CHAPTER 6

The Power of Online Synchronous Cognitive–Behavioral Group Intervention: A Get S-M-A-R-T Illustration

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In September 2019, I (L.W.) was presenting at the Indiana Annual Recovery Month Symposium at the Embassy Suites in Indianapolis. The presentation focused on content from a cognitive–behavioral substance use disorders program that addressed early interventions for synthetics-marijuana-alcohol-recreational-trouble (S-M-A-R-T). I (V.L.G.), an associate professor and clinical researcher from Indiana University School of Social Work, was present in the audience given my own clinical experiences in providing similar interventions for court-ordered clients* in a community mental health center, and I recognized that S-M-A-R-T was different.

At the end of the symposium, I approached the presenter, Lisa Werth, to discuss a collaborative evaluation of the intervention's empirical outcomes. We are licensed clinical social workers and licensed clinical addiction counselors, and both of us have many years of experience working with court-mandated individuals and a mutual desire to address the rates of recidivism (Gibbs & Lytle, 2020) and the latent variables that may influence recidivism (motivation). After talking and realizing that we had overlapping practice philosophies, values, and visions regarding improving the way the criminal justice and other referral systems manage substance use charges or problems, we began meeting to collaborate on developing a study to conduct a program evaluation of the cognitive–behavioral Get S-M-A-R-T curriculum (Gregory & Werth, 2022). Over the next several months, we met via

* Throughout this chapter, we use the terms "participants" and "clients" interchangeably.

videoconferencing software to discuss the study's aims, research design, variables, institutional review board issues, and the Get S-M-A-R-T curriculum.

IMPETUS FOR ONLINE COGNITIVE–BEHAVIORAL INTERVENTION

The initially planned face-to-face cognitive–behavioral group intervention for S-M-A-R-T was changed to an online synchronous cognitive–behavioral group intervention (OSC-BGI) in response to the COVID-19 pandemic (Parihar et al., 2021). Yet, beyond COVID-19, several concurrent factors also have helped catalyze the expansion of online cognitive–behavioral and other interventions (Shatri et al., 2021)—for example, specific clinical populations and their respective needs.

Prior research has made a theoretical and empirical argument for the unique benefit of online cognitive–behavioral interventions in addressing social anxiety disorder (Yuen et al., 2013). Online cognitive–behavioral intervention could have a beneficial role in expanding access to, and addressing the behavioral counseling component of, low-threshold buprenorphine treatment for persons who are prescribed medications for opioid use disorder (Gregory & Ellis, 2020). Given disproportionate use of mental health services for Black individuals (Center for Behavioral Health Statistics and Quality, 2021), online cognitive–behavioral interventions could overcome some barriers that limit access (Ellis & Anderson, 2021). Others have discussed the use of online psychosocial intervention to address barriers in rural communities that limit access to mental health services (Oldham, 2016). These changes had implications for one of us (L.W.), who was facilitating the intervention; both of us, who were conducting the research; and the clients, who received the OSC-BGI for substance use.

Types of Online Cognitive–Behavioral Interventions

Given the various motivations for utilizing online cognitive–behavioral interventions, both asynchronous and synchronous options exist. *Asynchronous online cognitive–behavioral intervention* involves the communication between the provider and the client that does not occur simultaneously (Chan et al., 2018). As described by Chan and associates, asynchronous approaches have the advantages of decreased reliance on immediate online access, greater accessibility via mobile phones, fewer time restrictions for both the provider and client, and the inclusion of videos, among other factors. *Synchronous online cognitive–behavioral intervention* includes live or concurrent video or telephonic communication between the provider and the client (Chan et al., 2018).

Empirical Support for Online Cognitive–Behavioral Interventions: Mental Health

In terms of cognitive–behavioral therapy (CBT) format, the proof of concept for asynchronous online intervention and synchronous online intervention has been substantiated via meta-analyses or randomized clinical trials (RCTs) for various mental health and substance use issues. A transdiagnostic online CBT meta-analysis (Păsărelu et al., 2017) showed the intervention demonstrated large, positive effects in the treatment of anxiety and depression and a moderate positive effect in quality of life. One meta-analysis compared asynchronous, synchronous, and face-to-face methods for persons with depression (Richards & Richardson, 2012); in that meta-analysis, the asynchronous subgroup had a moderate effect size on self-reported depressive symptoms that was significantly better than its synchronous counterpart at posttreatment. Yu and colleagues (2021) conducted a meta-analysis evaluating online and face-to-face CBT for neurological insomnia and found that online CBT had significantly greater total sleep time and improved anxiety relative to the control counterparts.

Empirical Support for Online Cognitive–Behavioral Interventions: Substance Use

While we were unable to find a meta-analysis evaluating the cumulative quantitative effects of online CBT (asynchronous or synchronous), several RCTs were available and supported the efficacy of the interventions. One RCT evaluated a computer-based training for cognitive–behavioral therapy (CBT4CBT) intervention in women who were primarily African American (Kelpin et al., 2021). The CBT4CBT RCT was a hybrid of both face-to-face and asynchronous electronic CBT intervention. This study was statistically underpowered, yet it had some small effects with outcomes favoring the CBT4CBT arm: fewer relapses, longer time until relapse, and more sobriety at the follow-up period relative to the control group.

Prior RCTs that have evaluated CBT4CBT have shown significant improvement with various substances relative to treatment as usual (Carroll et al., 2008, 2014; Kiluk et al., 2016). An RCT of alcohol consumption and symptoms compared two types of synchronous online CBT to asynchronous CBT (Sundström et al., 2016). That study found superior effects in the synchronous methods, showing a significant reduction in alcohol use relative to the asynchronous arm of the study. The extant body of behavioral science literature shows promise from studies evaluating the efficacy of online CBT interventions for clients with diagnosed substance use disorders.

Synchronous Online Cognitive–Behavioral Early Interventions for Court-Ordered Clients

The empirical reports of efficacy for online CBT interventions for substance use continues to grow given the aforementioned circumstances (Parihar et al., 2021) that necessitate them. Due to the progressive nature of substance use disorders, early interventions (Fornili & Haack, 2005)—such as familial, legal, financial, occupational, marital, and many others (American Psychiatric Association, 2013)—can be used to prevent medical and psychosocial problems stemming from substance use. As previously mentioned, because of issues presented by COVID-19, we empirically evaluated an early OSC-BGI aimed at addressing motivation and hazardous substance use for persons who are court ordered or otherwise mandated for intervention (Gregory & Werth, 2022). The study was conducted online in a synchronous group format using the S-M-A-R-T cognitive–behavioral early intervention. The Get S-M-A-R-T content is different from traditional court-ordered substance use classes in that it is an experiential curriculum offering exercises developed from principles of second- (J. S. Beck, 2021) and third-wave CBT (Hayes, 2016), motivational interviewing (MI; Miller & Rollnick, 2013), and positive psychology (Lopez et al., 2019). The OSC-BGI (S-M-A-R-T) is delivered in eight-, 12-, 16-, or 20-hour doses of clinical intervention. Rather than the 30 to 50 participants in a standard substance use education classroom, Get S-M-A-R-T is designed for small groups of 15 or fewer and is facilitated by two master's-level clinicians.

The preexperimental study (Gregory & Werth, 2022) demonstrated an association between the Get S-M-A-R-T OSC-BGI and positive improvements in motivation at posttest and recidivism and self-report of DSM substance use symptoms at 12-month follow-up. It was this experience with OSC-BGI that we both began to further realize the utility and potential benefits of OSC-BGI. The purpose of this chapter is to expand social workers' use of OSC-BGI through a description of an innovative example called Get S-M-A-R-T. We articulate principles and cognitive–behavioral interventions that are used in the synchronous online group format and also discuss the implications for social work values and ethics.

OSC-BGI: GET S-M-A-R-T

Overview

The purpose of Get S-M-A-R-T is to provide clients an opportunity to further examine their relationships between their substance and their goals, values, decisions, functioning in different domains of life, and underlying mental health. Get

S-M-A-R-T is an OSC-BGI that consists of either eight-, 12-, 16-, or 20-hour dosages/groups with unique, evidence-based curricula clinical exercises and materials for substance use and mental health intervention.

Get S-M-A-R-T explores underlying causes of substance abuse. The intervention does so while respecting and empowering participants to discover the source of their behaviors that causes legal or other functional problems. These sources can often include stress, limited coping skills, inadequate social support, a skewed perspective regarding the actual consequences of substance use, trauma, and mental health issues (A. T. Beck et al., 1993). Through specialized clinical exercises and group work, Get S-M-A-R-T encourages participants to explore their personal relationship with drugs and alcohol. The OSC-BGI helps clients develop constructive patterns for wellness through which participants begin to examine problematic behaviors and gain insight regarding potential solutions.

Providers and Group Size

Get S-M-A-R-T facilitators are licensed in clinical social work (or are other master's-level, mental health–oriented professional providers) and addiction. Due to the advanced clinical exercises as well as the skills required to manage common group dynamics that emerge in the program, two social work facilitators are recommended per class.

To promote a therapeutic environment, class sizes are capped at 10 participants for the OSC-BGI format. Smaller groups are conducted to create adequate time for sharing and participation that facilitates encouragement, hope, and increased internal motivation for positive change.

Principles

Synchronous online group facilitators are trained on the following principles:

- Validate without judgment (Linehan, 1993).
- Encourage participants to challenge each other (altruism; Yalom & Leszcz, 2020).
- Reward self-responsibility (affirmation; Miller & Rollnick, 2013) and other expressions of internal locus of control.
- Practice self-awareness and mindfulness (Segal et al., 2013).

These principles, properly executed and coupled with the Get S-M-A-R-T curriculum, provide a platform that encourages substantive and positive change. As discussed in Rogers's (1957) classic article, the most essential part of the synchronous

online Get S-M-A-R-T intervention is building a therapeutic alliance with the participants. Because this correlates strongly with social work values and ethics (NASW, 2021), it is also a strong foundation that allows the online intervention to be successful. You might wonder: How do you create a therapeutic alliance over an online platform? Well, much like you would do in person, you follow simple principles. These are also the principles of the Get S-M-A-R-T curriculum and certified facilitators.

Validate without Judgment

Linehan (1993) defined *validation* as communication that lets clients know both that their statements are sensible and understood given the circumstances and that the client is accepted. Each participant has a story that led them here, and, as a facilitator, it's crucial that we recognize and validate their emotions without judgment, blame, or shame. Example statements include: "It sounds like you're feeling . . ."; "Can you say more about that?"; "Help me understand . . ."; and "Thank you for sharing—I know this can be difficult to talk about." When doing this virtually, as in person, both verbal and nonverbal communication remains integral to the intervention. For example, leaning in, having eye contact, and showing interest and enthusiasm through tone of voice are important.

Encourage Participants to Challenge Each Other (Altruism)

One of the curative factors of group intervention is altruism (Yalom & Leszcz, 2020). Get S-M-A-R-T facilitates altruistic exchanges among group members that come in the form of questions, feedback, and supportive statements. These altruistic, client-to-client group behaviors are in part facilitated by the group members' modeling the facilitators' interactions with the clients. This is what Yalom and Leszcz have referred to as "imitative behavior."

In the context of the altruistic and imitative behavior curative factors, clients can identify behaviors and thought patterns in one another to help each of them recognize the flawed logic in themselves. A common example is when one client scoffs or shakes their head when another is giving excuses or rationalizing their substance use. You might gently bring attention to the scoffing client, asking why the client had that reaction to what the other said. Allow participants to hold each other accountable. Another key component is the balanced representation of principles. For example, through questions, affirmations, and feedback, the facilitators help balance the principles of validation without judgment and encourage participants to challenge each other.

Reward Self-Responsibility (Affirmation)

Affirmation has been a long-standing aspect of core skills pertaining to MI (Miller & Rollnick, 2013). Research has demonstrated the ability of affirmation to impact clinically relevant outcomes (Karpiak & Benjamin, 2004). Therefore, success of clients in Get S-M-A-R-T is conceptually and in part determined by rewarding or recognizing positive behavior. These participants might be so used to being treated like a number by "the system" that your encouragement could move mountains. Example statements include: "Everyone is on time! Thank you for that" and "I see no one has their phones out. We're off to a great start."

Practice Self-Awareness and Mindfulness

Facilitators may feel tired, distracted, or stressed outside of the virtual classroom. However, be mindful not to allow those things to be distractions once the synchronous online group begins. Similar to the CBT principle of therapeutic rapport (J. S. Beck, 2021) and Rogerian (Rogers, 1957) guidelines for establishing and maintaining therapeutic rapport, facilitators should be cognizant that they're always treating clients with respect and conveying empathy.

Segal and colleagues (2013) identified the importance of mindfulness and self-care pertaining to the group facilitators. Facilitators get themselves encouraged and excited before class about influencing positive change in clients and remain aware that everyone in the virtual room is a human deserving of an opportunity to grow and learn. Clients can tell whether the facilitators are engaged, and they will react accordingly. This is especially important online because facilitators must be the ones to keep the energy flowing in the room, which can be done by being mindful of one's own mood, emotions, and the way we approach the material and clients.

Practice Foundations

Consistent with CBT principles (J. S. Beck, 2021), the Get S-M-A-R-T curriculum is specifically designed to be educational and interactive. Therefore, the notion of and hope for change can be transformed from an elusive idea to a tangible, desirable, and attainable goal for participants. To that end, Get S-M-A-R-T has both positive psychology (Lopez et al., 2019) and MI (Miller & Rollnick, 2013) as the foundation of the curriculum. Other exercises are based in second-wave CBT (J. S. Beck, 2021) and dialectical behavior therapy (Linehan, 1993).

The OSC-BGI was innovative and was created to allow clients to create change in their lives. Furthermore, specific coping skills are taught and practiced. In the

context of OSC-BGI, Get S-M-A-R-T addresses underlying mental health concerns, and participants are guided in interventions consisting of mindfulness, meditation, breathing techniques, cognitive restructuring, and the benefits of being grateful.

Clients may have dichotomous (A. T. Beck, 1976) or even attribution errors in thinking and just push it away: "It's those stupid cops" or "It's just that I was pulled over for my taillight out." Other clients may have permissive automatic thoughts (A. T. Beck et al., 1993) pertaining to their justification for using a substance in a hazardous situation. As has been indicated at various times in this chapter, the facilitators instill the CBT model and principles early on, suggesting to participants that how they think about what has happened, including having to be here, will influence their emotions and behaviors (J. S. Beck, 2021). In addition to using MI and the spirit of MI throughout, participants are presented with some cognitive–behavioral intervention skills for addressing thoughts that may contribute to risk-taking substance use behavior. We start by asking for a show of hands: "How many people are excited to be here? How many are indifferent? How many are angry or feel it is unfair?" Validate feelings and help participants understand they can take charge of their thoughts.

Get S-M-A-R-T was developed to help clients feel heard, validated, and not judged. These factors are believed to contribute to quicker establishment of rapport during a brief intervention. We have found that all the activities of the curriculum that we had done in person can be done online. Most participants need a computer or smartphone, pen, and a paper to participate. Table 6.1 provides an overview of the Get S-M-A-R-T intervention schedule for the eight-,12-, 16-, and 20-hour doses (definition of postacute withdrawal symptoms from Haskell, 2022). Each dosage of the OSC-BGI includes all of the previous sections. For example, the 20-hour dosage receives every intervention in the table, whereas the 12-hour dosage receives only the 12- and eight-hour components. For those interested in learning more about the Get S-M-A-R-T curriculum, visit the Calla Collaborative Health website (see https://callacch.com).

Monitoring Client Progress Online

Additional benefits of the synchronous online group intervention are the ease and efficiency by which technology can be used to monitor progress via online scales. Online, outcome data collection from clients can be used for visual or statistical evaluations of progress. Since the data is collected online, there is no need to manually enter data, which saves time. The online evaluation of progress can be analyzed at the individual level or group level. Facilitators can view and use the data in a feedback loop to improve services. The deidentified data can also

Table 6.1: OSC-BGI: S-M-A-R-T Program Schedule

8-Hour Intervention			
Introduction of program	State laws exercise	Biology of addiction	Brain chemistry
Impaired driving prevention	Risk reduction triggers and coping skills	Substance use spectrum exercise	Creative approach to prevention
12-Hour Intervention			
Self-assessment and mental health	Pro or con exercise	Wisdom line exercise	Substance use and families
16-Hour Intervention			
Recap of 8- and 12-hour interventions	PAWS	Coping skills explored	Addiction and change
20-Hour Intervention			
Opiates	Experiential learning	Group support	Application of CBT
DBT skills	Affirmations	Defense mechanisms	Mindfulness and meditation

Notes: Each dosage includes all of the previous dosages. CBT = cognitive–behavioral therapy; DBT = dialectical behavior therapy; OSC-BGI = online synchronous cognitive–behavioral group intervention; PAWS = postacute withdrawal symptoms, emotional and psychological symptoms that remain after the initial withdrawal symptoms have subsided and raise the risk for relapse; S-M-A-R-T = synthetics-marijuana-alcohol-recreational-trouble.

be anonymously shared with the client, referral sources, and other stakeholders provided the appropriate precautions are taken.

The Get S-M-A-R-T curriculum has used electronic scales (Gregory & Werth, 2022) with adequate psychometric statistics for clients with substance use issues to measure client-relevant outcomes. Such scales have included the measure of depressive symptoms (Patient Health Questionnaire-9; Dum et al., 2008), anxiety (Generalized Anxiety Disorder-7; Delgadillo et al., 2016), satisfaction with life (Satisfaction with Life Scale; Di Maggio, 2016; Di Maggio et al., 2021), self-esteem (Rosenberg Self-Esteem Scale; Luoma et al., 2008), and motivation (University of Rhode Island Change Assessment Scale; Field et al., 2009). Using the technological benefits provided by OSC-BGI aids in upholding the CBT principle pertaining to monitoring client progress (J. S. Beck, 2021).

Group Scheduling and Referrals

As indicated in Table 6.1, Get S-M-A-R-T is designed as either an eight-, 12-, 16-, or 20-hour intervention. In its current form, the program starts on an evening from 5:00 p.m. to 9:00 p.m. Participants meet again the next day from 9:00 a.m. to 1:00 p.m. (eight hours total) or 9:00 a.m. to 5:00 p.m. (12 hours total). The remaining eight hours of programming for the 20-hour intervention occurs in the next three consecutive weeks, with participants meeting once a week for just under three hours a week. Since Get S-M-A-R-T is developed in a way in which exercises can be utilized à la carte style, it can be broken up in many effective ways. For example, an agency has used a 10-hour junior curriculum (Get S-M-A-R-T, Jr.) for adolescents; these participants meet two hours once a week for five weeks. Because Get S-M-A-R-T is modular, it can be facilitated in several different ways to meet agency needs.

Participants are often referred to participate in Get S-M-A-R-T from many sources. Most commonly, a referral originates from an agency, such as the court, probation, university counseling or other department, or an employer. Occasionally, a participant will come voluntarily because of a personal consequence.

Most often, participants who are referred for the eight-hour intervention have been arrested for impaired driving, public intoxication, minor consumption of alcohol, or possession of marijuana or synthetics. The eight-hour intervention is typically appropriate for people experiencing their first offense but who do not meet criteria for a diagnosable substance use disorder. Participants who are referred for the 12- or 16-hour intervention may still be experiencing a first offense or work violation, but their identified risk is more severe. For example, with impaired driving, the blood alcohol concentration may be higher than .15. People experiencing multiple consequences from their substance use are generally referred for the 12- or 20-hour intervention. Clients charged with possession of controlled substance are generally referred for the 20-hour outpatient intervention.

Table 6.2 provides examples of possible referral conditions that indicate a particular Get S-M-A-R-T dosage/group. Readers should be cognizant that recommendations are only made after a thorough assessment. The items in this table are only indicators and not a substitute for comprehensive assessment and consequent considerations for appropriate level of care.

Managing Problem Situations

Through trial and error, we have also learned that some people may not be appropriate for the online platform for different reasons—for example, a participant

Table 6.2: Client Indicators for Get S-M-A-R-T Dosage

8-Hour Intervention	12-Hour Intervention	16-Hour Intervention	20-Hour Intervention
First drug or alcohol charge	First offense, BAC >.15	Second drug/ alcohol charge	Multiple offenses
OWI BAC < .15	Changes in tolerance	Relationship or work issues	Other drug charges
Possession of marijuana	Some insight into choices	Blackouts	Multiple impaired driving offenses
Minor consumption < .15	Resistance or blaming	Potential mental health issues	Difficulty taking responsibility
Low-risk behaviors	Risky and dangerous behavior	Little insight into choices	Risk of substance use disorder
Demonstration of remorse	Additional consequences		

Notes: BAC = blood alcohol concentration; OWI = operating while intoxicated; S-M-A-R-T = synthetics-marijuana-alcohol-recreational-trouble.

who may be under the influence of a substance, may continue to use vape device or cigarettes despite reminders, may be disrespectful to other participants, or may allow projection of anger to spread to other members and create a bad "vibe" in the room. In extreme cases, we have removed people from the Get S-M-A-R-T program. Typically, this involves one facilitator's asking the client to step out; we then call them privately and explain that they cannot continue in the intervention due to breaking the rules. A follow-up call is scheduled to determine next steps.

Typically, coordination with the probation officer or other referral source can determine what the next steps are. For example, in one case, we had a client who was intoxicated and had to be removed; it turned out they needed a referral to a higher level of care. Another example was a client who was making sexually inappropriate comments to another participant; they were referred to an individual intervention format. This was also true for another client who was disruptive in the online platform, but when that client started doing the work individually, they seemed to get much more serious about Get S-M-A-R-T. Some individuals for several clinical reasons may have optimal outcomes in an individual setting rather than in a synchronous online group format.

Synchronous Online Group Format

As described at the beginning of this chapter, we initially planned on conducting an empirical evaluation of efficacy pertaining to the face-to-face group intervention called Get S-M-A-R-T. This was the initial plan because the Get S-M-A-R-T intervention was originally facilitated in person. The shift to an OSC-BGI came about to continue serving the increasing needs of people struggling with substance abuse and mental health concerns. Therefore, the face-to-face group intervention, like interventions facilitated by many other providers around the world in 2020 (Knechtel & Erickson, 2021), quickly transitioned to an online format; an interactive platform was created for participants to connect, learn, and engage with one another.

The synchronous online Get S-M-A-R-T includes using videoconferencing software that allows facilitators to share their screen to walk through some of the exercises because participants will also be actively engaging in the exercises at home. Participants also have access to a virtual workbook if they had not picked a workbook up at their designated location.

Unexpected Situations

Because this format was new to me (L.W.) and to my cofacilitator, the learning process included on-the-fly experiences and had some bumps along the way. For example, when the facilitators noticed a participant attending online while driving with three children in the back seat of the car, due to safety concerns, we created the rule that participants could not attend online while driving, moving around (we all get dizzy!), and at work (for privacy). We also had to remind participants that everyone on the platform could see others in their camera view, including family members' activities. It was a trial and learn for us all because we were adjusting to the COVID pandemic. Eventually, we got better at facilitating the OSC-BGI. In hybrid formats consisting of both online and face-to-face clients, the facilitators allowed one to three clients, wearing masks, to come in person to the classroom while having the others online.

Additionally, based on idiosyncratic experience, I (L.W.) found it crucial to have one face-to-face facilitator in the actual physical setting and another facilitator online. This arrangement was preferable because it enhanced active participation and group cohesion between the face-to-face and online clients. This hybrid model also came with some learning curves. Simple things, such as where to position the camera so everyone online could see the in-person participants and the facilitator and having a good microphone in the room so that online participants could hear participants sharing in the room, continued to improve from month to month.

Given the real-world events (Knechtel & Erickson, 2021; Shatri et al., 2021) that catalyzed the widespread need for synchronous online group and other online interventions, the pros and cons for both clients and providers/facilitators become more profound. The pros:

- Convenience: No travel time, parking, or commute
- Safety of participation within your own space/home
- Ease of social anxiety (participants could mute or turn off video when feeling anxious)
- Small class size
- Paperless monitoring of client progress online
- Access to people (participants attending from all over the state or country)

The cons:

- Privacy and confidentiality not guaranteed
- Internet connection a possible issue for rural participants
- Internet lags creating some delay and awkwardness in sharing
- Interruptions at home (e.g., participants' children, pets)

Strategies for Conducting Effective Synchronous Online Interventions

Based on my (L.W.'s) experience with transitioning from face-to-face to OSC-BGI, we have learned a number of strategies to accentuate the pros or benefits of synchronous online group intervention and minimize the cons. When setting up the boundaries and virtual classroom expectations for Get S-M-A-R-T, clients are informed before the first group meeting of the following basic guidelines for participation:

- Please enter the virtual room with your video "on" and your audio "muted."
- Please attend the program in a quiet area of your home. Please do not attend while driving or at work when others are present.
- Please do not use mood-altering chemicals (including smoking, vaping, and chewing tobacco) while in the program.
- We encourage participation and sharing, and to allow for a smooth transfer of communication online, please keep yourself muted unless you are talking.

- We will provide frequent breaks, and it is important to mute and turn video off when on break.
- We encourage participants to be respectful of one another by allowing each person to have their own opinions and feelings in a nonjudgmental manner.
- We review confidentiality: It is a virtual classroom, so we cannot guarantee confidentiality because we do not know each participant's personal surroundings. We review the limits of confidentiality and mandated reporting.

Group Session Structure

In accordance with the CBT principle of structured sessions (J. S. Beck, 2021), the cognitive–behavioral Get S-M-A-R-T intervention has structure. The Get S-M-A-R-T sessions, regardless of group dosage, are divided into three sections: (1) introduction, (2) intervention exercises, and (3) summary and reflection.

The introduction includes reviewing the online expectations, facilitator introductions, and client introductions that contain their reasons for coming and something novel about the client. The introduction also includes validation of the client's thoughts and emotions regarding their typically mandated referral and affirmation as well as the client's presence and participation. An important component of this introduction is initially empowering the clients to take ownership of their own path. The facilitators explain the purpose of the Get S-M-A-R-T intervention (see Table 6.1) and the importance of clients' being able to explore their ambivalence (Miller & Rollnick, 2013). The interventions exercises are determined by the day and which dosage of Get S-M-A-R-T the clients have been recommended to complete. The summary and reflection section involves a review of the session's content, feedback from the client's regarding the session, and plans for the next session.

OSC-BGI: SOCIAL WORK VALUES AND ETHICS

Thus far, we have discussed the convergence of the COVID-19 pandemic and other factors that prompted an expansion in online CBT or cognitive–behavioral interventions and the efficacy of OSC-BGI. We also provided a social work–facilitated example of an OSC-BGI with options for addressing online transitions. Another necessary component of this chapter includes the implication for social work ethical principles and standards (NASW, 2021). In prior discussions of OSC-BGI, these social work ethical principles and standards have been alluded to but not clearly discussed. This section of the chapter seeks to briefly identify several

of the relevant ethical standards contained in the NASW (2021) *Code of Ethics* as it relates to OSC-BGIs.

When considering or conducting an OSC-BGI, social workers are to facilitate their interventions in a manner that is adherent to the *Code of Ethics* (NASW, 2021). As the *Code of Ethics* pertains to OSC-BGI overall, in the context of social work principles, a number of ethical standards can be used to guide social work OSC-BGI. For example, social workers in the United States providing OSC-BGI should use the NASW (2021) *Code of Ethics* Ethical Standards to guide Informed Consent (1.03), Competence (1.04), Cultural Competence (1.05), Conflicts of Interest (1.06), and Privacy and Confidentiality (1.07), among others. Likewise, social workers providing OSC-BGI outside the United States should use their analogous entities and documents to guide their ethical conduct of OSC-BGI in social work practice.

CONCLUSION

Social workers are the most abundant providers of mental health services in the United States (Heisler, 2018). The profession's mission (NASW, 2021) focuses on social workers' improving the well-being of human beings and places specific emphasis on empowering those individuals who are marginalized. Persons with substance use disorders face a wide range of familial, social, occupational, academic, legal, or medical issues (American Psychiatric Association, 2013) in addition to stigma that permeates policy and treatment (Earnshaw, 2020).

Several factors make this chapter particularly relevant: an increase in access to online communication, partly made available through smartphones; policies addressing online telehealthcare delivery (McElroy et al., 2020); the abundant empirical evidence supporting CBT (Hofmann et al., 2012); and promising research on synchronous CBT interventions (Sundström et al., 2016). With the convergence of these factors, it is anticipated that this chapter will aid social workers in considering and further expanding their OSC-BGI services in an ethical manner that fulfills the mission of the social work profession.

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