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From both sides: Participant and facilitator perceptions of SMART Recovery groups

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Abstract

Introduction and Aims. *The Self-Management and Recovery Training (SMART Recovery) program provides facilitated mutual aid for people with addictions. To date, little research has examined SMART Recovery. This paper examined participant and facilitator perceptions of the helpfulness of cognitive behaviour therapy tools in SMART Recovery groups. SMART Recovery's strengths and areas for improvement were also explored, as well as overall participant satisfaction with SMART Recovery.* ***Design and Methods.*** *This exploratory study was conducted as part of the first national survey of SMART Recovery in Australia. Paper surveys were posted to all registered SMART Recovery groups for participants. SMART Recovery facilitators were emailed a link to an online survey.* ***Results.*** *Overall, satisfaction with SMART Recovery was moderate to strong. Participants and facilitators perceived the cognitive behaviour therapy tools incorporated within SMART Recovery to be helpful. Participants and facilitators nominated the group experience and the SMART Recovery tools and strategies as helpful aspects of SMART Recovery. Participants and facilitators were concerned with improving public knowledge about SMART Recovery groups, updating the structure and content of SMART Recovery groups, and increasing training for facilitators.* ***Discussion and Conclusions.*** *SMART Recovery displays strengths as communicated by those who utilise its services. However, there are opportunities to continue to improve SMART Recovery. Updating the training for facilitators and increasing communication between SMART Recovery Australia's head office and its facilitators may serve to improve service delivery. Future research should focus on examining the efficacy of SMART Recovery groups on participant outcomes.* [Kelly PJ, Raftery D, Deane FP, Baker AL, Hunt D, Shakeshaft A. From both sides: Participant and facilitator perceptions of SMART Recovery groups. *Drug Alcohol Rev* 2017;36:325–332]

Key words: SMART Recovery, mutual support group, cognitive behaviour therapy, consumer perception, service evaluation.

Introduction

For people experiencing substance use problems, mutual support groups are the most widely accessed form of support [1]. Advantages of mutual support groups include being cost-effective to implement, typically free for participants, and an easily accessed form of ongoing care [2]. The most well-known mutual support groups for addictions are 12-step approaches, such as Alcoholics Anonymous (AA), for which there is considerable research [3–6]. Research examining other formats of mutual support groups has been limited [7,8]. The need for, and importance of, providing alternate mutual support groups (i.e. different in format to AA) has been clearly highlighted in the literature [8,9], and it is essential that research starts to critically evaluate a range of different models of mutual support [10].

Self-Management and Recovery Training (SMART Recovery) is one of the most widely used mutual support groups. Since its incorporation in 1992, SMART Recovery has rapidly grown with over 1000 groups being held internationally [11,12]. The SMART Recovery approach was specifically developed to reflect current evidence-based practice in the addiction field [8,9]. As such, SMART Recovery incorporates well-established psychological principles from a range of approaches including motivational

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interviewing (MI) and cognitive behaviour therapy (CBT) [9]. SMART Recovery groups provide participants with evidence-based tools to aid recovery. Table 1 provides a summary of the therapeutic tools used as part of the SMART Recovery facilitator manual [13]. SMART Recovery is quickly growing in membership [12], and so, it is critical that the research base continues to grow to ensure that best evidence practice is being delivered.

The founders of SMART Recovery have expressed a desire to continue to update SMART Recovery as evidence in the field progresses [8]. However, to date, there has been limited research specifically examining SMART Recovery. One study has compared SMART Recovery with an online, abstinence-orientated adaption of the SMART program [14]. Other research has largely compared SMART Recovery and 12-step approaches [8,15,16]. Only one study has examined the therapeutic aspects of SMART Recovery groups. In a cross-sectional survey of people accessing SMART Recovery groups in Australia, the predictors of participants' self-reported use of cognitive and behavioural skills were explored [17]. Group cohesion was found to be a significant predictor of the use of self-reported cognitive restructuring by participants outside of group sessions. The provision of between session tasks (i.e. homework) at the end of SMART Recovery groups was most strongly associated with the self-reported use of behavioural activation [17].

An aspect of SMART Recovery that has not been previously examined is the perspective of SMART members. The importance of examining the 'participant experience' has been recognised within the broader mental health literature [18,19] and provides a mechanism to facilitate service development and promote consumer centred care [20]. There is also an opportunity to examine the experience of facilitators leading SMART Recovery groups. A unique aspect of SMART Recovery is that groups are led by facilitators, who may be professional or non-professional people. Following a 2-day training course, facilitators are free to establish and run groups. SMART Recovery encourages an interactive discussion where participants can talk about their current problems rather than just tell their addiction story [13]. Facilitators guide this discussion and provide psychoeducation utilising SMART tools and other CBT- and MI-based techniques. Given their role within the group, facilitators are in a unique position to provide additional insights into what components of SMART Recovery they believe are most helpful. Adding the perceptions of program facilitators to those of the participants allows a more comprehensive evaluation of the program. Additionally, identifying areas of agreement and disagreement between facilitators and participants provides the opportunity to address differences in expectations and perceptions. Conducting this research ensures that SMART Recovery is able to deliver the most appropriate service to its users.

The current study examined participant and facilitator perspectives regarding the delivery of SMART Recovery groups. This study was conducted as part of a broader cross-sectional survey of participants [refer to 17] and facilitators. The perceived helpfulness of the SMART Recovery tools as well as the perceived strengths and areas in need of improvement within SMART Recovery were explored. Additionally, participant satisfaction with the program was examined.

Table 1. *Description of SMART Recovery tools*

Tool	Description
Cost benefit analysis	Based on motivational interviewing, compares the benefits and costs of making a change versus not making a change.
Goal setting	When ready to make a change, sets the goal to achieve. The goal can be reviewed at any point.
Change plan	Determines a plan to achieve the goals, including potential barriers and solutions.
Urge logs	Based on mindfulness, keeps track of urges and how they are dealt with and allows a person to examine triggers for urges, and the efficacy of their strategies for dealing with urges.
Problem solving	Based on CBT, allows the person to write down a worrying event, real, or imagined and then work through the beliefs associated with it and the potential consequences of buying into each belief.
Role plays	Used within groups, role plays allow scenarios to be acted out in a safe space to allow practice of coping skills or development of a 'script' for an event.
Thoughts, feelings, and actions	Based in REBT*, this is a worksheet for writing down and challenging negative thoughts, with the aim to learn to automatically challenge negative thoughts.

*Rational Emotive Behaviour Therapy (REBT; [29]) aims to identify and challenge irrational beliefs through awareness of one's cognitions and thought patterns.
CBT, cognitive behaviour therapy; SMART Recovery, Self-Management and Recovery Training.

No specific hypotheses were generated, as the study was exploratory in nature.

Materials and methods

Participants

SMART Recovery participants. All participants were attending SMART Recovery groups in Australia. At the time the survey was distributed, there were approximately 104 active SMART Recovery groups. Because of the way SMART Recovery groups are organised, there is no central register of participants. Facilitators report that on average, about five to six participants attend each group. Thus, it is estimated that approximately 582 people attend SMART Recovery in Australia. During the study period, 124 SMART Recovery participants completed the survey (about 20%). Of the 124 participants, 56.5% were male ($n = 70$), with an average age of 40.65 years (SD = 11.38). The majority were born in Australia (73.5%). The most common problem behaviour was alcohol misuse (73%) followed by tobacco smoking (46%) and illicit drug use (42.7%). Largely, participants nominated alcohol as their primary substance of abuse (72.3%). Further detailed demographic data from this survey has been reported previously [17].

SMART Recovery facilitators. All facilitators listed with SMART Recovery were sent an email containing a link to the online survey ($n = 170$). Of this number, 65 completed the survey (38%). The average age of facilitators was 47.29 years (SD = 11.97), with 55.4% being male. Of the respondents, 53 said that they currently or had previously facilitated a SMART Recovery group (81.54%). On average, facilitators had been delivering a SMART Recovery group for 2.94 years (SD = 2.62), with 52.3% facilitating only one group. Groups had an average of 5.82 participants (SD = 3.20).

As both surveys were anonymous, comparison between respondents and non-respondents was not possible.

Measures

Helpfulness of SMART Recovery tools. Participants and facilitators were asked to rate how helpful they found each of the tools used in SMART Recovery (refer to Table 1 for tools). Each tool was rated on a 5-point Likert scale. Response anchors were 1 (not helpful), 2 (slightly helpful), 3 (helpful), 4 (very helpful), and 5 (extremely helpful). If respondents did not recognise a tool, they were able to select a sixth option, 'I'm not sure what this is'.

Qualitative data. Participants and facilitators were given the opportunity to nominate which aspects of SMART Recovery they found most helpful and the areas in which SMART Recovery could be improved. Two open-ended questions were asked, "What parts of SMART Recovery do you find most helpful?" and "How do you think SMART Recovery could be improved?" For simplicity, these four response categories will be shortened to *participant strengths*, *participant improvements*, *facilitator strengths*, and *facilitator improvements*.

Client satisfaction. Participants' satisfaction with SMART Recovery was rated using the eight-item Client Satisfaction Questionnaire (CSQ; [21]). The CSQ is a reliable and valid [22] measure used widely in studies to evaluate the acceptability of a service or intervention [23]. The scale is rated on a four-item Likert scale, with seven of the items having a rating scale that ranged from 1 (quite dissatisfied) through to 4 (very satisfied). For the item "Have the services you received helped you to deal more effectively with your problems", the rating scale was from 1 (no, they seemed to make things worse) to 4 (yes, they helped a great deal).

Procedure

In June 2013, hard copies of the group members' surveys were sent to each of the registered SMART Recovery groups. Facilitators were encouraged to distribute the surveys within a 1-month period. As there was variability in the training and experience of the group facilitators and also to ensure fidelity to the research design, facilitators were provided with a standard script to introduce the survey. Participants were provided with a participant information sheet, survey, and reply paid envelope. The surveys were returned directly by mail to the research team at the University of Wollongong. Group members were informed that participation was voluntary and that the questionnaire was anonymous. No incentives were provided to promote completion of the survey.

Facilitators were sent emails asking them to complete a survey online (Survey Monkey). Facilitators were told that participation was voluntary and their responses would remain anonymous. They could choose to enter a draw to win an Apple iPad by providing their email address at the end of the survey. The University of Wollongong Human Research Ethics Committee provided approval to conduct the study.

Statistical analysis

Categories were ranked based on the number of corresponding responses. All calculations were completed in SPSS 21. To determine the perceived helpfulness of the SMART Recovery tools, means were calculated for each tool. Responses indicating that participants were not familiar with the tools were excluded from the mean calculation. Higher scores indicated higher helpfulness. Tools were then ranked in order of helpfulness. Confidence intervals (95%) for the means were calculated for each tool, in order to place the differences in means in perspective to sampling variability and as an estimate of the probability that they are statistically different [24].

The responses to the questions "What parts of SMART Recovery do you find most helpful?" and "How do you think SMART Recovery could be improved?" were reviewed by a member of our team (PK), who developed a categorisation system (refer to Tables 3 and 4). PK and DR independently rated all responses according to the categories. Categories were ranked based on the number of corresponding responses. Raters agreed on 90% of the coding for participant strengths, 96% on participant improvements, 83% on facilitator strengths, and 89% on facilitator improvements. Cohen's kappa was performed to assess the inter-rater reliability between the two raters for each section. All ratings were included. Inter-rater reliability was excellent for participant strengths ($k = 0.87$), participant improvements ($k = 0.97$), and facilitator improvements ($k = 0.86$) and good for facilitator strengths ($k = 0.79$).

A total satisfaction score was obtained by summing the CSQ item responses (range 8–32) with higher scores indicating higher satisfaction. The mean item response was also calculated across the eight items.

Results

Helpfulness of SMART Recovery tools

Overall, participants rated 'cost benefit analysis' as the most useful tool, with 'role plays' being rated as the least useful. High rates of participants responded "I'm not sure what this is" to 'change plan', 'urge log' and role plays. Facilitators rated 'problem solving' as the most helpful tool, with change plan and role plays ranked last. Additionally, change plan and role plays were the only tools to receive the "I don't know what this is" response from facilitators. Table 2 shows the comparison of the helpfulness rankings by participants and facilitators. Although the overall rank order was similar between participants and facilitators, inspection of means and confidence intervals suggests that participants perceived cost benefit analysis, 'goal setting', 'thoughts, feelings, and actions', and urge log as less helpful than did facilitators.

Strengths of SMART Recovery

Table 3 provides the strengths of SMART Recovery as endorsed by participants and facilitators. For participants, the group experience was the most commonly endorsed strength of SMART Recovery. Participants appreciated "hearing experiences of how other people cope" and the chance to have "interactive discussion[s] to talk about problems and get feedback". Facilitators also endorsed the group experience, emphasising the importance of "participants being able to relate to each other and realise they are not abnormal" and that people on the way to recovery "find the sessions helpful as a reminder of what it was".

Tools and strategies rated highly with both participants and facilitators. Participants commented on the usefulness of "practical strategies to put in place to help us overcome and deal with our addiction problems", with the simplistic nature of the tools adding to "feeling that being a realistic achievement you could possibly achieve". Facilitators supported the benefit of having easy to use tools on hand, "[Rational Emotive Behaviour Therapy] is easy to learn, sits well with other therapies… focuses on solutions and positive approaches".

Facilitators endorsed the underlying philosophy of SMART as a strength. Most responses referenced the "here and now" aspect of SMART, "not focusing on the past, just today and the future" and "avoiding the tendency to rehearse historic reasons and justifications for the addiction". Participants confirmed the focus on the present as a strength, "emphasis on mindfulness and only focusing on last 7 days and the next 7 days". Facilitators also commended the flexibility of SMART Recovery, its "broad focus on addictions in general" as well as its ability to "be tailored to meet a broad range of issues and groups". Facilitators also appreciated the strength-based approach SMART Recovery takes, that it "build[s] on clients own strengths and personal responsibility" and gives the participants "ownership of one's recovery".

Areas for improvement

Table 4 contains suggestions from participants and facilitators. Participants most commonly responded that SMART groups should be made more freely available, suggesting "more groups per week" and "more locations for meetings". This sentiment was also shared by some facilitators (e.g. "more groups so participants have more choice"). A quarter of participants suggested that group structure and delivery could be modified, although

Table 2. *Perceived helpfulness of SMART Recovery tools*

	Not sure what this is (%)		Mean (SD) [95% CI]		Ranking	
	Participants	Facilitators	Participants	Facilitators	Participants	Facilitators
Cost benefit analysis	13.2	—	3.77 (1.08) [3.55–3.98]	4.30 (0.77) [4.06–4.54]	1	1
Goal setting	6.0	—	3.74 (0.93) [3.57–3.92]	4.09 (0.91) [3.81–4.37]	2	3
Problem solving	13.8	—	3.62 (0.91) [3.44–3.80]	4.24 (0.94) [3.59–4.17]	3	2
Thoughts, feelings, and actions	18.1	—	3.49 (0.94) [3.30–3.69]	4.02 (0.87) [3.75–4.30]	4	4
Change plan worksheet	29.3	1.5	3.35 (0.91) [3.15–3.55]	3.36 (0.88) [2.97–3.59]	5	6
Urge log	28.7	—	2.91 (1.09) [2.67–3.15]	3.59 (1.04) [3.27–3.91]	6	5
Role plays	32.2	3.1	2.69 (1.13) [2.44–2.95]	2.59 (1.09) [2.10–2.84]	7	7

Items were rated on a 5-point Likert scale. Response anchors were 1 (not helpful), 2 (slightly helpful), 3 (helpful), 4 (very helpful), and 5 (extremely helpful).
SMART Recovery, Self-Management and Recovery Training.

Table 3. *Most helpful aspects of SMART Recovery groups rated by both group participants and facilitators*

		Participants		Facilitators	
Categories	Examples	%*	Rank	%*	Rank
Group experience	'client participation', 'ability to relate to others', 'chance to get feedback from peers', 'opportunity to have a voice and contribute to discussions'	43.2	1	25.0	3
Tools and strategies	'setting short-term goals', 'creating plans', 'worksheets or print-outs', 'examining alternative behaviours'	21.6	2	34.7	1
Structure and facilitation of the sessions	'not too rigid', 'regular routine', 'the structure', 'check in" or 'check out', 'establishing an agenda'	10.0	3	11.1	4
Psychoeducation	'practical information provided', 'education about addiction and treatment', 'examining what causes addiction', 'advice from facilitator'	8.4	4	2.8	5
Underlying philosophy of SMART groups	'solution based, rather than focusing on problems', 'keeping things in the present', 'not labelling participants'	8.4	4	26.4	2

*Respondents may have nominated multiple categories.
SMART Recovery, Self-Management and Recovery Training.

suggestions were often contradictory. Some suggested "longer in duration", but others said "a 60-min meeting could serve us just as well". More structured meetings were suggested by some, "15-min manual work time, being able to put tips and certain points… in writing straight away", but others proposed a "slightly less structured approach".

Facilitators' responses generally centred on a more consistent approach, with one facilitator saying that their "group suffers from 'too many facilitators' causing a too broad and inconsistent delivery" and another suggesting, "better checking on integrity of program". Facilitators were most concerned with improvements to training and updating the content of the groups. Many facilitators indicated that they would appreciate more ongoing support, such as "newsletters or tips and tricks of ways to manage common issues" and that it "would be valuable to regularly access refresher courses". Facilitators suggested having "regular swapping of ideas from facilitators" such as through "annual meetings". While not as often mentioned by participants, there was support for more training, "volunteers may need regular updates/professional supervision to stay focused".

Updating the content of groups was also a priority. Facilitators wanted an update to the tools used in SMART. Facilitators suggested having "even more practical tools" and updating the current resources to be relevant, "up to date handout, too Americanised". Participants shared the desire for more practical tools, suggesting "examples of people's schedule in recovery", that is, "what they fill their time up with", and having "a bit more information on

Table 4. *Areas of improvement within SMART Recovery as nominated by group participants and facilitators*

Categories	Examples	Participants		Facilitators	
		%*	Rank	%*	Rank
Increased number of groups	'more evening groups', 'two meetings per week', 'more sessions in (specific geographic region)', 'more groups in more areas'	30.4	1	8.3	3
Structure and program delivery	'longer sessions', 'unity across SMART Recovery groups', 'more time for clients to talk freely', 'less structure', 'more structure'	25.0	2	8.3	3
Updating content of groups	'more topic nights', 'more tools', 'make tools more practical', 'more education', 'some Aboriginal groups', 'more information'	19.6	3	30.6	1
Promoting the groups	'more people attending groups', 'promoting the groups better', 'better advertising'	10.7	4	16.7	2
Refreshments	'light refreshments', 'chocolate biscuits'	5.4	5	—	5
Promoting social support	'establishing sponsorship like AA', 'group outings organised for participants'	3.6	6	—	5
Facilitator training	'Volunteers may need regular updates to stay focused', 'more regular workshops', 'refresher courses', 'increased facilitator training'	3.6	7	30.6	1
Additional funding	'more funding'	1.8	8	2.8	4
Paying off fines	'SMART could agree to be an organisation that the hours of attendance works towards paying off fines or community hours'	—	9	2.8	4

*Respondents may have nominated multiple categories.
AA, Alcoholics Anonymous; SMART Recovery, Self-Management and Recovery Training.

particular strategies would be an advantage". Some facilitators proposed more specificity for meeting agendas such as "topic nights with guest speakers" and "Indigenous specific course and materials". This was again supported by participants, who suggested "looking at case studies" and having "different topics to talk about every week".

Satisfaction with SMART Recovery

The average satisfaction score was 28.17 (SD = 3.91). The mean rating for individual items was 3.55 (SD = 0.62). Based on the four-item Likert scale stems, this suggests that participants reported being between mostly satisfied to very satisfied with SMART Recovery

Discussion

The study was conducted as part of the first national survey of SMART Recovery in Australia. The tools used within SMART Recovery received high ratings of helpfulness. Overall, participants tended to rate the helpfulness of SMART Recovery tools as slightly lower than facilitators. Given the relatively low ratings of the urge log by both groups and the differential between them, it may be useful to review the training and use of this tool in order to increase its effective use. The aspects that make SMART Recovery unique as a mutual support group were recognised and appreciated by both participants and facilitators. On average, most participants agreed that the various tools were helpful and a strength of SMART Recovery, but they also indicated a desire to have updated or additional tools. There was a high level of participant satisfaction with the quality of service being provided.

Given that the tools used within SMART Recovery are recognised and perceived as helpful by both facilitators and participants, it is not surprising that many participants indicated that they would appreciate more practical help. Allowing group participants the space to discuss what tools they may find helpful and giving facilitators a way to communicate this to SMART Recovery national office would likely be beneficial. Additionally, participants indicated high levels of unfamiliarity with change plan, urge log, and role plays. The limited awareness of these tools suggests that they are not commonly used across all SMART groups. Urge logs form a core part of the SMART Recovery program, and so, it is concerning to see such high rates of unfamiliarity from participants. However, it may simply be that they are not known specifically as urge logs within groups. In regard to change plan and role plays, this may be a reflection of the limited training facilitators received in these particular tools. Change plans and role plays do not form a core part of the SMART Recovery program but rather are presented as additional tools facilitators

may choose to incorporate into their groups. It is possible then that facilitators do not feel confident or capable in employing these tools with their groups, lending to the low reported 'helpfulness'.

The group experience was highlighted as an important part of SMART Recovery. It was commonly reported that the interactive nature of the groups allows participants to "shar[e] freely and then receiv[e] feedback". For participants, the benefits of the group discussions go both ways; for participants new to recovery, they can hear other people's experiences and "not feel alone", and those who had been in recovery for longer felt they had a "chance to give back [the] same assistance" they had received. Group cohesion has been shown to be important within mutual support groups; studies with AA have shown that higher group cohesion is associated with higher member retention [25,26], resulting in better participant outcomes [26]. Within SMART Recovery, higher group cohesion appears to help facilitate the use of CBT techniques outside the group sessions [17]. It is a positive outcome that both the participants and facilitators endorsed the importance of the group experience within SMART Recovery.

An overarching theme of feedback was the desire for an update to the content and structure of SMART Recovery. Views on what these changes should entail were highly variable, and although this may reflect individual differences, it may also reflect variances in group delivery. Increasing contact between trainers and facilitators may address the need for "better checking on integrity of program". A number of facilitators emphasised the need for regular contact with the SMART Recovery Australia office and more opportunities to network with other facilitators. Providing refresher courses, workshops, and more communication with the SMART Recovery national office and other facilitators may aid facilitators to stay up to date.

As SMART Recovery prides itself on being an evidence-based organisation, it is important that the organisation aims to provide evidence-based care not only to group members but also to the professional development of facilitators. This would include ensuring that the SMART Recovery Australia head office implements best-evidence methods of providing facilitators with access to relevant research findings or policy changes. There may also be a need to develop strategies to better assess fidelity to the program.

There are several limitations of this study. Estimated response rates were relatively low. This can be attributed in part to the survey design. This has implications on the generalisability of the research data. Additionally, the self-report nature of the surveys is a potential limitation. Particularly in relation to the questions regarding SMART tools, rates of unfamiliarity with tools may have been lower if participants had the opportunity to clarify tools with researchers. Only groups in Australia were involved, and so, results may not reflect SMART Recovery groups internationally. It must also be noted that data on non-respondents was unable to be gathered, meaning that different SMART Recovery groups may be not be equally represented in the current study. The study only examined the perceived helpfulness of tools, and as such, no conclusions can be drawn regarding the actual efficacy of these tools. Future research examining the effect of these tools as used in SMART Recovery is required. It would be beneficial to explore the use of role plays, which received the lowest perceived helpfulness ratings despite being a core component of cognitive behavioural therapy and being an effective teaching and learning tool [27,28]. There is a dearth of evidence supporting the efficacy of SMART Recovery in aiding addiction recovery. It is hoped that results from this largely exploratory study can be used to conduct more focused investigations of the effectiveness of SMART Recovery and its components. This may include randomised controlled trials and longitudinal follow-up of the SMART Recovery groups.

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