

Growing SMART

Lessons from SMART Recovery UK – 2010 to 2014

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Why does the UK experience matter?

The growth in UK meetings in the four years from 2010 was so dramatic and exceptional that to care about SMART Recovery is to care about the UK experience.

Of course some of the factors that enabled this success may be localised in place and time. It is not *inevitable* that they can be generalised to the future of SMART Recovery in the UK, or internationally. This paper aims to dissect the ‘growth model’ adopted by SMART Recovery UK (SRUK) so that the movement both here and overseas can consider what might be relevant going forwards. As such, this is not a prescriptive or didactic paper: it is a confident assertion of what worked for a particular time and place, but what this means for the future is for others to decide.

Why now and why in this format?

Due to problems around the governance of SRUK, ADASHN (the upstream owners of SMART Recovery in the USA) removed the license for the UK charity to operate. The staff team, including the Director, were TUPE transferred to ADASHN in June 2014 and toward the end of 2014 a new charity, ‘UK SMART Recovery’ was formed to continue the UK network. By this time the Director and several other people had moved on and there was no substantive handover from SRUK to UKSR. It appeared that key lessons may be lost, which seemed a huge disservice to the volunteers, trustees and staff who worked so hard for the previous charity. Arguably this would also be a loss to the international SMART Recovery community as well.

Was UK growth really ‘dramatic and exceptional’?

Since the premise of this paper is that growth in the UK has been ‘dramatic and exceptional’, the first thing we must do is justify this substantial and apparently hubristic claim.

The UK went from fewer than 40 meetings in 2010 to almost 500 meetings by autumn 2014. This is a 1,000% growth in four years. The *pace* of growth steadily increased during this period, with over three new meetings added each *week* in the final year.

During the same period there was solid growth in the USA, but this was a fraction of that seen in the UK. The difference between the organisations was so dramatic that it should invite closer examination and discussion. It should also be noted that several other countries have seen strong growth – with Australia, Canada and Denmark all having more meetings per capita than the USA.

The rest of the paper will explore why and how the UK growth was achieved. The overall case that will be put forward is that the UK team faced a relatively benign environment, though put in place a considered and intentional ‘growth model’ to take advantage of these opportunities. The exceptional growth was a combination of good strategy, favourable circumstances and the hard work of many people.

Favourable circumstances.

In 2010, the UK team believed that they faced a once in a generation opportunity to embed the programme into the heart of the cultural response to addiction in the UK. The following is a brief overview of favourable circumstances that have been covered in more detail elsewhere. (1)

The Recovery Agenda

Addiction treatment in the UK was dramatically shaped by the policy aim of reducing HIV / AIDS amongst injecting drug users and later on by the political push to reduce drug related crime. Over a twenty year period from 1985 this led to a substantial, state funded treatment system focussed on harm reduction, needle exchange and opiate substitution therapy. Services existed which focussed on abstinence though the funding system did not make this a high priority.

In the lead up to the 2010 general election two trends began to converge. On the one hand, a grass roots recovery movement began to gain confidence – appealing for more recovery ambition and increased access to abstinence based interventions. On the other, the Conservative party was influenced by an anti-methadone, anti-harm reduction, abstinence focussed approach to addiction and sought to dismantle what they saw as a failed system.

These trends converged to create a tsunami of interest in new ways of supporting people to achieve recovery outcomes beyond ‘mere’ harm reduction. SMART Recovery was well placed to ride this wave of interest, though first needed to establish credibility on a national scale and develop a roll-out model that would scale.

Secularism and non-dominance of 12-Step approaches

The UK is one of the most secular countries on earth, with only one in twenty people regularly attending a place of worship and a slim majority saying they have no religion at all. Although the 12-step Fellowships have in many respects adapted to local conditions and many atheists enjoy using these groups, there was clearly a strong cultural appetite for a secular alternative.

The UK treatment system is largely none 12-step based so pre-existing links with the Fellowships were not strong. It was easier to get ‘mind-share’ in the UK than it might be in countries with an overwhelmingly 12-step system. In practice the interests of SMART Recovery were significantly *aligned* with those of the Fellowships; for example supporters of both organisations shared the desire for better links between treatment and mutual aid.

National Health Service

Finally, the socialised (or ‘single payer’, in American parlance) healthcare system in the UK lends itself to strategies that work ‘with and within’ the system. There is a substantial cadre of professionals who have the leverage to ‘steer’ the addiction treatment system, so there was ‘someone to talk to’ in order to promote treatment system engagement with SMART Recovery.

A note on the role of volunteer / peer facilitators

Volunteers are central to SMART Recovery and the growth in UK meetings rested firmly on volunteer shoulders; well over 200 people in recovery gave freely of their time to run meetings and support local networks over the four year period. Most of this document focusses on aspects of the organisations strategy *other* than volunteers not because they are not important, but because the UK approach in this area was not exceptional or *particularly* different from the approach in other countries. Indeed the UK team was attempting to follow the lead of the US, which had built an impressive layer of volunteer led support infrastructure. This was an area where the UK was playing catch-up and indeed faced significant challenges, touched on in the discussion section at the end of this document.

Was success inevitable?

In light of the favourable circumstances it is likely that SMART Recovery would have grown in the UK even if a very different organisational strategy had been pursued. The case made in this paper is that the *scale* of growth was the direct consequence of a set of intentional and strategic steps taken by the charity to take best advantage of the favourable circumstances faced by the organisation. We now turn to the components that comprise this intentional ‘growth model’.

Components of the SRUK growth model

Goal setting

This may sound dry and even trite, but growth was achieved because that was the goal SRUK set itself and many people focussed on and worked hard to achieve that goal.

The Director and Trustees agreed a set of three year objectives against which progress would be measured. These objectives included concrete targets, such as to be running over 400 SMART Recovery meetings per week.

This was fleshed out by the staff team into more detailed strategic objectives and a detailed work-plan. Progress against this plan was reported at every board meeting, with traffic light monitoring on specific actions. It should also be noted that the strategic objectives covered a range of harder to quantify but important outcomes, such as volunteer engagement and the quality of SMART Recovery meetings.

No claim is being made here that this was a sophisticated process, it was standard good practice: the Board set strategic objectives and then held the executive to account for delivery. What *is* being claimed is that this was a critical factor in achieving growth in the UK; the staff team were told it was their *job* to achieve rapid growth – whilst improving quality – and volunteers were included in the process and excited by the same goal. The Director should have expected to be vulnerable if he failed to meet agreed targets and had been unable to proffer a convincing explanation!

This issue is worth mentioning in this document because this approach may not be the norm in SMART Recovery internationally, which could dampen the potential of the movement.

Partnership Scheme

The Partnership Scheme was a bespoke and carefully designed business model to drive growth. It has been spectacularly successful.

The partnership model had a somewhat complicated provenance, discussed in Appendix B. What follows is a description of the model finessed in 2010 through discussions with the Board and consultation with the network.

Treatment and Recovery Organisations which provide support to people struggling with addictions could become Partners of SMART Recovery UK. This entailed signing a legal agreement and paying a license fee. The agreement put responsibilities on both the Partner and SMART Recovery: SMART Recovery agreed to provide training to the staff and clients of the Partner and give permission to use a wide range of copyrighted materials. Staff then do the online training and become 'SMART Recovery Champions'. They could then run meetings, but are also encouraged to actively seek out service users to do the training themselves and then transition meetings to become peer led. The Partners thus had a *contractual responsibility* to encourage peer led meetings.

The scheme is win-win, as all successful partnerships tend to be. The Partners benefit by building peer oriented support structures for their service users. This often led to a growth in free standing, peer-led meetings in the local community which became an important source of after-care. This helps their clients achieve better treatment outcomes and impress whoever is funding their services. The scheme benefited SRUK because it resulted in a large number of meetings being created that would not otherwise exist – and also provided a reliable stream of un-restricted income for the charity.

It was found that professionally led SMART Recovery meetings do not *always* become peer led and do not *always* result in local peer led meetings. This attracted some criticism that SRUK merely 'professionalised' SMART Recovery. Conversely, it is clear that the involvement of professionals *massively* increased the availability of peer led meetings and *most* professionally led meetings transitioned to become peer led in time. There is typically a lag of around a year from signing the Partnership to new peer led meetings getting established – and sometimes this never happened.

The core pricing model was for Partners to pay a £500 annual fee for each treatment site in the Scheme.

Scale of the Partnership Scheme

Well over 300 care and treatment providers signed up to the Partnership scheme, with over 500 treatment sites involved. Nearly all partners renewed year on year and because of this, the UK operation was financially robust.

The scheme also helped drive the high profile of SMART Recovery within the recovery and treatment sectors. Over 3,000 professionals (perhaps 20% of the *entire specialist workforce!*) received training from the organisation over the four years.

Although the success of the scheme was not unexpected, it would be true to say that it exceeded expectations. A mechanism of success that had not been predicted was the impact of staff mobility. Many of the staff at Partnership sites *really* like what SMART Recovery offered, and when they

moved jobs they took that enthusiasm with them. This achieved a slow burn viral effect with face to face drug and alcohol workers becoming enthusiastic emissaries for the programme. The Partnership model helped SRUK grow because the Partners became vested in and cared about the organisations success.

Block agreements with Commissioners

The core pitch of the Partnership scheme was to care and treatment providers, though SRUK also offered the model as a block agreement for Commissioners. The Commissioners were mostly local authority substance misuse Commissioners responsible for funding treatment and support in their local areas. The block agreement was based on a single annual payment, for an unlimited number of partnership sites within an area. This approach was particularly effective in Scotland, where most people now live in an area covered by such an agreement.

The spirit of partnership and search for allies

Although the Partnership model included the Licensing of intellectual rights, it was not merely a sub-licensing model. The Partnership scheme works so well because Partner organisations became vested in the success of SRUK, they want to see a flourishing network of peer led meetings and saw shared interests in terms of shared values as well as business interests. Partnership should be thought of in relational rather than purely transactional terms, they are more valuable and sustaining if you invest your goodwill for the long term.

The key was to identify people or organisations with overlapping interests, where helping them achieve their goals coincided with them helping SRUK achieve its own targets. For example, SRUK worked with ADFAM, a national organisation working with family members affected by addictions, to help roll out the SMART Recovery Family and Friends program in the UK. ADFAM had a pre-existing network of meetings and was able to contribute some staffing capacity. With their help, a pilot F&F scheme was launched at 30 sites and a road-map agreed that it was believed would lead to in over 100 weekly meetings within a year.

SRUK also developed a strategic Partnership with a not for profit training provider to help build capacity to deliver face to face training. This provided SRUK with a professionally developed training package and a three day 'training the trainer' event for a team of Facilitators who were interested in paid work as trainers. The training partner also helped run the initial courses, mentored new trainers and helping the organisation work toward a high quality, professionally supervised peer training team. This was very much secondary training capacity to the online training described below, though was intended to be a complimentary option.

Quality and distribution of materials

The entire team believed in the value of the programme as it came to the UK from the USA, though felt it needed to be anglicised and polished. Over the four years the team, including volunteers, honed, re-wrote or re-packaged most of the programme materials for use in the UK, including writing a Facilitators Manual from scratch, re-writing the prisons programme, UK versions of most materials used in meetings and a range of publicity materials. Although SRUK probably put more effort and focus on this than other countries, it was not the quality of materials that made the biggest difference; it was the approach to distribution.

Since the Partnership model was so effective at bringing in revenue, SRUK could afford to provide free materials to peer led meetings in volume. Prospective peer facilitators were sent a free Facilitators Manual on completion of training. When they actually started a meeting, Facilitators were sent a free SMART Recovery Handbook along with substantial pack of free leaflets, participant flyers and posters. When running a meeting, they could request further batches of leaflets and posters which would also be sent out without charge.

Because of the financial support of Partners, SRUK was able to send out huge volumes of free materials, dramatically raising the profile of SMART Recovery and making it easier for peer Facilitators to start meetings.

Ready access to online training

The task of training new Facilitators is arguably the biggest single barrier to growing SMART Recovery. The SRUK team realised in 2010 that face to face training would not 'scale' to the growth ambitions because the per-person cost was prohibitive.

The solution was online training. The team set up an installation of Moodle, an open source e-learning platform, and spent three months creating a set of courses from an introduction to SMART Recovery through to the skills needed to run a meeting. This approach allowed the organisation to train *thousands* of people with *relatively* modest administrative support and course grading. A further benefit of being so cost effective was that the organisation could now provide the training free, further increasing the volume of people engaging with SMART Recovery, even if they did not go on to actually start a meeting.

Although the online training does not cover all training needs and does not work for everyone, it was a vital component of the growth model. The approach was later adopted by the team in the USA.

Social policy engagement

Although the policy changes around the 'recovery agenda' were helpful, it was by no means certain that SMART Recovery would succeed. Quite understandably, and correctly, dozens of organisations and interest groups sought to position their own programmes or ideas within the policy ferment. Although there was a great deal of support for SMART Recovery in 2010, there was also a lack of knowledge, some resistance and pockets of outright hostility.

SRUK made engagement with officials and influencers a priority:

- To raise the profile of SMART Recovery within the emerging recovery agenda.
- To promote a 'many paths to recovery' way of thinking about recovery, thus the importance of choice and a need for diverse range of programmes.

Activities included responding to consultations, eg. (2) and producing briefings targeted at key audiences. eg. (3)

The 'many paths to recovery' approach of the organisation stance was welcomed by the vast majority of officials, who recognised that this would widen access to mutual aid and improve recovery outcomes. The team also convinced senior managers that the Civil Service Code required

an even handed approach between SMART Recovery and the 12 step fellowships. Persistent engagement ensured the organisation had a seat at the table to be consulted on key documents such as the PHE Facilitating Access to Mutual Aid framework. (4)(5)

The approach taken was that mutual aid worked, should be encouraged by the state and National Health Service, but that officials should not play favourites. This message got across. Over the four year period, a substantial number of important strategic documents mentioned SMART Recovery in ways that were useful to the organisation. In effect, state-funded addictions treatment service have been *required* to engage service users with SMART Recovery as *well as* 12-step based mutual aid. This is a terrific platform for growth. (6)(7)(8)(9)

With this policy endorsement, the role of SMART Recovery was advanced by many dozens of Commissioners, MoJ, DoH, NTA and PHE officials, who nudged, supported, encouraged, recommended and occasionally cajoled treatment and recovery organisations to engage with SMART Recovery alongside other forms of mutual aid and other approaches to recovery support.

It is important to note that there is a ‘non-linear’ relationship between public policy engagement and inclusion in reports such as those cited. This does not however diminish the importance of this activity and it was without doubt a key component of the UK growth model.

Staffing capacity

The growth model depended on volunteers, but it also depended on a small and highly committed staff team to run the Partnership scheme and support infrastructure for the organisation.

The sheer volume of work needed full time commitment over an extended period and this was neither realistic nor fair to expect from volunteers. Although staff performed a huge range of tasks, notable contributions to the growth model included promotion and administration of the Partnership scheme, building and supporting the training infrastructure and building collaborative relationships with officials at a local and national level.

Discussion

Balancing volunteerism and a focus on growth

In 2010, some people argued to take SMART Recovery UK forwards without paid staff and that with the partnership approach was too ‘professionalised’ and distant from peer led mutual aid. The conclusion of the consultation was that as long as the primary focus was to increase the number of peer led meetings then engagement with professionals was worthwhile. It is important to note that this was not a consensus position and a small number of people left the organisation at that point.

The UK approach sat squarely within the historical view of SMART Recovery as a partnership between people in recovery and professionals. That said, the decision to set up the Partnership scheme and embrace rapid growth *inevitably* had an impact on the balance between the role of volunteers and the role of staff.

In 2010 SRUK had perhaps two or at most three volunteers who did more than run their own meetings and few volunteers in any role with more than two years recovery under their belts. Over the following four years, SRUK greatly expanded the opportunities for volunteers to take on

leadership roles and become more involved in the running of the organisation, though this was still quite modest compared to the long standing and stable volunteer structures built up in the USA over the last two decades.

With the expansion of the (be it still small) staff team, there was some risk of volunteers feeling the new approach was too managerialist and insufficiently inclusive. A few volunteers continued to press for an entirely peer led and democratic leadership model, reflecting some of the tensions back in 2010. This would have been a perfectly legitimate step for the organisation to take, though it was not the direction the Board chose and would probably have resulted in a *far* slower pace of growth, leaving thousands of people without the benefit of SMART Recovery.

Bill White described the SMART Recovery approach as a ‘hybrid’ approach to mutual aid, (1) which seems realistic, fair and desirable. SRUK aimed to have a clear roadmap toward greater peer inclusion and involvement, without abandoning good management practices, safeguarding and strategic business planning. The approach taken was to increase peer involvement in leadership roles *progressively*, as the number of volunteers in *stable long term recovery* increased. This required visible commitment on the part of SRUK and patience on the part of volunteers – and perhaps both fell a little short on occasion!

International applicability

Some aspects of what is described here as the SRUK growth model are already used in other countries, developed locally or imported as part of what was a rich exchange of ideas within the international SMART Recovery community. Other aspects of the SRUK model might yet be successfully transplanted.

Partnership with treatment services may be easier in countries with an identifiable treatment *system* and easiest of all in countries with socialised healthcare. For reasons described above, it is easier to roll out a model and scale nationally if there are people holding the levers of power at a national level – influence them and you influence everyone. In some countries there may be segments of a treatment system that would be easier to target for Partnership. For example in the USA, the private 12-Step rehab sector might be tougher than the socialised, single payer Veterans Affairs system.

Reflecting on the SRUK experience *might* be valuable to people in the international SMART Recovery community and Appendix A tries to distil the key ingredients.

Taking things forwards

It is important to emphasise that just because something worked in the past does not mean it will work in the future. Priorities and circumstances change. Although this document contains some strong opinions, it does not offer blueprint and nor is it a critique of alternative models. It is merely a considered viewpoint, left on the table for the benefit of those who follow.

Hopefully it provides nutritious food for thought!

Acknowledgements and thanks

This document offers a record of and commentary on the achievements of a large number of people at SMART Recovery UK from 2010, who built on the efforts of Fraser and others who came before.

The final word must be a huge thank you on behalf of the tens of thousands of people who benefitted from the successes described. Most of all, thanks are due to the hundreds of Volunteers, but also to the Trustees, Commissioners, Partner organisations and Champions; many of whom remain involved in taking SMART Recovery forwards. Finally, a particularly loud thank you to the staff, in reverse order of appearance: Diana Mitchel, Leigh Proctor, Steve Crawley, Jardine Simpson and Carol Hammond.

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Appendix A: Key components of the SRUK growth model.

Team of full time staff

- the growth model required infrastructure support that could not realistically be provided solely by volunteers – rapid growth was *predicated* on employing staff to work alongside volunteers

Solid business planning and team engagement

- with clarity of objective, work-planning and performance management of staff against growth targets

Partnership Scheme

- including incentive structure so Partners must encourage the creation of peer led meetings and a revenue stream to support the organizations infrastructure
- build strategic partnership arrangements with organizations with complimentary interests and can offer expertise or access to new growth opportunities.

Distribution of free promotional materials

- make it easy for people to promote SMART Recovery by providing as many promotional materials at no cost as can be afforded.

Low barriers to becoming a Facilitator

- provide free access to training and programme materials to anyone who wishes to become a peer Facilitator.

Social policy engagement

- influence government and planning structures to create a benign operating environment for the Partnership scheme in particular and SMART Recovery in general

Commitment to quality

- continual improvement of programme materials, including increased use of professional designers, along with a visible commitment to science / evidence.

E-learning platform

- with open access to some modules to increase engagement
- other than introductory course, access to professionals limited to those in the Partnership scheme

Appendix B – History of the SRUK Partnership Scheme

At various points in the history of SMART Recovery, particular treatment providers have been given permission to use the contents of the SMART Recovery programme. (10)

In 2007, Phoenix House approached SRUK with a proposal to run SMART Recovery meetings within residential rehabs and train service users to run meetings on discharge. SRUK rejected the proposal, though the staff involved at Phoenix would later become a Trustee and Director of SRUK and return to these ideas. In 2008 a UK charity called Addaction was given permission to use the programme by ADASHN, though this did not, in the main, involve the training of peers to run meetings and was not a revenue model.

The game-change for SMART Recovery in the UK was a proposal put together by Professors Nick Heather and Keith Humphreys and submitted to the Department of Health in partnership with Alcohol Concern. The pilot project received £100,000 in funding over two years, to test whether alcohol treatment services could successfully initiate peer led SMART Recovery meetings. The model involved identifying interested services, who in turn identified interested clients who then attended a training session on how to run meetings. The pilot finished in late 2009 with the evaluation (11) concluding that treatment services *could indeed* be successful in initiating peer led SMART Recovery groups.

All parties viewed the pilot as a great success; the initial six sites had grown into 25 peer led meetings over the following year. It was not however an *unqualified* success: it was felt that more training for staff would have helped provide better support for new peer facilitators, and there was no revenue model to support the national infrastructure that the report recommended.

SMART Recovery UK had deeper problems: without an adequate revenue stream or change of direction, the charity would soon be bankrupt. The Trustees thought partnership was the way forwards and initially discussed a model that involved charging treatment services a fee for each client attending meetings within their services. They brought in a consultant (who later became the Director) to work with them on what became a more viable model, largely reprised from the Phoenix proposal from three years earlier. (12)

Proposals were then discussed through a national consultation process and further refined into what became the UK Partnership Scheme, which remains basically unchanged since 2010. ADASHN initially refused permission for SRUK to proceed with the scheme, though Joe Gerstein won them over. In 2014 ADASHN moved toward piloting a Partnership model based on the UK scheme.

Appendix C – References

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