A feasibility study of Moving On In My Recovery: An acceptance-based group programme for people in recovery from substance addiction

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Executive Summary

This project set out to test the feasibility and acceptability of the Moving On In My Recovery (MOIMR) programme. MOIMR is a 12-session, acceptance-based cognitive behavioural group programme that was co-produced and is co-facilitated by treatment professionals and service users in recovery (Hogan, 2016). The primary aim of MOIMR is to bridge the gap between formal treatment provision and mutual aid (i.e., to assist service users who have attained a period of abstinence in treatment to access wider mutual aid).

Sixty-one participants were recruited from six group programmes hosted by BCUHB substance misuse services and the North Wales Recovery Community. Aside of assessing feasibility for a larger randomised controlled trial, study aims were to determine whether participants experienced improvements in terms of their psychological flexibility and wellbeing. Participants completed baseline questionnaires prior to starting the group programme, immediately following the last group session (12-weeks after baseline), and then again, at a further 3-month follow up; at the two follow-up sessions participants completed the baseline questionnaires and took part in a focus group. Participants who dropped out of the group programme were also contacted at the follow-up time-point and they were interviewed about their experience.

The study confirmed that a larger randomised controlled trial (RCT) to evaluate the effectiveness of Moving On In My Recovery would be viable. Using predetermined criteria, it was established that recruitment was feasible, that the study measures were suitable and they were completed satisfactorily. Attrition (at 52%) was higher than anticipated although possibly at a level that is reasonable for this population and an intervention of such intensity. The ecological validity of the intervention itself was high: participants reported that the intervention had a profound effect on their lives and the skills they acquired had led to improvements in confidence, self-esteem, communication and in many other ways. Significant improvements in recovery capital, mood and anxiety were shown at the end of the group programme and these were sustained at a three-month follow-up; psychological flexibility and social functioning was significantly improved at the three-month follow-up. Three-month abstinence rates improved from 55% at baseline to 62% at post-group to 68% at a three-month follow-up. Follow-up interviews with seven participants who dropped out of the programme yielded insufficient data for analysis.

The service users' perspective of the intervention was highly positive. All of the participants who were interviewed praised the programme highly, and some of those who dropped out indicated that they intended to join a group in the future. The participants particularly valued the co-facilitation of groups by people with lived experiences. Interestingly, many participants described their initial reluctance to attend a group-based intervention, but also how this resistance lifted as they became more comfortable in the group setting. Participants described being on a shared journey with other group members and even with the facilitators. It seems that the structure and framework of the group was something that had been missing from the lives of the people struggling with addiction. The group made profound impacts on the participants' lives, and many felt it should be more widely available and as a form of continuous support for people in recovery. In short, participants were transformed from being reticent about groups to being champions of them.

Background

Drug misuse is a global crisis: the United Nations Office on Drugs and Crime (World Drug Report, 2020) estimated that in 2018 more than a quarter of a billion people used drugs, with 35.6 million people suffering with drug use disorders. There is no doubt that in the United Kingdom we also have a serious substance misuse problem: in the latest statistics more than 250,000 people accessed treatment services in 2018/2019, which had increased by 4% from the previous year (Office of National Statistics, 2019). These statistics show that opiate users represented the majority of people in treatment at 52%; however, alcohol represents a growing concern for treatment services with 60% of new referrals reporting primary concerns with alcohol. Of the estimated 586,797 people believed to be dependent on alcohol in England, just 18% accessed treatment.

Substance dependence represents a leading cause of premature mortality (Degenhardt et al., 2013), and it is the fifth highest cause of preventable deaths in the UK (ONS, 2018); of course, it also contributes to the other leading causes of preventable deaths, like cancer, cardiovascular disease, injuries and respiratory disease. Substance dependence is also associated with mental health difficulties, with over half of the people who enter treatment reporting co-morbid mental health problems (ONS, 2019).

Treatment services have had limited effectiveness in providing sustained recovery for service users. For example, of the 120,000 people who exited treatment in 2018/2019, less than half (approximately 57,000) managed to leave treatment successfully (ONS, 2019). A recent study by Hogan, Jabeen, Race and Rettie (2018) found that 83% of individuals who accessed treatment at a detoxification unit in the UK successfully completed their pharmacological detoxification. Despite these promising completion rates and continuous improvements in these services, relapse rates after treatment are still very high. Relapse rates post-detoxification for alcohol dependency are between 60% and 90% and are believed to be higher for other drugs (Aguiar, Neto, Lambaz, Chick, & Ferrinho, 2012; Becker, 2008; Raistrick, Heather, & Godfrey, 2006; Spada, Nuamah, Luty, & Nikcevic,2008). A multitude of factors can determine relapse, including a lack of coping mechanisms, interpersonal problems, low self-efficacy and maladaptive motivation (Marlatt & Donovan, 2005; McKay, 1999).

It is evident that recovery from addiction does not end once a patient has left these treatment services (Drug Strategy, 2010; Welsh Assembly Government, 2013). The recovery movement has recognised the complexities of addiction, and it purports that recovery is a process that takes years to complete (Best & Laudet, 2010; Laudet, 2007; Welsh Assembly Government, 2013). As a result of this change in perspective, there is a new focus in both research and practice on the concept of recovery (Best & Laudet, 2010; Drug Strategy, 2015).

There is now a diverse range of mutual aid groups available within the UK (Drug Strategy, 2017; Humphreys, 2004). Recovery research has focused on the effectiveness of, and involvement in, traditional 12-step groups, such as Alcoholics Anonymous (AA; Pagano, White, Kelly, Stout, & Tonigan, 2013) or other well-established mutual aid group, such as SMART Recovery (Campbell, Hester, Lenberg, & Delaney, 2016). These groups have received support in the literature, with group involvement in both SMART and AA associated with greater levels of

abstinence than without this involvement (Campbell et al., 2016; Pagano et al., 2013). Despite the effectiveness of, and the rise in, mutual aid groups, there has been a barrier from treatment providers supporting the transition to mutual aid (Best et al., 2016), mainly due to clinicians' negative attitudes to mutual aid.

In order to bridge the gap between treatment services and mutual aid, it is essential to improve the chances of long-term, sustained recovery for people with substance use disorders. The Moving On In My Recovery programme (Hogan, 2016) was specifically designed to provide the necessary skills to support recovery and to bridge the gap from treatment to sustained recovery.

The introduction of 'third wave' therapies has led to new developments in the treatment of substance use disorders. These approaches use mindfulness and acceptance-based strategies to reduce the likelihood that internal triggers (i.e., thoughts, emotions, memories) will lead to substance use (Lee, An, Levin, & Twohig, 2015). Acceptance and Commitment Therapy (ACT) has shown promising effectiveness for those with comorbid substance use disorders and mental health problems (see Bowen et al., 2009; Witkiewitz, Bowen, Douglas, & Hsu, 2013). Within the ACT framework, substance use is seen as a form of 'experiential avoidance' (Hayes, Wilson, Gifford, Follette, & Stroshal, 1996), whereby individuals use substances to avoid unwanted thoughts, feelings and physiological experiences. The Moving On In My Recovery group programme uses the underlying ACT model in combination with service users' lived experiences: it combines evidence-based strategies with co-production. Co-production has also been shown to be an effective component of psychological interventions for substance use disorders (Park, 2020).

Aims

The primary aim of this project was to test the feasibility and acceptability of the Moving On In My Recovery programme. Secondary aims were to determine whether participants experienced improvements in terms of their psychological flexibility and wellbeing.

Inevitably, some participants do not start group programmes or drop out of them early. Little is known about these people or those who decline to engage in wider mutual aid. This project aimed to fill these gaps in our knowledge by (a) answering questions about why this might happen and (b) helping us to identify further ways to support people in treatment.

We hypothesized that from baseline to the post-group time point psychological flexibility would increase, and improvements in psychological wellbeing and functioning would also occur. We also anticipated that these gains would be maintained at the three-month follow-up.

In keeping with the original design and delivery of MOIMR, we wished to retain direct service-user involvement in conducting this study. Thus, we utilized a volunteer peer to help to collect data and to co-facilitate the semi-structured focus groups at the post-group and follow-up points.

We aimed to eliminate or at least reduce any bias caused by participants' agreement to take part in this study. To that end, we paid all participants (whether they dropped out of treatment or they remained committed to attending MOIMR groups) for their

participation. All participants earned £5 for completing the standard set of pre-assessment measures; they earned £10 for completing the set of post-group assessment measures and undertaking an interview (i.e., a focus group for MOIMR 'completers' or an individual interview for MOIMR 'dropouts'); all participants earned £10 for completing the set of 3-month follow-up assessments and undertaking an interview.

Moving On In My Recovery

Moving On In My Recovery (MOIMR) is a 12-session, acceptance-based cognitive behavioural group programme that was co-produced and is co-facilitated by treatment professionals and service users in recovery (Hogan, 2016). The primary aim of MOIMR is to bridge the gap between formal treatment provision and mutual aid (i.e., to assist service users who have attained a period of abstinence in treatment to access wider mutual aid); the MOIMR programme itself, however, has become its own form of mutual aid, with many group participants going on to develop their own legacy Moving On In My Recovery groups after completing the MOIMR programme.

The MOIMR programme was initially developed from Welsh Government grant funding in 2014. The developers of the programme asked more than 100 people in recovery and clinicians working with substance users two questions: (a) what topics were important to discuss when service users were leaving treatment services and (b) what strategies and techniques helped them the most? The programme covers many topics related to mental wellbeing and substance misuse (e.g., dealing with loss, stigma, shame, anxiety, depression, and relapse; see Appendix A for a full list of these topics). All topics and strategies used are based on psychological theory and are evidence-based techniques that have been shown to work in practice. The programme adopts an underlying psychological model aligned to Acceptance and Commitment Therapy (ACT).

ACT-based therapies are intended to enhance psychological flexibility. Psychological flexibility is a person's capacity to maintain awareness of (and acceptance of) their present state, without attempting to control or avoid unpleasant or aversive internal experiences (Hayes, Luoma, Bondm Masuda, & Lillis, 2006). The pursuit of a richer and more meaningful life can be achieved when one is open to (and accepting of) distressing internal experiences as one moves in the direction of personal values (Kashdan & Rottenburg, 2010). In direct opposition to this stance is experiential avoidance, whereby an individual gives up on the pursuit of meaningful activities as result of distressing internal experiences, which ultimately leads to greater suffering (Hayes et al., 2006).

In order to enhance psychological flexibility, the MOIMR programme includes a weekly challenge. This process encourages participants to make contact with difficult experiences and to approach them with curiosity. The programme refers to this process as "leaning in". Participants are encouraged to explore experiences as they are directly felt in a mindful way. Challenges are typically based on the weekly topics discussed in each session, but they are broadly related to participating in activities in support of recovery or the enhancement of wellbeing (e.g., doing gentle exercise, reading a book chapter, writing in a journal, contacting a friend, doing something that has been postponed because it feels aversive).

Besides ‘leaning in’, the programme follows a second main principle called ‘letting go’. Letting go draws on the ACT-based principles of diffusion from attention capturing cognitions and emotions. Participants are encouraged to let go of unhelpful thoughts, memories and internal content through fostering acceptance of these difficult experiences. Letting go is a particularly challenging task and typically develops slowly following group discussion of difficult and challenging experiences.

The programme also includes a weekly check-in. The check-in provides an opportunity to discuss the participants’ progress and the outcome of the challenge set from the previous week. It also helps to establish connections among the participants and for them to be able to hear about others’ personal ongoing experiences. In order to further consolidate the learning, at the check-in facilitators also tend to highlight the skills and topics learned during the programme.

Each group session takes approximately two hours to complete. The first 45 minutes to 60 minutes is dedicated to the check-in. This is typically followed by a 10-minute comfort break. The next 45 minutes is dedicated to exploring a specified topic, which is presented on PowerPoint slides via a projector. The programme uses a highly professional set of images that depict a number of psychological concepts, often by using metaphors or stories to explore each topic. Discussion is encouraged throughout. A further 5 minutes is dedicated to setting a weekly challenge for each individual. These challenges are specific, measurable, achievable, realistic and timely. The facilitator records them, so that they are ready for the next week’s check-in. Following the group, the facilitators spend 15 minutes debriefing the session by following a debrief guide (see Appendix B).

Method

Participants

The study recruited 61 participants who attended 6 separate MOIMR groups. There were 39 (64%) males and 22 (36%) females. The mean age of participants was 43 years-old (Range 23 to 67). Alcohol was the primary drug of concern for 37 (61%) participants, heroin for 16 (26%) participants, cocaine for 5 (8%) participants and ‘other’ (amphetamine, ketamine) for 3 (5%) participants. At the time of entry into the study, 54% of the sample had been abstinent from substances in the previous three months.

A total of 29 participants (48%) completed the MOIMR programme and the first post-group follow-up, and 25 participants (41%) completed the three-month follow-up. Table 1. displays the recruitment and retention rates for each separate group.

Table 1. Number of Participants Recruited into the Study by Group Location and Follow-up Rates.

Group Location	Eligible Participants (n = 69)	Recruited Participants (n = 61)	Post-group Follow-up (n = 29)	3-month Follow-up (n = 25)
Bangor 1	15	13	7 (54%)	7(54%)
Caernarfon	7	7	1 (14%)	0 (0%)
Colwyn Bay	13	11	7 (64%)	6 (55%)
Rhyl	8	8	3 (38%)	1 (13%)
Shotton	16	14	6 (43%)	6 (43%)
Bangor 2	10	8	5 (63%)	5 (63%)

Ethical Approval

Ethical approvals were obtained from Bangor University School of Psychology Ethics Committee and the Integrated Research Application System. The study was registered with Betsi Cadwaladr University Health Board Research & Development Department. The study was also registered with the Health and Care Research Wales Portfolio.

Design

The study employed quantitative methods (i.e., a within-participants repeated-measures design) over three time points (i.e., baseline, post-group, and a three-month follow-up). The study also employed qualitative methods (i.e., two focus groups for each separate group at the post-group and three-month follow-up time points). Feasibility was assessed using pre-determined criteria (see Table 2.).

Instruments

The *Recovery Strengths Questionnaire* (RSQ; Hogan, 2016) is a 15-item self-report questionnaire. It assesses five dimensions of recovery capital (social strengths, physical strengths, activity strengths, personal strengths and attitudinal strengths). Respondents record their current satisfaction on a 0 (not at all satisfied) to 10 (totally satisfied) scale. The measure assesses strengths derived from attending mutual aid support (i.e., internally generated recovery capital) and strengths derived from the wider community (i.e., externally generated recovery capital). Cronbach's alpha showed that reliability for the scale is $\alpha = .93$ (see Rettie, Hogan, & Cox, 2018).

Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a 9-item questionnaire designed to measure low mood and depression. This measure also contains validated clinical norms. Respondents self-report the frequency of various clinically significant symptoms during the past two weeks on a four-point Likert scale ranging from 0 (Not at all) to 3 (Nearly every day). Internal reliability was

found to be high (Cronbach's alpha = .89) and test-retest reliability was .84 (Kroenke, Spitzer & Williams, 2001).

General Anxiety Disorder (GAD-7; Spitzer, Kroenke, Williams and Löwe, 2006) is a 7-item questionnaire designed to assess level of anxiety. This measure also contains validated clinical norms. Respondents self-report the frequency of various clinically significant symptoms during the past two weeks on a four-point Likert ranging from 0 (Not at all sure) to 3 (Nearly every day). The GAD – 7 was found to have high internal consistency (Cronbach's alpha α = .92) and a high test-retest score of .83.

General Health Questionnaire (GHQ 12; Goldberg & Williams, 1988) is a 12-item questionnaire designed to assess mental health and social functioning. It is a shorter version of the original 60-item General Health Questionnaire (GHQ 60; Goldberg, 1972). Items are rated on a 4-point scale (e.g., from 1 "Better than usual" to 4 "Much less than usual" or 1 "Not at all" to 4 "Much more than usual"). Higher scores on the questionnaire indicate poorer mental health. Example items are "Have you recently lost much sleep over worry?", "Have you recently been thinking of yourself as a worthless person?". Cronbach's alpha has shown that the reliability of this scale is α =. 93 (see Levin et al., 2012).

Brief Experiential Avoidance Questionnaire (BEAQ; Gámez et al., 2014) is a 15-item questionnaire. It is a brief version of the original 62-item Multidimensional Experiential Avoidance Questionnaire (MEAQ; Gámez, Chmielewski, Kotov, Ruggero, & Watson, 2011). The BEAQ is designed to assess experiential avoidance. Items are rated on a 6-point scale (e.g., from 1 "strongly disagree" to 6 "strongly agree"). Higher scores indicate elevated levels of experiential avoidance. Example items are "When unpleasant memories come to me, I try to put them out of my way" and "I rarely do something if there is a chance that it will upset me". Cronbach's alpha shows that the BEAQ has good internal consistency (α =. 93).

Acceptance and Action Questionnaire–Substance Abuse (AAQ-SA; Luoma, Drake, Kohlenberg, & Hayes) is an 18-item scale containing two subscales: (a) Values Commitment, and (b) Defused Acceptance. It measures psychological flexibility in relation to substance use related thoughts, feelings, and urges. The focus of the AAQ-SA is on one's relationship to or the functions of private events, versus the content of the events themselves. Cronbach's alpha has shown that internal consistency for this scale is α =. 85.

Procedure

Participants eligible to take part in the study were those who had enrolled on a Moving On In My Recovery (MOIMR) group programme within Betsi Cadwaladr University Health Board (BCUHB) Substance Misuse Services and the partner recovery organisation North Wales Recovery Communities. Group members were informed about the study at a welcome event, which was held prior to the start of the group programme. Participants then arranged to meet the research team[1] prior to the start of Session One of the MOIMR programme. Participants were paid £5 for completing the pre-group (baseline) questionnaires.

[1] In keeping with the original MOIMR design and philosophy, each interview was supported by a person in recovery (i.e., with lived experience of addiction).

Following the last group session (i.e., week 12) of the group programme, participants were again asked to complete the baseline questionnaires and to undertake a focus group interview (see Appendix C for the interview schedule) about their experiences of the group programme. Participants were paid £10 for their time. At this time point, all participants who had failed to complete the group programme were contacted to arrange a time for them to attend an interview and to complete the baseline questionnaires again. They were also paid £10 for their time.

Three-months from the last group session, participants were again asked to complete the same baseline questionnaires and to undertake a focus group interview about their experiences since completing the group programme; participants were again paid £10 for their time. Participants were then thanked and debriefed about the study.

Results

Feasibility Outcomes

Five feasibility outcomes were assessed in this study. The study used predetermined criteria (see Table 2) to assess feasibility.

1. The recruitment rate was 88% and therefore greater than the predetermined level (i.e., the green criterion was recruitment greater than 80%) and therefore acceptable: of the 69 people who enrolled in the 6 MOIMR group programmes, 61 people participated in the study.
2. The retention rate at the post-group time-point was 48%; therefore, it did not meet the predetermined level (i.e., the green criterion was that more than 60% of the sample would be retained in the study). The retention rate did partially meet the requirement (i.e., it fell within the amber criterion of 45% to 59%). Of the 61 participants who started the study, 29 were retained at the first follow-up time point.
3. The retention rate at the three-month follow-up was 41%; therefore, it did not meet the predetermined level (i.e., the green criterion was that more than 50% of the sample would be retained in the study at the three-month follow-up). The follow-up retention rate did partially meet the requirement (i.e., it fell within the amber criterion of 40% to 49%): of the 61 participants, 25 were retained at the three-month follow-up.
4. The quality of completed questionnaire data was high at 95% (e.g., that is completed questionnaires without missing data) and therefore was at the predetermined level (i.e., the green criterion was that greater than 90% of data sets would be complete).
5. The follow-up rate of those dropping out of the MOIMR group programme was 22%; therefore, it did not meet the predetermined level (i.e., the green criterion was that more than 50% of the sample who dropped out would be retained in the study at the post-group follow-up); n = 7 participants who dropped out of the MOIMR group were contacted at the follow-up time point; therefore, it met the red criterion (i.e., feasibility would not be demonstrated if fewer than 30% of the group participants who dropped out of the group could not be contacted at follow-up).

Table 2. Pre-determined Feasibility Criteria

Criterion	Critical Feasibility Outcome	Proposed Thresholds on Critical Outcome	Outcome
1. Recruitment rate	The number of group participants consenting to take part in the study	🟢 Feasibility will be demonstrated if 80% or more of group participants consent to take part in the study. 🟠 Feasibility will be partially demonstrated if 50% of participants consent to take part in the study: future recruitment is possible but additional recruitment strategies will be necessary. 🔴 Feasibility will be partially demonstrated if less than 50% of participants consent to take part in the study then feasibility is not demonstrated.	🟢 From a total of 69 participants who attended the groups 61 (88%) consented to participate.
2. Study retention	The number of group participants retained in the study	🟢 Feasibility will be demonstrated if 60% or more of group participants are retained at follow-up. 🟠 Feasibility will be partially demonstrated if 45% to 59% of group participants are retained at follow-up. 🔴 Feasibility will not be demonstrated if less than 45% of group participants are retained at follow-up.	🟠 From a total of 61 participants who attended the groups 29 (48%) completed the follow-up session.
3. Study follow-up	The number of group participants retained at the three-month follow-up	🟢 Feasibility will be demonstrated if 50% or more of group participants are retained at the three-month follow-up. 🟠 Feasibility will be partially demonstrated if 40% to 49% of group participants are retained at the three-month follow-up. 🔴 Feasibility will not be demonstrated if less than 40% of group participants are retained at the three-month follow-up.	🟠 From a total of 61 participants who attended the groups 25 (41%) completed the three-month follow-up.
4. Data quality checklist	The amount of missing data from completed questionnaire	🟢 Feasibility will be demonstrated if more than 90% of participant questionnaires are fully completed. 🟠 Feasibility will be partially demonstrated if 80% to 89% of participant questionnaires are fully completed. 🔴 Feasibility will not be demonstrated if less than 80% of participant questionnaires are fully completed.	🟢 95% of all questionnaires were fully completed.
5. Group Non-Completers contacted at follow-up	Participants who dropped out of the groups contacted at follow-up	🟢 Feasibility will be demonstrated if 50% or more of group participants that drop out of the group are contacted at follow-up. 🟠 Feasibility will be partially demonstrated if 30% to 49% of group participants that drop out of the group are contacted at follow-up. 🔴 Feasibility will not be demonstrated if less than 30% of group participants that drop out of the group are contacted at follow-up.	🔴 22% (n = 7) of participants who dropped out of the study were followed up.

Baseline Data (Completer versus Non-Completers)

There were no apparent differences between those who were retained in the study (Completers) and those who dropped out (Non-Completers). For example, the Completers group (n = 29) had n = 18 males and n = 11 females and the Non-Completers group (n = 32) had n = 21 males and n = 11 females. The average age of the Completers was 44 years old (Range = 23 to 67) and for the Non-Completers, it was 43 years old (Range = 25 to 66). The proportion of primary drugs of concern was very similar in the two groups: Completers versus Non-Completers, respectively, were Alcohol: 49% versus 51%; Heroin: 27% versus 25%; Cocaine: 3% versus 13%; and for 'other drug' it was 7% versus 3%. The three-month abstinence rate prior to the study was 55% for the Completers and 53% for the Non-Completers. There was no significant difference between the Completers and the Non-Completers on any of the baseline measures (see Table 3.).

Table 3. Mean Baseline Questionnaire Scores and Standard Deviations for Completers and Non-Completers.

Questionnaire	Completer M (sd)	Non-Completer M (sd)
Recovery Strengths (RSQ)	86.7 (25.2)	88.5 (25.4)
Low Mood (PHQ-9)	15.1 (7.9)	15.8 (7.1)
Anxiety (GAD-7)	13.2 (6.4)	14.2 (5.9)
Social Functioning (GHQ-12)	5.6 (4.4)	5.7 (4.4)
Values (AAQ-SA)	43.3 (7.0)	44.5 (9.6)
Acceptance (AAQ-SA)	32.4 (12.5)	28.2 (10.3)
Experiential Avoidance (BEAQ)	59.0 (14.8)	59.6 (14.4)

*_Note_: All differences were non-significant.

Main Quantitative Outcomes

Recovery Strengths: A repeated-measures ANOVA showed a significant effect for time, $F(1,48) = 16.8$, $p < .001$. After Bonferroni corrections, Recovery Strength was still significantly lower at baseline [M = 85.1 (*sd* = 23.8)] than at either of the follow-up time points: post-group: M = 100.8 (*sd* = 22.8), $p < .01$, and at the 3-month follow-up: M = 104.3 (*sd* = 26.3), $p < .001$ (see Figure 1.).

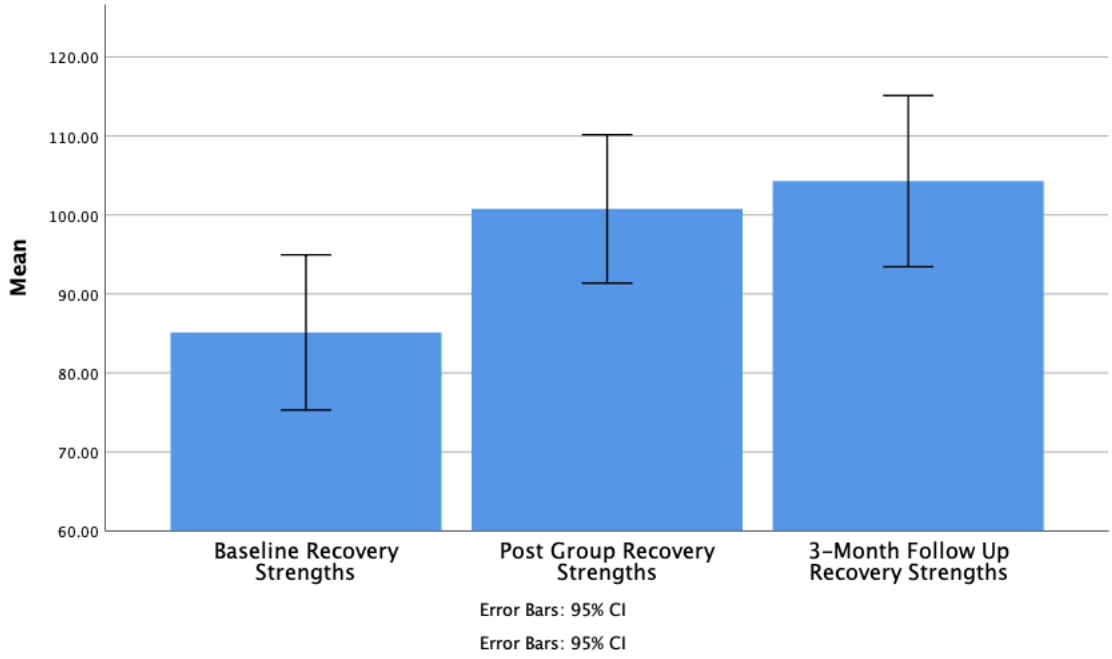

Figure 1. Recovery Strengths at Baseline, Post-Group Completion and at a 3-Month Follow-up.

Low Mood: Repeated Measures ANOVA showed a significant effect for time, $F(1,48) = 11.4$, $p < .001$. Bonferroni tests showed that Low Mood was significantly higher at baseline [M = 15.6 (*sd* = 7.4)] than at either of the follow-up time points: post-group M = 11.3 (*sd* = 6.3), $p < .01$ and at the 3-month follow-up M = 9.1 (*sd* = 7.9), $p < .001$ (see Figure 2.).

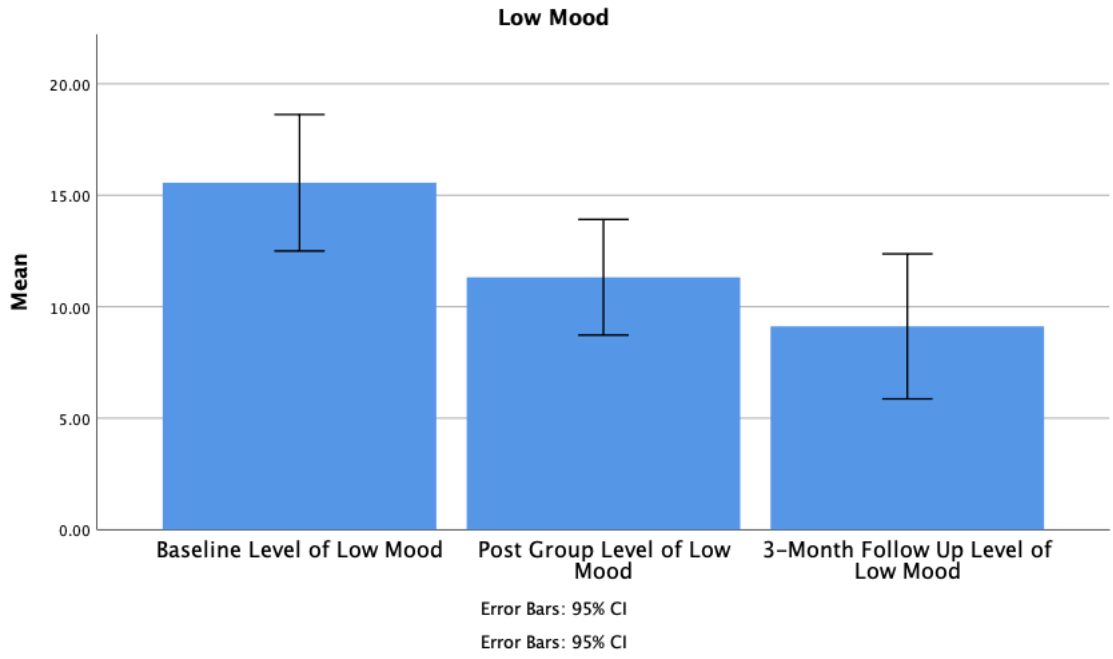

Figure 2. Mean Scores of Low Mood at Baseline, at Group Completion and at the 3-Month Follow-up.

Anxiety: A repeated-measures ANOVA showed a significant effect for time, F(1,48) = 14.0, $p < .001$. Bonferroni tests showed that Anxiety was significantly higher at baseline [M = 13.5 (*sd* = 5.9)] than at either of the follow-up time points: post-group M = 9.0 (*sd* = 5.7), $p < .01$ and at the 3-month follow-up M = 7.9 (*sd* = 6.6), $p < .01$ (see Figure 3.).

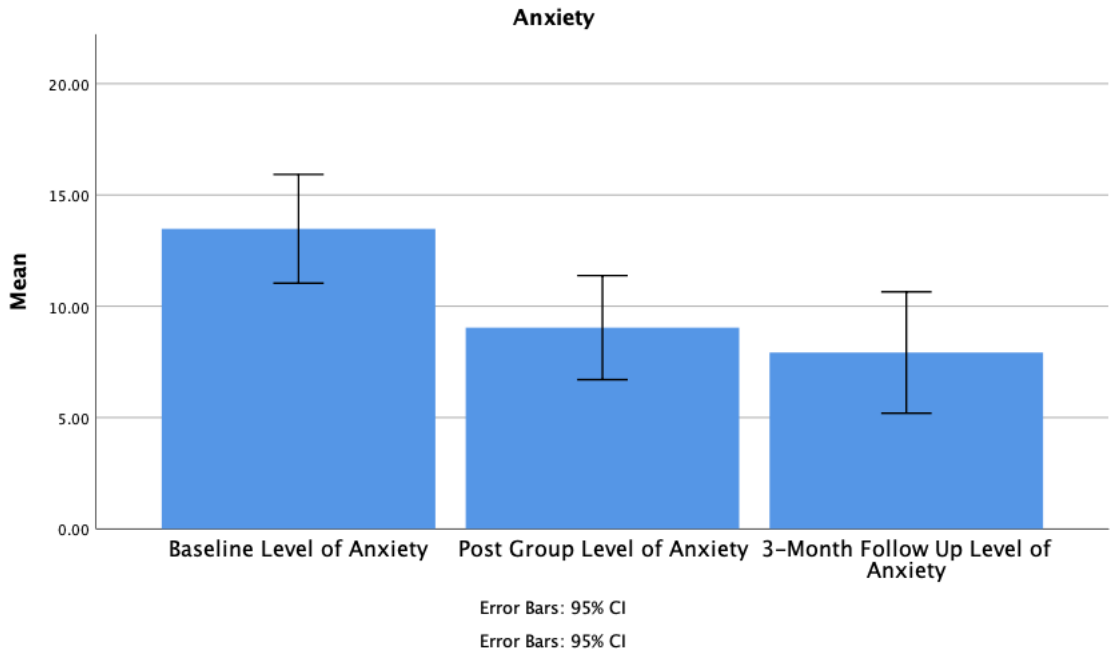

Figure 3. Mean Scores of Anxiety at Baseline, at Group Completion and at a 3-Month Follow-up.

Social Functioning: A repeated-measures ANOVA showed a significant effect for time, F(1,48) = 6.5, $p < .01$. Bonferroni tests showed that Social Functioning was significantly more impaired at baseline [M = 17.6 (*sd* = 9.4)] than at the 3-month follow-up [M = 11.5 (*sd* = 7.8), $p < .05$]; however, the difference at the post-group timepoint was non-significant [M = 12.6 (*sd* = 8.4), $p > .05$] (see Figure 4.).

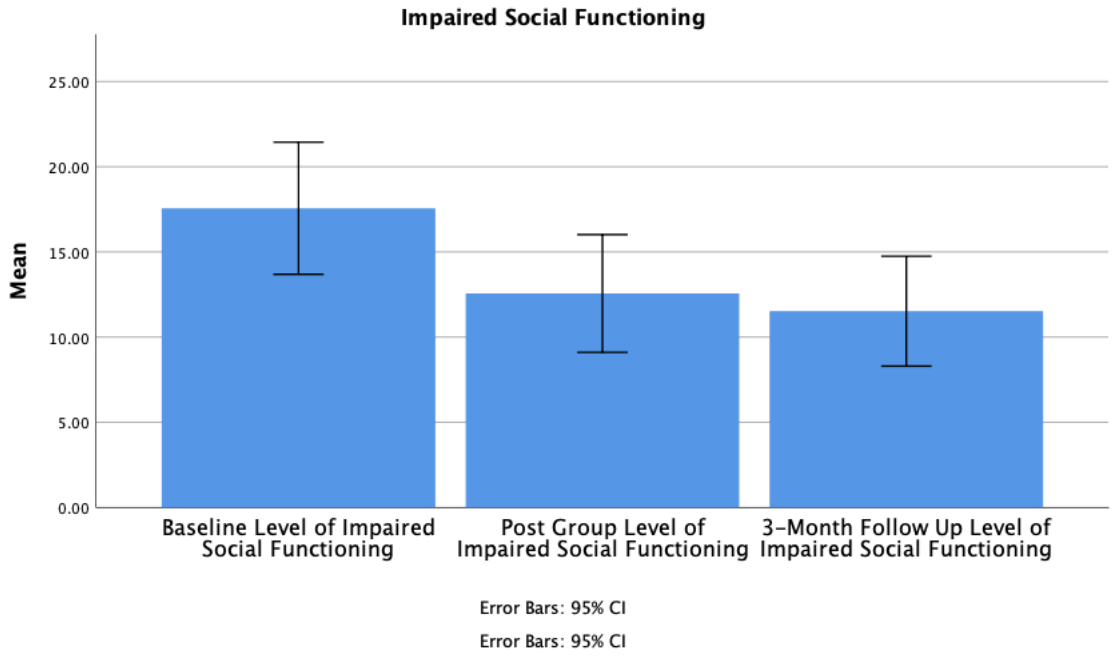

Figure 4. Mean Scores of Impaired Social Functioning at Baseline, at Group Completion and at a 3-Month Follow-up.

Values: A repeated-measures ANOVA showed a significant effect for time, F(1,48) = 4.2, $p < .05$. Bonferroni tests showed that connection to values significantly increased from baseline, [M = 43.8 (*sd* = 6.0)] to the post-group follow-up [M = 48.4 (*sd* = 7.9), $p < .05$]; however, at the 3-month follow-up it was a non-significant difference [M = 47.6 (*sd* = 9.5), $p > .05$] (see Figure 5.).

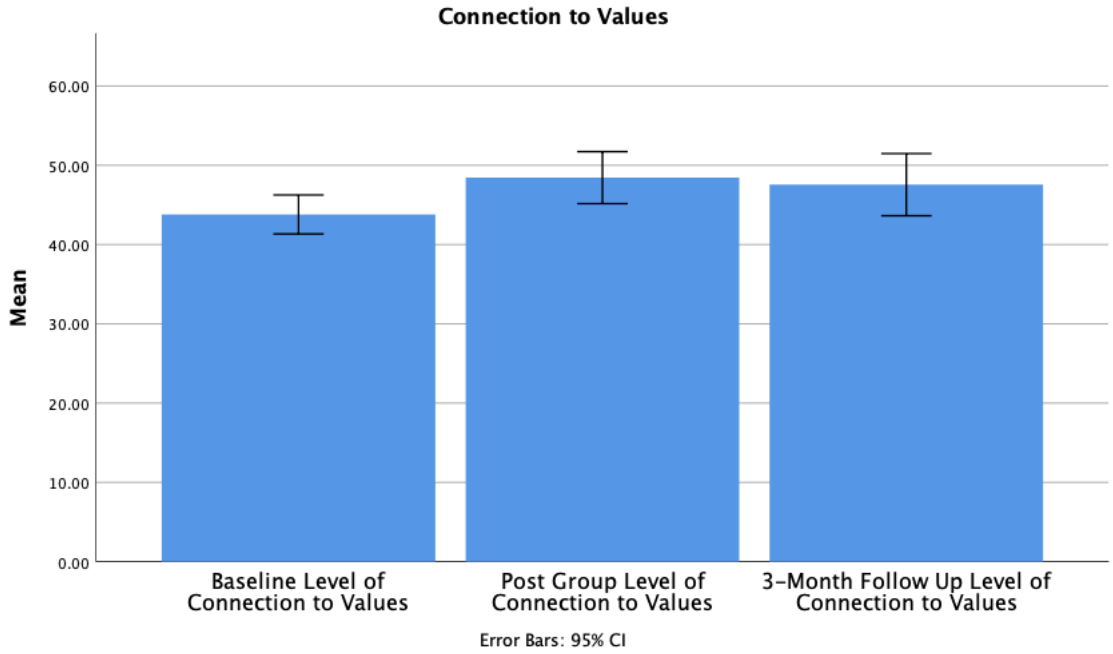

Figure 5. Mean Scores of Connection to Values at Baseline, at Group Completion and at a 3-Month Follow-up.

Acceptance: A repeated-measures ANOVA showed a non-significant effect for time, F(1,48) = 3.1, *p* > .05. There was no difference from baseline [M = 31.8 (sd = 11.2)] to the post-group follow-up [M = 38.0 (sd = 13.5)] nor to the 3-month follow-up [M = 37.8 (sd = 13.7)] (see Figure 6.).

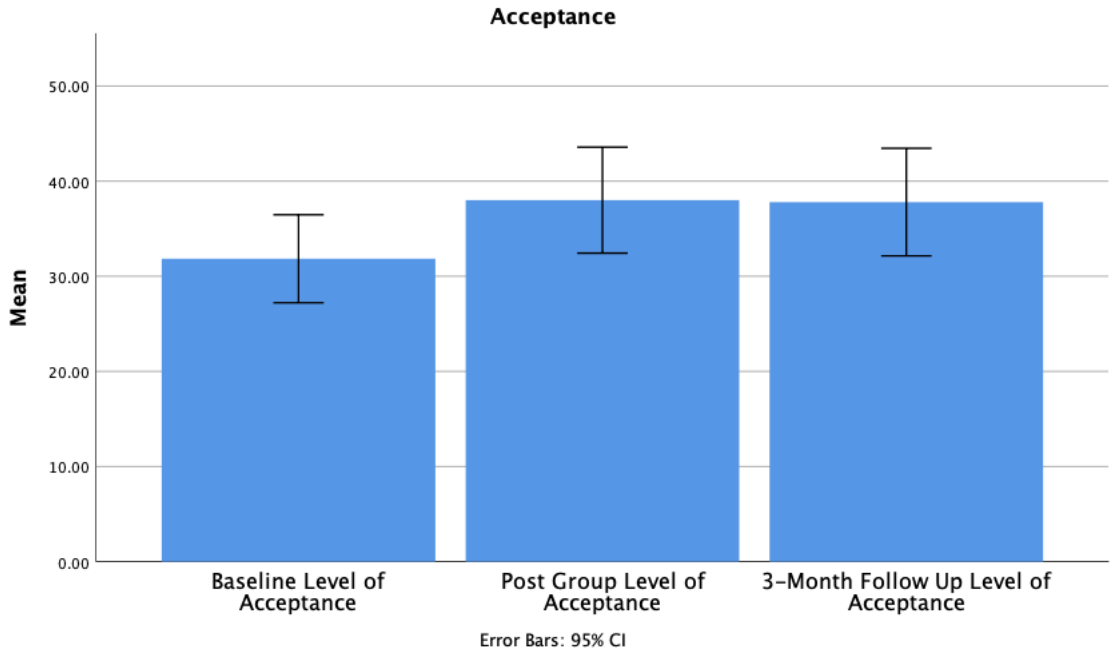

Figure 6. Mean Scores of Acceptance at Baseline, at Group Completion and at a 3-Month Follow-up.

Experiential Avoidance: A repeated-measures ANOVA showed a significant effect for time, F(1,48) = 4.7, *p* < .05. Bonferroni tests showed that Experiential Avoidance was significantly greater at baseline [M = 59.9 (*sd* = 14.7)] than at the 3-month follow-up [M = 53.6 (*sd* = 13.1), *p* < .05] however, it was a non-significant difference to the post-group follow-up [M = 56.8 (*sd* = 15.6), *p* > .05] (see Figure 7.).

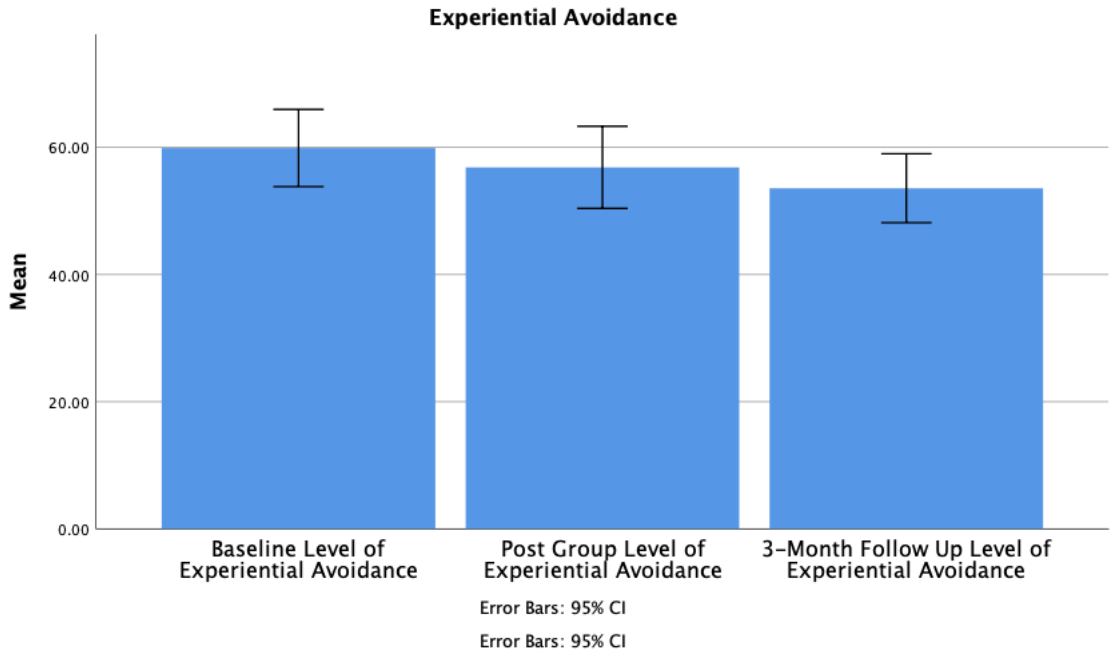

Figure 7. Mean Scores of Experiential Avoidance at Baseline, at Group Completion and at the 3-Month Follow-up.

Abstinence rates across the three timepoints are shown in Figure 8. At Baseline, 55% of participants had been abstinent during the previous three-months; at Post-group, 62% of participants had been abstinent during the previous three-months; and at the 3-month follow-up 68% of participants had been abstinent during the previous three-months.

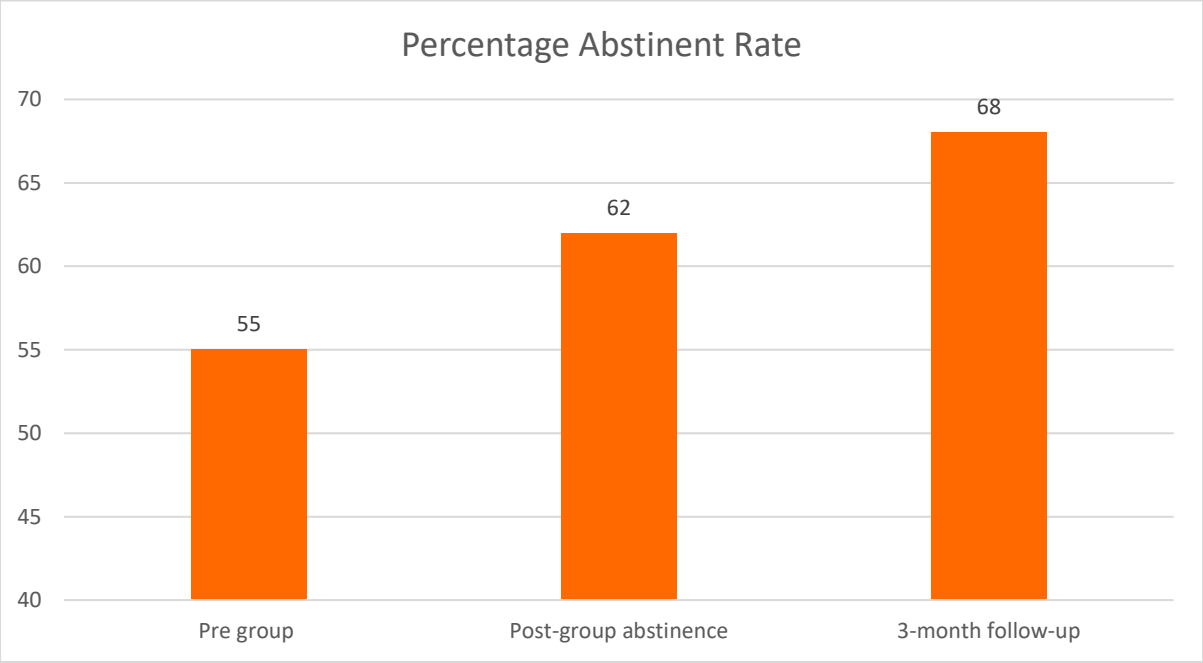

Figure 8. Percentage of Persons With Three Months or More of Abstinence at Baseline, at Group Completion and at the 3-Month Follow-up.

Qualitative Outcomes

The focus group interviews were audio recorded. The recordings were then transcribed and analysed by following the six-phase approach to Thematic Analysis (Braun & Clarke, 2012). The following steps were taken: (1) the research group familiarised themselves with the data by reviewing the transcripts of the focus groups; (2) initial codes were generated from the data; (3) themes were searched in the transcripts; (4) potential themes that best represented the codes and the data overall were selected; (5) themes were defined and named as clearly as possible; and finally (6) a report was written about the thematic analysis of the data. Analysis revealed four main themes in the transcripts of the focus groups. The themes in the transcript, the codes assigned to them, and examples of the codes that are direct quotes from the participants are listed below.

Theme 1: The Challenges and Benefits of Attending MOIMR

Many participants described an initial reluctance to attend a group-based programme. They reported downplaying the group's effectiveness or their own need to participate. This initial reluctance was, however, balanced against the participants' need to work on their recovery within the structure that MOIMR provided. The codes and examples of these codes are as follows:

i. An initial reluctance to attend:

"I was the biggest sceptic."
"I just didn't want to do it."
"I dreaded it."
"I was not keen on groups."

ii. The importance of structure:

"It had a structure that kept me focused."
"The structure is a big help."
"It has a framework."
"Each week there is a focus on a theme. . . other mutual aid groups don't do that."
"The structure is a big help."

Theme 2: Realising that I am not alone

A very strong theme was the sense that prior to entering the programme many people felt alone and isolated in their recovery from addiction. Other people in the group impacted on the participants and there was a sense of a shared journey. The group deepened participants' ability for perspective-taking. Co-facilitation by people with lived experience was also highly valued. The codes and corresponding examples are as follows:

i. The impact of others in the group:

"I realised that I am not alone."

"It was good to be involved with other people, you know, sharing, talking and hearing other people."
"I just thought there was something wrong with me. . .. I have come to realise I can't help the way I feel and I should accept that it is okay to feel this. . ..No one judged me. In this group I was just accepted for me, who I was, so that I have a problem but that problem doesn't define me. . ..I've learned not to control my thoughts but to go with them. . .. It helped me to stop hating yourself as much for what you had done. . .. Moving On helped me see the bigger picture."

ii. A shared journey:

"No one judged me. I was accepted for who I was."
"To have people who have been there and done it. . .relatable."
"I made real friendships."
"It was an opportunity to really discuss ideas and topics."
"You know you are not on your own and we all moved on together."

Theme 3: The impact of MOIMR

Many participants described how MOIMR had impacted them in unexpected ways. They learned specific skills to cope with cravings and urges, to lean into discomfort and to let go of painful thoughts and memories. The programme also helped participants to learn about themselves.

i. The impact of the group on recovery:

"It shocked me back to life."
"From being the biggest sceptic. I was totally shocked by the impact."
"The change in me is quite amazing."
"It gave me knowledge, wisdom, and power."
"Feeling like I want to get up and go."
"It has improved my self-esteem."
"You learn a lot about yourself."
"It has had a profound effect."
"There is no hiding."

ii. The skills acquired from the group:

"Leaning in – I'd spent my whole life leaning out – avoiding."
"Dealing with emotions—loss"
"Looking at myself."
"It has given me confidence—I can talk in groups."
"I have come out of my shell."
"I can tackle my problems head on."
"It has given me discipline, focus."
"I am communicating and that is massive for me."
"Relationships."
"It has given me coping mechanisms in my armory."

Theme 4: Additional considerations for MOIMR

Many participants described MOIMR as not being a course that could simply just one time. In fact, many participants advocated that it should be done more than once. A frequent observation was that the participants did not want to see the course come to an end. Realising they would not have the group to attend was a particularly difficult experience for them.

i. The need to do it more than once:

"You need to do it more than once."
"I've done the course three times and you learned more each time you do it."
"It's like the first time you're not ready and then the second or even third time it comes together, you know?"
"I did the course a couple of times, because you tend to do it more than once to really get all the other gen [sic] and benefit from it as well."

ii. A need to continue with recovery:

"It has to lead on to something."
"I really looked forward to a Tuesday and for it not to be there was really difficult."
"It has got to lead on to something."
"Just do it nationwide. Do it nationwide, and you'll probably see a rise in addicts become . . . I didn't know about any of this. All I knew about was CAIS and counselling and the NA group. But then since I've had an option to re-structure my life again . . .Moving On In My Recovery . . . It just needs to be more nationwide so people that have been there and doing what we have done can also have the opportunity if they want it."

Non-Completers of MOIMR

A total of 7 participants who dropped out of the study were available to be contacted at the post-group follow-up stage (i.e., 12 weeks after the baseline interview). Pairwise comparisons showed that the drop-outs had marginal improvements across time on the Recovery Strengths Questionnaire from baseline, M = 79.1 (*sd* = 20.4), to the follow-up, M= 88.4 (*sd* = 20.2); on the PHQ-9 from baseline, M = 18.9 (*sd* = 4.8), to the follow-up, M = 14.1 (*sd* = 5.6); on the GAD-7 from baseline, M = 17.1 (*sd* = 3.5), to the follow-up, M= 14.1 (*sd* = 5.5); and on the BEAQ from baseline, M = 53.6 (*sd* = 16.4), to the follow-up, M= 54.3 (sd = 13.4). Despite the improvement that the follow-up scores suggested, they were largely equivalent to the baseline scores of the entire sample.

Due to the drop-outs' high levels of intoxication, the qualitative interviews with them yielded unsuitable transcripts for analysis. In general, the participants who were interviewed described not being at a stage in their recovery where they were ready for the intervention: two of them reported how they were still using heroin; another had been made homeless. In some cases, participants described how they attended the group programme to "to get on prescription quicker for the withdrawals" and to get fast-tracked for treatment.

Discussion

This study sought to establish whether a larger randomised controlled trial (RCT) to evaluate the effectiveness of Moving On In My Recovery would be viable. We have reached the conclusion that a RCT would indeed by feasible, and we recommend that it be carried out. We reached this conclusion on the basis of (a) the ease with which the feasibility study was executed, and (b) the promising outcomes that it yielded for the participants who completed this study. Of course, we cannot be sure that the improvements in participants' lives demonstrated in this study can be attributed solely to the intervention or whether another intervention would bring equivalent or possibly better outcomes. A RCT would allow us to draw these additional conclusions.

The study recruited participants from 'real-world' treatment services. We aimed to recruit 80% of the service users who were accessing the Moving On In My Recovery programme and this target was easily surpassed in that we recruited 85% of the targeted participants. We were unable to screen the individuals who were recruited for their suitability for the intervention itself, as these decisions had already been made by the treatment services. The attrition from the study was high at 52%. A recent systematic review and meta-analysis of dropout rates in psychosocial interventions for substance use by Lappan, Brown and Hendricks (2020) found the average drop-out rate was around 30%. Lappan et al. did, however, find that drop-out rates were higher for dependent users than non-dependent users, higher in group programmes than individual interventions, and higher in interventions that had more than seven sessions or lasted more than 90-minutes. All of these things characterized the MOIMR intervention and the sample of participants whom we recruited. In the present study, drop-out rates were also higher in those locales where the groups had only recently been established (e.g., 86%). In those locations where the groups had been running longer, fewer people dropped out of the study (e.g., 36%).

The aim of the Moving On In My Recovery programme is to target participants who are relatively stable in their recovery and those who have already achieved abstinence. The objective is to assist these participants in maintaining their abstinence and possibly exit from treatment when doing so seems feasible. The actual three-month abstinence rates upon entering the study were somewhat lower than expected at 54% of the sample. These rates had improved at the post-group timepoint (i.e., to 62%) and had improved still further at the three-month follow-up (68%). Given the acceptance-based and behavioural features of the intervention, it is possible that some of participants were not entirely suitable for the intervention.

There were no demographic or functioning differences between those participants who were retained in the study (i.e., the Completers) and those who dropped out (i.e., the Non-completers). The implication is that the Completers were representative of the entire sample. Participants who were retained in the study engaged in the follow-up interviews and were fully compliant on completing the assessment measures. This was less easily achieved with the participants who had dropped out of the MOIMR programme but who were contacted at the follow-up. In the main, the participants who dropped out did so because they had relapsed (i.e., had resumed their substance use at a dependent level) or because they had

continued to use substances at dependent levels. The quality of these participants' answers on the questionnaires and their ability to participate in interviews was greatly impaired as a consequence.

The outcome measures selected for the study reasonably captured the changes expected from this intervention, and they were easy enough for the participants to complete. The recovery capital of participants and their level of low mood and anxiety all improved from baseline to the post-group time-point, and these improvements were maintained at the three-month follow-up. Social functioning, connection to values (a subscale of the AAQ-SA), and experiential avoidance all showed significant improvements, but only at the three-month follow-up. This might be as a consequence of a lack of sufficient power in the study to detect improvements but also theoretically, these aspects of improvement require significant behavioural changes; therefore, they might take greater practice and more time to achieve. The intervention specifically targeted psychological flexibility. Although there were promising outcomes on some of these measures, significant changes were not detected on the acceptance scale of the AAQ-SA, even though the mean scores were in the expected direction.

The service users' perspective of the intervention was highly positive. All of the participants who were interviewed praised the programme highly, and some of those who dropped out indicated that they intended to join a group in the future. The participants particularly valued the co-facilitation of groups by people with lived experiences. Interestingly, many participants described their initial reluctance to attend a group-based intervention, but also how their reticence about groups lifted as they became more comfortable in the group setting. Participants described being on a shared journey with other group members and even with the facilitators. It seems that the structure and framework of the group was something that had been missing from the lives of the people struggling with addiction. The group made profound impacts on the participants' lives, and many felt it should be more widely available and as a form of continuous support for people in recovery. In short, participants were transformed from being reticent about group treatment to being champions of it.

Conclusions and Recommendations

- The Moving On In My Recovery programme is a viable intervention for a larger randomised control effectiveness trial.
- The measures used in the study were acceptable to participants.
- Recruitment into groups that have previously been established within a service location are likely to have better retention rates than newly established group programmes.
- Service users' involvement in the research process is highly valued and recommended for future endeavours.
- Moving On In My Recovery appears to have good ecological validity and promising outcomes.

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Appendices

Appendix A – Session List

No.	Name	Aim	Activity
1	The Next Step in My Recovery	Introduce programme outline expectations.	Assess progress to date and set goals.
2	Anchor Points and Lifestyle Balance	Understand psychological system and what gives us stability.	Gain stability by building anchor points.
3	Protecting My Mental Wellbeing	Understand what can undermine wellbeing and actively protect it	Protecting mental wellbeing with active steps.
4	Coping with Anxiety	Understand anxiety, learn to cope or seek advice; develop and use skills to deal with it.	Coping strategies in the top ten hand out skills guide.
5	Managing Low Mood	Understand low mood and learn how to cope or seek advice for it; develop and use skills to deal with it	Activity scheduling as the principle method of management.
6	Shutting the Door to Relapse	Understand how and why it occurs and to take steps to lessen individual risks.	Look at own high-risks and plan to minimise or avoid these.
7	Peer Support	Understand the value of peer support; consider how one gives and / or receives it.	Committing to doing something for others or being gracious and accepting help.
8	Our Relationships	Understanding how relationships are important and what makes them toxic	Strengthening relationships and building positive networks
9	Being Me	Understanding why I am who I am and gaining flexibility around it.	Looking at the roles we all play and developing willingness to live towards our values.
10	Dealing with Life's Losses	To understand the process of loss and use acceptance skills to get through the pain	Use acceptance and normalisation to understand and cope with losses in life
11	Stigma and Me	Understand the cost of self-stigma and to take steps to be more self-compassionate	Develop a level of self-compassion to let go of self-stigma using mindfulness
12	More Steps in My Recovery	Take stock of and celebrate achievements and to assess progress. To say goodbye	Review sessions. Re-assess progress. Set goals. Say goodbye with a letter.

Appendix B – Group Process Form

WEEK No._____ DATE_____

Group Process – Self-Rating Form

			No Evidence	Slight Evidence	Definite Evidence
Start	Introductions	Did you name check everyone?			
	Outline	Did you explain the focus of today's session?			
	Check In	Did you check with how each person had been in the previous week?			
		Did you review each person's weekly challenge?			
		Did you connect the progress made to skills learned and content of previous sessions?			
	Formula for Success	Did you make reference to the formula for success?			
General Group Process	Warmth / Genuineness	Did you recognise the gains made; support the disclosure of sensitive material; normalise struggles?			
	Empathy	Did you reflect your understanding to participants appropriately - including with body (nodding etc)?			
	Discussion	Did you let people talk about relevant issues and draw on the experiences of other people in the group?			
	Time Management	Was the pacing Okay? Did you cover all the material? Was there enough time for the weekly challenge?			
	Managing Contributions	Did everyone contribute? Did you keep people on track?			
	Group Motivation	Is the group involved in the group process (i.e., are they contributing / making changes)?			
	Participant understanding	Is the group able to relate to / understand the material?			
Ending	Weekly Challenge	Did you set the weekly challenge and encourage participation (eg did facilitators participate, too)?			
	Feedback	Did you check out how the session went?			

Appendix C Interview Protocol

Qualitative Interview Protocol

What we want to do is to have a brief chat in which I will ask you a few questions about your experience of being involved in MOIMR. I am looking to hear from you as much as possible, so I will keep the questions brief. Please feel free to say what you think is important.
Before we start, may I record this interview to allow us to analyse the data? The contents of this interview will normally be shared only within the research team for research purposes. Your name will be anonymous in any report that we produce.
All of your responses will remain confidential, however, there are times when we must pass on information; for example, if we are concerned about your wellbeing or we think that someone is at risk of harm.

If you feel you do not want to answer a particular question, or stop the interview, that is completely fine.
Do you have any questions before we begin recording?
Just for the tape, am I ok to ask you to repeat what you said?
May I have your permission to record this interview?

Key Components	
Introduction: Consent Purpose Confidentiality Questions	Ensure participant previously read the information sheet and provided written consent before beginning the interview. Remind participant of the interview purpose, and check that they are happy to proceed. Explain issues around consent including consent to be recorded and ensure confidentiality. Make sure the participant is able to ask questions.
Begin Recording	State participant number and gain verbal consent on the recording itself.
Questions: Broad opening; Open-ended (no specific order); Use probes as Needed.	Could you please tell me about your experience of being involved in Moving On In My Recovery (MOIMR)? How has this group impacted on your overall recovery experience? More specifically, what aspects of this recovery group have been important for your recovery? To your knowledge, how is this group different from mutual aid and 12-step groups such as SMART, NA and AA? To your knowledge, how is this group similar to mutual aid and 12-step groups such as SMART, NA and AA? *Example probes*: Could you please give an example? Is there anything else? Could you expand on that please? What do you mean by...?
Closing Further Questions Next steps	Let them know that you have asked all your questions. Then give them the opportunity to add anything they think might be important or valuable: 'Is there anything else you would like me to know or that you think is important to help us understand your experience better? In closing the interview, ensure the participant has time to ask any further questions. Debrief interview, and explain that a full verbal and written debrief will be provided at the end of the study after completing the questionnaire.

Non-completers of MOIMR Interview Protocol

Thank you for agreeing to be interviewed by us about your experiences of attending the Moving On In My Recovery Programme. We would like to ask you some questions about what it was like for you. Of course, there are no right or wrong answers and you can be re-assured that your responses will remain strictly confidential.

First, can you tell me how many group sessions did you attend?

When you agreed to participate in the programme how much did you know about it?

What did you expect you might get from participating?

Please can you tell me about your experience of being involved in Moving On In My Recovery (MOIMR) Group?

What did you see as the benefits of attending?

What did you see as the barriers of attending?

Can you please tell us why you decided not to keep attending the Moving On In My Recovery (MOIMR) programme?

What are the barriers that might prevent a person to not want to complete the Moving On In My Recovery (MOIMR) programme?

Is there anything that make you more likely to complete the Moving On In My Recovery (MOIMR) programme?

Is there anything you would like to tell us or add?

Many thanks for your time.