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Providing addiction services during a pandemic: Lessons learned from COVID-19

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ABSTRACT

During the COVID-19 pandemic, social distancing measures have made in-person mutual help groups inaccessible to many individuals struggling with substance use disorders (SUDs). Prior to the pandemic, stakeholders in our community had sponsored a program to train volunteers to facilitate local Self-Management and Recovery Training (SMART Recovery) groups. As a result, the community established seven weekly SMART Recovery groups, which more than 200 community members attended. In March 2020, the community discontinued these groups due to the COVID-19 pandemic. To provide SMART Recovery during social distancing, we developed a one-on-one phone-in service for people with SUDs and addictions: the SMART Recovery Line (SMARTline). In this paper, we share our experience training volunteers to facilitate SMART Recovery groups and SMARTline. As a result of our experience, we have learned to: (1) establish plans in advance to migrate services from face-to-face settings to remote platforms; (2) consider remote platforms that are easily accessible to the greatest number of individuals; (3) include as many stakeholders in the planning process as possible; (4) consider recruiting volunteers to help in the provision of services, especially since many people want to help fellow community members during crises; and (5) anticipate and prepare for crises well before they occur.

1. Addiction mutual help groups and the impact of COVID-19

We are in the midst of the COVID-19 pandemic. More than one-third of adult Americans have reported high levels of psychological distress during the beginning months of this pandemic (Keeter, 2020). Researchers have speculated that the stress and isolation that COVID-19 has caused will result in increased frequency and severity of mental health problems, including substance use disorders (SUDs) (Columb et al., 2020; Dubey et al., 2020; Marsden et al., 2020; Ornell et al., 2020). In-person mutual help groups (MHGs), including Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Self-Management and Recovery Training (SMART Recovery), and others are essential resources for millions of individuals struggling with addictions (Kelly & White, 2012). Unfortunately, most in-person MHGs have been temporarily discontinued in response to COVID-19 (Hoffman, 2020). Below, we share our experience establishing and facilitating SMART Recovery services in our community before and during the COVID-19 pandemic.

2. SMART recovery in our community prior to COVID-19

Our community of Douglas County, Kansas, has a population of 122,259 (U.S. Census Bureau, 2019). More than 8% of Douglas County residents under age 65 have no health insurance and 17% live in poverty (U.S. Census Bureau, 2019). In fall 2018, a group of county stakeholders (including community members, elected officials, addiction specialists, and health care professionals) met to discuss how to best develop sustainable safety-net services for these and other individuals who might exhibit difficulty accessing professional addiction services. After considerable research, stakeholders agreed that SMART Recovery groups were well suited to meet the needs of this population.

SMART Recovery is a network of MHGs offered worldwide. Volunteer facilitators who complete 20 h of online training lead SMART Recovery groups. Participants provide support to one another and learn to use SMART Recovery tools (i.e., structured exercises) to support addiction recovery (Horvath & Yeterian, 2012). The SMART Recovery national office reports that there are 3500 active, in-person weekly meetings internationally, attended by at least 10,000 participants ("SMART Recovery Fast Facts," 2019). Participation in SMART

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Recovery has been associated with reduced substance use severity, reduced substance use–related problems, and greater abstinence from substances (Campbell et al., 2016; Hester et al., 2013; Zemore et al., 2018).

To establish SMART Recovery groups in Douglas County, two major stakeholders (a community foundation and county government) agreed to support a volunteer SMART Recovery group facilitator training program. These stakeholders formed a program development committee to plan this program and recruit volunteer group facilitators. The committee recruited volunteers directly through social service agencies, education institutions, volunteer services, and health care facilities. Whenever possible, committee members visited institutions and agencies, to describe the proposed program, answer questions, and address concerns. The committee also sent press releases to local media outlets and published at least one full-length news article describing the program.

Volunteers were required to complete a three-stage training process prior to facilitating their own group. In stage one they had to successfully complete the standardized online SMART Recovery facilitator training program (www.smartrecovery.org). In stage two they had to complete a newly developed live training program. And in stage three they needed to co-facilitate SMART Recovery groups with a more experienced facilitator until both agreed that the new facilitator was ready to facilitate his/her own group. Volunteers included lay community members, mental health care professionals, individuals who had attended SMART Recovery groups, undergraduate students, and peer support specialists, among others. During online training, volunteers learn about basic counseling skills, motivational interviewing, stages of change, cognitive behavioral principles and techniques, and group dynamics. However, due to the online format of this training, volunteers do not have opportunities to apply acquired knowledge or practice new skills. Hence, during live training, volunteers participated in at least 16 additional hours (in 4-hour sessions) of in-person practice where they discussed and role-played basic counseling and group facilitation skills. They learned about and practiced open and closed questioning, active listening, empathetic responding, maintaining group focus, and managing challenging situations. After role-playing, trainers and other trainees provided them with feedback. And then trainers, who were experienced SMART Recovery facilitators, modeled various skills so all could observe and learn from them. To supplement this learning, volunteers assisted in facilitating local SMART Recovery groups. Prior to the pandemic, 21 volunteers had completed all training and volunteers were actively facilitating SMART Recovery groups.

As a result of the volunteer SMART Recovery group facilitator training program, our community had established seven weekly SMART Recovery groups (whereas none had previously existed in our community). These included four groups at various community institutions, one group for college students at a local university, one group for inmates at the county jail, and one group for clients at a community mental health center. We obtained participant data through naturalistic observation from five of the seven SMART Recovery groups as part of a quality improvement project that the Institutional Review Board at the University of Kansas Medical Center approved.

Prior to the COVID-19 pandemic, 229 different participants attended these new groups. Approximately one-fifth of these participants attended five or more groups, and the most active participants attended more than 50 group sessions. During sessions, participants sought help for a wide range of chemical and behavioral addictions, including addictions to alcohol, methamphetamine, cannabis, opioids, nicotine, and gambling. Some participants also asked for help with binge eating, compulsive sexual behavior, and compulsive shopping. Most participants (83%) attended SMART Recovery to achieve or support abstinence from addictive behaviors. The remaining 17% expressed a desire to "control" addictive behaviors. Thirty percent of participants reported multiple addictions and one-third reported additional mental health problems (e.g., depression, anxiety, PTSD). SMART Recovery reached those who would otherwise have had difficulty accessing professional addiction services; approximately 22% of our participants were unemployed or receiving disability and approximately 3% were homeless.

3. Responding to COVID-19: SMARTline

In March 2020, our community introduced social distancing measures, and community agencies where SMART Recovery meetings were held (e.g., the public library) suddenly closed without notice. As a result, all in-person group sessions were immediately terminated. Because participants' contact information had not been collected, there was no established mechanism for contacting SMART Recovery group members. After considering these circumstances, community leaders and trained facilitators agreed to an alternative method for delivering services to community members—they established a telephone-based SMART Recovery line (SMARTline).

SMARTline is a one-on-one phone-in service, based on SMART Recovery principles and practices, that operates daily for all community members seeking help for addictions. Similar to live SMART Recovery meetings, SMARTline aims to provide social support and rudimentary cognitive behavioral techniques to support individuals in addiction recovery. SMARTline also functions as a referral service: interested participants are directed to online SMART Recovery groups and other community resources. The only additional operating costs associated with SMARTline are carrier charges required to maintain cellular service. Like SMART Recovery groups in Douglas County, volunteers who complete online and live training facilitate SMARTline.

SMARTline training began in spring 2020, with a group of volunteers attending weekly meetings led by more experienced addiction professionals. Training resembled in-person SMART Recovery group facilitator training. Volunteers reviewed the use of SMART Recovery tools and basic counseling skills, they role-played as SMARTline facilitators, and they received feedback following role-playing.

SMARTline facilitator training is adapted from live SMART Recovery group facilitator training, with adjustments made for differences between services. For example, because SMARTline is delivered to individuals rather than groups, greater emphasis is placed on developing rapport between individuals, compared to greater focus on group processes in SMART Recovery group facilitation. Also, because SMARTline involves only audio contact, volunteers are encouraged to incorporate SMART Recovery tools without the benefit of diagrams, handouts, or worksheets common with SMART Recovery groups. Accordingly, facilitators assist participants in guided discussion, asking questions such as, "What are some advantages and disadvantages of quitting or continuing your addictive behavior?" Volunteers engage in weekly group supervision to discuss challenges, receive feedback, and develop facilitation skills.

4. Mechanisms of change in SMART Recovery and SMARTline

Moos (2008) outlines potential *mechanisms of change* (i.e., active ingredients) for in-person MHGs. These include social control (e.g., bonding, cohesion, goal direction, structure or monitoring), social learning (e.g., imitative modeling, expectations of positive and negative consequences), behavioral choice (e.g., non-addictive activities, alternative reinforcers), and coping (e.g., identifying and responding to stressors, building self-efficacy, developing effective coping skills). Kelly et al. (2012) focus on similar mechanisms of change in a sample of AA participants. These include improvements in social networks, social self-efficacy, and negative affect self-efficacy. Kelly et al. (2009) hypothesize that these mechanisms are present to varying degrees in all in-person MHGs. Yalom and Leszcz (2005) propose 11 therapeutic factors associated with group therapy and MHGs participation: instillation of hope, universality, imparting of information, altruism, corrective recapitulation of the primary family group, developing social

skills, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.

While we have not yet formally assessed potential mechanisms of change or therapeutic factors associated with SMARTline, we assume that at least some are functional during SMARTline calls. For example, by discussing experiences with a trained facilitator on the phone, individuals are likely to feel supported, gain hope, receive useful information, and consider alternatives to engaging in addictive behaviors. Because SMARTline does not provide a group experience or continuous relationships, callers are less likely to benefit from many of the group dynamics that Yalom and Leszcz have described. Nonetheless, SMARTline is designed to provide at least brief exposure to the most salient mechanisms of action and therapeutic factors.

5. SMART Recovery and SMARTline: evidence and feasibility

Studies have found that SMART Recovery is likely to help those who attend meetings (Campbell et al., 2016; Hester et al., 2013; Zemore et al., 2018). One longitudinal study, comparing four MHGs (AA, SMART Recovery, Women for Sobriety, and LifeRing), found SMART Recovery to be as effective as AA at six-month follow-up (Zemore et al., 2018). Researchers have conducted only one randomized trial of SMART Recovery (Campbell et al., 2016; Hester et al., 2013). At three- and six-month follow-up, Hester et al. (2013) and Campbell et al. (2016) found participation in SMART Recovery to be effective in increasing percent of days abstinent, reducing drinks per drinking day, and reducing alcohol related problems. However, this study compared three groups that all received some adaptation of SMART Recovery. Without the presence of a control group, the effectiveness of SMART Recovery remains unknown. Hence, SMART Recovery is promising, but current research support for its effectiveness is limited (Beck et al., 2017).

To our knowledge, live community-based training of lay volunteers in SMART Recovery group skills is a novel process; we were unable to find other examples of such training in the literature. We assume that such training enhances standard SMART Recovery online training by providing opportunities for skill practice and direct feedback. While SMART Recovery facilitators are typically current or past group members in recovery, lay volunteers also include a wide array of individuals who simply wish to help other community members. We are in the process of developing a fidelity instrument to measure the degree to which facilitators in our community are reliably delivering SMART Recovery, and we certainly hope to measure the impact of training community volunteers to facilitate SMART Recovery groups.

We searched for one-on-one telephone services like those offered through SMARTline (i.e., adapted from SMART Recovery), and did not find any service like SMARTline in the literature. Given that SMARTline is a novel approach, we are only beginning to understand feasibility, accessibility, utility, sustainability, and logistical issues. As with our community SMART Recovery groups, we have been tracking basic SMARTline use patterns and will continue to do so. We hope that such tracking will enable us to modify our processes to make SMARTline further accessible and beneficial to the community. We will be particularly interested in questions such as:

- To what extent are all-volunteer, community-based addiction services both helpful and sustainable?
- To what extent do volunteers and participants remain involved in such programs when they move from live meetings to remote (technology-assisted) contact?
- To what extent does community demand for remote addiction services change as social distancing restrictions are relaxed and in-person MHGs resume?
- What outcome measures are most appropriate, as we consider studies of the impact of services such as SMARTline?
- To what extent are remote services like SMARTline scalable to other communities?
- How do services such as SMARTline most effectively function and collaborate with existing conventional addiction treatment services?

6. Recommendations

The COVID-19 pandemic has resulted in profound challenges. Like other crises, this pandemic has necessitated innovation. Thus far, our attempts to innovate have taught us at least the following lessons:

- Addiction services can be made available during a crisis, when conventional resources are not available;
- Community agencies are willing to partner with stakeholders to provide addiction services;
- Volunteers are eager to contribute to the sustainability and growth of addiction services; and
- Resources such as SMART Recovery provide a framework for training volunteers to deliver addiction services.

Based on our experience providing addiction services in the midst of the COVID-19 pandemic, we recommend the following for providing addiction services during a public health emergency:

- Establish advance plans to migrate services from face-to-face settings to remote platforms;
- Consider remote platforms that are easily accessible to the greatest number of individuals (including simple telephone hotline-like services);
- Include as many stakeholders in the planning process as possible;
- Consider recruiting volunteers to help in the provision of services, especially since many people want to help fellow community members during crises; and
- Anticipate and prepare for crises well before they occur.

At the time of this writing, we are beginning to implement SMARTline. We hope that this resource, analogous to a suicide hotline, will provide ongoing services to those with addictions.

7. Conclusion

During the COVID-19 pandemic, many substance use and addiction recovery services, including MHGs, have turned to delivering services remotely. Prior to this pandemic, we developed a novel volunteer facilitator training program to develop and support local SMART Recovery groups. As a result, our community established seven weekly SMART Recovery groups between October 2018 and February 2020. More than 200 community members, struggling with a wide variety of chemical and behavioral addictions, some of whom were homeless or unemployed, attended these groups.

Unfortunately, due to the COVID-19 pandemic, the community discontinued all in-person SMART Recovery groups. To resume SMART Recovery services, we developed a one-on-one phone-in adaptation of SMART Recovery: SMARTline. The purpose of SMARTline has been to provide social support, encourage hope, and stimulate potential coping skills to replace addictive behaviors. Our experiences with SMART Recovery and SMARTline programs should enable us to evaluate the sustainability and accessibility of these services. Furthermore, we hope to determine how sustainability and accessibility of these services were impacted by the COVID-19 pandemic.

CRediT authorship contribution statement

Bruce S. Liese, PhD: Program conceptualization and design; project administration; training and supervision of volunteers; funding acquisition; methodology; data curation and analysis; writing of original draft

Corey M. Monley, BGS: Assisted in program design, administration, and volunteer training; data curation and analysis; reviewing and editing of manuscript

Declaration of competing interest

None.

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