










# Online SMART Recovery mutual support groups: Characteristics and experience of adults seeking treatment for methamphetamine compared to those seeking treatment for other addictive behaviours

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## Abstract

**Introduction:** The COVID-19 pandemic prompted the transition of Australian Self-Management and Recovery Training (SMART) Recovery mutual support groups to virtual delivery. This study examined the self-reported experience of online SMART Recovery groups for people seeking support for methamphetamine use (alone or in combination with other behaviours) compared to those who did not endorse methamphetamine use as a reason for seeking support.

**Methods:** An online survey invitation was embedded in the post-group exit page. Items assessed participant demographic characteristics, experience, engagement and perceived contribution of the online group to recovery. Unique responses ( $n = 1414$ ) were analysed using chi-square.

**Results:** After alcohol, methamphetamine use was the second most common behaviour to prompt online SMART Recovery group attendance ( $n = 205$ , 14.5%). People attending for methamphetamine use were more likely to endorse multiple addictive behaviours ( $n = 137$ , 66.8% vs.  $n = 371$ , 30.7%,  $p < 0.001$ ). Irrespective of whether people attended for methamphetamine use or not, participant ratings of experience, engagement and perceived contribution to recovery were positive and largely comparable. People attending for methamphetamine use were significantly less likely to set a 7-day plan (72.7% vs. 81.9%;  $\chi^2 = 9.47$ ,  $p = 0.002$ ).

**Discussion and Conclusions:** Findings support the acceptability of online SMART Recovery groups for people experiencing addictive behaviours, including methamphetamine use. To maximise the benefits of these groups, further evidence on how best to support people to develop a change plan within a time-limited, online group setting is needed. Online mutual support groups may help to reach and support people who might not otherwise engage in treatment and support, including people who use methamphetamine.

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**KEYWORDS**

digital recovery support services, methamphetamine, mutual support, SMART Recovery, substance use disorders

## 1 | INTRODUCTION

Methamphetamine use is a global health problem [1]. Of concern, people typically delay or avoid seeking treatment [2]. Available interventions for methamphetamine use disorders are limited [3, 4], with accumulating evidence for cognitive behaviour therapy [5]. SMART Recovery (Self-Management and Recovery Training) offers mutual support groups for people who experience a range of addictive behaviours [5]. Groups are led by trained facilitators and are informed by principles and strategies from motivational interviewing and cognitive behaviour therapy [5]. Evidence supports the benefits of mutual support groups including SMART Recovery [6, 7]. However, research specifically focussing on populations who use methamphetamine is limited [8, 9]. Furthermore, following the social distancing measures introduced during the COVID-19 pandemic, SMART Recovery transitioned to predominantly online group delivery [10]. Although evidence for the utility of virtual delivery of treatment and support for addictive behaviours is growing [11, 12], little is known about participant experience of such group-based mutual support for substance use. Virtual delivery offers potential to increase access and confidentiality which is particularly important for those who use methamphetamine since most (60%) identify embarrassment or stigma as their main barriers to treatment [13] and research indicates that only a minority receive treatment [14]. Online treatment has been suggested as one strategy to overcome these and other barriers to treatment [15]. The aim of the current paper is to examine similarities and differences in participant ratings of engagement, experience and the recovery supportive contributions of online SMART Recovery groups for people seeking support primarily for their methamphetamine use compared to those who did not endorse methamphetamine as a reason for seeking support.

## 2 | METHOD

A self-selected convenience sample was recruited from Australian SMART Recovery groups delivered using video conferencing software Zoom. Participants had to be at least 18, and have attended at least one online SMART Recovery group. An invitation to complete an anonymous online questionnaire was embedded into the post-group Zoom exit page. This link was embedded into all Australian SMART Recovery groups conducted during the study period using a Zoom meeting link assigned by

SMART Recovery Australia. Participants were asked to complete the questionnaire only once, based on their most recent online group experience. The questionnaire captured basic demographic information and addictive behaviours that prompted them to attend the online SMART Recovery group. In addition, eight items assessed participants' experiences of the group. Using a five-point Likert response scale (1 'Strongly Disagree' to 5 'Strongly Agree') items assessed the degree to which participants felt they were (i) welcomed; (ii) supported; and (iii) had an opportunity to contribute; (iv) perceived skill of the facilitator; (v) whether they experienced technical difficulties; (vi) acquisition of practical information and strategies; (vii) degree to which the group was experienced as helpful; and (viii) intention to continue attending. Participant use of the 'seven-day plan' was also assessed. The seven-day plan is a core behaviour change technique within SMART Recovery groups. Participants are encouraged to use each group to develop a change plan, comprising one or more realistic, personally meaningful goals for the upcoming week. Progress towards this plan is reviewed in subsequent groups and the plan revised as needed following feedback and self-reflection. This study was approved by the Joint University of Wollongong and Illawarra Shoalhaven Local Health District Health and Medical Human Research Ethics Committee.

### 2.1 | Analyses

All analyses were conducted in SPSS Version 27. Participant postcode was used to classify the location of respondents according to the five categories of 'remoteness' defined by the Australian Standard Geographical Classification (major city, inner regional, outer regional, remote, very remote). As the Likert scale data that captured participants' experiences of the online groups was positively skewed (see Figure S1, Supporting Information), for ease of interpretation and meaningful comparisons [16], response categories were collapsed (strongly disagree/disagree vs. slightly agree/agree/strongly agree) for analysis. A sensitivity analysis was also conducted using a more conservative approach to dichotomisation (strongly disagree/disagree/slightly agree vs. agree/strongly agree). Survey responses from people attending for methamphetamine (alone or in combination with other behaviours) were compared to people who did not endorse methamphetamine as a reason for seeking support using two-sided  $\chi^2$  (or Fisher's exact test where

appropriate). Bonferroni correction was applied to adjust for multiple comparisons.

### 3 | RESULTS

#### 3.1 | Sample

A total of 1612 questionnaires were completed between 15 June 2020 (when data collection commenced) and 1 November 2021 (when data was downloaded for analysis). Duplicate respondents were identified based on a combination of IP address, gender and age ( $n = 139$ ), and only the first survey of these participants was included. Forty-eight participants declined to have their anonymous data used for research purposes, eight were younger than 18 and three were completed by facilitators, leaving a sample of 1414 survey respondents.

#### 3.2 | Participant characteristics

Participant characteristics are presented in Table 1. A slightly higher proportion of participants were male (52.5%), around three-quarters were aged between 25 and 54 years (74.3%) and most were located in major Australian cities (70.4%). Alcohol use was the most frequently endorsed reason for attending an online SMART Recovery group (71.5%). A total of 14.5% of participants reported attending for methamphetamine use, with 85.5% attending for behaviours other than methamphetamine use. People attending for methamphetamine use were more than twice as likely to report difficulties with multiple behaviours of concern (66.8% vs. 30.7%), with a significantly greater proportion of people attending for polydrug use (including cannabis: 31.2% vs. 10.9% and 'other drugs': 34.1% vs. 17.1%) or gambling (16.5% vs. 3.6%) in addition to methamphetamine use. A significantly greater proportion of people aged 25–34 (32.7% vs. 19.3%), and a smaller proportion of people aged 55–64 (5.4% vs. 16.3%), or people who identified as female (39.5% vs. 47.4%) or transgender/ nonbinary (2.4% vs. 0.6%) attended SMART Recovery for methamphetamine use compared to people not seeking support for methamphetamine use.

#### 3.3 | Group experience

Overall, there was a high level of participant satisfaction with the online SMART Recovery groups (Table 2). Irrespective of whether people attended for methamphetamine use or not, the majority of participants (>90%) felt

welcomed, supported, had an opportunity to contribute, felt the groups were well facilitated, took away practical strategies, experienced the groups as helpful and expressed an intention to continue attending. About a fifth of participants (21.5%) experienced some level of technical difficulties during the group. People attending for methamphetamine use were significantly less likely to set a 7-day plan (72.7% vs. 81.9%). No other significant differences were identified between people attending for methamphetamine use compared to people not seeking support for methamphetamine use. These findings were replicated in a sensitivity analysis conducted using a more conservative approach to dichotomisation (Table S1).

### 4 | DISCUSSION

This is the first study to examine the similarities and differences in how people seeking support for methamphetamine use experience online SMART Recovery groups compared to participants attending for other addictive behaviours. Across both participant groups, self-reported ratings of engagement, experience and perceived contribution of online groups to recovery were positive and largely comparable. This lends further support to the acceptability of online groups for addictive behaviours [17, 18], and adds to prior research demonstrating the potential of online SMART Recovery groups for supporting a range of people, including those who use methamphetamine [8]. Amphetamines account for 24% of all publicly funded treatment episodes in Australia [19]. This comprises service users attending all publicly funded services including counselling, withdrawal management, assessment, support and case management, rehabilitation, pharmacotherapy, information and education and 'other' services [19]. In comparison, our figures are derived from a single service delivered remotely thus, the comparative proportion of participants accessing online SMART Recovery groups highlights the potential of this service for people seeking support for methamphetamine use. Not only are these findings important in light of the current global pandemic and public safety, but also they demonstrate the ability to reach and provide support to difficult and under-served populations (e.g., rural/remote, those without transport, otherwise detained). This is particularly important for people who use methamphetamine whereby treatment seeking is characterised by a range of barriers [13], including limited available treatment and support options. Finding that people who use methamphetamine engage with and gain benefit from mutual supports groups is particularly encouraging given the lack of effective pharmacological agents and modest

TABLE 1 Participant characteristics

	Total (N = 1414)	Methamphetamine (n = 205)	Other (n = 1209)	$\chi^2$	$p^a$
Age, years (n = 1414)				32.95	<0.001
18–24	6.5%	4.4%	6.9%		—
25–34	21.2%	32.7%	19.3%		<0.001
35–44	27.7%	31.2%	27.1%		—
45–54	25.4%	22.9%	25.8%		—
55–64	14.7%	5.4%	16.3%		<0.001 <sup>b</sup>
65+	4.5%	3.4%	4.6%		—
Gender (n = 1408) <sup>c</sup>				10.87	0.006
Female	46.3%	39.5%	47.4%		0.031
Male	52.5%	58%	51.5%		—
Non-binary or transgender	0.84%	2.4%	0.6%		0.008 <sup>b</sup>
Aboriginal and/or Torres Strait Islander	2.4%	2%	2.4%	0.210	0.808
Location (n = 1354) <sup>d</sup>				3.595	0.218
Major city	70.4%	68.8%	70.7%		—
Regional or remote	24.8%	29.8%	23.9%		—
International	0.6%	0%	0.7%		—
Problems with more than one behaviour (% yes)	35.9%	66.8%	30.7%	99.467	<0.001
Behaviour(s) that prompted attendance <sup>e</sup>					—
Alcohol	71.5%	32.1%	77.9%	181.759	<0.001*
Cannabis	13.9%	31.2%	10.9%	59.756	<0.001*
Tobacco	12.1%	16.0%	11.3%	3.616	0.040
Other drugs	19.7%	34.1%	17.1%	31.852	<0.001*
Gambling	5.5%	16.5%	3.6%	56.364	<0.001*
Food	8.7%	11.7%	8.1%	2.733	0.107
Other behaviours	4.8%	4.3%	4.9%	0.092	0.861
None	1.7%	0.4%	1.8%	2.102	0.238

<sup>a</sup> $p$ -values are presented for each chi-square analysis conducted. For each significant chi-square derived from the comparison of more than two cells,  $p$  values for each significant follow-up analysis are presented to signify the source(s) of the overarching effect.

<sup>b</sup>Due to the small number of participants in these categories, findings should be interpreted with caution.

<sup>c</sup> $n = 6$  participants attending for other behaviours did not answer this question.

<sup>d</sup> $n = 3$  participants attending for methamphetamine and  $n = 57$  attending for other behaviours did not provide a postcode.

<sup>e</sup>Participants could select more than one behaviour; therefore, comparisons are made for each behaviour.

\* $p < 0.00625$  (Bonferroni  $\alpha$  adjusted for eight comparisons).

effect sizes from psychological interventions [3, 4]. Moreover, the modelling, shared experience and acceptance that characterises mutual support groups could potentially help counter stigma and self-stigma which is reported to be common among people who use methamphetamine [13]. Efforts to enhance awareness of this important source of support and foster participant engagement are warranted, for example, via assertive linkage programmes [20].

This study also lends insight into the unique experience of people who use methamphetamine. People

seeking support for methamphetamine were twice as likely to be experiencing multiple addictive behaviours (cannabis, other drugs and gambling—but not alcohol problems). This finding supports earlier research on the complexity (poly-substance use) of this population [21]. Furthermore, compared to people seeking support for behaviours other than methamphetamine use, fewer developed a 7-day plan. This has important clinical implications since such self-regulatory behaviour change techniques (e.g., goals and planning; feedback and monitoring) represent important predictors of treatment

**TABLE 2** Comparison of self-reported experience<sup>a</sup> of online groups for people attending for methamphetamine (alone or in combination with other behaviours) compared to participants not seeking support for methamphetamine use

	Total (N = 1414)	Methamphetamine (n = 205)	Other behaviours (n = 1209)	$\chi^2$	p
<b>Engagement</b>					
I felt welcome at today's meeting	96.0%	95.6%	96%	0.080	0.847
I felt supported and understood by people attending the meeting	95.8%	95.6%	95.8%	0.013	1.000
I had an opportunity to contribute to the group discussion	95.8%	95.1%	95.9%	0.238	0.707
<b>Experience</b>					
Today's group was well facilitated	95.8%	95.1%	95.9%	0.238	0.707
I experienced technical difficulties during the meeting	21.5%	26.3%	20.7%	3.331	0.080
<b>Contribution to recovery</b>					
I took away practical strategies/ideas/tools from today's group to help me manage my behaviour	94.7%	92.2%	95.1%	2.985	0.092
Overall, I found today's group helpful	95.6%	93.7%	95.9%	2.190	0.141
I plan on continuing to attend SMART online	97.0%	96.1%	97.1	0.603	0.507
Did you leave today's meeting with a 7-day plan? (% yes)	80.6%	72.7%	81.9%	9.476	0.002*

<sup>a</sup>Values are reported as % of participants endorsing 'slightly agree', 'agree' or 'strongly agree'.

\* $p < 0.005556$  (Bonferroni  $\alpha$  adjusted for nine comparisons).

outcome [22]. It may be that the complex needs of this population (e.g., multiple addictive behaviours) make it more challenging to develop a 7-day plan within a time-limited group setting. This difficulty may be further compounded by the unique challenges of the virtual environment. For example, reduced access to non-verbal communication, challenges in maintaining sustained attention (e.g., due to a greater number of environmental distractions) and technological glitches that disrupt the flow of communication all have the potential to make it harder to conceptualise, refine and develop a realistic 7-day plan. To maximise the helpfulness of SMART Recovery groups for people seeking support for methamphetamine (i.e., by informing group content, structure and facilitator training), efforts to understand participant needs and preferences, and to characterise the elements of psychosocial treatment and support that predict treatment outcome are needed. Fostering participant engagement with supplementary resources to support independent development of the 7-day plan may also be of benefit (e.g., SMART Track) [23–25].

Several limitations are worth mentioning. The current findings are based on a convenience sample of cross-sectional data capturing participant opinion on a single group occasion. This anonymous cross-sectional design

did not allow for clear delineation of unique responders and it is possible that unique responders were accidentally screened out (e.g., individual respondents using public libraries or community centres). We are unable to comment on the duration of participant engagement, number of groups attended and how these variables may have influenced participant ratings. The data collection period also overlapped with various COVID-related restrictions (e.g., stay at home orders) which differed in extent and duration across each state and territory. Likert scale items were dichotomised for analysis, and although this approach aides interpretation [16], the number of response categories was positively skewed. Selection bias is also an important consideration since data is derived from a convenience sample of participants who chose to complete the survey. People who did not engage with the online group (e.g., due to dissatisfaction and/or technical difficulties) may have left the group early and therefore not received the post-group survey invitation. Despite these limitations, this study generates new knowledge regarding the potential of online SMART Recovery groups for supporting a range of people, including those who use methamphetamine. For the vast majority of participants, online SMART Recovery groups were rated favourably with regard to participant engagement,

experience and contribution to recovery. This represents an important foundation for improving accessible, community support options for people who use methamphetamine. An important caveat is that about a fifth of the sample reported experiencing some degree of technical difficulties during the group. As such, understanding the impact of technical difficulties on participant experience and outcomes, and developing novel solutions to overcome identified challenges are important priorities for future research. Longitudinal approaches to investigate the effectiveness of online mutual support groups over time, and qualitative approaches to examine enablers and barriers to this approach are also warranted.

### AUTHOR CONTRIBUTIONS

Authorship follows International Committee of Medical Journal Editors recommendations [26]. All authors made substantial contributions to conception, design, methods and/or the content of the current publication. Alison K. Beck: Conceptualisation, methodology, formal analysis, investigation, data curation, writing—original draft, review and editing, project administration, funding acquisition. Briony Larance and Peter J. Kelly: Conceptualisation, methodology, writing—review and editing, supervision, funding acquisition. Victoria Manning, Leanne Hides, Amanda L. Baker, Frank P. Deane and Anthony Shakeshaft: Conceptualisation, methodology, writing—review and editing, funding acquisition. Dayle Raftery: Formal analysis, writing—original draft, review and editing. All authors offered critical revisions to the manuscript for important intellectual content, have approved the final version of this manuscript and agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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### CONFLICT OF INTEREST

No financial conflict of interest exists. Alison K. Beck, Briony Larance, Peter J. Kelly, Victoria Manning, Leanne Hides, Amanda L. Baker, Frank P. Deane and Anthony Shakeshaft volunteer as members of the SMART Recovery Australia Research Advisory Committee.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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