day/time of online meeting**	**Total**
Site 1	3	Monday 2-3.30pm	14	Monday 2-3.30pm	17
Site 2	8	Thursday 2 - 3.30pm	12	Thursday 2-3.30pm	20
Site 3	13	Friday 10 -11.30am	10	Friday 10-11.30am	23
Site 4	3	Wednesday 4pm	12	Saturday 2-3.30pm	15
	27		48		75

5.3. Pilot group uptake and attendance

Each service collected group attendee numbers, including repeat attendances for all SMART Recovery meetings held during the pilot. Overall, there were 486 participant attendances – 138 at face-to-face groups, and 348 at online meetings. Figures five and six (below) outlines participant attendance across the pilot project. Figure three outlines participant attendance as the pilot progressed. Two distinct upward trends are noted; increases in attendance occurred between December 2019 and February 2020 and from March 2020 to the close of data collection in August.

Figure five also provides a summary of repeat participation. The columns represent the number of participants each month who had already attended at least one session of SMART

Recovery run by a pilot site. Overall, it is noted that the trend in repeat participants occurred in a similar fashion to total attendances. For example, during December 2019 pilot sites reported 19 attendees overall, of these, 25% of participants attended more than one meeting. By the conclusion of the pilot program, 52% of all the attendees had previously attended a SMART Recovery meeting at one of the pilot sites.

Figure 5. ***Total group participants, and repeat attendances per month at all pilot sites***

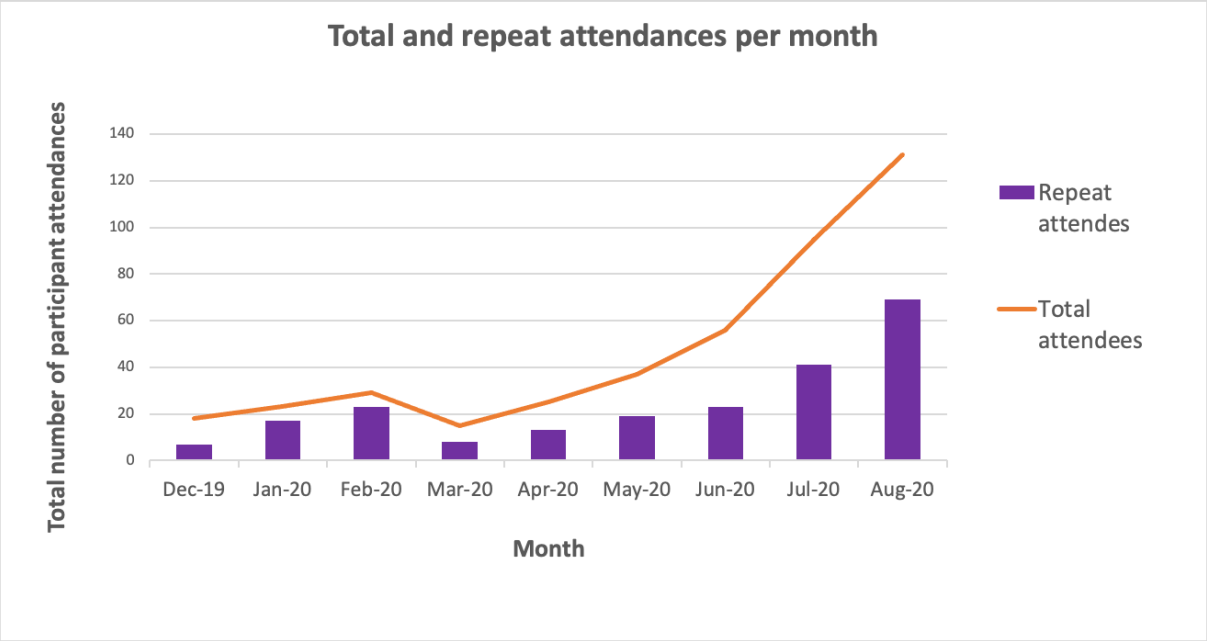


Figure six outlines the average number of *meetings* available per month across all sites. The columns represent average *participants* per meeting over this same time-period. While the number of groups dipped during March 2020, the average number of participants in each group increased at this time. As the second implementation of groups levelled out between - June and August - there were an average of 16 groups running per month. Simultaneously, the average number of participants per group increased. Overall, both the number of meetings and the number of participants increased during the pilot, demonstrating a substantial demand for SMART Recovery.

Figure 6. ***Average participants and average meetings per month at all pilot sites***

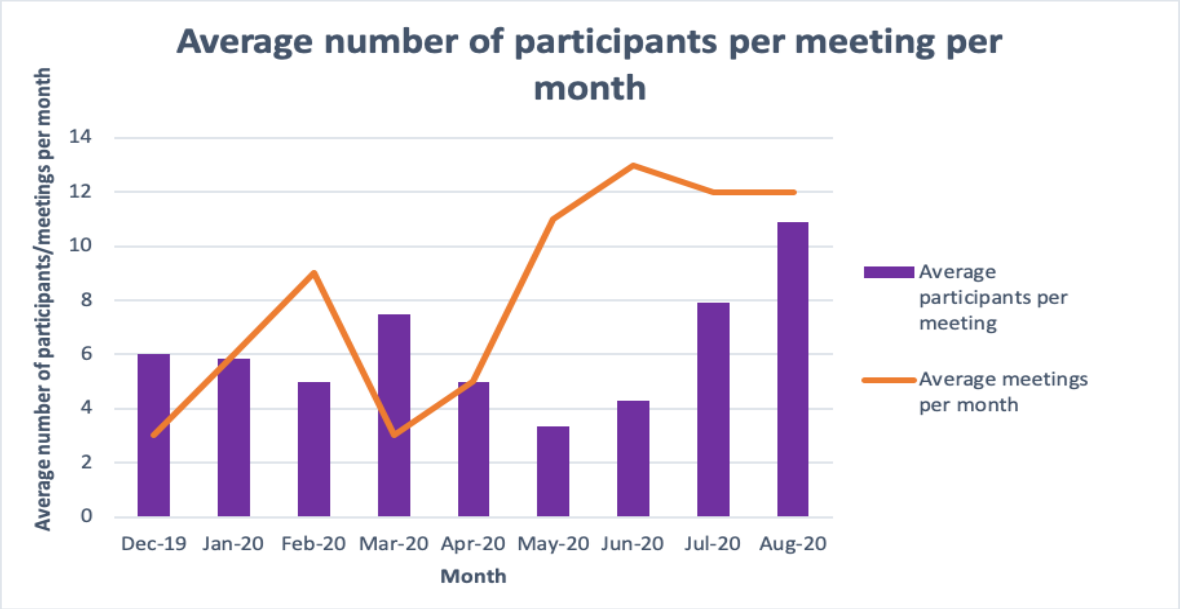
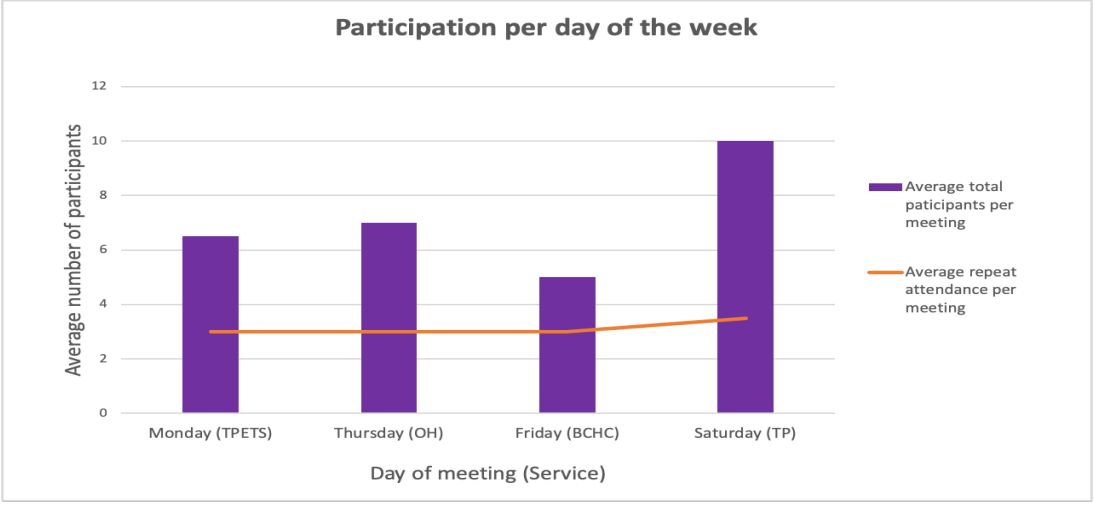


Figure seven provides a breakdown of participation by days of the week. Participation was relatively similar across groups run during the week. However, it is clear that a large number of participants were attending the Saturday group. In contrast, the average number of repeat attendees by day of the week remains relatively stable. This may suggest that many attend the same meeting every week, which is actively encouraged (to optimise group cohesion and connection with peers). However, whilst the online Saturday group has a similar number of regular attenders, it also attracts a higher number of those new to SMART Recovery, possibly as a result of it being the only one available when community AOD services are closed.

Figure 7. ***Average participation and repeat attendance per day of the week***



Most importantly, the pilot study clearly demonstrated that it is feasible for AOD services to offer SMART Recovery groups as part of their program. The rates of attendance are a testament to the demand for peer support in addition to the one-on-one counselling clients receive, and also to the commitment of clinicians and peers to offer this form of recovery support in addition to their usual roles and duties.

Attendance numbers across the pilot provide several insights into considerations for future SMART Recovery groups. The establishment of a new group is likely to take several weeks to months until there is a critical mass of regular group members, though this may be accelerated if groups are open and offered online (via video-conferencing). The changes in group numbers and composition during the pilot may reflect the shift from face-to-face to online meetings, which for most sites needed to be run through the existing SMART Recovery Australia online platform. The advantages of offering SMART Recovery via online meeting platforms (i.e., Zoom) include increased accessibility to regional and even remote parts of Victoria, and convenience (e.g., no travel required). This platform is also conducive to more regular attendance and greater anonymity (with some preferring not to use their cameras or real names). However, some of the drawbacks include a lack of required equipment (e.g. no internet access, no computer), lack of privacy among those living with others, and a more fluid, ever-evolving group dynamic with new-comers who were not necessarily clients of the pilot sites attending each week.

These data also provide some insight into participation trends. In the first instance we note that participant numbers per group may act as a function of the number of groups offered. For example, if a service offered three groups per week, they might find participant numbers lower than if they only ran one group. Lower numbers are not necessarily negative, as they ensure that each member of the group will be offered a chance to contribute and facilitate group bonding. At the same time, too few participants can also increase pressure placed on those participants and limits the diversity of perspectives SMART Recovery groups can offer. Offering fewer groups may provide for more stability in participants - the regulars - but may also fail to provide for those who may require more *ad hoc* support. One challenge for facilitators when group numbers exceed the optimal 8-10 members (with the Saturday group

frequently attended by 15+) is maintaining the integrity of the SMART Recovery program (e.g. ensuring everyone gets to speak, utilising SMART Recovery tools). Finally, it is important for services to consider running groups throughout the week, including weekends, when clients have fewer support options at their disposal during times when craving, substance use and resulting harms often peak.

6. RESEARCH OBJECTIVE FIVE: Benefits of attending

6.1 Participant surveys

All persons who attended pilot-group SMART Recovery meetings were invited to complete a participant survey at the conclusion of each meeting. This survey was designed to measure individuals' reason(s) for attending the meeting, their experiences with facilitators and other group members, as well as their health and wellbeing at the time of the meeting and in the time between their attendances at SMART Recovery meetings. Completion of surveys was voluntary. Survey responses were anonymous; however, participants were asked to provide a unique identifier so that surveys could be tracked over time (comprising their mother's maiden name, postcode and year of birth).

Surveys were initially distributed by facilitators in face-to-face groups directly to participants. After the move to online groups, an online survey was created, and the link distributed to participants via the Zoom chat function. Encouraging group members to complete paper surveys in a face-to-face context was significantly easier than doing so online, as facilitators could discuss confidentiality procedures with the participant in-person and answer questions about the survey. Many participants, particularly those attending SMART Recovery as part of another program (i.e., forensic clients or those attending as part of a recovery-oriented practice whilst in rehabilitation) refused to complete the survey due to concerns that their information would be shared. Encouraging survey participation proved challenging in an online environment, where participants were often anonymous and left immediately after meetings concluded. However, participants in online meetings were more inclined to complete the SMART Recovery Australia ultra-brief post-meeting survey, and so this was

included as a method for assessing benefit of group attendance. Data from the three formats are presented below.

The more detailed survey (i.e., the survey developed specifically for the pilot) adapted the 4-item Treatment Effectiveness Assessment (TEA) (Ling et al, 2012). The TEA assesses how much participants felt they had improved since their last SMART Recovery group in terms of five key domains:

1. AOD use ("How much better or worse is your drug/alcohol use?");
2. Physical health ("How much better or worse is your physical health?");
3. Mental health and wellbeing ("How much better or worse is your mental health and wellbeing?");
4. Personal responsibilities ("How much better or worse are you in taking care of your responsibilities?"); and
5. Feelings of connection with others ("Do you feel you are more connected with others?").

Participants assessed these statements on an 11-point scale, from -5 (much worse) to +5 (much better) with 0 representing no change. To view the full survey, including demographic questions, see appendix E.

6.2 Face-to-face survey respondents

Surveys were analysed at two levels, firstly with each survey response recorded as an independent event. This resulted in a **n=74 events (**by 32 participants), the vast majority were attending for alcohol problems (see Figure 8) with a high proportion of females in the 45-64 age groups and a higher proportion of men in the 25-44 age groups (see Figure 9)**.** The second level of analysis looked at a subset of participants responses over time.

Figure 8 ***Pilot site survey respondents reported substance/behaviour of concern (n=32)***

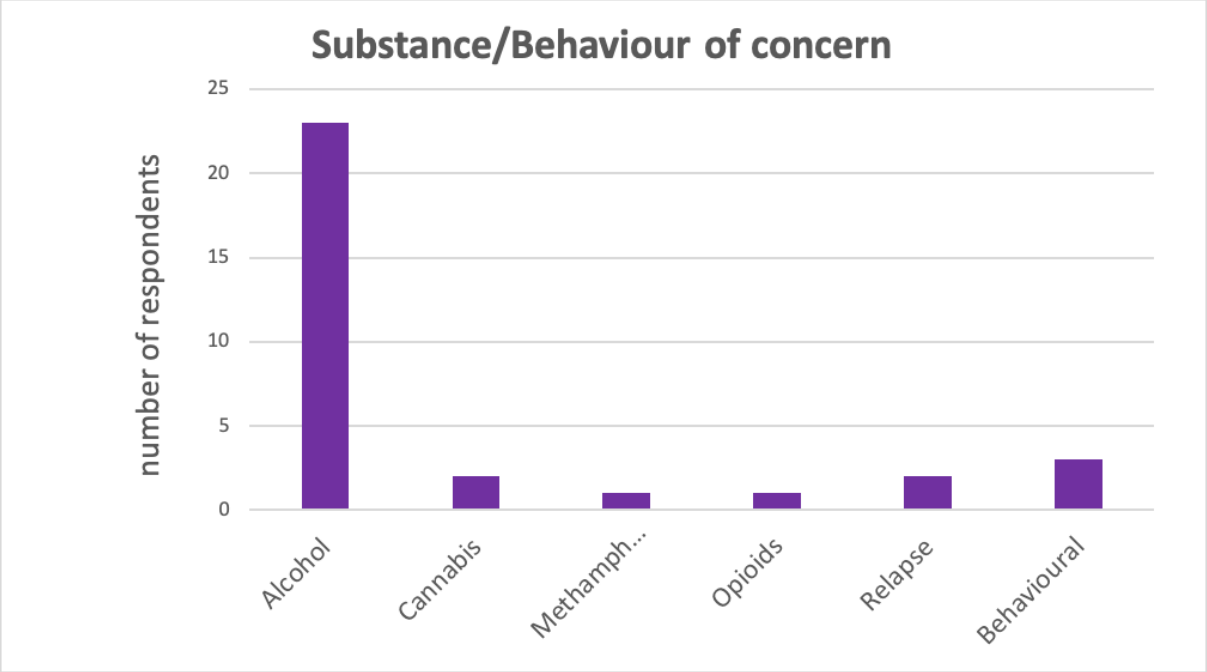
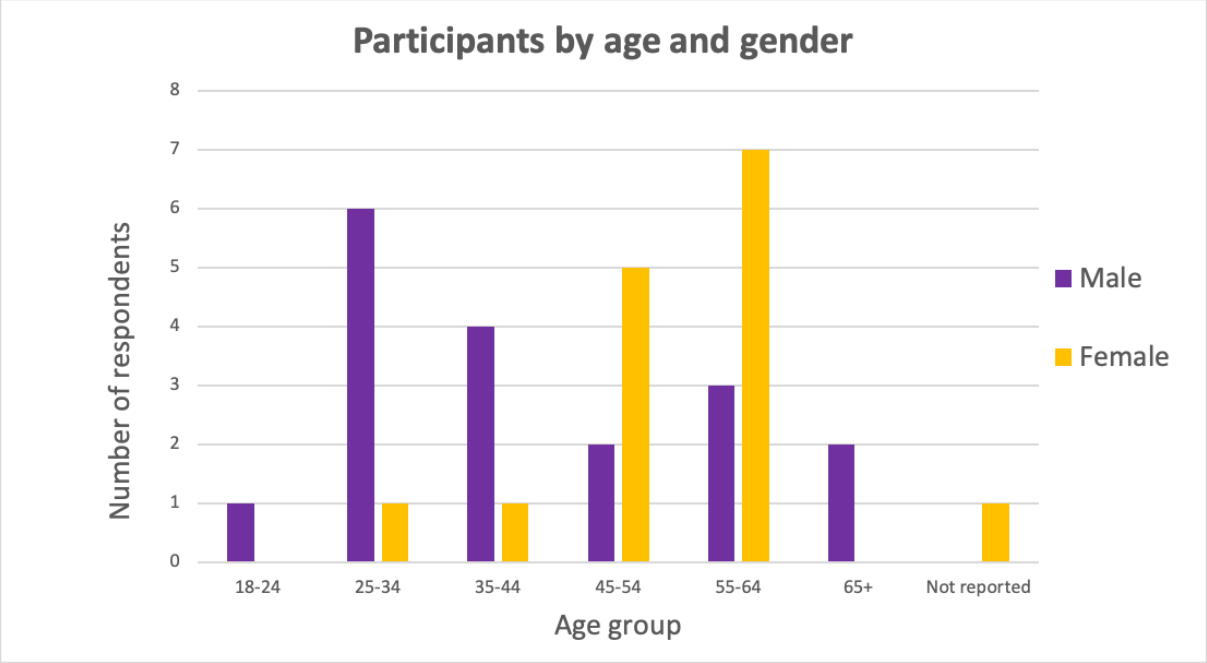


Figure 9. ***Pilot site survey respondents by age and gender***

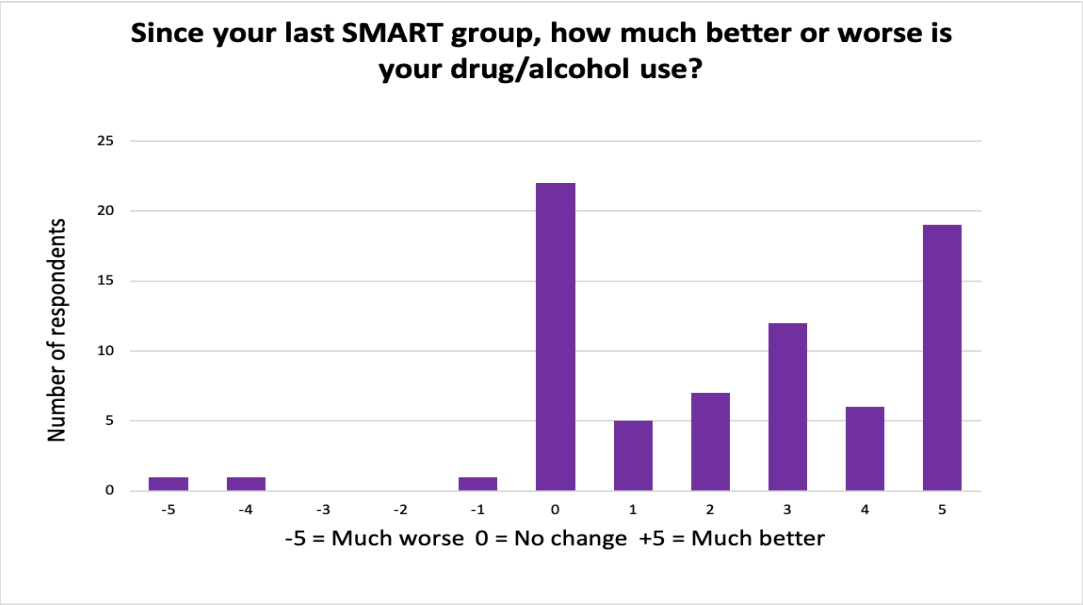


6.2.1 Responses to the Treatment Effectiveness Assessment

In total, 66% of respondents reported a positive change (reduction in alcohol/drug use) since their last SMART Recovery meeting, with 30% of respondents reporting no change which could

also indicate maintained abstinence (see Figure 10). Fewer than 5% of participants reported an increase in use since their last SMART Recovery meeting.

Figure 10. ***Reported changes in AOD use since attending SMART Recovery groups (n=74)***



In other domains, 63% reported a positive change and 28% no change in their physical health and 73% reported a positive change and 19% no chance in their mental health and wellbeing since their last SMART Recovery meeting (see Figure 11). Encouragingly only 7% reported a decline in either their mental or physical health and wellbeing.

Similar trends were noted in respect to lifestyle factors with 73% reporting that they were better able to take care of their personal responsibilities and 86% reporting that they were better connected with others since their last SMART Recovery meeting (see Figure 13). Encouragingly, only 1 respondent reported a decline in personal responsibilities and none reported feeling more disconnected from others during the same period.

Figure 11. ***Reported changes in physical and mental health and wellbeing*** **(TEA)**

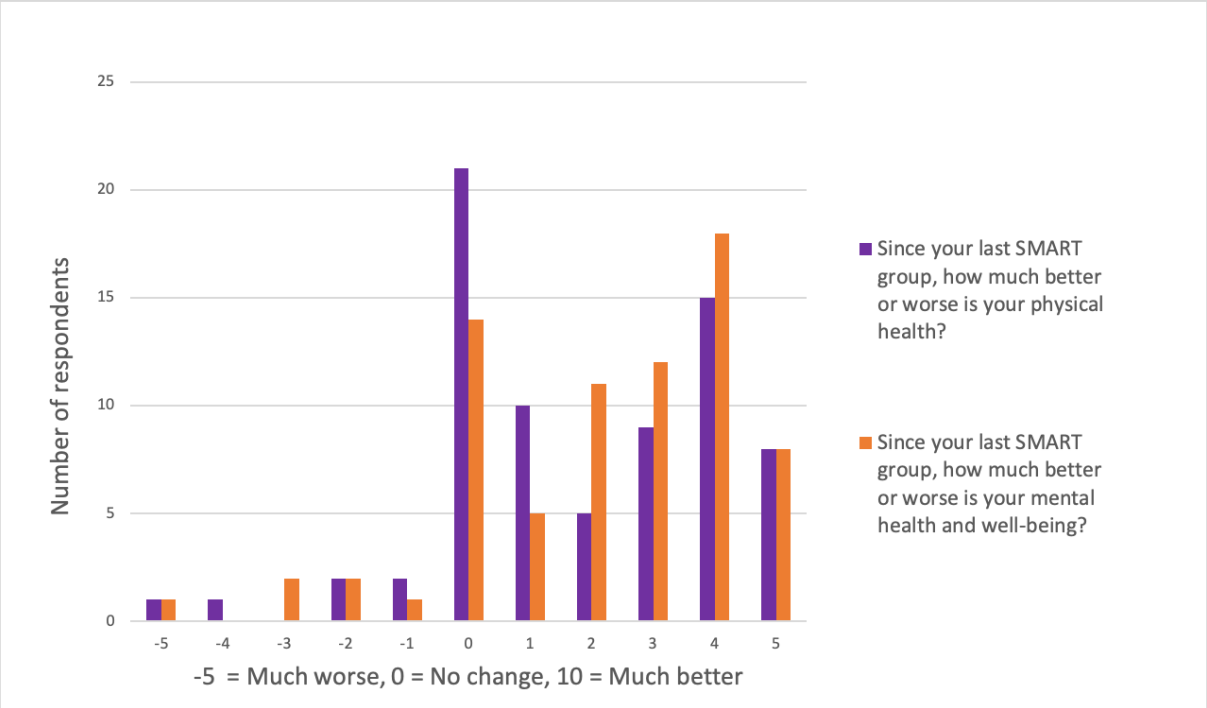
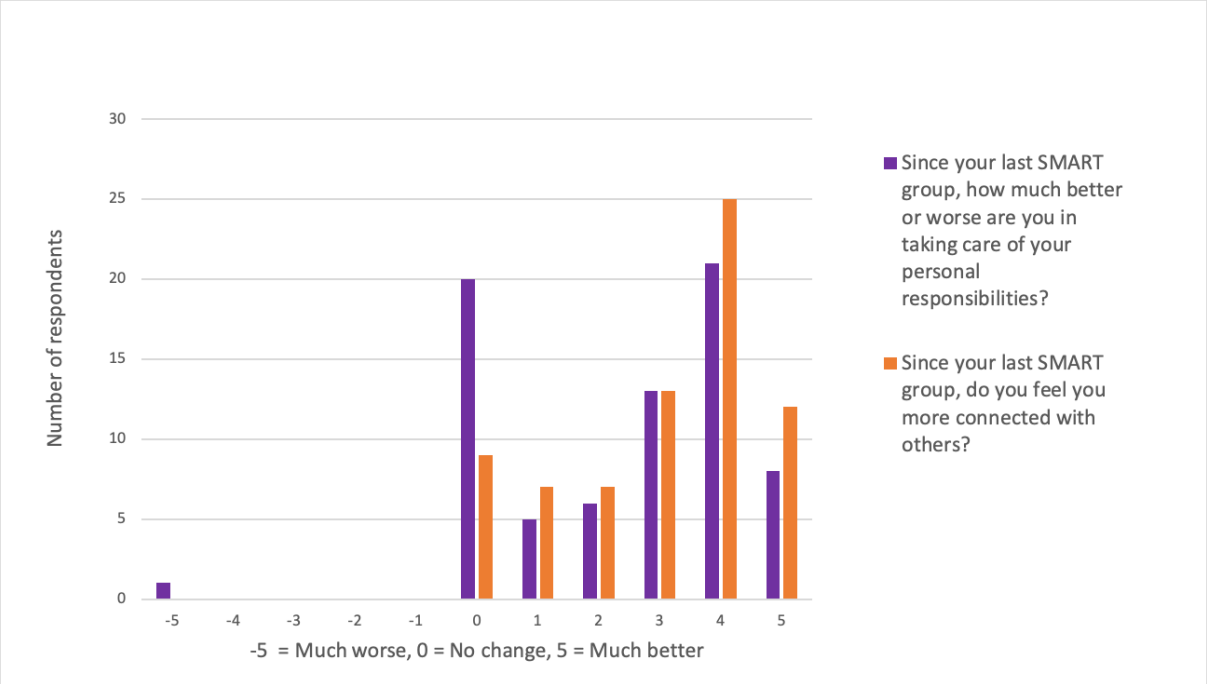


Figure 13. ***Reported changes in personal responsibilities and connectedness (TEA)***

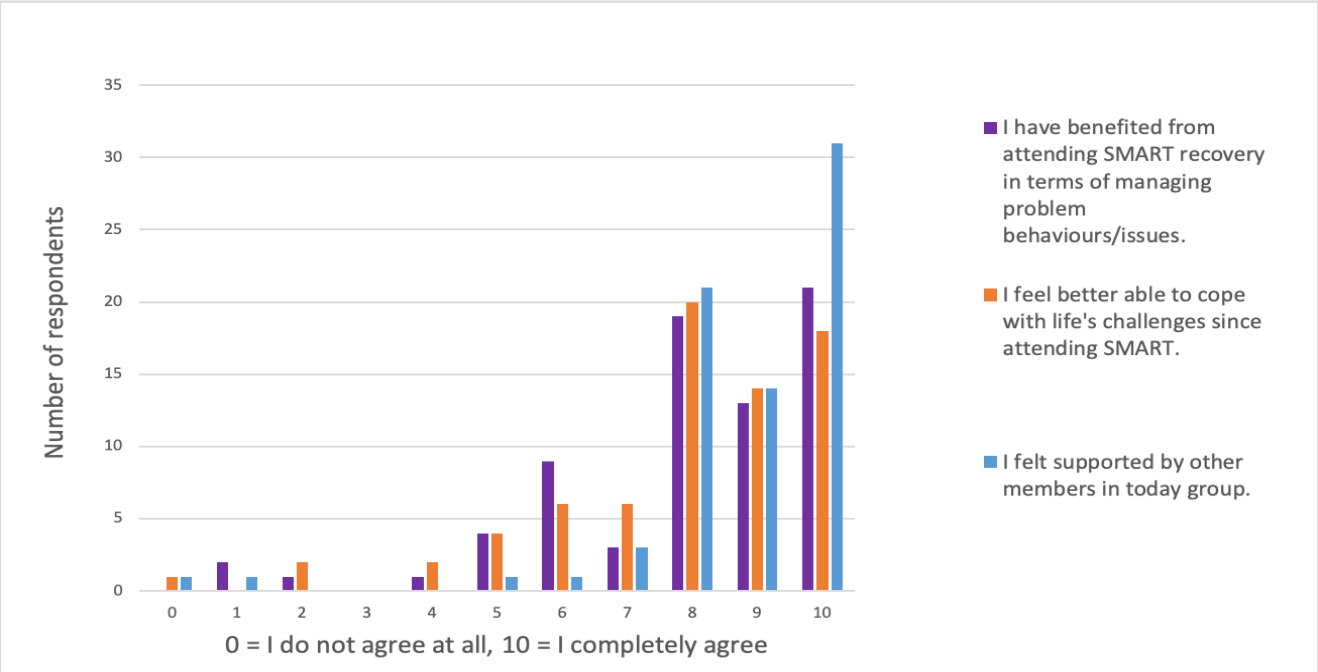


Survey respondents responded to 3 statements on the benefits of attending groups on a Likert scale where '0' = 'completely disagree' through to '10'= 'completely agree' (see Figure 14)

- 72% indicated that they could better manage problematic substance use

- 71% that they were better able to cope with life's challenges
- 90% that they felt supported by members of the group during the meetings

Figure 13. ***Participants level of agreement with post meeting statements***



6.2.2 Participant responses over time

Several participants completed multiple surveys, however, few participants attended every group consistently and completed the post-group survey. Nonetheless, there were four participants who attended and completed surveys at 7 sessions enabling the examination of changes over time. These case studies provide an example of how SMART Recovery can bolster recovery when added to formal AOD treatment.

In the following figures, participant 1 is a 60 year old male, participant two is a 50 year old female, and participant three is a 65 year old female. All three participants reported alcohol as their substance of concern, yet all three reported abstinence throughout their participation in the SMART Recovery pilot. Participant four is a female, aged 35, but did not specify primary drug of concern, but noted that her reason for attending SMART meetings was to prevent

relapse. Each participant is represented by the coloured lines indicated in the legend below across figures 14a-e.

Figure 14a. ***Responses over time – physical health***

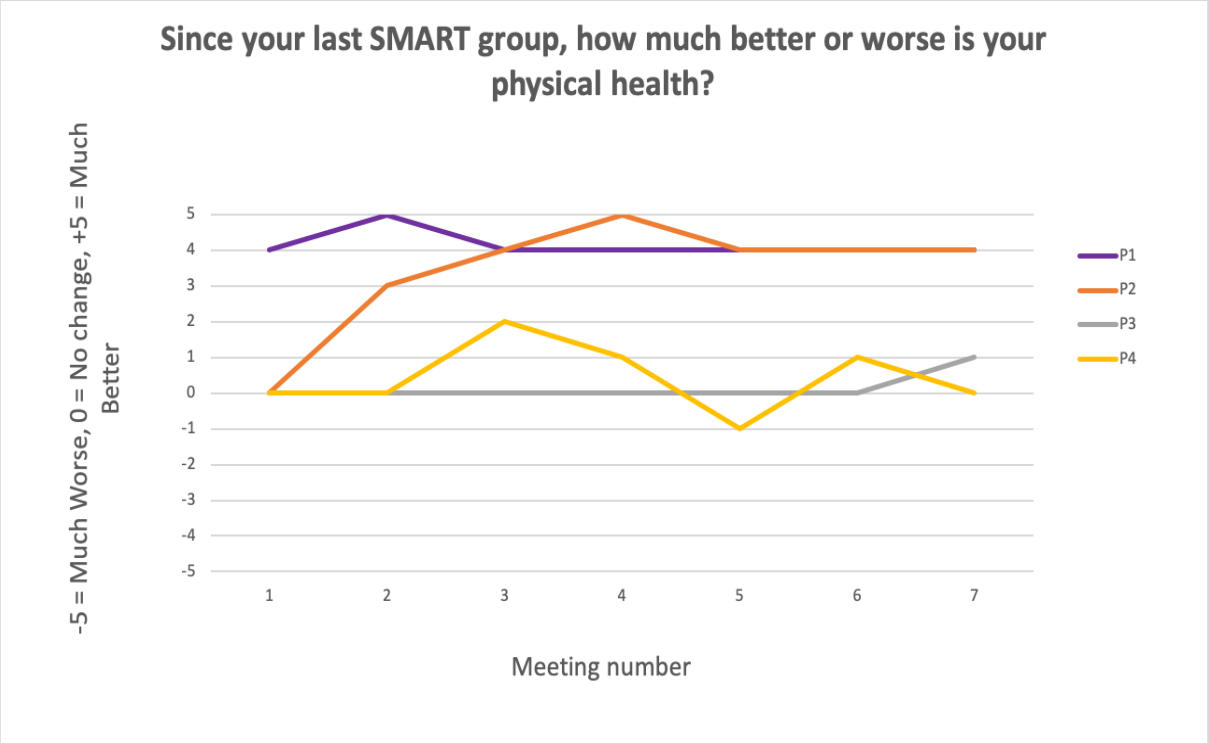


Figure 14b. ***Responses over time – mental health and wellbeing***

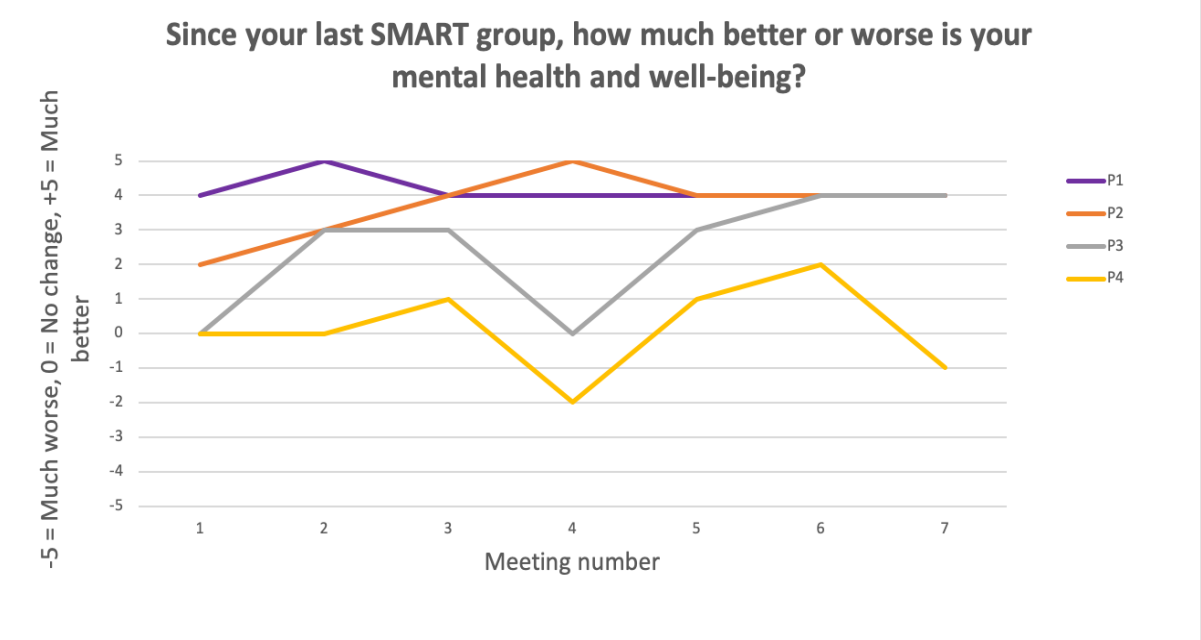


Figure 14c. ***Responses over time – personal responsibilities***

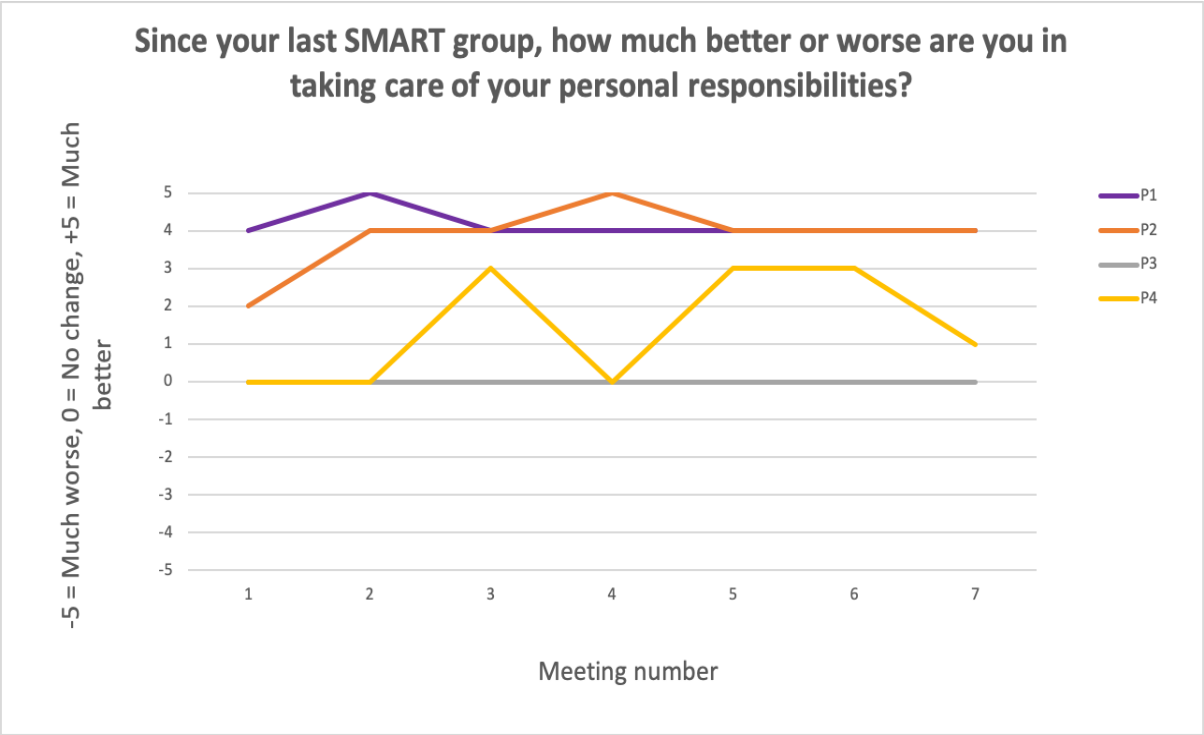


Figure 14d. ***Responses over time - connectedness***

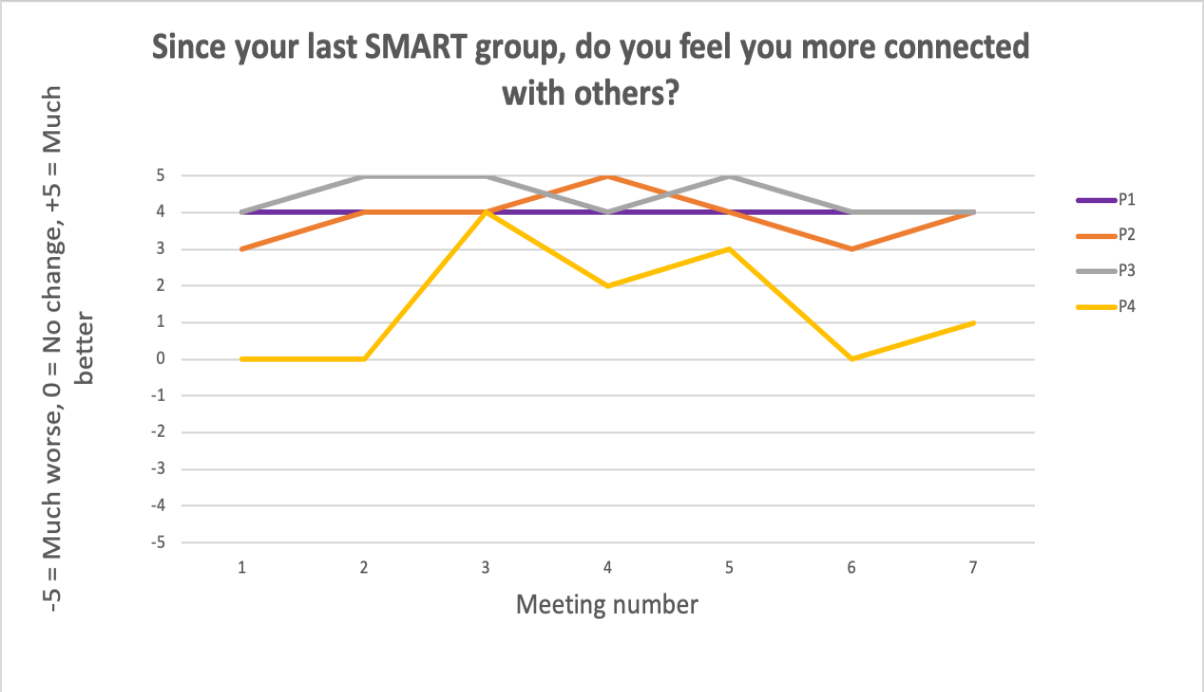
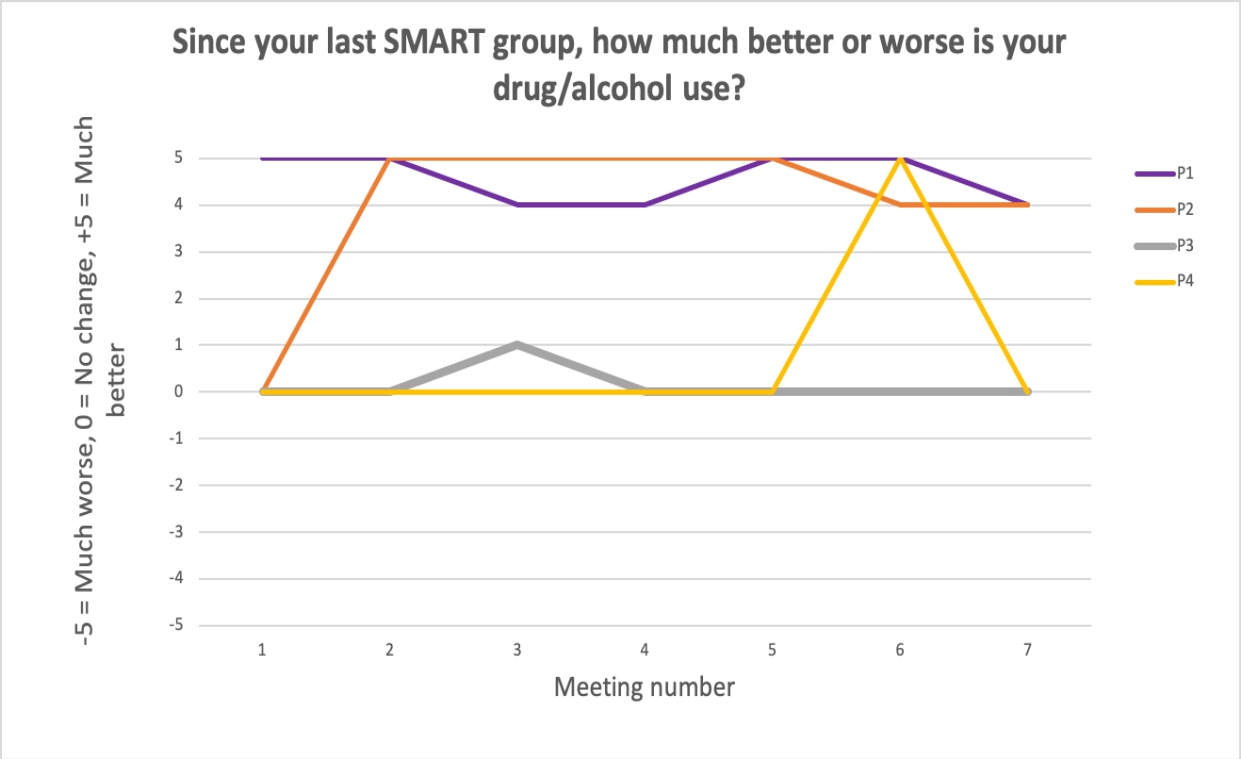


Figure 14e. ***Participants reported changes in AOD use over time***



Firstly, none of the four regular attenders showed any deterioration in their substance use during their engagement with SMART Recovery, and only case-example 4 reported a decline on any of the other domains. Participant one (male, 60 years old), reported improvement in his alcohol use which was maintained over time, as well as improvements in his physical and mental health, improved capacity to manage his responsibilities, as well as increased connection with others which was maintained over time.

Participant two (female, 50 years old), also reported instantaneous improvement in her alcohol use, which was maintained over time, which was followed by an improvement in other domains after regular attendance at SMART Recovery meetings. Of particular note are the consistent increases with respect to her physical and mental health during her first four attendances at SMART Recovery meetings (Figure 14 a and b), which was subsequently maintained over time.

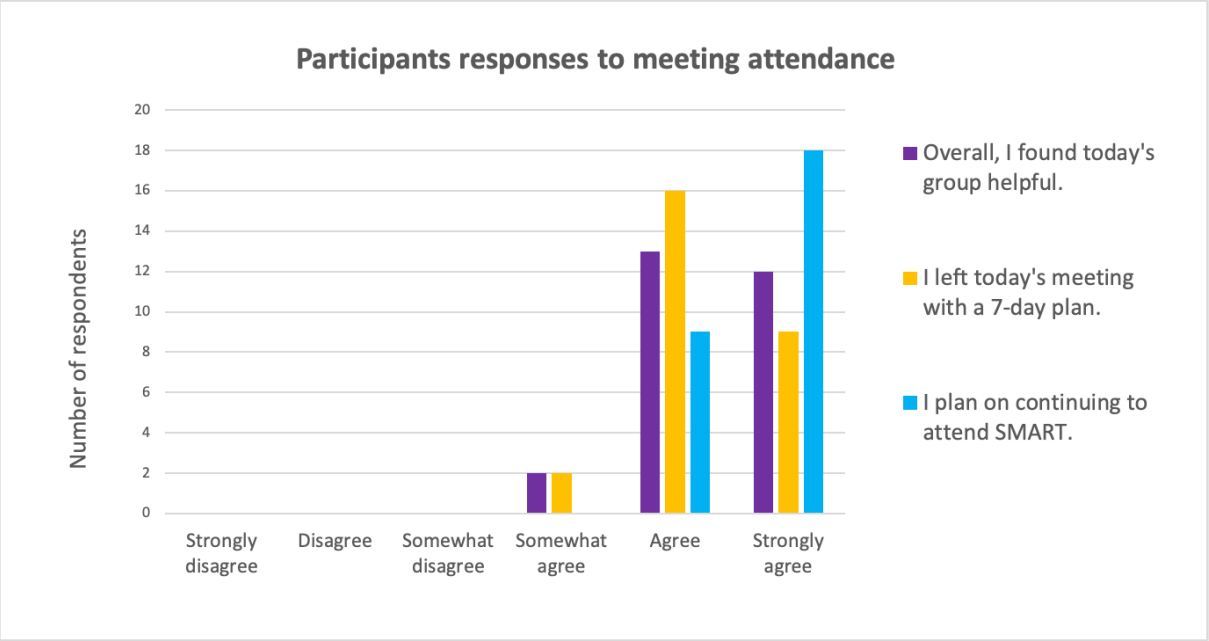
Participant three (female, 65 years old) in contrast, showed little improvement over time in her substance use, except for marginal improvement in her alcohol use reported at the 3rd SMART Recovery meeting. However, on closer inspection this was because she was already abstinent from alcohol when she started attending SMART Recovery groups and successfully maintained her abstinence over time, hence there was no change. She reported no improvement in her physical health except at meeting number 7. In contrast, she reported some improvement in her mental health and wellbeing which then deteriorated around week 4, before improving again for the remaining duration of her SMART Recovery attendance, suggesting overall that her mental health improved, stabilised, and then improved again. She reported zero change in her ability to meet her personal responsibilities throughout her participation in the SMART Recovery meetings, however she reported substantial improvements in her connections with others which were maintained over time.

Participant four reported that her reason for attending SMART Recovery was to manage potential relapse and hence the lack of change (as with case-study 3) reflected continued abstinence from alcohol. Nonetheless, she still reported a substantial improvement in her alcohol use at week 6. She reported fluctuations in her physical and mental health throughout her SMART Recovery attendance, in both instances a slight deterioration was reported compared to previous weeks. Encouragingly she reported ongoing improvements in her personal responsibilities and in connecting with others, albeit with a dip in improvement in these two domains between week 3 and 4.

6.3 Participants online experiences

Participants (n=32) who completed the survey after an online meeting were asked to report on their experiences in the group (given this new format, this was decided to be important). Participants' responses to the meeting are presented in Figure 15. All but two participants agreed/strongly that they found the meeting helpful, left the meeting with a 7-day plan and all agreed/strongly agreed that they intend to continue attending.

Figure 15. ***Participants responses to online meeting attendance*** **(n=74)**



6.4 Data from the SMART Recovery Australia brief evaluation

Following the implementation of online meetings, SMART Recovery Australia (SRAU) invited participant to complete to assess the transition to the online format (for survey questions see Appendix F). Access to data pertaining to the meetings run by the pilot sites was made available for analysis (n=30).

6.4.1 SMART Recovery Australia survey participant demographics

Participants were a roughly equal mix of males (n=14) and females (n=16) (Figure 17). Male participants reported being between the ages of 18 and 55, and female participants spanned a similar but older age range, reporting to be between the ages of 25 and 65+. Participants reported a number of reasons for attending SMART Recovery meetings. Amongst those who completed the survey, alcohol use was by far the most frequently reported reason for attending, and more so among female than male participants (Figure 18).

Figure 17. ***SMART Recovery Australia survey respondents by age and gender***

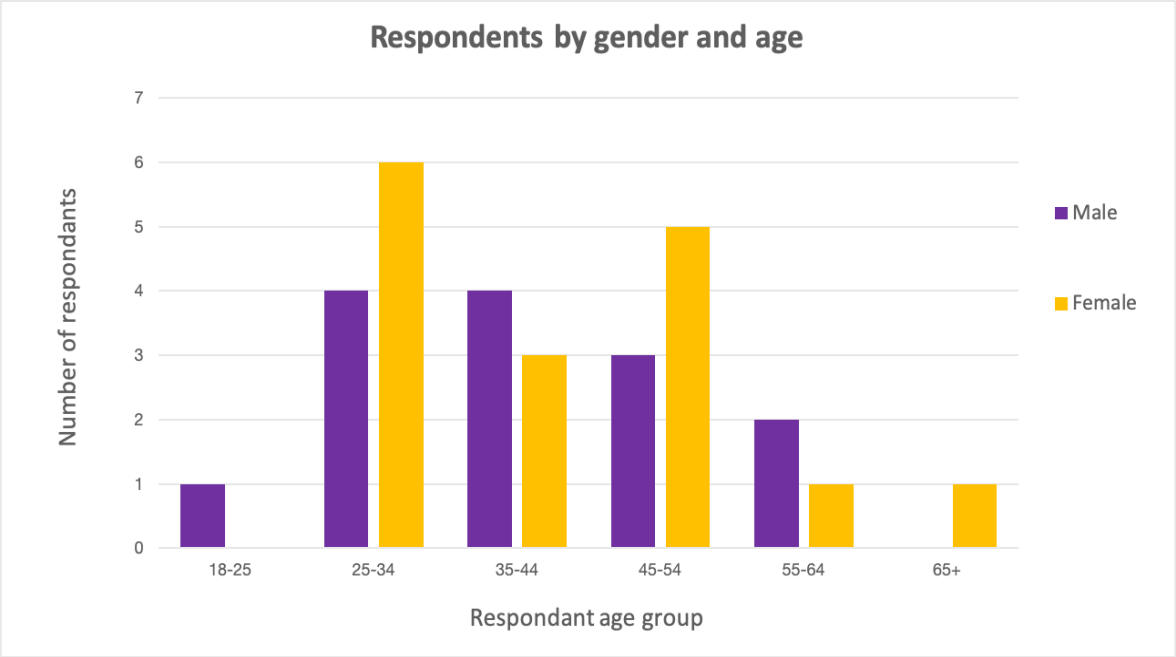
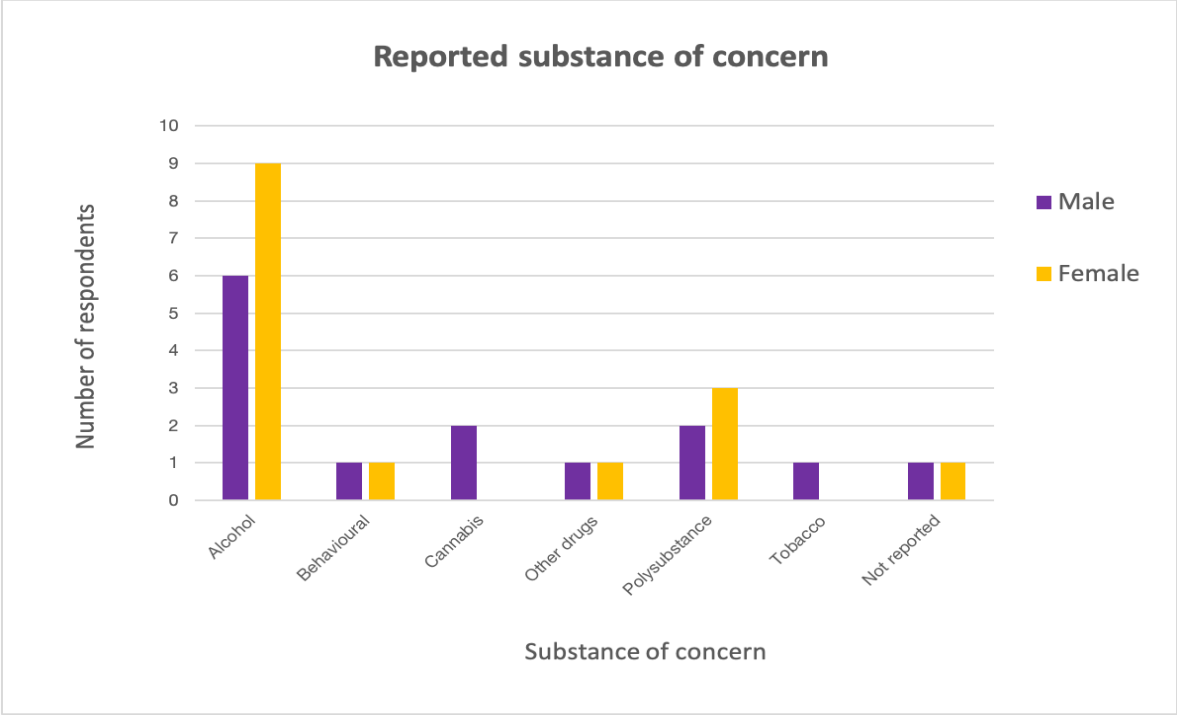


Figure 18. ***SMART Recovery Australia survey respondents reported substance of concern by gender***



6.4.2 SMART Recovery Australia survey participants experience of meeting attendance

The SMART Recovery Australia survey provided participants with the opportunity to express their feelings towards each meeting across a number of factors. Overall, participants agreed or strongly agreed that they felt welcomed (93%), supported (93%) and able to contribute (93%) to the meeting on the occasion in which they completed the survey (Figure 19). Finally, all participants agreed/strongly agreed that the meeting had been helpful (83%) and that their intention is to continue attending (96%) (Figure 20).

Figure 19. ***SMART Recovery Australia survey respondents post meeting assessment***

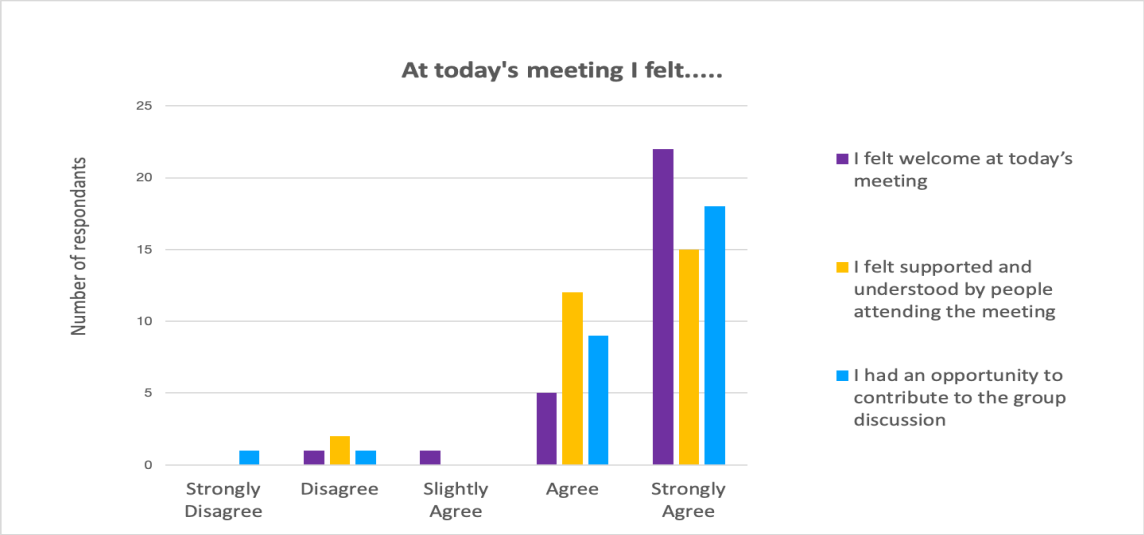
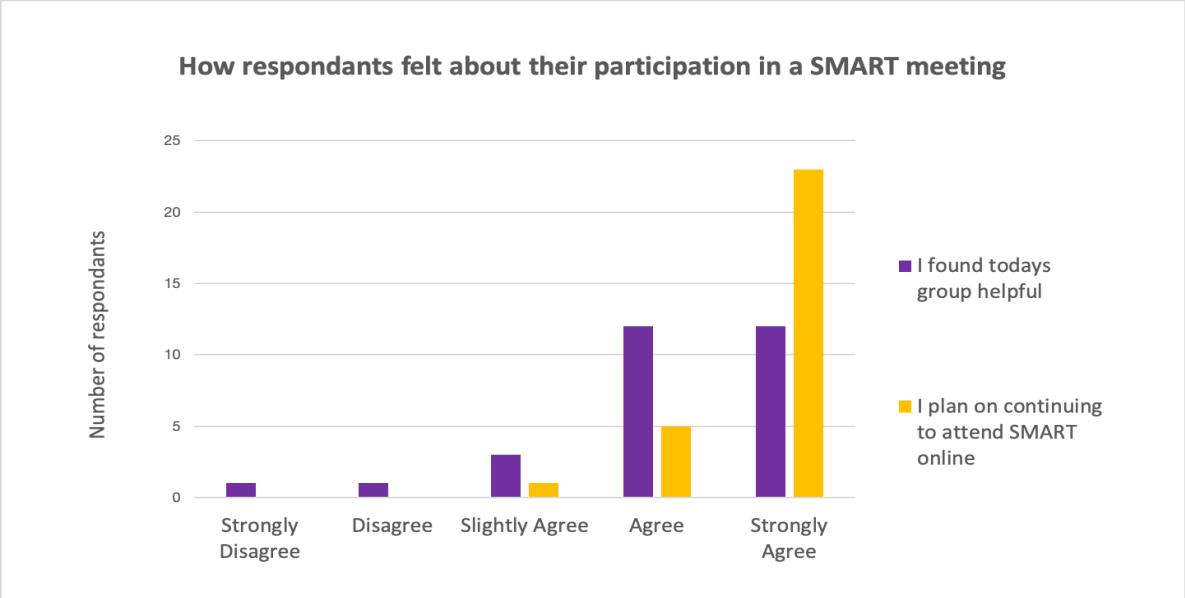


Figure 20. ***SMART Recovery Australia survey respondents post meeting assessment***



6.5 Summary and conclusion of participant survey data

In summary, the uptake of meetings was very good, with 138 participant attendances among the 27 groups held face-to-face and a total of 384 participant attendances in the 48 groups run online. In terms of attendance rates, all groups had both regular members, and new members attending each week, though there was a steady increase in the proportion of regular attenders after May 2020 by which time the online groups were well-established.

Similar responses were observed in the experiences and reported benefits of attending SMART Recovery across online and face-to-face groups. Participants reported reported feeling welcomed to the group, able to contribute, understood and supported by fellow group participants and two-thirds intention to continue attending. With respect to addressing their AOD problem, the majority felt that the meeting had been helpful to them and that they had left the meeting with a plan for the next 7-days to achieve their self-nominated goal. Participants completing face-to-face-surveys also responded to several questions regarding their substance use, health and wellbeing. Almost all participants (96%) reported an improvement in their substance use (i.e., reduction or successful maintenance of abstinence). Two-thirds reported improved physical health since attending SMART Recovery, and around three-quarters reported improved mental health, being better at taking care of personal responsibilities, and improved connections with others.

7. RESEARCH OBJECTIVE FIVE: Exploring experiences of SMART Recovery

7.1 Method

To garner an in-depth understanding of the experiences of those involved in the pilot qualitative interviews were undertaken with group participants, facilitators and service managers between July and August 2020. All interviews were completed using a semi-structured interview schedule (see Appendices H, I, J). Interviews were developed with the aim of understanding the individuals' experience with the pilot. Whilst interviews explored the experiences of different stakeholders (i.e., participants, facilitators and managers

perspectives), the interviews questions were broadly consistent to enable comparison of ideas and themes across the different stakeholder groups.

All interviews were recorded and transcribed verbatim. As per the second phase, qualitative interviews were analysed using the Framework approach to thematic analysis. This involved developing and agreeing upon a coding framework, coding interviews in the NVivo qualitative data management program, and identifying common themes based on the aims of the project and participants' experiences and perspectives.

7.2 Experience of participants

Ten SMART Recovery participants who attended groups at one of the four pilot sites involved in this project undertook qualitative interviews with a member of the research team. Four participants lived in Melbourne, four in rural/regional Victoria and two outside Victoria. Participants mean age was 44.3 years, with five identifying as female, four as male and one as non-binary. Two participants identified as homosexual while eight were heterosexual. All but one participant was born in Australia, and none identified as Aboriginal or Torres Strait Islander. Seven participants' primary drug of concern (PDOC) was alcohol whilst for three it was illicit drugs. Many participants noted that they had been abstinent for months if not years and were attending SMART as a form of recovery maintenance or because of certain life stressors, rather than to reduce or change their substance use. Eight participants had attended either AA or NA in the past, with seven attending 12-step groups at the time of the interview.

The semi-structured interviews with participants explored why they started SMART Recovery, their experiences of attending groups, perceived impacts, experiences of the facilitators and other group members, how it fitted with treatment they were receiving and how it compared to other forms of mutual aid (see appendix I for the interview schedule). Finally, participants were also asked to reflect on how SMART Recovery could be improved and their experience of the online format. Eight themes were identified, these were: (1) motivation to attend SMART recovery, (2) peer-to-peer learning opportunities among participants, (3) SMART Recovery as an adjunct to formal treatment, (4) connecting with others, (5) practical

application and 7-day focus, (6) perceptions of SMART Recovery run by AOD services, (7) perceptions of facilitators, and (8) future considerations for SMART Recovery Groups.

Motivation to attend SMART Recovery

Many participants had engaged in formal treatment and felt that these services were no longer relevant to them (i.e., their AOD use had stabilised) but were keen to continue to engage in informal support. Participants were clear that they appreciated SMART Recovery as it departed from the typical/standard treatment framework. SMART Recovery provided for the maintenance of treatment gains, acting as a form of continued care:

> *"I have a personal view of doing activities which help and enhance my recovery, and it was to help and enhance my recovery that I started SMART." (Elizabeth)*

Several participants noted that their focus had transitioned from merely resisting the urge to use drugs or alcohol, onto the 'bigger picture'. This included learning how to live without alcohol or drugs, rebuilding social connections and engaging in life, substance-free. SMART Recovery meeting were safe spaces to practice living life free of addiction:

> *"I think for me, it's about life now, you have to learn how to live your entire life now... So every week I think we learn how to live life." (Esme)*

> *"The reason I got into this group was for recovery and I did it to live life, and it's not just about the behaviour of using, I have to learn to live life again and that entails everything. So a group like SMART, I've really been able to talk a bit more and focus a bit more about life and how to do that now I'm sober, because it's really different, even interacting with people and talking with people, having a conversation, going to the shops and paying bills, walking out the front to go to the letterbox that was something I couldn't do." (Linsey)*

Another participant recognised that attending SMART Recovery gave him a sense of purpose:

"I really have benefited. It gives me purpose. While I'm unemployed, when you have a substance abuse problem you have no purpose in life. SMART gives me purpose. But also you have to restart." (Esme)

Notwithstanding the shift in focus from treatment to recovery, participants appreciated the fact that the group was associated with a treatment service, as this provides a metaphorical safety net. They were aware that recovery was a long-term process:

"For me I use it mainly just for lifestyle and wellbeing right now, but I know if I were to have cravings or anything or thoughts like that, I know I'd be able to talk about that." (Gregory)

"I just needed to have something to fall back on if I started to struggle." (Kayla)

"I don't know if I would have come this far in the last few months." (Kayla)

Participants of the pilot program highlighted the importance of SMART Recovery in their recovery journey. They noted that this was an opportunity for them to actively engage in their recovery and build pro-social connections.

Unsurprisingly, most participants experience of other mutual aid groups was predominantly AA/NA, with several participants articulating a preference for the more secular, active-participatory nature of SMART Recovery, with several making direct comparisons in the way in which they are run, and several reporting negative experiences of 12-step groups. SMART Recovery provided them an option in their choice of mutual aid engagement:

"I didn't want to go to AA because I'm not religious although I've talked to people who have said that yeah you can get around that as choosing your higher power as something else, but for me it just doesn't click… " (Ben)

”I didn’t find it [AA] intellectually useful for me anyway. I don’t mind telling my story … but there was no cognitive discussion.” (Anton)

“I wasn’t getting anywhere with the 12-step program and in fact I had been abused on more than one occasion.” (Joshua)

“I don’t really get into the higher power thing, and I think NA has a tendency to get off topic and people just sharing war stories, and it's more about using, and sometimes it can trigger me I guess. I prefer SMART how it's all goal based and stuff.” (Gregory)

Participants also indicated that they liked the harm-reduction focus of SMART Recovery and its embracing of behaviour change at all levels, recognising that recovery is not a linear journey and that an individuals’ goals may change over time:

“I believe that I’m probably alive because of SMART. I believe stopping drinking and reducing drinking has preserved me in a way that wouldn’t have happened otherwise, and that’s the important thing about SMART’s harm minimisation focus.” (Joshua)

“If you don’t want to be abstinent, if in the future you eventually want to have a glass of wine a week, I’m not in that place at the moment, but you know there is none of that discussion in AA.” (Anton)

Another perceived advantage of SMART Recovery was that the smaller, more intimate groups (compared to larger groups like AA/N) with its regular attenders fostered a sense of belonging, with some participants noting that seeing ‘familiar faces’ each week made it easier for them to build relationships with other participants and facilitators each week. In addition, knowing that certain people were attending the same group made participants accountable for the goals they had set for themselves:

“So it’s the positive connections you get out of the group, they make yah strive for more." (Esme)

Peer-to-peer learning opportunities among participants

Several participants alluded to the collective expertise in the group and opportunities to learned from one-another, including by being with people they may not otherwise have encountered, be that exchanging strategies for managing craving or stress, inspirational quotes, books, podcasts, or non-alcohol beverage alternatives:

> *"What I like about SMART is there's that diversity, so there's different life experiences that people talk about that you can learn from." (Ben)*

> *"Every week I get something out of it, what other people suggest, even if its just a phrase or an idea, I take that away." (Esme)*

As well as its interactive nature, participants acknowledged the spirit of mutual aid and importance of reciprocity, providing feedback, relating to one another and providing encouragement:

> *"I like how It's, how you can interact and give feedback to people and hear other peoples experiences and relate to them….. like I compare it to NA where people just share but you can't really give them feedback or chat to them about what they've said it's not really interactive so I prefer having the interactive setting." (Gregory)*

> *"It is peer support and you can bounce off each other it's made it so much easier because there are so many people who can relate to my situation and it's just been heart-warming and just such a good experience." (Tayla)*

> *"I think the mutual support of SMART is good because it's not about facilitators dishing out advice, it's mutual support" (Elizabeth)*

Participants also recognised how the altruism afforded through mutual aid can reinforce their own recovery and wellbeing:

"I have benefited hugely. It's beneficial enough for me for my own recovery but I've also found it beneficial to be able to help other people." (Elizabeth)

SMART Recovery as an adjunct to formal treatment

Several participants noted how SMART Recovery represents an informal source of support that intersects with and complements formal treatment:

"Those medical services and individual counsellors you're coming across, the stuff you're learning in SMART is not too different to that, there might be more acceptance and commitment therapy in some of those services than there is in SMART, but it slots in very nicely with those and the medical model." (Joshua)

"It's the best thing I've seen apart from my psychologist, it's the best thing, it's really good, I'm really impressed." (Anton)

Participants also indicated that they used the SMART Recovery group to discuss every-day problems (i.e., trouble sleeping, anxiety, stress etc.,), and overcame these by brainstorming solutions with other group members and with facilitators). Motivation for attending often transcended alcohol or drugs (i.e., urges/cravings, relapse/lapse), and revolved around everyday issues that may not always have warranted treatment-seeking, or requests for assistance elsewhere. In this way, groups met the disparate and evolving needs of clients.

With online groups running every day of the week, it was clear from the interviews that many were attending more than one group a week, with some attending meetings daily. What this suggests is that if people can be introduced or get a 'taster' to SMART Recovery via their treatment service, they may be more likely to attend other SMART Recovery meetings run in the community (e.g., on evenings or weekends) offering another source of out-of-hours support, when most needed:

"I've been attending SMART in general for months and I try to get to one every day. If I have free time I just hop online and see if there is one soon and there seems to always be one soon. I just do whichever one works for me." (Kayla)

Connecting with others

Connection emerged as a theme in terms of the benefits of attending SMART Recovery across three levels; connection with the AOD service, connection with the facilitator, and at its pinnacle, connection with other participants. Whilst connection with the affiliated AOD service and the facilitators was seen as important, it was the connection with other members that participants appeared to be valued most highly. It was apparent that many participants attended the group to establish connections with others, for some in which they were unable to do with their personal networks. At a base level, SMART groups circumvented feelings of isolation:

"I would recommend it to anyone who even just feels lonely. Addiction can be a very isolating thing." (Linsey)

"Everyone has been really open and willing to share about everything, no one was hiding behind anything, you could feel it was genuine and there was trust. …its easier to talk to people who aren't your close friends." (Ben)

"I've been sober for quite a while, but I've been doing it by myself since AA didn't work for me and I wanted a community of people in the same boat to be able to get advice and share my story and give others advice." (Kayla)

Other participants were motivated to attend groups with the explicit purpose of establishing a social connection:

"I really appreciate the ability to just connect with people." (Linsey)

“You have to restart your life all over again because obviously you have to wipe everyone that’s a user, or it's handy to. So it’s the positive connections you get out of the group." (Esme)

"Generally speaking I find people very accepting and I find people have things to contribute to one another- even if not, enough people go away feeling accepted and nurtured and cared about by other group members, and I think that at different times people may take away different things they may try for themselves.” (Joshua)

Others were bolstered or encouraged by the social connections they had already formed within the group:

“It's nice when I go back to the meetings and they recognise me and welcome me back and talk to me and it's only been a positive experience really.” (Gregory)

Notwithstanding the level of connection they had experienced, participants noted that they were able to connect with group members regardless of whether they knew them, or had interacted with them in previous meetings. Just the knowledge that they were attending a SMART Recovery group suggested to participants they it would offer an open and non-judgemental experience where they could explore their current circumstances:

“I still felt trust even though I didn’t know anyone.” (Ben)

“One of the good things about SMART is it’s a safe space that every week I can go and talk about issues I may be having.” (Elizabeth)

Connection was built on the premise that others in the group had experienced similar thoughts, feelings and ideas to themselves, and were dealing with similar issues in their own lives:

“Like that we’ve all got something in common that we’re trying to resolve”. (Ben)

"What I find good is that the addictions run across the board, certainly in the meetings I've been to the majority have been alcohol, but there have been cocaine, and meth and all sorts of things and I find that really good because actually the challenges that we all have... are really pretty similar, I mean addiction is addiction." (Anton)

Connection was also the process of sharing their own experiences. Participants felt that by sharing their own experiences they were able to inspire others at the earlier stages of their recovery:

"I like sharing with the other people, and it's nice seeing people in the first stages of their recovery and helping them, because I'm 15 months clean now, so it's awesome to give back because I would have loved to have received that when I was in that position." (Kayla)

"It's nice to get that, when they give their spiel on what worked last week and what didn't, it's nice when they say what you said really helped, because then it makes you feel like what you said helped and it makes you feel like they've listened." (Linsey)

Participants noted the value of sharing experiences of issues beyond AOD problems:

"I went to a youth one, that goes until you're 25, and there was a girl there, I have autism and she had also been recently diagnosed with autism, it wasn't about alcohol or drugs or anything, it was just sharing experiences." (Kayla)

Practical application and 7-day focus

SMART Recovery groups were more than just a safe space to give and receive support, SMART Recovery groups provided participants with the opportunity to play an active role in their own recovery. Participants often compared this to experiences they had in other mutual aid groups:

"Patting people on the back for what they'd done and people telling their stories [in AA], and it was a bit of sort of, people saying woe is me, but I've done this wonderful thing, but you know, that's not actually helping me with what the problems are." (Anton)

"SMART is a bit more action. The [12-step] fellowship can just be people chatting away and saying what people want to hear." (Linsey)

"I think it's very practical, SMART is practical, solutions focused." (Elizabeth)

"I also really enjoy the work part of it, looking at what's worked well for you and what's worked well for others and sharing ideas about the next 7 days. I enjoy people helping and sharing what works for them, whether it works for me is a different story, but at least I have another idea that I can try." (Julia)

For participants, being active in their own recovery meant multiple things. Engaging in SMART Recovery groups assisted participants to develop the capacity to reflect, problem solve, and manage their own emotions. In sum, participants developed the capacity to manage and drive their own recovery:

"It's not often that I'm taught how to maintain my sobriety, but what has occurred is I've been challenged about trying to modify my drinking and that's probably been helpful." (Joshua)

The focus on the immediate future (the week ahead) was favoured by several participants:

"The focus is on encouraging everyone to have a plan for the next week and we kind of report back on it and usually the reporting back is very honest and failure in total success which is very healthy." (Anton)

"I think the goal setting is an excellent element, I think what's very good is that at the

subsequent meeting the question that I've always heard asked is "how did you go with your plan?"(Anton)

"I always make a plan, I may not complete the plan like I'd hoped too - but you know in the beginning, the goal setting thing, sometimes bothered me a little bit. But also in the beginning I would also set unrealistic 7-day plans, I had good intentions, so for me it was also learning about, you know, is it achievable." (Julia)

Participants indicated that goal setting was helpful, that its iterative nature and focus on small, achievable goals help build confidence and motivation, and that feedback from peers and facilitators could help adjust goals that were not met to make them more achievable:

"I also think just having that short-term goal and planning for the week ahead and then coming back and talking about how you went and what you can do differently. Like it's really easy to make small adjustments and move forward." (Gregory)

Further to this, participants can create their own goals and choose their own pathway through recovery:

"Whatever the goal is for each person in SMART, they talk to you about that – it's not just a group thinking of like, staying sober is the aim, they tailor it to you. (Gregory)

"I like the fact that if I'm abstaining, I get support, but if I change my mind and I want to try and manage my drinking, I get support - I'm not left alone." (Joshua)

"Some things worked some things didn't and so I just came back and shared about that and adjusted things and then re-did them... I really like how it's an ongoing thing to work on and you just make small adjustments." (Gregory)

How, when and where SMART Recovery ran was of utmost importance to participants; who noted that just the provision of SMART Recovery groups provided them with practical ways to

support their self-efficacy and agency. Having options for engagement facilitated feelings of independence:

> *"I wouldn't be able to go to the group and get the support I need if they weren't online so it would be a shame if they didn't carry on." (Joshua)*

> *"I wanted to do something on the weekend, and I didn't really want to do it in the morning and yours is at 2pm which is a great time." (Anton)*

For participants SMART Recovery supported their own journey of recovery by providing social connections which assisted behaviour change, and by supporting self-efficacy.

Perception of SMART Recovery run by of AOD service's

Participants shed light on perceived benefits of integrating SMART within treatment services and indeed, within existing treatment programs at those services (i.e., rehabilitation, withdrawal programs). Having the SMART Recovery group embedded within the AOD treatment system provided a level quality assurance:

> *"With non-SMART groups there aren't the same checks and balances on things compared to if you were employed at a professional service." (Joshua)*

> *"I've been a client of turning point for years and also given consumer feedback so…I know the kind of high-quality organisation it is, which adds a great deal of weight to their meeting. It's like a guarantee almost, of quality." (Elizabeth)*

> *"I was aware the group was connected to Turning Point but didn't know much about it. It probably swayed me and I looked for ones connected to treatment services and services with a good reputation like Odyssey House." (Ben)*

This also provided the opportunity to maintain the relationships they had developed during the earlier stages of their recovery. Knowing that their trusted clinicians were running groups

motivated some participants (particularly those new to SMART Recovery, or who experienced high anxiety) to attend and contribute to group discussion:

> *"I think because you're a part of the service you kind of have a different relationship with the facilitators...but ___ isn't just a facilitator she's also a worker for me and I've known _____ since 2016, so I have a relationship with them...With SMART the relationships are there. There are benefits to that – they know when I don't want to talk and when to push." (Julia)*

> *"There are many meetings run around Australia that are independent meetings. But the value of this meeting that I'm attending is that they have that quality backing behind it of a high quality AOD service which is one of the things that really appealed to me about doing it. Because I've known about SMART for years but I've never done it." (Elizabeth)*

Several participants also acknowledged that they would not have attended SMART Recovery were it not for the pilot, even if they had prior knowledge of its existence in the community:

> *"I probably wouldn't have been aware of it if it was a free-standing group. I think for that reason and others it's good that it was connected to Ballarat Community Health. Yeah you don't know what's out there until someone says "oh you should go to this group" you know?" (Esme)*

Participants also recognised that SMART Recovery was an informal support that they could dip in and out of:

> *"Most days I go to SMART, I've slowed down a bit now just because I'm living life more now but I definitely go once a day and there were a few days I've gone a few times a day especially if I feel like having a drink." (Joshua)*

Perceptions of facilitators

As well as the reciprocal support among group members, participants understood that the facilitators were an important part in their recovery. Facilitators were integral to keeping the group focussed and encouraging participants to explore the connection between their thinking patterns and behaviours:

> *"I guess some of us can go on and on and get off track and it becomes irrelevant to anything and I think the facilitators need to be there to say "oh well we may come back to that" I think it is very beneficial for them to do that." (Esme)*

> *"There is a distinct advantage to going to groups led by professionals, they pick up what you're saying better, they rephrase it better and lead you places better and are more capable of drawing from the group things group members are able to use, and rightly so because they're professionals!" (Joshua)*

Participants did not appear to know whether their facilitators were clinicians or peers, and many were surprised to learn of the distinction during qualitative interviews. That being said, some participants noted that *other* group members might have a preference:

> *"I have no idea whether ____ or ____ are clinicians or not, but they're very good, but it may be a good idea to flag that and people can choose based on that, but I don't mind either way it's just an idea." (Anton)*

> *"I would...hate to see peer facilitators disappear." (Joshua)*

Participants did however differentiate between being directed as opposed to being supported. Like the other members of the group, facilitators were seen as sources of support:

> *"I think the mutual support of SMART is good because it's not about facilitators dishing out advice, it's mutual support. The opportunity is mutual support and not anything dictated from the top." (Elizabeth)*

Future considerations for SMART Recovery groups

In recognising the key role that facilitators played, several participants highlighted the importance of restricting the number of participants so that every group member was afforded a chance to speak at each meeting. Whilst the optimal number in the 90-minute session is approximately 8 participants, the online open format meant that high attendance at some groups necessitated a deviation from the SMART Recovery model. This also highlight the importance of having a bank of facilitators at the service who could run additional groups or, in the online space, use break-out rooms and spilt the group into two or more smaller groups.

Participants also spoke of the way in which the groups were run, specifically, the advantages and disadvantages of online and face-to-face meetings. Some of the strengths of face-to-face meetings included opportunities for more organic bonding and connections with group members that are not easily emulated online, where talking is more stilted:

> *"We got chatting a bit beforehand in face-to-face groups so there's that social interaction that's not part of the actual group whereas with the remote group we just wait silently on mute until everyone is in the room and there isn't that social element to it before or after we kick off." (Ben)*

> *"I think having the option of both online and face-to-face groups would be good, but for me who wants a social connection maybe there's a bit more of that in the face-to-face groups." (Ben)*

The advantages of online meetings included the convenience (no travel requirements) and increased accessibility of the group (physically and logistically) which enabled people to attend multiple times a week and some multiple times a day. It also enabled facilitators and participants to send private message via the chat function and to share links and resources with the group. It was also noted to offer greater anonymity and safety, particularly for those who might more anxious about attending an in-person group:

"I wouldn't be able to go to the group and get the support I need if they weren't online so it would be a shame if they didn't carry on." (Joshua)

"There is no current SMART meeting in Geelong. I wouldn't be able to do Turning Point meeting face to face because you're in Melbourne and I'm in Geelong! Its a two train trip!" (Elizabeth)

"Personally, I think people are actually much more comfortable talking online about such personal issues, that's my observation, and yes people can talk to one another, some don't put up videos which is their prerogative, but I suspect that if they didn't put up videos they wouldn't go to a face-to-face meeting." (Anton)

This is further illustrated by the participant below:

"I think zoom is just as effective. I think that I'm an extravert and I like to be around people and I like face-to-face, but I had severe anxiety when I first got clean so Zoom was perfect for me because it wasn't so daunting for me to walk into a room even though it was daunting when we eventually got back to face-to-face. But for where I am now I prefer face-to-face, but it could be very daunting for people who are early in recovery and really anxious. Zoom may be good for them."(Esme)

Participants indicated hope that the online groups would continue post-COVID, but some also showed an appetite for face-to-face meetings:

"I think if it were face-to-face I wouldn't go to meetings. I've really benefited from being able to pick up my phone, and someone is there for me. It would be a shame if once this virus stuff was sorted out if it was just gone." (Tayla)

"I intend to keep going with it at least once a week, and it might be nice when restrictions ease and they go back to face-to-face it might be a nice social thing too." (Gregory)

Conclusion

Participants in the pilot meetings embraced the holistic nature of the program with its focus on the bigger picture. The interviews indicated that participants were committed to addressing the impact of addictive behaviours on their lives, and applying the strategies learned in treatment and/or SMART Recovery to manage emotional distress, as well as engaging in pro-social activities that help maintain abstinence or reduce harm from AOD use.

7.3 Experiences of facilitators

Semi-structured interviews were conducted with all 10 pilot facilitators (see table 6 for gender and service breakdown). The interviews explored challenges they encountered while running SMART Recovery groups, elements they believed made for successful meetings, and how their clients responded to SMART were also discussed (see appendix G for the interview schedule). The key research question for facilitators was:

> *What are the key learnings from the pilot that should be considered when embedding SMART Recovery into the wider Victorian AOD treatment system?*

The six key themes that emerged from the analysis were, (1) support, (2) education, (3) program integrity, (4) facilitator responsibilities, (5) integration with current treatment offerings/modalities, and (6) implementation considerations for its wider roll-out.

Support

Facilitators agreed that support from service managers, treatment staff and group members was a key element in the successful implementation and maintenance of SMART Recovery groups. For facilitators in the pilot program, support was multifactorial.

One way service managers could support staff was by training multiple facilitators. Training a large team took the pressure off individual clinicians who were running SMART Recovery groups in addition to their formal responsibilities:

"We have four people running our group so it makes it easier for us, but if there was one of us there is no way we could maintain that." (Lucy)

Managers could also support facilitators by providing necessary resources, and giving staff implicit and explicit permission to prepare and facilitate groups, and complete any necessary tasks (administrative and promotional) amongst their other commitments:

"We're all really busy and delivering a group it's not just the delivery time, there's prep and there's you know the work to do afterwards so being able to manage that and the support of your extended team is important." (Amy)

Collegiality and mutual support among facilitators was also considered important. Having multiple facilitators within a service provided opportunities to debrief and reflect on the process of facilitation:

"It's not treating, you need to help people help one another, we [clinicians] would debrief and we would talk about that." (Adam)

"As we go along we debrief on what went well, and not so well, and we try the next week to tighten up our group running skills." (Catherine)

Other clinicians within the AOD team could support the program by facilitating referrals, exploring the mutual aid and recovery paradigm with clients, and providing them with information about the SMART Recovery program:

"It would be talked about in the day rehab program as something to attend you know maybe towards the end of it just to get used to it so that it can be something they move onto yeah and also through ___ and also just you know through the counselling team– and it was also put on the ____ website." (Amy)

"We have like meetings once a month with all our clinicians - it's not just each section and we would always bring it up and managers are always talking about it." (Karen)

Notably, facilitators sought the support of the participants themselves, and were cognisant of the role participants played in the success of the program. Participants' ongoing attendance and referral by 'word of mouth' supported the maintenance of the group:

"Group members would promote it. We had a few going on to the AA and NA meetings so they would talk about it and share about the group." (Lucy)

The role of participants in this support structure was reinforced by the fact that all facilitators were highly encouraging of group members eventually becoming peer facilitators, and many viewed peer facilitators as key to the long-term sustainability of SMART Recovery groups at their service:

"I'd love to be able to offer that opportunity to peers to say if you wanted we could train you at our expense I think that would be great. It would be great to have side by side peer and clinician facilitation – the double act." (Catherine)

Ultimately, support was bi-directional. Participants were supported by facilitators, whilst facilitators understood that without participant commitment the group could not exist. Facilitators supported one another (both within and outside groups i.e., via debriefing or referral), and were supported by the service in which they were employed. The findings suggest that support at each one of these levels is one of the keys to running successful SMART Recovery groups.

Education

Whilst support was acknowledged as important, it's overall utility in establishing and maintaining SMART Recovery groups appeared to be limited by the level of training and education about the SMART Recovery program. Education appeared to be the mechanism by

which support could be enlisted. Educating other clinicians at the service about the SMART Recovery model, and the informal referral process was considered important:

> *“We emailed____ staff with information and encouraged clinicians and detox/stabilisation units to promote it - and had information available at all sites.” (Val)*

> *“One of the points of confusion was around referral pathways and you know, how do you refer? I think the informal pathways are something that when people work within institutional settings – it takes people a while to get the heads around it you know you don't actually need a piece of paper you just need to turn up.” (Adam)*

Education for participants was noted on two fronts; with respect to clinicians but also participants. It was noted that participants often brought preconceived notions about what the group offered, based on prior direct and indirect interactions with 12-step groups:

> *"I think to a degree, people joining the group bring their own version of what they think they're going to get in the group - they use language they’ve used in other groups..." (Adam)*

> *"It was important to speak to that new person and give them a little bit of information about what to expect." (Amy)*

For pilot facilitators, education and support came hand-in-hand. They were not able to rely on the support of colleagues or other AOD service staff without providing accurate information regarding the program and dispelling misconceptions. It was through these efforts to educate others both internally and externally (i.e., by attending clinical meetings and service locations) that facilitators were able to build relationships which subsequently supported the groups. Similarly, by educating participants about the differences between the SMART Recovery program and other support groups (i.e., 12-step), they were able to engage them in the SMART Recovery model.

Maintaining program integrity

Facilitators noted that consistency in the delivery of the manualised program was an integral part of the overall success of the group. By being consistent in applying the SMART Recovery message and principles, facilitators felt prepared to support the processes of behaviour change and peer support.

Facilitators came to the pilot with an array of experiences. All felt that learning to be a facilitator under the SMART Recovery program was beneficial for their professional development:

> *"It's been really enjoyable and I've learnt a lot, but it's also had quite a few challenges for me in terms of my presentation skills and listening skills, so it's actually been great because it's taught me a lot." (Catherine)*

> *"It's also been beneficial to learn the techniques of motivational interviewing and doing a round of questioning where you're guiding them to come up with a clear path of what they're going to do with their week." (Aaron)*

> *"It's a learning process, but it's not how I work typically. This is good for me too." (Mike)*

Once they had mastered the strategies and methods of the manualised SMART Recovery program, facilitators were cognisant that it was not a matter of merely reproducing the program verbatim. Understanding the core tenets of the program and following the manualised model enabled them to maintain the integrity of the program:

> *"We always try to keep it in the spirit of MI [Motivational Interviewing], and we try to focus on why change is important for people, what their plan is for the next week, what needs revising, what's really driving them to want change." (Catherine)*

“The motivational interviewing and strength based techniques. Sometimes group members forget about the really good things that they’re doing and it's really important to reinforce them and be positive.” (Lucy)

Both peer and clinician facilitators were clear that maintaining the integrity of the program meant maintaining the integrity of their role. The SMART Recovery program was not a treatment program but a vehicle for recovery, their role as facilitators of change was integral to the SMART Recovery program, even if this was a challenge for them:

“We don’t want to tell the client what to do, we want them to come up with their own plan or to help each other do that and lead that idea themselves.” (Stuart)

“It’s not treating, you need to help people help one another." (Adam)

“It's their journey and they have to get to the crossroads. Taking a back seat was difficult.” (Mike)

Maintaining the integrity of the SMART Recovery model involved ensuring that SMART Recovery groups were inclusive groups. Participants could be from different demographic backgrounds, at different stages of their recovery journey, or seeking support for different behaviours:

"Your diagnosis doesn’t matter to us, we leave those labels at the door –and then you can say – this is what SMART stands for, real solutions using the power in the room." (Adam)

“Regardless of what they’re using people will sort of bond with people with similar issues, but there are heaps of people helping each other based on their emotional states and everyone can relate to that generalised advice and support.” (Catherine)

Maintaining the integrity of the SMART Recovery program also meant considered practical considerations. Both very small (<3) and very large (>10) group numbers made facilitators feel that they had to depart from the SMART Recovery model:

> *"The barriers are the amount of participants – too few, it's like a counselling session, too many people and it's difficult to give everyone a chance to have a chat and air why they have attended the group, their concerns and what they need help with." (Catherine)*

Engaging in training and learning the key skills of the SMART Recovery program were the first step in maintaining the integrity of the program. The second step was understanding the role of SMART Recovery as a vehicle for recovery.

Facilitator responsibilities

Facilitators considered SMART Recovery as a recovery tool that was distinct from the usual care they provide in the context of addiction treatment. By focusing on facilitation (not treatment) pilot facilitators acknowledged and recognised the role of the program in participants recovery. One way this is achieved is in the provision of a safe space for participants:

> *"To have a safe space, to have a space that people feel welcome and comfortable and can access care." (Amy)*

The issue of participant safety arose a number of times, in relation to the online groups:

> *"People are generally very accepting of each other, but there are times when some participants are visibly uncomfortable with people sharing details of their offending behaviours, particularly those involving violence. We sometimes have women leave when they are out-numbered by male participants, or have had them promote a women's only alternatives, so women-only SMART groups might be quite popular." (Catherine)*

Facilitators emphasised the importance of encouraging self-efficacy in participants when promoting long-term and sustained behaviour change:

> *"We don't want to tell the client what to do, we want them to come up with their own plan …. I think as long as we stick to that philosophy of them being the leads of their own life." (Stuart)*

> *"They're owning it. It's so much easier to actually do stuff if you decide that you're going to do it rather than when someone else is telling me to." (Karen)*

> *"If anything, I feel that it really empowers people, it helps people to see that they are capable of creating change in their lives." (Adam)*

Facilitators were aware of the role of peer support in the process of recovery and were active in supporting this process:

> *"I think in SMART, more people speak and the experience is more shared. It's not a focus on just one person, SMART is a lot more focused on the group, the group dynamics and who is helping who. I'm yet to get one person give bad advice." (Catherine)*

> *"We start talking to one person about challenges and the rest of the group buts in and helps out – that's something I really like about this group." (Stuart)*

Ultimately, facilitators understood that this was a multifaceted process:

> *"It's the mutual aid part – they love that even if they don't action it – that's what they come for. I don't even know sometimes if it's part of that 7-day plan or more feeling connected and social connection, maybe a bit of both. Connection of the group but also being able to set goals." (Lucy)*

Overall, facilitators were clear advocates of the SMART Recovery program and understood the importance of the program in their client's recovery. Both peers and clinicians were keen to see the program continue, however, were acutely aware that integration in the wider AOD treatment system and into their local services would require significant investment from multiple parties.

Integration with current treatment offerings/modalities

Facilitators felt that embedding SMART Recovery groups within treatment services would enable them to provide oversight, which would enhance the programs credibility:

> *"We wanted to embed one into our service to keep it consistent." (Lucy)*

> *"Some people feel more comfortable in SMART because it's run by trained facilitators and there is an aspect that these people know what they're doing, sort of thing. If I trust the service, I trust this group." (Aaron)*

The SMART Recovery model offered structure to time-poor facilitators. They were able to deliver an evidence-based program without expending extra time and energy developing group-plans and activities. Using the same program across services provided also provided consistency:

> *"I guess in some ways an ability to structure it better because I was sort of trying to structure things and keep them to a topic myself, whereas SMART was going to offer that in a much more fine-tuned way, and not on my own." (Amy)*

However, facilitators noted that at the level of the individual AOD service, flexibility is advantageous:

"I guess tweaking it without changing anything but just being able to cater for the participants to the best way we could but still delivering the model as it is meant to be." (Amy)

Flexibility in integration meant that SMART Recovery could be easily included into treatment pathways and in fact complemented their existing suite of services:

"When people finish the 8-week day-hob program they would transition them to ___ for more support. SMART Recovery is also used in that way; we transitioned our ___ group into SMART. It's almost like bridging support." (Amy)

"Frequent attendees are participants who are engaged in _____ rehab and SMART is part of recovery." (Val)

SMART Recovery was seen to be viable for use in the context of several different treatment philosophies (i.e., peer-based services and those run on a more medical model):

"It aligns [with our treatment philosophy] really well, it fits in really good – it's really small and achievable and it fits into the harm minimisation perspective to help people with whatever they need help with. It complemented our services as well." (Lucy)

"_____ runs on a slightly more medical model... SMART is an additional support." (Val)

Facilitators felt that embedding SMART Recovery into the current treatment system was highly advantageous. SMART Recovery served as an important step on the care and recovery continuum, allowing participants to choose their own goals (i.e., abstinence or controlled use) within the context of a treatment service:

"If people don't want to be abstinent, SMART is really important to have an opportunity to improve their lives without looking at it in a black and white kind of way." (Aaron)

By providing SMART Recovery groups, the service was able to engage people who were not formal treatment seekers, but continued to need support during their recovery:

> *"SMART can be an entrance for people who aren't sure yet." (Aaron)*

Facilitators recognised that people would naturally gravitate towards options that aligned with their needs, values and personal philosophy, which may change over time. Being able to provide options for their clients was important:

> *“We need a lot of different programs; one size does not fit all.” (Mike)*

> *"It's important to recognise that a lot of people will be doing both [referring to 12 step and SMART Recovery] types of groups and they’re trying to work out what works for them." (Aaron)*

The ease with which the SMART Recovery program was perceived to fit in with the philosophies and treatment pathways of multiple services, its potential to engage those early in their treatment journey, and provide an important option for recovery support, were considered important facets of the program among pilot facilitators.

Implementation considerations

Informing considerations for the future, broader implementation of SMART Recovery groups in Victorian AOD treatment, were reflections of facilitators on some of the localised processes and experiences of running groups. Flexibility was again considered a fundamental principle to this process, as exhibited by changes required in response to the COVID-19 pandemic.

At the commencement of the pilot, facilitators were aware that implementation would require consideration and resolution of multiple logistical factors. This included identification of suitable days and times to schedule groups, with the understanding that the specific week-day and time could influence both group numbers and participant demographics:

“People talk about how they don’t know how they’re going to get through their weekend without using or drinking. It’s [Saturday] a much better time than a Wednesday at 4, which clashed with people working.” (Catherine)

“I think we need to look at more of the type of people that we're working with … around people that have family’s so people with responsibilities - a late group when there isn’t childcare responsibilities isn’t always practical - so some funding for childcare [is needed] we have facilities for childcare but no one to provide that care." (Karen)

There were conflicting views expressed on the need to adapt the SMART Recovery model to cater to specific clients. This was noted in two respects. Firstly, as a strategy which would facilitate peer bonding and group cohesion (i.e., by creating closed groups for certain group members who had consistently attended the same group over a certain time-period or based on context - such as for those who graduated from a rehab program at the same time):

"I think we could offer more meetings too- people have talked about member-only meetings, if we have a core group you can make it a closed group and keep them going…" (Catherine)

Secondly, it was noted that the program could be adapted based on client need. For example, groups could be created specifically for those with particular characteristics (i.e., women, young-people, people with ABI or those using specific substances similar to an AA/NA concept):

“For people who have ABI and a lot of problems - brain damage and mental health issues. They have bad memories – and SMART is really useful for them, because it's one small group per week and it's not too overloading.” (Mike)

“Group was closed to forensic clients only who attended corrections.” (Val)

Others saw this as a departure from the SMART Recovery model, noting that they felt that the program cater to all so there was no need to create specific groups:

> *“Any behaviour you’re struggling with, you can come down to SMART.” (Stuart)*

> *“The idea that you can say to someone, you can come here to SMART Recovery, and it doesn’t matter what the behaviour is, it doesn’t matter if it’s alcohol or drugs, SMART Recovery will work on anything and we know it works.” (Adam)*

Discussion regarding its potential future implementation also generated commentary regarding who should be selected to facilitate groups. Both peer and clinician facilitator saw benefit in a group co-led by one clinician and one peer-facilitator:

> *"A peer led thing is really good, and that’s why I’m involved, to have that peer aspect, but there’s two sides to it because we have clients in intoxicated states and really tough states and sometimes they have ABI and sometimes it’s really good to have a clinician there." (Stuart)*

The demarcation between peer and clinician was seen as an arbitrary and unhelpful dichotomy, with group members responding equally well to peers and clinicians alike. It may be that unless facilitators explicitly create a distinction, group members do not recognise one:

> *“Even with the clinicians I’ve co-facilitated with, they’ve even had a lived experience or someone close to them has- it’s not like I’m the peer facilitator and you’re the clinicians and that’s how we interact within the group, it hasn’t really been like that. Yeah, so far I haven’t really seen a huge gap there to be honest. Group members still respond to the clinicians in a positive way." (Aaron)*

The occurrence of the COVID-19 pandemic and the subsequent government restrictions had a direct impact on pilot sites. Despite facing unprecedented uncertainty and challenges in transitioning to telehealth models for day-to-day service delivery, facilitators were receptive

to continued and persistent encouragement and assistance from the research team to transition to the online SMART Recovery platform, so that they could continue to support their clients during the pandemic:

> *"[We were] still delivering the model as it is meant to be." (Amy)*

Similarly, online groups provided facilitators with the ability to host groups across multiple days and times without the requirement of a physical space or travel, therefore increasing the overall accessibility of the group:

> *"The [online] group runs every Saturday from 2-3:30 on Wednesday afternoons, when it was face-to-face, it was 4-5:30 on Wednesdays. We get way more people now. This [Wednesday] one really only got 1 person each time, the three sessions I ran had one person, a different person. Now on Saturdays we get around 13 people." (Catherine)*

The online meetings provided additional support for those living in regional/rural Victoria:

> *"I think online meetings should be run on top of face-to-face, as we have had multiple people form interstate and regional areas." (Val)*

Whilst the online platform provided flexibility and was immediately available at no-cost to the participating pilot sites, it was noted that the immediate support available was also a key component of this, with the Zoom platform managed and organised by SMART Recovery Australia who offered free training sessions for facilitators in running SMART Recovery groups online. All pilot facilitators took part in this additional training.

There was surprisingly little negative commentary or experiences shared in relation to embedding SMART Recovery groups. One issue that arose among facilitators related to the challenges that came with accommodating forensic clients. The uptake of SMART Recovery among forensic clients was poorer and they observed that those mandated to attend were less inclined to actively participate. There were also concerns about the safety and comfort of

other participants when details about offending behaviour was shared, recognising that at times this needed to be delicately managed by facilitators to maintain a healthy group dynamic.

In summary, facilitators highlighted the importance of maintaining program integrity, which was achieved by learning, understanding and ensuring consistent delivery of SMART Recovery program material, building self-efficacy in participants, and enhancing peer support. Integration into AOD services will likely require substantial support from managers and clinical staff and efforts educating and promoting it to clinical staff, external services and participants alike.

7.4 Experiences of service managers

Managers from three pilot locations were interviewed to explore their experiences of the pilot (see Appendix H for the interview schedule). The key question for managers was:

> *What are the key learnings from the pilot that should be considered when embedding SMART Recovery into the wider Victorian AOD treatment system?*

The manager from one of the sites was not interviewed as this facilitator fell under the reporting structure of another site when the project was implemented. The interviews explored some of the challenges and key considerations for running SMART Recovery groups from a managerial/governance perspective. The key themes that emerged from the analysis were, (1) managing risk, (2) managing resources, (2) balancing the needs of multiple stakeholders.

Managing risk

As managers, they were removed from the day-to-day running of the group, and as such viewed SMART Recovery as only one aspect of the service they managed. For example, one manager noted that the mutual aid focus was appreciated by clients, but felt that maintaining

therapeutic oversight, to mitigate any high-risk behaviour on behalf of the participants was also important:

> *"It's an opportunity for people to undertake and provide more, you know, peer support but within a therapeutic and safe space… although, it's you know, client-directed, the facilitators are still there to be able to identify anybody who might be struggling and checking in with them later." (Elaine)*

Balancing client's needs and expectations with duty of care in the therapeutic space requires a balancing act. Managers must consider the program from the perspective of Government agencies, service executives, facilitators and participants.

Several issues raised by managers fell under the designation of risk management. As managers, they had to consider which aspects of the SMART Recovery program could increase risk of harm to the agency, to staff and to clients. One consideration was to embed SMART Recovery as a tool of continued care to provide ongoing contact with clients, who may have or be nearing completion of formal treatment:

> *"For clients who were maybe, you know, coming to an end with their counselling treatment, so people who maybe were having their counselling sessions pushed out to fortnightly or monthly, we're able to come into the group as well." (Elaine)*

Moreover, they saw clinician facilitators, who were also qualified to support potentially complex presentations, as important to maintaining the safety of participants in the group, this may be increasingly difficult to manage without clinically trained facilitators:

> *"I think one of the challenges is that because SMART operates in the mental health space, we've had a few people where mental health was their prime concern, and once again skilled clinicians can definitely manage that." (Theo)*

SMART Recovery groups had the backing of SMART Recovery Australia, and adopt the evidence-based practices of CBT and MI. Managers identified this as an important aspect of the program which provided weight to the program and its effectiveness:

> *"So I guess for us, having this structure and ability to have the backing from SMART Recovery is, you know, really beneficial and it's been really well-received." (Elaine)*

Jurisdictional issues were also raised by managers, cross jurisdictional concerns - both location wise and service wise - were seen as a potential risk to the service and the staff. One manager explained how one service, which failed to establish their own SMART Recovery group, simply referred their clients to other services' support groups. This was noted specifically in respect to online meetings where the participants could dial in from any online location. In the first instance, this was seen as a potential risk to the reputation of the staff member and the service:

> *"He [facilitator]told me he had someone from _____ corrections in a group – but that brings a lot of complications…..you might have someone who is sitting there without their video on so you don't really know if they are, or are not, participating….or they've just tuned in and will come back in an hour and ask for a certificate of attendance." (Theo)*

Similarly, it was noted that multiple participants were being referred to SMART Recovery groups from the court, or from corrections services. This increased the risk to staff, who may not have had experience with forensic clients, and risk to other clients of the service:

> *"And then we had a court trying to get SMART set up, I gather they didn't get it up before COVID started, so then they wanted to send all their clients towards ours… if all the forensic people start appearing because they're ordered to go there it can change the dynamic of the group." (Theo)*

Managing resources

Resources were paramount in the minds of the managers interviewed, of particular concern was where they could source funds and, once sourced, how they could use these to their full capacity. Managers were aware that they required a sizable team of trained facilitators to sustainably run SMART Recovery at their service. This included allowing for staff turnover, reallocation of experienced staff and the impact on caseloads:

> *"Perhaps having more clinicians trained ... that would be helpful." (Antonio)*

> *"I'm taking my more skilled clinicians off complex cases to run this." (Theo)*

Managers were aware that to provide SMART Recovery in a meaningful way, their staff may be required to work after-hours and delivery SMART Recovery in various modalities:

> *"Something to consider will be the option to run after-hour sessions to have a wider appeal which will then enhance the uptake and attendance rates." (Antonio)*

Similarly, they noted that by implementing SMART Recovery programs, there was the potential to train peer facilitators:

> *"We might find our own peer facilitators which might seed another group and allow us to keep building it and explore whether it would work in other locations." (Theo)*

Managers were highly conscious of how the implementation of a new program would impact upon their reporting obligations as part of the wider AOD system, this included reporting to their specific service executive and in respect to reporting to DHHS:

> *"We may have to think how such activities could contribute to our overall KPIs." (Antonio)*

"[I had] concern about taking my clinicians off their regular duties and whether they would be able to meet their targets or not." (Theo)

Managers placed considerable emphasis on securing funding of any future SMART Recovery program. It was noted that whilst the program had been considered in the past, in most instances, lack of funding had hindered its implementation:

"We have never thought it could be possible due to lack of adequate resources." (Antonio)

"It wasn't at the top of priorities and it also wasn't clear how you would get funded to do it and it's very difficult to do anything you're not funded for." (Theo)

Managers showed that there was considerable confusion surrounding how groups were to be funded and if they were funded, how this could sufficiently support the maintenance of the program:

"We're not technically funded to do a group, although you know, it does fit into the guidelines, so we can I suppose 'stat' [relating to statistics, reporting] the work that we are doing, but you know we are just doing the work in a different way I guess, so if there were stand-alone funding, funded treatment type that would be great, it would be much more straightforward that way." (Elaine)

"I don't know whether the DTAUs we earnt doing it, compensated for the DTAUs we lost, by not doing our normal work." (Theo)

Balancing the needs of multiple stakeholders

Managers noted on several occasions that part of their decision-making involved them taking into consideration the 'wants and needs' of their staff, as well as the 'wants, needs, and expectations' of their clients, and reconciling this with legal and reporting obligations:

Managers perceived SMART as an important opportunity to provide their staff with varied work, and regarded it as a valuable learning and development opportunity:

> *"For general growth of AOD workers, it's the ability to be exposed to group work in a formulaic and structured way, so it's also an opportunity for those who want to grow their skills." (Theo)*

> *"I like to provide everyone with that opportunity to vary their workload...anything that is available that we could use to upskill people." (Elaine)*

From the perspective of the managers this was important in balancing staff development with workload:

> *"I guess to provide a group that had some structure behind it and, you know, that was evidence-based and all of those wonderful things, because the group that we were doing, you know, we were developing new content for that, you know, as we went ..." (Elaine)*

Managers could also see the value of SMART Recovery for clients in offering accessible care, regardless of a person's stage of recovery, including while scaling down formal treatment:

> *"It can be adapted to all stages of clients' journey." (Antonio)*

> *"I also see SMART as a maintenance vehicle for people who are doing well and as a result they may have got employment and can't do the daytime stuff, but still want a maintenance dose, so to speak." (Theo)*

Managers understood that SMART Recovery provided opportunity for their clients to develop a level of control over their recovery:

"The clients seem to learn sometimes a lot more from each other than what they do from us...we really put the client in the forefront and it's about you know how they want to proceed with the treatment or the recovery, and I think that SMART operates in the same way it gives clients a voice and some autonomy over their own recovery." (Elaine)

Finally, managers also noted that SMART Recovery participation could also provide clients with the opportunity to become peer workers:

"I was also seeing SMART Recovery of having the possibility of producing another generation of consumer representative or possibly a peer worker etc., it's another potential benefit if it all took off." (Theo)

Conclusion

In summary, the perspectives of the participants, facilitators and managers elicited in the semi-structured interviews, provide much optimism for the role of SMART Recovery in the broader Victorian AOD treatment system. Moving from participant, to facilitator to manager, the focus shifts from the individual, to the group, and on to the broader treatment system. Thus, from the perspective of each stakeholder group, SMART Recovery carries different implications. As such, it is important to consider all three perspectives in the planning its wider implementation in the future.

8. RESEARCH OBJECTIVE SIX: Practical implementation strategies

The final objective was to consolidate all the recommendations for the successful implementation of SMART Recovery from the earlier phases of the project, as per table 8 outlining the key challenges and recommended action/solution. This provides a summary of the key considerations as well as practical guidance for services wishing to offer SMART Recovery as part of their program.

Table 8. ***Identified challenges and recommended actions to implementation***

Identified challenge	**Recommended action**
Embedding SMART Recovery within organisational structure	Integrate smart within current treatment offering (i.e., as a form of post-treatment aftercare or when reducing contact with treatment service) Integrate SMART facilitation into clinicians formal work roles (i.e., each facilitator trained must facilitate a certain number of groups within a set time frame) and reallocate other responsibilities accordingly Assign a SMART 'manager/champion' who will be responsible for certain practicalities and logistics (i.e., answer emails, liaise with referrers, handle the facilitator roster) Train a sizeable group of facilitators and implement a rotating roster of facilitation Consider whether new staff could become facilitators, and whether the highly manualised program and support from SMART Recovery Australia can facilitate their learning (consider putting SMART Recovery information in staff onboarding materials) Complete a screening/intake questionnaire with new SMART group members to ensure SMART is appropriate for them and ensure they receive adequate care Offer training to staff as a professional development opportunity (i.e., once staff reach a certain milestone/threshold)
Encouraging referrals to the group by internal staff	Host regular information sessions/webinars about SMART Recovery and what it is/can offer their clients – clinicians should present SMART Recovery as an option for clients as part of individual care and aftercare planning Allow relevant staff/clinicians to sit-in on groups (provided group members consent to this) Establish soft targets for referrals within client-facing teams
Encouraging referrals to the group by external organisations/ clinicians	Host regular information sessions/webinars around SMART Recovery, including what it is, what it can offer their clients, and how to refer clients to the group Highlight that connection to the service and use of trained facilitators ensures oversight and maintains group safety (use as 'selling point'). The more formal

	these sessions are the better. Consequently, senior management may be required to reach out to representatives from external organisations Assign a 'key contact' (ideally a facilitator) who will be responsible for liaising with external organisations (champion as above), and is their 'key contact'. This can include, dropping off flyers, answering questions, accepting warm referrals - ultimately this will depend on building relationships with external organisations and creating a more integrated system Leave tailored and accessible information at external organisations (i.e., flyers, posters) about your *specific* SMART Recovery group (time, location, parking, whether face-to-face or online, whether there is child-care available, and any other key information - i.e., women only groups) as well as SMART groups generally Place information regarding SMART (i.e., what it is, how and when to refer clients to the group) into staff on boarding/training materials
Encouraging *initial* member participation	Effectively adapt groups to cater to key client demographics to some degree (i.e., a woman only/parents group may require childcare facilities and to be scheduled around school pick-up and drop-off) Advertise groups targeted towards key demographics in appropriate places (i.e., groups for women/parents may benefit from advertising at child/maternal health/care services) Involve key stakeholders in advertising (i.e., recovery-oriented Facebook groups, community forums etc.,) Create information specifically about your SMART group to be given to potential group members - information about how many people typically attend, the formats it's offered in (face-to-face and/or online), what SMART is and what it isn't (potentially include 'testimonials') or direct comparisons to other forms of mutual aid (which should be referred to as another, valid - but different - option) Survey clients about what time and day they would like a SMART group to be scheduled, and what format they would prefer - take this into account when scheduling the group Offer online groups: Online groups are an important access point for many (i.e., for those who cannot or will not travel to attend face-to-face groups, or for whom the concept of mutual aid is anxiety provoking in a physical context) Hold intermittent 'introductory groups' whereby interested people can attend a group to learn more about SMART Recovery, potentially with a support person (these groups can be online or face-to-face)

	Encourage clinicians within the service (both during one-on-one treatment and as part of other interventions) to explore the mutual aid and recovery paradigm with clients in order to build familiarity with SMART Recovery
Encouraging *ongoing* member participation	Explain SMART Recovery to group members prior to them attending (what it is and what it is not) Assist group members with becoming familiar with the group. For example, utilise the same meeting room each time and point out reception/facilities to group members (if groups are face-to-face), hold the group on the same time/day, avoid cancelling groups without ample notice Check-in with group members one-on-one to ensure they are satisfied with the group/intermittently seek feedback from group members (ensure feedback can be provided anonymously), particularly those that cease attending
Garnering and retaining support from management	Demonstrate group outcomes/efficacy by collecting anonymous participant outcome data or collecting regular feedback from SMART group members Any outcome monitoring should focus on more holistic factors (i.e., increases in wellbeing, goal-achievement as a result of SMART attendance) Nominate one facilitator to monitor outcomes across all groups
Training clinicians and/or peers	Adequate funds must be set-aside/budgeted in order to train facilitators and maintain an adequate team (by reference to the number of groups held each week)
Scheduling groups on an ideal day/time	Assess client need before scheduling group(s) - several groups may need to be established in order to accommodate the number of participants Consistency in group day/time may encourage repeat attendance

Selecting peer or clinician facilitators	As noted, group members rarely (if at all) identified a difference in quality between groups run solely by clinicians or by one clinician and one peer facilitator - thus, services should not be concerned that utilising one or the other will affect group quality. However, choice of facilitators may be informed by the nature of the service and its philosophy (i.e., is it a peer-driven service?) It is unlikely that group members will agree to transition into a formal peer facilitation role. Consequently, peer facilitators should be sourced from other avenues (i.e., clinicians with lived experiences, peer workers) and offered formal and paid roles within the service If certain group members do wish to become peer facilitators and are eligible to do so (i.e., have attended for several months and are 'stable') ensure they understand and are prepared to assume the responsibility that group facilitation entails (outline the commitment and ensure recruitment is not pre-emptive) If no peer facilitators are available, consider engaging experienced/long term participants in informal facilitation (after discussing this with them)
Adequately supporting facilitators	Provide adequate resources to facilitators to support them in delivering groups (primarily time) Allocate a consistent room for face-to-face groups to be held Put structures in place to allow facilitators to engage in regular debriefing and provide opportunities for collaboration and reflection (between other facilitators at their service as well as between services)
Adequately catering to participant needs and complexities	Interviews revealed a large degree of referral of participants from services without SMART Recovery to groups at other services. It is important that more SMART Recovery groups are established within specific services, particularly when certain clients (i.e., forensic clients, young clients, clients with a history of sexual assault, clients with ABI) may particularly benefit from groups within the context (i.e., safety and relative expertise) of the original/referring service, and/or may create administrative and/or relational difficulties and complexities for services that accommodate those clients
Encouraging healthy relationships between facilitators and group members	Facilitators should avoid positioning themselves as 'experts' (and thus establishing an unwanted hierarchy). Facilitators should call on group members to contribute before offering their own opinions/advice, but should eventually do so

	Facilitators should introduce themselves at each meeting (introduction can include/reference lived experience if facilitators feel comfortable doing/if this is relevant) and restate group-rules (potentially calling on established group members to do so) Ensure clinician facilitators do not refer their own clients to SMART Recovery without first informing them that they may be facilitating, establishing appropriate boundaries and if this isn't possible potentially referring clients to an alternative/associated SMART Recovery nearby (after notifying that service, thus assisting services/facilitators to manage capacity)
Encouraging healthy relationships between facilitators	Facilitators should prevent a hierarchy from forming between peer and clinician facilitators Facilitators should be given opportunity to 'debrief' and reflect on their role with SMART Recovery Australia and other facilitators.
Encouraging healthy relationships between group members	Allow for adequate time both before and after groups for group members to interact informally (potentially supplying tea and biscuits) Go through group rules (i.e., regarding cordiality and respect) before each group meeting, potentially asking a group member to go through these rules to encourage group buy-in Facilitators should ensure group members do not go off on lengthy 'tangents' and should effectively manage disruptive/aggressive clients (i.e., place the client into a break-out room if the group is held online). Likewise, facilitators should offer necessary support to vulnerable clients
Managing group size	If groups become overly large (i.e., more than 15 people attending for several groups) it may be time to establish another group to ensure that the SMART model can be maintained Both small and large groups may require facilitators to depart from the SMART model. In large groups (which may be difficult to predict beforehand in an open-group context) be sure to flag with participants that not everyone will get a chance to speak, assure those that did not get a chance to speak that they will be prioritised the following week Potentially utilise closed groups, potentially for bonded groups (i.e., for those exiting rehabilitation/detox), and who may require more care and stability in the provision of peer support
Utilise SMART resources	Utilise the SMART facilitator manual and draw on activities when engaging with participants (i.e., provide hand-outs to participants) Encourage facilitators' to attend webinars and other in-service training run by SMART Recovery Australia.

9. DISCUSSION AND RECOMMENDATIONS

This study aimed to examine how SMART Recovery can be embedded in Government-funded AOD treatment, using a mixed-methods approach to address six key research objectives and conducting a pilot demonstration project in four addiction treatment services. All of the objectives were successfully met despite adopting alternative approaches, meeting-delivery and assessment methods in response to the changing landscape as a result of the COVID-19 pandemic.

The **first objective** was to examine how SMART Recovery could fit into existing funding frameworks by identifying suitable DTAU's that services could use to comply with treatment delivery targets. According to SMART Recovery Australia, the average duration of attendance at independent SMART Recovery groups in the community is approximately 3-months, with some participants attending for more than a year. However, for most participants attendance is sporadic, with people typically attending for a few weeks and then missing groups and engaging again when needed in the future. As such, the most appropriate DTAU was the 'Brief Intervention- Group DTAU' in the counselling stream which allows for one-off attendance. However, it may be more appropriate to identify an entirely new funding source to support the wider implemented of SMART Recovery. It is worthnoting that whilst typical duration in SMART Recovery is highly variable, people often as and when they need to (weeks to months) and research with an offending/correctional population suggests a therapeutic effect was found after 10-11 sessions.

- **Recommendation 1a: Services could use the Brief Intervention- Group DTAU unless a new funding source can be identified**

- **Recommendation 1b: DHHS consult with AOD providers in regards to the impact SMART Recovery program may have to existing targets and performance challenges (i.e., over and underperformance)**

The **second objective** was to solicit interest from AOD providers to be part of the pilot demonstration project and to select three services. Twenty services submitted an expression of interest indicating a strong appetite for offering SMART Recovery as part of treatment. The selected pilot sites included two AOD services in metropolitan Melbourne (one of which served forensic clients) and one regional site which ran an AOD program within a community health service. A fourth group later emerged when one of the facilitators relocated to another department of one of the AOD services. Managers nominated 10 facilitators, 8 clinicians (some of whom had lived experience) and 2 peers to be trained to deliver groups as part of the pilot.

- **Recommendation 2: Given the extent of interest in running SMART Recovery and the demonstrated implementation success of the pilot, the wider roll-out of SMART Recovery should not be delayed**

The **third objective** was to consult with facilitators already running SMART Recovery groups in the community about their experiences running groups, to understand barriers and facilitators that could inform the way in which the pilot site operated to maximise chances of success. Semi-structured interviews were held with 6 facilitators (3 clinician and 3 peers); four of which were attached to community services that also provided AOD treatment programs; and two of which ran independent SMART Recovery groups. Two key themes that emerged pertained to referral and logistical issues. Facilitators acknowledged the importance of referrals in sustaining healthy group numbers, noting that lack of knowledge about the SMART Recovery model among clinicians prevented referrals. Participation and sustained attendance was reported to be heavily influenced by logistical/practical issues such as location (proximity to public transport) and time of day, with many noting the need to consider employment and child care responsibilities. Two further themes that emerged involved the role of the facilitator; with discussion around the importance of them being there merely to guide and not as experts, and the theme of group cohesion or bonding which was considered integral to ongoing attendance. This aligns with existing literature suggesting that group cohesion is a mechanism of action for both continued attendance and other outcomes in AA (Rice & Tongian, 2011), secular peer support groups (Sotskova et al, 2016), and in SMART Recovery specifically (Kelly et al, 2017; Kelly et al, 2015). Finally, when asked what would support the

implementation of SMART Recovery groups, it was clear that getting the necessary 'buy-in' from managers and clinicians within the AOD service was key as well as identifying suitable resources. Indeed, referral to peer support is a recommendation in the next edition of the Australian Guidelines for the Treatment of Alcohol Problems (Haber et al, in press). Similarly, in the UK, the NICE guidelines are "give information on the value and availability of community support networks and self-help groups (for example, Alcoholics Anonymous or SMART Recovery)" (NICE, 2011). Facilitators also noted the need to elicit support and partnerships with other AOD services and the broader health, social and welfare/legal system in terms of making steady but appropriate referrals. Also considered critical to the successful implementation was the promotion and advertising of meetings, having a sufficient number of trained facilitators and provisions for their ongoing supervision, and utilising support and resources available through SMART Recovery Australia. Finally, facilitators made a number of recommendations on how to run effective groups and respond to some of the common challenging situations that are encountered (see Table 5).

- **Recommendation 3a: Services should ensure all their staff and partner-organisations are familiar with the SMART Recovery model and promote their meetings and refer suitable clients**

- **Recommendation 3b: Services must consider the specific needs of their clients when scheduling meetings**

- **Recommendation 3c: Service managers need to allocate sufficient resources (e.g., SMART Recovery trained facilitators and a physical space to run groups)**

The **fourth objective** was for facilitators to undergo training, and for them to implement at least one weekly SMART Recovery group at their service, and to monitor the uptake of SMART Recovery, attendance rates and benefits of attending groups (group participant perspective) using quantitative survey methods. All facilitators participated in a 2-day in-person training run by a SMART Recovery Australia trainer. Between December 2019 and February 2020 all sites had implemented SMART Recovery groups.

The uptake of meetings was very good, with 138 participant attendances among the 27 groups held face-to-face. In March, when COVID-19 responses meant groups could no longer operate in- person at the AOD services, meetings inevitably ceased for a brief period, then transitioned to an online platform. Whilst this provided for the continuation of the pilot, this meant that groups were opened-up to others who were not receiving treatment at pilot services. Again, the uptake of groups was good, with a total of 384 participant attendances in the 48 groups run on-line. In terms of attendance rates, all groups had both regular members, and new members attending each week, though there was a steady increase in the proportion of regular attenders after May 2020 when the online groups were well- established. Both the number of meetings and the number of participants increased during the pilot, demonstrating a substantial demand for SMART Recovery. Participation was relatively consistent across groups run during the week, though the group run on Saturday group regularly had the highest number of participants.

In terms of the post-meeting surveys (n=74), almost all (96%) of respondents reported a reduction in use, or maintenance of abstinence, of their primary drug of concern, two-thirds reported improved physical health and three-quarters reported improved mental health, ability to take care of their personal responsibilities and even more felt they were better connected with others since their last SMART Recovery meeting. Two-thirds intended to continue attending SMART Recovery meetings. Responses to items indicated that the vast majority felt they had benefited in terms of managing problem behaviours, felt better able to cope with life challenges since attending SMART Recovery and felt supported by other members in the group. The data from 4 participants who attended 7 consecutive groups providing a snapshot of benefits over time showed improvements were far-reaching and maintained over time. These findings confirm previous research trials and quasi-experimental study studies demonstrating the benefits of attending SMART Recovery (Blatch et al, 2016, Penn & Brooks 2000; Zemore et. al 2018; Atkins & Hawdon, 2007).

It is important to acknowledge that with the absence of a control group (i.e., people not attending SMART Recovery), the aforementioned improvements cannot be directly attributed to SMART Recovery attendance itself and cannot be disentangled from treatment effects and

other factors impacting on substance use, health and wellbeing. Nonetheless the data illustrate the multiple ways in which AOD clients benefited from attending SMART Recovery and future research should investigate the effectiveness of SMART Recovery against a control group or again other forms of mutual aid in a well-powered, randomised control trial.

Whilst the responses of clients of the pilot sites could not be identified from the SMART Recovery Australia post-meeting responses of the online group participants, it was evident that they too benefited, with all participants agreeing that the meeting was helpful, that they left with a 7-day plan, and that they would continue to attend SMART Recovery meetings. However, 30 attenders also completed the more detailed survey indicating that were also indicative of positive experiences from groups, with over 90% of respondents feeling that they were felt welcome, supported and able to contribute to the group, that they intended to continue attending, with 83% finding that the group had been helpful.

Whilst the benefits of attending were assessed quantitatively using three different methods, they all lead to the same conclusion that clients derive substantial benefit from attending SMART Recovery, not only in terms of better management of their AOD use, but in terms of their health, wellbeing and sense of connection with others. These findings echo the findings of the paucity of existing research on the effectiveness of SMART Recovery. In an RCT of online versus in person SMART Recovery, Hester et al (2013) reported significant reductions in the percentage of days abstinent from alcohol and significant reductions in average drinks per day among those who continued drinking in both groups. Research has attempted to delineate mechanisms of action in peer support groups, most of which are addressed in the SMART Recovery model through its application of CBT, MI and mutual aid principles. These can be grouped as cognitive mechanisms (building self-efficacy and motivation and cognitive restructuring), behavioural mechanisms (activity scheduling) and social mechanisms (group cohesion, increased social connectedness) (Kelly et al, 2017).

- **Recommendation 4a: Based on the uptake, attendance rates of both regular and new participants and the reported benefits of attending across all pilot sites, SMART Recovery should be rolled-out across the sector**

- **Recommendation 4b: Given the clear benefits for clients in terms of improved substance use, health and wellbeing and social connections, services should continue to monitor client outcomes**

The **fifth objective** used qualitative interviews to explore the experiences of (1) participants, (2) facilitators, and (3) service managers. Among participants, the qualitative interviews provided even more compelling evidence for the benefit of SMART Recovery in addition to formal AOD treatment. Participants indicated an interest in engaging in informal support once their AOD use had stabilised (after being in treatment), and spoke of how it can bolster their recovery journey and gave them a sense of purpose. It was clear that SMART Recovery provided unique and complementary support above and beyond what they received from formal AOD treatment and one-on-one counselling. The peer-to-peer learning from people with diverse life experiences and lived experiences was perhaps the best example. Harnessing the collective expertise of those with lived experience was considered to be hugely advantageous. It was apparent that many participants attended the group to establish connections, which is documented in the literature (Kelly et al, 2017). SMART Recovery supported their own journey of recovery by providing social connections, supported behaviour change, and increased feelings of self-efficacy. Similarly, participants recognised how by helping others they were also helping themselves. The idea that 'helping helps the helper" has also been reported in the 12-step literature (Zemore et al, 2004). SMART Recovery also seemed to be a good fit with its harm-reduction focus and several participants indicated a preference for SMART Recovery over 12-step groups.

In relation to the SMART Recovery model itself, participants embraced the active participation, practical, solutions-focussed content, its focus on goal settings and plans for the next 7-days, as well as the 4-points of the model addressing the building and maintenance of motivation to change, the management of urges and craving, problem-solving and lifestyle balance. Importantly, participants perceived there were key benefits of integrating SMART Recovery within existing treatment programs (i.e., rehabilitation, withdrawal programs), both

in terms of maintaining relationships with the service and feeling that SMART Recovery would be credible and effective if connected to the service.

In terms of future considerations, participants also spoke of the way in which the groups were run (limiting groups to around 8 person), with many discussing the advantages and disadvantages of online and face-to-face meetings, their comments indicating a preference for both options. Interestingly, participants did not show a preference for either peer or clinician facilitators, recognising that they play a critical role in managing groups dynamics, keeping the groups focussed, accountable, and eliciting peer support.

- **Recommendation 5a: Given the multiple ways in which clients benefit from SMART Recovery, all services should aim to offer SMART Recovery as part of the program or refer clients to SMART Recovery meetings run in the community**

- **Recommendation 5b: Services should aim to run enough groups and have enough facilitators to maintain an optimal group size of 8-10 participants**

- **Recommendation 5c: Services should consider offering both in-person and online SMART Recovery groups as a form of stepped-down aftercare**

- **Recommendation 5d: Services should consider running groups for specific populations (e.g., women-only or forensic-only)**

The pilot facilitator interviews elicited findings that centred around 6 key themes. These had considerable overlap with those identified by existing facilitators interviewed as part of objective 2. Pilot facilitators identified support from service managers, treatment staff and group members as critical to the successful implementation and maintenance of SMART Recovery groups and highlighted the importance of education and training among other clinicians. Another key theme was program integrity, with facilitators noting that consistency in the delivery of the program was a key to its success. This was closely linked to the the theme concerning facilitator responsibilities; acknowledging and recognising the role they played in

participants' recovery by guiding discussion, as opposed to their usual role of providing treatment. Facilitators shared positive views about the integration of SMART Recovery with current treatment modalities, its fit with the philosophies and treatment pathways and recognised its potential to offer both bridging support for those embarking on a treatment episode, as well as stepped-down care for those completing treatment. Finally, with regards to considerations for the future and the broader implementation of SMART Recovery groups in Victorian AOD treatment, facilitators reflected in localised processes and experiences of running groups.

- **Recommendation 5e: Services need to create a forum (e.g., Community of Practice) to allow facilitators to engage in regular debriefing, supervision and foster opportunities for collaboration and reflection (between other facilitators at their service as well as between services)**

- **Recommendation 5f: Services need to find ways of identifying and attracting peers as facilitators and exploring reimbursement models to maximise sustainability**

- **Recommendation 5g: Managers must adopt flexibility in staff working hours and load, so that facilitators can run groups when there is greatest demand (e.g., outside of office hours) and must consider it a legitimate part of their role.**

The manager interviews centred around managing risk of harm to the service reputation, their staff and their clients. Another key theme was managing resources, specifically how they could deliver SMART Recovery within their current funding activity agreements. The third themes was balancing the needs of multiple stakeholders and reconciling this with legal and reporting obligations.

- **Recommendation 5h: Managers should allocate at least 2 facilitators and 0.1 EFT per group.**

- **Recommendation 5i: Services wanting to run online groups (e.g. to cater for regional/remote clients) should consider running these as closed-groups (i.e., attended only by clients of the service) so that facilitators are better-placed to manage group dynamics. This this will require investment of use of the services own video-conferencing (e.g., not using the SMART Recovery Australia platform).**

- **Recommendation 5j: Managers will need to undertake further risk-assessment when catering for forensic clients to maintain participant safety (e.g., consider offending behaviour, Apprehended Violence Order's and group composition)**

Whilst the quantitative findings demonstrated the overwhelmingly positive engagement and gains from SMART Recovery, the qualitative interviews from all three stakeholder provided rich data on the subjective experiencing of SMART Recovery and provide unique insights in to how the groups should be optimally run.

The **sixth objective** was to consolidate all the recommendations for the successful implementation of SMART Recovery from the earlier phases of the project in a table outlining recommended actions/solution to challenges. This resulting summary table outlines key considerations and provides practical guidance for services wishing to offer SMART Recovery as part of their program.

9. CONCLUSION

In conclusion, the pilot study demonstrated that not only was it feasible to deliver SMART Recovery within AOD treatment services, but it generated numerous and extensive benefits for clients. It is likely that SMART Recovery offers a cost-effective model for supporting multiple clients with minimal staffing requirements. Whilst there are training costs for facilitators and subscription fees, these would be quickly offset by savings in clinician time, where 8 clients could receive recovery support delivered by single clinician and single peer over a 90-minute period. In light of the reported improvements in health and wellbeing, social connection and reduced substance use, and the wider availability of SMART Recovery groups

outside of office hours, it also has the potential to support clients who may otherwise rely on acute health services for support in times of need.

It is important to highlight that whilst we have demonstrated the feasibility of embedding a peer support group in treatment by piloting an already established model, there may be alternative peer groups that could be embedded in treatment. SMART Recovery was used in the pilot, because it draws on evidence-based approaches widely used in Victoria AOD treatment (e.g., CBT, MI, ACT etc.) and has multiple resources that can be drawn-on. It is important to acknowledge that whilst the 4 pilot sites successfully demonstrated that SMART Recovery can be delivered as part of their AOD treatment program, this provides much optimism for, but in no way guarantees its successful replication in other AOD services. Much of its success can be attributed to the dedication, passion and commitment of service managers, facilitators and researchers involved. This was evidenced by the determination to continue SMART Recovery groups despite seismic shifts in the way in which AOD care was delivered during the global pandemic. It was fortuitous that the pilot project had progressed sufficiently for facilitators to pivot to online meetings. This enabled the pilot sites to provide ongoing care for their clients and helped meet the unprecedented demand for online recovery support as AOD issues were compounded by unemployment, lack of social support, and isolation during the lockdowns. As such, there is hope that the findings and recommendations from this pilot study will pave the way for extending recovery support to clients throughout the Victorian AOD treatment system.

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APPENDIX

Appendix A: Exploration of DTAU's

Treatment	Contacts	DTAU	DTAU +15% forensic loading	DTAU +30% ATSI loading
Counselling Standard	12+ hrs: 4 sessions x 3hrs	0.910	1.047	1.183
Price ($)		$747.10	$859.17	$971.23
Counselling Complex	36+ hrs: 12 sessions x 3hrs	3.414	3.926	4.438
Price ($)		$2,802.86	$3,223.29	$3,643.72
Care and recovery coordination Price ($)	42hrs x 15 sessions with additional CRC support	2.222	2.555	2.889
		$1,824.24	$2,097.88	$2,371.51
Brief intervention – group (Counselling Stream) Price ($)	One off treatment per client: 1 session	0.130	0.150	0.169
		$106.73	$122.74	$138.75

Appendix B: VAADA eNews advertisement

Turning Point are seeking expressions of interest to pilot SMART Recovery groups within existing funding models in Victorian AOD services. There is strong evidence that peer support/mutual aid in combination with specialist AOD treatment leads to improved outcomes, including reduced substance use, improved wellbeing and increased recovery capital.

Self Management and Recovery Training or 'SMART Recovery®' is a form of strengths-based peer support mutual aid aimed at reducing problem behaviours. There are now 340 SMART Recovery groups in Australia of which <10% are in VIC.

SMART Recovery draws on evidence-based approaches to addiction treatment, primarily Cognitive Behavioural Therapy (CBT) and Motivational Interviewing (MI). SMART Recovery does not focus on a abstinence-based nor substance-specific approach to recovery, nor is it predicated on spirituality or finding a 'higher power' which some clients may find alienating. Instead, SMART Recovery aims to tackle addiction through a structured skills-based recovery program co-facilitated by a clinician and trained peer, designed to enhance motivation for change and to help manage lifestyle and behavioural difficulties.

How can your service get involved?

The Department of Health and Human Services is funding Turning Point researchers to undertake a project exploring how SMART Recovery groups can be embedded within existing treatment services (and funding models) to ensure they are sustainable and to examine whether this enhances treatment retention and outcomes at 1-month and 3-months. Turning Point are seeking the participation of three existing outpatient treatment services, at least one of which should be in a regional service.

Eligible services will receive fully funded training for clinicians and peer facilitators and assistance with establishing and running SMART Recovery groups for the duration of the project.

If your service would be interested in taking part in this exciting project, please contact Katherine Mroz at Katherine.Mroz@Monash.edu

Appendix C: Expression of interest questionnaire

1. Do you currently offer peer support groups at your service? If so which one?
2. Approximately how many outpatient clients do you see per week?
3. Do you have an idea about how many clients would be interested in taking part in SMART Recovery?
4. Do you currently have any staff or "peers" trained in SMART Recovery?
5. If we could provide funded training for 2-3 clinicians and peers what barriers do you foresee occurring to running groups? Do you have adequate facilities (room available for up to 10 people) and willing clinicians and peers interested in running the groups long-term?
6. Do staff/clinicians have capacity to assess retention in AOD treatment among those attending smart groups?
7. Do you foresee any issues with assessing outcomes (substance use and QOL etc.,) among those who attend the groups? *This will be assessed using the smart track app or hard-copy questionnaires.*
8. Who will be our point of contact?
9. Are you currently funded to deliver brief intervention-groups? We are exploring whether this activity could count towards your targets with the new DTAU weighting.

Appendix D: Interview schedule for pre-existing facilitators

1. How long has your service been running SMART groups? If they stopped, how long did they run for, why did they stop running, and roughly how many attended groups? How many peers/clinicians ran the groups? Do they/have they run others e.g., AA NA?
2. What are the main challenges associated with running SMART Recovery groups, and how are these challenges overcome?
3. What are the practical/logistic considerations to running groups?
    a. Practical issues in setting up group meetings at sites
    b. Potential scheduling clashes with other interventions/peer groups meetings
    c. Adequate resources for room and photocopying
    d. Adequate additional and refresher training available for new and existing facilitators
    e. Communication with the SMART Recovery national office and other facilitators
    f. Location/accessibility of the service
4. What are the financial considerations to running groups?
    a. Do peers have money for basic necessities (e.g., phone, bus tickets)?
5. How are they promoted/advertised?
    a. Are there any other ways that clients report hearing about SMART recovery?
6. How are clients encouraged to attend SMART Recovery groups?
7. What are the barriers to attendance?
8. What are the facilitators to attendance?
9. Was management support adequate?
10. To what extent was SMART a good fit with your service?

Appendix E: Participant survey questionnaire

Participant ID# | | | | | | | | | | |

So that you remain confidential, the participant ID is made-up from the first 2 letters of your mother's maiden name + your year of birth + and your postcode

Today's Date ___/____/_____ How **many times** have you attended this group?

_____

1. Are you male or female? (select one)

☐ Male ☐ Female ☐ Other

2. What is the drug/behaviour you are or were most concerned about?

Please specify: _____

4. In the month before this SMART group, how many days did you use the substance you are/were most concerned about: _____ (0-28) Days

5. In the past week how many days did you use the substance you are/were most concerned about: _____ (0-7) Days

6. when was your last smart group? ___/____/_____

Since your last SMART group…

1. How much better or worse is your physical health? *Think about your physical health: Are you eating and sleeping properly, exercising, taking care of health problems or dental problems, feeling better etc.?*

Much worse					No change					Much better
-5	-4	-3	-2	-1	0	1	2	3	4	5

2. How much better or worse is your mental health and well-being? *Are you feeling better about yourself and about life in general?*

Much worse					No change					Much better
-5	-4	-3	-2	-1	0	1	2	3	4	5

3. How much better or worse are you in taking care of your personal responsibilities? *Think about your living conditions, family situation, employment, relationships, paying your bills, following through with your personal or professional commitments?*

Much worse					No change					Much better
-5	-4	-3	-2	-1	0	1	2	3	4	5

4. Do you feel you more connected with others? *Having a sense of belonging, purpose and connections with others?*

Much worse					No change					Much better
-5	-4	-3	-2	-1	0	1	2	3	4	5

5. How much better or worse is your drug/alcohol use? *Consider drug/alcohol craving, frequency and amount of use, money spent, time spent drug-affected, being sick, in trouble etc.,*

Much worse					No change					Much better
-5	-4	-3	-2	-1	0	1	2	3	4	5

Additional questions for online meetings:

1. I have benefited from attending SMART Recovery in terms of managing problem behaviours/issues
2. I feel better able to cope with life's challenges since attending SMART
3. I felt supported by other members in today's group
4. Overall, I found todays group helpful
5. I left today's meeting with a 7-day plan
6. I plan on continuing to attend SMART
7. (If you attended last week) My 7-day plan helped me

Appendix F: SMART Recovery Australia online survey questions

1. First Name
2. Last Name
3. What is your age?
4. What is your gender?
5. What is your postcode?
6. Are you of Aboriginal and/or Torres Strait Islander descent?
7. What behaviours of concern prompted you to attend today's meeting? (It's OK to tick multiple behaviours).
8. Please indicate how much you agree with the following statements
9. Did you leave today's meeting with a 7 day plan?
10. Was this your first SMART Recovery meeting (either online or in person)?
11. Did you leave last week's meeting with a written 7-day plan
12. How helpful was the 7 day plan from last week's meeting?
13. How do online meetings compare to in person meetings?
14. In what ways/how is SMART different from other support groups, programs or treatments you've tried? (Which bits of SMART meetings make sense/are helpful to you?)

Appendix G: Pilot group facilitators – Qualitative interview schedule

Interview number: _____ Date: _____

Interview schedule for SMART facilitators

SECTION A: Introduction

Thank you for agreeing to share your thoughts with us as part of this research.

The Department of Health and Human Services has funded us to explore your experience with SMART Recovery. This may help to improve SMART Recovery groups in the future.

We are keen to get your input and there are a few broad areas that we'd like to cover but this is a pretty informal chat. The interview will take about 45 minutes to an hour.

Before we begin, could I please confirm with you that you have had a chance to read the information we sent you via email about the study?

□ Yes

□ No – summarise PICF or arrange to call back at another time

Do you have any questions before we go on?

SECTION B: Consent

Ok, so before we start, if it's ok with you I will turn on the recorder and begin by recording your consent to participate. Then we will move onto some demographic questions and the interview.

Is that ok? (If the interview is in person, consent can be recorded in writing on the PICF).

RECORDER ON

- I have read the Participant Information Sheet or someone has read it to me in a language that I understand.
- I understand the purposes, procedures and risks of the research described in the project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project without affecting my future care.
- I give consent for the interview to be audio-recorded.

RECORDER OFF

We can start the interview now if you're ready? No Yes

RECORDER ON

SECTION C: In-depth interview

1. Where is your service located?
2. Are you a service manager or supervisor?
3. If you facilitated groups, are you a clinician or peer facilitator or both?
4. If you facilitated groups, how many did you facilitate as part of this study?
5. Has your service previously or currently offer any other form of mutual aid (i.e., AA/NA)?

Implementation experiences

1. Tell me a bit about your service and why/how your SMART group got started? [Prompts: How long was the service contemplating starting SMART groups, how did you first find out about SMART?]
2. What does your SMART group look like now? [Prompts: time, place, frequency, how many members, who are the frequent attendees etc.
3. How were clients/community members informed about the group? *[Prompts: referral, advertising]*
4. Were workers/clinicians at your service informed about SMART Recovery? If so, how were they informed?
5. If you facilitated groups, can you describe your experience of facilitating SMART Recovery at your service? *[Prompts: group dynamics, space, attendance rates, SMART content]*
6. What were some of the barriers to running groups? Did you encounter any challenges? [Prompts: Was the organisation supportive, did you have adequate resources, did you feel that the SMART training was sufficient]
7. What were some of the facilitators to running groups? What worked well?
8. How well does SMART align with the treatment philosophy of your organisation?

Sustainability and improvement

9. What does your SMART group require in order to remain sustainable and useful in the future?

10. How could your SMART group be improved, if at all?

11. How could the SMART **model** in general be improved, if at all?

Perceived impact of SMART

12. How do you feel group members benefited from attending SMART if at all? [Prompts: did they achieve their goals? Increased confidence, learnt skills, social support, AOD goals, life impacts, wellbeing]

13. How do you think SMART compares to other forms of peer support (e.g. AA/NA)?

Conclusion

Before we finish up, do you have any other thoughts or feedback about implementing SMART? We've covered a great deal today. Thanks for being so generous and thoughtful with your time and valuable input. I'll email/post your reimbursement so you should receive that shortly.

RECORDER OFF

Appendix H: Pilot service managers – Qualitative interview schedule

Interview number: _____ Date: _____

Interview schedule for SMART service managers

SECTION A: Introduction

Thank you for agreeing to share your thoughts with us as part of this research.

The Department of Health and Human Services has funded us to explore your experience with SMART Recovery and why you chose to implement SMART at your service.

We are keen to get your input and there are a few broad areas that we'd like to cover but this is a pretty informal chat. The interview will take about 25 minutes.

Before we begin, could I please confirm with you that you have had a chance to read the information we sent you via email about the study?

□ Yes

□ No – summarise PICF or arrange to call back at another time

Do you have any questions before we go on?

SECTION B: Consent

Ok, so before we start, if it's ok with you I will turn on the recorder and begin by recording your consent to participate. Then we will move onto the interview.

Is that ok? (If the interview is in person, consent can be recorded in writing on the PICF).

RECORDER ON

- I have read the Participant Information Sheet or someone has read it to me in a language that I understand.
- I understand the purposes, procedures and risks of the research described in the project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.
- I give consent for the interview to be audio-recorded.

RECORDER OFF

We can start the interview now if you're ready? No Yes

RECORDER ON

1. What were the reasons SMART was not running at your service before the pilot?
2. Why do you think SMART Recovery got started at your service? (i.e., were you supportive of it)
3. What do you see as the barriers and facilitators to running groups at your service?
4. What has been your experience of SMART at your service? What worked well and what didn't? (i.e., what did you or your team learn)
5. As a manager did you have any concerns (if any) of your staff running in person and online groups? (i.e., staff time, meeting targets, or do you think SMART helped maximise staff time?)
6. Do you plan to continue SMART Recovery long-term at your service? Why?
7. If yes, will you continue running them online, face-to-face or both?
8. What do you think SMART adds to your service offering? (What kind of client benefits most from it? Is it best as a form of bridging support, early intervention, aftercare, step down etc.,)
9. What do you think smart needs in order to remain sustainable at your service? (do you need to train more clinicians, would this require additional funding?)

Conclusion

Before we finish up, do you have any other thoughts or feedback about implementing SMART? We've covered a great deal today. Thanks for being so generous and thoughtful with your time and valuable input. I'll email/post your reimbursement so you should receive that shortly.

RECORDER OFF

Appendix I: Pilot group members - Qualitative interview schedule

Interview number: _____ Date: _____

SMART group member's interview

SECTION A: Introduction

Thank you for agreeing to share your thoughts with us as part of this research.

The Department of Health and Human Services has funded us to explore your experiences of SMART Recovery groups. This may help to improve SMART Recovery groups in the future.

We are keen to get your input and there are a few broad areas that we'd like to cover but this is a pretty informal chat. The interview will take about 45 minutes to an hour.

Before we begin, could I please confirm with you that you have had a chance to read the information we sent you via email about the study?

□ Yes

□ No – summarise PICF or arrange to call back at another time

Do you have any questions before we go on?

SECTION B: Consent

Ok, so before we start, if it's ok with you I will turn on the recorder and begin by recording your consent to participate. Then we will move onto some demographic questions and the interview.

Is that ok? (If the interview is in person, consent can be recorded in writing on the PICF).

RECORDER ON

- I have read the Participant Information Sheet or someone has read it to me in a language that I understand.
- I understand the purposes, procedures and risks of the research described in the project.
- I have had an opportunity to ask questions and I am satisfied with the answers I have received.
- I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.
- I give consent for the interview to be audio-recorded.

RECORDER OFF

We can start the interview now if you're ready? No Yes

RECORDER ON

SECTION C: In-depth interview

Ok, so I'll start by asking some demographic questions:

1. What is your current age? _____years
2. Where do you live?
3. What gender do you identify as?
    (a) Male/Female/Non-binary/Self-identify: (please specify)
4. Do you identify as…? (tick all that apply)
    (a) Straight/Heterosexual/Gay/Lesbian/Homosexual/Bisexual/Queer/ Prefer not to say/Self-identify: (please specify)
5. Where were you born?
6. Do you identify as Aboriginal and/or Torres Strait Islander?
7. What is your highest level of education?
    (a) Postgraduate degree/Graduate diploma/Graduate Certificate/Bachelor Degree/Advanced Diploma/Diploma/Certificate 3 or 4/Year 12/Year 11 or below (includes Certificate 1 and 2)
8. Are you currently employed?
9. What was your primary drug of concern (if at all)?

We can now move onto the interview questions.

Previous Mutual Aid Engagement

9. Have you attended other forms of peer support in the past?

a) If yes, what kind? (i.e., AA, NA etc.,)

b) If yes, how many times did you attend these groups? _____ _____times

c) Over what time period? ____ _____

d) If yes, what was your experience attending these groups?

Current Mutual Aid Engagement

10. How many times have you attended this particular SMART Recovery group? _____time

11. Over what timeframe? _____months/weeks

12. Why did you decide to start attending SMART Recovery? [Prompt: what was your goal? Was there a behavior you wanted to change? AOD related?]

Experience of SMART

13. How did you find out about SMART? [Prompts: Through your treatment service? Did they encourage you to attend?

14. Could you tell me a little bit about your experience of participating in SMART? *[Prompt: What have been the most and least helpful parts?]*

15. Can you describe your experiences with the facilitators? *[Prompts: engaging, inclusive, directive]*

16. Can you describe your experiences with the other attendees? *[Prompts: supportive, disruptive, cohesive]*

17. What strategies, if any, have you used/tried since attending? Were they helpful? [Prompts: building motivation, coping with urges, problem-solving, lifestyle balance, building a plan]

18. What were your thoughts about the group being connected with a treatment service? *[Prompts: what did you think about clinicians running the groups]*

Perceived impacts of SMART

19. How do you feel you have benefited from attending SMART if at all? [Prompts: did you achieve your goals? Increased confidence, learnt skills, social support, AOD goals, life impacts, wellbeing]

20. How do you think SMART compares to other forms of peer support (e.g. AA/NA)?

Improvements and suggestions

21. How can SMART groups be improved if at all?

22. Would you recommend SMART to others? Why/why not?

23. How have you felt about the online format?

Conclusion

Before we finish up, do you have any other thoughts or feedback about SMART?

We've covered a great deal today. Thanks for being so generous and thoughtful with your time and valuable input. I'll email/post your reimbursement so you should receive that shortly.

RECORDER OFF