challenges

MDPI

Article

Professionals' Views on Challenges in Inpatient Substance Abuse Treatment during COVID-19 Pandemic in Finland

Eeva Ekqvist [1,*], Tuija Karsimus [1], Arja Ruisniemi [1,2] and Katja Kuusisto [1]

[1] Faculty of Social Sciences, Tampere University, 33100 Tampere, Finland; tuija.karsimus@tuni.fi (T.K.); arja.ruisniemi@samk.fi (A.R.); katja.kuusisto@tuni.fi (K.K.)
[2] Department of Health and Welfare, Satakunta University of Applied Sciences, 28130 Pori, Finland
* Correspondence: eeva.ekqvist@tuni.fi; Tel.: +358-504377120

Abstract: The pandemic caused by COVID-19 (an acute respiratory illness caused by a coronavirus) has had harmful effects on people in need of special support. People with problematic substance use are recognized as such a group. The pandemic has raised the need for sufficient treatment and services during these unpredictable conditions. At the same time, it poses severe challenges to their production and provision. The purpose of the study was to use content analysis to qualitatively examine Finnish professionals' (N = 22) views on (1) the challenges posed by COVID-19 in working in inpatient substance abuse treatment, (2) how these challenges have been addressed, and (3) what the consequences of the challenges and the solutions to them are. The findings confirmed that COVID-19 has caused drastic changes in the organization of treatment and daily practices. Professionals experience challenges in preventing infection from spreading into and within treatment units. They also describe difficulties in applying social distancing in treatment that is based on therapeutic communities. The pandemic has also challenged communication and co-worker support among professionals. These challenges have led to practical solutions that, in turn, have their own consequences for treatment practices. We conclude that the quality of treatment has to some extent been impaired because of the pandemic.

Keywords: COVID-19; inpatient; substance abuse; treatment; professional; Finland

Citation: Ekqvist, E.; Karsimus, T.; Ruisniemi, A.; Kuusisto, K. Professionals' Views on Challenges in Inpatient Substance Abuse Treatment during COVID-19 Pandemic in Finland. *Challenges* **2022**, *13*, 6. https://doi.org/10.3390/challe13010006

Academic Editor: Palmiro Poltronieri

Received: 15 December 2021
Accepted: 14 February 2022
Published: 17 February 2022

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Copyright: © 2022 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (https://creativecommons.org/licenses/by/4.0/).

1. Introduction

People referred to inpatient substance abuse treatment (also known as residential treatment) often experience severe social, psychological, and physical consequences of their alcohol, drug, or prescription drug dependencies. In such cases, outpatient treatment has been considered insufficient, and more intensive support is needed to help patients in their complex life situations. During treatment, professionals seek to help patients to achieve improvement in various life domains, such as intrapersonal well-being, social relationships, and life functioning [1–3]. In substance abuse treatment, an effort is made to identify the root causes of problematic substance use and to find alternative action models using, for example, cognitive-behavioral methods [4,5].

Since 2019, the pandemic caused by COVID-19 (an acute respiratory illness caused by a coronavirus), including the social distancing that it has caused, has affected all these domains of patients' lives (see, e.g., [6,7]). Professionals have highlighted the severity of the harmful effects of the pandemic on people with problematic substance use. According to Marsden et al. [8], the pandemic may have exacerbated addictive behavior, relapses, loneliness, depression, and even suicidality, which raises the need for sufficient treatment and services during these unpredictable conditions.

Previous research indicates that professionals' work-related satisfaction in the field of substance abuse treatment is positively influenced by patients' opportunities to pursue their goals and choices [9]. The pandemic has limited these opportunities, and professionals

have been facing new challenges due to patients' worsened situations. At the same time, previously successful treatment interventions and methods have been unavailable for use. In inpatient treatment settings, close patient contacts with professionals and other patients have been reduced where possible, and visiting hours have been limited or canceled in order to prevent COVID-19 from spreading in treatment units. Additionally, in-person mutual help groups, such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (see [10]), which offer a place for peer support alongside the professional help received in inpatient treatment, have been inaccessible or highly limited [6,11–15].

In addition to these therapeutic aspects of working in inpatient treatment, other dimensions of daily practices have changed. Staff meetings, both official and unofficial, and contacts to other treatment units and patients' networks have changed from face-to-face meetings to online or telephone meetings [15]. Digital stressors and technostress (see, e.g., [16]) are now present more than ever for professionals working in inpatient treatment settings. Many professionals working in social and health care organizations still require significant support regarding digitalization and teleworking, despite improvements in associated practices [17].

Working in the substance abuse field is challenging even without the effects of the pandemic. Emotional exhaustion; mental health issues such as secondary trauma, stress, and burnout; and high turnover intention rates (i.e., one's attitude to quitting the job) have been widely reported [18–22]. Organizational and management practices and an overall rewarding, positive, and respectful work environment play a crucial role in supporting professionals in coping with their workloads [22,23]. In inpatient substance abuse treatment settings, support from various sources at work, such as colleagues and supervisors, helps professionals to successfully carry out their work. When patients are part of the treatment community and take part in the daily practices of the treatment unit, they may also be a source of support for professionals [24–26]. However, because of social distancing, professionals are facing new challenges in supporting each other and patients.

Due to the recent advent of the pandemic, there are only a few scientific papers that address the actual impacts of the COVID-19 pandemic on inpatient substance abuse treatment [12,14,27]. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), European service providers across drug services (i.e., outpatient and inpatient treatment and harm reduction services) have encountered several COVID-19-related challenges. At the beginning of the pandemic, access to personal protective equipment (PPE) was not at an adequate level leading to concerns about professionals' vulnerability to infection. Service providers have reported having staffing shortages and problems in enrolling new patients, and they worried if people in vulnerable situations received information on COVID-19 and had access to hygiene-related services and services using telecommunication [28]. In this article, we examine professionals' views on (1) *the challenges caused by COVID-19 in working in inpatient substance abuse treatment*, (2) *how these challenges have been addressed,* and (3) *what the consequences of the challenges and the solutions to them are*. As the evolution of COVID-19 is still unpredictable, research is needed to improve treatment practices in arenas traditionally characterized by close contacts with patients and other professionals.

The rest of this article is organized as follows: first, the research design is described. The results of the research are then presented and later discussed with the conclusions and suggestions for the future research.

2. Materials and Methods

2.1. The Research Units and Their Core Practices before COVID-19

This study was conducted in two inpatient substance abuse treatment units located in Finland as a part of a research project entitled *Change in patient's well-being and rehabilitation activities in inpatient substance abuse treatment.* The treatment units provide non-medical, therapeutic, community-based treatment for both individuals and families. Treatment periods usually last from one to three months, but for families they may be longer. Munici-

palities bear the majority of the treatment costs, and referral to treatment usually originates from public health and social services.

In treatment units, professionals from the social or healthcare professions apply cognitive behavioral therapy; i.e., the focus is on providing information about recovery, relapse, and behavioral patterns in order to achieve change in problematic substance abuse. Therapeutic communities are both a way of organizing daily practices during treatment (i.e., cooking, cleaning, etc.) and a therapeutic method including group sessions in addition to individual sessions with professionals. Patients are also encouraged to take part in AA or NA groups during and after their treatment.

Patients in individual treatment share bedrooms, bathrooms, general living, dining, and leisure areas either with their treatment group members or with all patients in the unit. Families in treatment live in an apartment in a terraced house located in the treatment unit's yard area, but therapy sessions and leisure activities usually take place in communal areas. Children are provided with either daycare in the unit's kindergarten or schooling in the local state school depending on their age. One key element in the treatment is practicing coping methods at home or visits to public arenas such as grocery shops. These exercises are needed in order to see how patients cope outside the treatment unit. Contacts outside treatment are also important in terms of supporting family relationships and organizing living conditions after discharge.

2.2. Data and Participants

The data were collected through semi-structured focus group interviews (n = 9) in two inpatient treatment units in December 2020 and January 2021. In total, 22 professionals either from health or social services (n = 17), administrative staff (n = 3), or supporting professionals (such as maintenance and catering staff, n = 2) took part in the interviews. Their experience of working in the treatment units ranged from three months to 26 years, and their age varied from 24 to 65 years. In the interest of anonymity, more specific information about them was not collected.

Two researchers of the research group conducted and recorded the interviews via Zoom. The interviews lasted from 50 to 90 min and resulted in 125 pages of transcribed text. Interviews followed roughly a thematic interview frame including questions on how pandemic had affected the patients' opportunities to enter treatment and their wellbeing at entry, how practices and the treatment provided had changed in the treatment unit, and how aftercare had changed. More detailed information on interview themes can be seen in Table 1.

In this article, we focus on how practices in the treatment unit changed and professionals' descriptions of solutions arrived at this changed and challenging situation. The interviews were somewhat retrospective in nature, as the questions concerned spring 2020, the first wave of COVID-19. However, after summer 2020, the same restrictions were reintroduced as the second wave was emerging. Thus, our interviewees discuss not only the situation when the first wave hit but also their experiences in late 2020 and early 2021.

Research permission was obtained on 15 December 2020 from the background organization of the treatment units. Participants' consent was requested after they had been informed about the study. They were free to withdraw from the study at any stage. The research complied with the guidelines of the Finnish codes of research ethics and governance [29,30] and with the codes of research integrity in Europe [31].

Table 1. Themes of the interviews.

Themes	Sub-Themes
Gaining access to treatment	Numbers of patients Parties making the referral Changes in queueing systems Working with risk groups

Table 1. *Cont.*

Themes	Sub-Themes
Patients' states of health on arrival in treatment	Changes in substance use Physical and mental well-being Changes in life situations Changes in treatment plans
Special arrangements from the perspective of work	Working in critical times Changes arrangements and their effects on working and activities Sick leaves
Special arrangements from the patients‘ perspectives	Changes in interaction between patients and personnel and among the personnel Patients‘ attitudes Living in a treatment community Negative and positive effects
Isolation	Limiting visits Limitations in arranging group work and meetings with parties outside the treatment units Reduction of therapeutic leaves
Discharge	Planned implementation of treatment Follow-up treatment plans
Things learned from the experiences of the previous spring	

2.3. Analyzing Method

Qualitative analysis of the data was conducted using content analysis [32] with Atlas.ti (version 9; Scientific Software Development GmbH, Berlin, Germany). The analysis started by carefully reading through the transcribed interview talk multiple times. The focus was on sections where professionals described either challenges in organizing and providing treatment caused by COVID-19 or how these challenges had been or should have been met. Then, we analyzed the consequences the professionals attributed to these challenges and solutions or the lack thereof. Our analysis was more focused on interpreting and understanding rather than quantifying. We identified three major challenges labeled as (1) prevention of COVID-19, (2) applying social distancing in inpatient treatment based on therapeutic communities, and (3) communication and co-worker support among professionals. Some of the challenges had multiple solutions, and some remained to some extent unsolved. Their consequences have also been considered. Excerpts are presented to illustrate professionals' talk addressing both practical and therapeutic issues. These challenges and their solutions are somewhat intertwined and overlapping, but they also have distinguishing features, which are discussed next. In each excerpt, W = woman and M = man, and I = interview with the number of the interview (1–9).

3. Results

3.1. Prevention of COVID-19

Living in a treatment unit with other patients coming to treatment from different regions of Finland for different time periods constitutes a risk of contracting COVID-19 infection for both patients and professionals. This necessitated preventive and quarantine protocols. Ways of preventing COVID-19 from spreading in the unit include (1) using personal protective equipment (PPE) such as face masks or shields, (2) sanitation of surfaces, (3) quarantine while waiting for COVID-19 test results, and (4) social distancing in all treatment and daily practices.

Using personal protective equipment, PPE, is the "new normal" in the treatment unit in situations where at least two people are present in the same room. This has led to new ways of meeting patients entering treatment:

"When the new patient comes, I try to constantly watch for his arrival from the windows. When he arrives, I run to meet him at the parking lot. I approach him without a mask, just to give him the glimpse of a person behind the mask. At intake there is a pretty long interview and so on, so if there's a strange person and behind a mask all that time so... I don't know what kind of effects it has on the patient, who is quite often timid also. But I find that even an opportunity to see the faces, even a glimpse of that person you meet here—I think it's important."

(W3 in I2)

The need for inpatient treatment may produce mixed emotions in patients such as shame, guilt, and sadness, but hopefulness and empowerment may also emerge, as the patient is taking steps to recovery. In this delicate situation, meeting the patient without a mask is crucial. This may help patients to feel more welcome and ease the integration with the treatment. The professional in question had changed her behavior in order to ensure a safe first meeting with the patient by wearing no mask and greeting the patient outside.

Using PPE may cause physiological symptoms such as "difficulties in breathing, you get tired, suffer from headaches, it makes you sneeze" (W1 in I9). Professionals may feel not only physiological but also emotional consequences of using PPE with patients:

"When I meet very anxious or even slightly psychotic patients, it makes me feel like I'll take my mask off because that person is already anxious enough. I haven't taken it off, but when that person is so anxious and even somewhat paranoid and ready to suspect everything . . . In these situations where you're talking about psychic morbidity or . . . , so I see a risk, even a challenge there. I mean, how the patient perceives [mask use] tangibly. I need to say at least, that it is not pleasant to wear the mask. In addition, it certainly affects my own coping..."

(W1 in I2)

As mental health issues often appear with problematic substance use, professionals meet patients who may be psychotic, anxious, or otherwise in a distressed state. Barriers to viewing professionals' facial expressions can increase fear and paranoia in their patients, which may lead to potentially unsafe or challenging situations. Using PPE conceals many of professionals' (but also patients') non-verbal cues such as facial expressions; thus, using eyes and eyebrows, as well as appropriate body postures, is needed more than without masks in building a therapeutic alliance. Using a mask can take a toll on professionals' coping, as ethical considerations of using a mask and both physiological and emotional consequences and the need to use different ways of communication arise on a daily basis.

Not all prevention measures taken are negative; they may also have a positive impact on relationships between patients and staff:

"When we clean these surfaces twice a day, then I think it's both fair and good practice that both employees and patients are involved in it. So, it's not only the patients who take care of the surroundings. We will participate all together in this communal effort."

(W2 in I3)

In treatment units, patients take part in daily practices such as cleaning and cooking. Due to COVID-19, the need to sanitize surfaces multiplied, thus increasing patients' workload. However, the staff decided to take part in cleaning to show companionship with patients. Preventing COVID-19 is a mutual goal for patients and professionals: "We are in this together" (W2 in I6).

Flu symptoms before or during treatment necessitated COVID-19 testing and quarantine. As the treatment units in question had no such testing facilities, they had to arrange safe transportation from units to the local testing facility. During the waiting period, patients were placed in quarantine in a quarantine area, or if they were in family treatment, the family was in quarantine in their apartment. As the pandemic has continued for a long period of time, new testing and quarantine protocols and measures have become normal practices:

"There is a certain room reserved for quarantine situations. At first, when there was someone there, our patients where like "bloody hell, now there's someone!". And now it's just that "oh, now there's someone isolated again" [laughing]. Now it makes me laugh. Well, this is a serious issue, but it shows how our perception of normal change."

(W1 in I2)

In early 2020, placing someone in quarantine evoked mixed feelings in both patients and professionals. Over time, patients and professionals have become more accustomed to someone being isolated from others. However, when patients in therapeutic communities change, experiences may differ:

"When one of our patients went to an isolation, right after the whole community was thinking what if it's corona and at least I belong to a risk group. It was like a panic if it's corona."

(W1 in I9)

Professionals and patients with longer treatment periods play an integral part in providing informational and emotional support in these situations, where fear of COVID-19 threatens to disrupt the dynamic of the treatment community and treatment: "You noticed how important your own calm attitude towards that unexpected situation was for your patients" (W3 in I2). In addition to using PPE and creating protocols for testing and quarantine, social distancing was adopted into daily practices. This entailed rethinking and reorganizing social events such as dining, group sessions, leisure activities inside and outside of the treatment unit, and smoking, where patients from different therapeutic communities used to encounter each other:

"Mealtimes are staggered, so that the communities spend as little time as possible in the canteen at the same time. We have appointed certain tables, where each community eats. So there is no sitting at the same table. There are no simultaneous group activities, but each community carries out its weekly programme by themselves in their own communities. The city has closed recreational facilities, so there is no chance to do such things in your spare time. [—] In the smoking area situated outdoors, patients from different communities may visit at the same time, but there are instructions, tags on the post, reminding them to keep a safe distance."

(W3 in I2)

Social distancing was required not only of patients and professionals in the treatment units but also of patients' family members and friends. Visiting hours in the treatment units were limited, but new ways of incorporating family members were created:

"We wanted to make patients' close ones a part of their rehabilitation process. But now all such meetings are held over the phone or Teams. So, it effects that you do not meet your loved ones face-to-face. We can't allow visitors other than patients' children. Only underaged children can visit."

(W1 in I9)

Even though meeting via Teams or other online meeting applications was deemed not as good as meeting face-to-face, it is still better than not meeting family members and close friends at all. With long-distance relationships, telecommunication is a viable solution in supporting patients' constructive and meaningful relationships even after the pandemic.

Opportunities for therapeutic leaves were under strict consideration, but they have been seen as an integral part of longer treatment periods. Usually, therapeutic leaves are carefully planned in terms of practicing coping skills, but a new aspect emerged due to COVID-19: "Patients have also had to plan [therapeutic leaves] in that way and consider in advance for example about the number of contacts they will have during home training" (W2 in I6). Thus, therapeutic leaves would still have been possible if deemed necessary and carefully planned with COVID-19 in mind. However, with changing regulations in different parts of Finland and changes in the incidence of COVID-19 infections, patients

may have been in situation where therapeutic leave for one patient was possible and for others not.

All in all, preventive measures were successful in the treatment units in question; COVID-19 did not spread in the units.

3.2. Applying Social Distancing in Inpatient Treatment Based on Therapeutic Communities

In treatment based on therapeutic communities, social distancing is a drastic change not only in organizing practical issues but also in the ideology behind treatment and the treatment methods used. In therapeutic communities, interaction between patients is central as the aim is to help each other and to learn from others. During treatment, patients are part of their own group, a therapeutic community, and they are encouraged to take part in peer support groups (AA or NA). Patients also take part in other group sessions in the treatment unit, such as the relapse prevention group, which aims to increase awareness and build coping skills to reduce both the likelihood of relapse and its severity if it does occur, and the parenting group, provided to support patients in parental issues. Applying social distancing led to limiting access to group sessions:

> *"Before the pandemic, [parenting groups] had participants from throughout treatment unit, so that those participating individual-based treatment could also participate. Now these groups have been solely for participants in the family-based treatment and parenting groups have not been offered to others. Something is probably lost there; patients in other communities lose the opportunity to participate in parenting groups. Then because of the smaller group of participants, probably some knowledge sharing will be lost compared to what a bigger number of participants could bring to it. On the other hand, parenting is such a sensitive area that there's also a lot of good things in it that those groups are only for those patients in family-based treatment."*
>
> (W2 in I6)

Limiting access to group sessions to certain patients only may put patients in unequal situations. Sharing experiences and views is central in therapeutic communities, and minimizing group sizes also restricts the variety of conversations. However, this solution may also have positive effects on group dynamics in dealing with delicate issues.

Professionals in the treatment units have different kinds of skill sets in arranging therapeutical group sessions. When therapeutic communities have been separated from each other, professionals are also separated from other communities. This has led to a situation where quality of the treatment may be lower than before:

> *"We don't have a person in every therapeutic community who knows how to lead a Relapse Prevention group (RP group). [—] It's different for patients then and the quality is not so good if the worker is reading the manual of what I need to do next. That's it. Or what tasks should be done, without knowing their purpose or how this is related to relapse prevention. [—] What gets me is that, according to feedback, the RP group is our most popular group ever here."*
>
> (W2 in I9)

Social distancing has revealed possible deficiencies in professionals' abilities to perform in different therapeutic situations. If these are recognized and properly addressed, professionals will receive the education they need, and in the future, professionals will be better equipped to apply different treatment methods if needed.

Patients are encouraged to take part in peer support groups in addition to their inpatient treatment. Due to COVID-19, peer support groups all over the world have strictly limited participants, cancelled their activities altogether, or moved to online environments. As peer groups are considered an important support for professional treatment, patients have been motivated to host their own AA or NA meetings in their treatment units or to take part in online meetings:

> *"It's that you have found [peer support groups] in China and England and everywhere. And one thing we have noticed that has been increasing is this GA [Gamblers Anony-*

mous], that is, groups for people addicted to gaming. [—] It has added to patients' knowledge when they have found out that they also have gambling addiction."

(M1 in I7)

Taking part in online meetings has extended the range of options in terms of both availability of groups at different times of the day and themes discussed. Having behavioral addiction alongside substance abuse may come out during the treatment; thus, GA groups bring extra support for those patients in need of it. As face-to-face meetings have been limited to members of the respective therapeutic groups, online meetings serve the purpose of seeing and hearing from others outside the treatment.

3.3. Communication and Co-Worker Support among Professionals

COVID-19 has increased the need for communication and co-worker support among professionals. Informational support, such as gathering and sharing information, is extremely important in situations that are new and where multiple changes happen at the same time:

"In spring, when [COVID-19 pandemic] started, it was just as chaotic. There was no preparation at all, there was no operating plan, or any instructions being prepared. As a matter of fact, none of us knew anything. [—] At some point it was, of course, easier, preparations could be made, and restrictions imposed by the hospital district, the government and the like were more aligned. [—] And the hospital district and regional state administrative agency outlined more carefully and more clearly what the constraints are."

(W2 in I4)

Providing inpatient treatment is highly regulated even in normal settings, and when drastic changes happen at national and global levels, professionals expect clear guidance from national social and health care authorities. The treatment units in question, and also the national decision-making bodies, were caught off guard in terms of clear guidance and protocols for organizing daily practices and treatment in inpatient treatment settings during the global pandemic.

In order to make changes happen, information should flow from the national level to the treatment units' administrative staff, then to the professionals conducting treatment and support tasks, and finally to patients. This multilayered dissemination of information is prone to informational gaps, and the change in communication from face-to-face meetings to telecommunication has not helped it:

"There are misunderstandings, no information is passed on. We are always in different groups and at different meetings just like before, but we discuss less than before of how we have understood the things at hand. When there [at the computer] you might do something else and then you will exclude things at that point. The information is not conveyed the same. Quite a lot is not understood, or is misunderstood, or information doesn't get through."

(M1 in I4)

Information gaps between professionals were also noticed by patients: "There is no consistency and clarity with us, the staff, so to our patients it really matters a lot and creates uncertainty among them. Additionally, they are able to exploit it" (W2 in I4). Better communication and documentation of meetings lead to similar practices and rules in all treatment communities; thus, fewer negotiations and experiences of unjust treatment emerge. For better communication within treatment units, professionals discussed a need for a new etiquette when online meetings are used: "We've taken a digileap, and in a way, things are running. However, we are not on a mode to keep our cameras on, or that each of us comments something or gives some response such as giving a thumbs up or thumbs down sign, or to give any reaction to what another one is talking or telling you about, or responding when we're trying to make a decision" (W3 in I3). Online meetings often focus

on particular themes or issues and opportunities for sharing personal experiences and changes in one's life, and other unofficial discussions are left aside:

> *"When the corona pandemic started, it probably was a really scary thing for many people and even in their personal lives it caused a lot of new things, such as your kids were at home [distance education or away from day care] and the spouses might have been laid off. And then this malaise might erupt here at work. This effects a lot. And when we don't see each other, the sense of community among the staff disappears. You get in touch with each other through these faceless online tools."*
>
> (W1 in I3)

Professionals' personal lives have also been affected by COVID-19, which may sometimes spill over to the workplace; in addition, stressors from work may affect professionals' personal lives.

> *"One can't help thinking that it creates a feeling of being outside when you don't see each other or are not able to chat. Also other things than when it comes to work. When having coffee or in the canteen, it has always been such a nice moment during the day when you have been able to discuss whatever comes up. But now, when we cannot do that, it's pretty burdening and stressing. A lot of things remain to be contemplated at home too, then."*
>
> (W2 in I9)

The need for emotional support is eminent in the data; however, in the interviews the professionals said nothing about how this need could be addressed in the workplace. Lack of proper ways to have informal discussions and see each other has produced experiences of loneliness and has divided the professionals' unity.

4. Discussion

Inpatient substance abuse treatment is characterized by close contacts between professionals and patients. COVID-19 has caused drastic changes in organizing treatment and daily practices, and in this article we examined professionals' views on (1) *challenges caused by COVID-19 in working in inpatient substance abuse treatment*, (2) *how these challenges have been addressed*, and (3) *what the consequences of the challenges and the solutions to them are*. Results are summarized in Table 2.

The first and most important challenge was preventing COVID-19 infection from spreading into and within the treatment units. Solutions to this challenge are widely recognized and endorsed: using personal protective equipment (PPE), sanitation of surfaces, implementing COVID-19 testing and quarantine protocols, and applying social distancing [6,14]. According to EMCDDA [28], no outbreaks of COVID-19 were reported, as was the case for example in some treatment facilities for the elderly in some European countries, even when people abusing substances have been identified as being at high risk of COVID-19 [33].

Concerns about unintended consequences due to hastily implemented adaptations in normal working practices in different treatment settings were voiced [28]. In our study, professionals shared their experiences of the negative physiological and psychological effects of using PPE and ethical considerations of using masks with distressed patients; see also [34]. While COVID-19 testing and quarantine protocols evoked mixed emotions in both patients and professionals, sanitation of surfaces produced a concrete and practical way of combatting COVID-19 together when both patients and professionals took part in these measures. In the treatment units, the need for social distancing caused rethinking and reorganization of daily practices and social events [14], which led to the second challenge.

Applying social distancing in inpatient treatment based on therapeutic communities proved somewhat problematic. This challenge especially concerned treatment methods used in treatment units and peer support groups. Limiting the availability of treatment methods and restricting group sizes produced unequal opportunities for patients to take part in therapeutic group sessions. Additionally, communication within sessions changed,

as there were fewer participants to voice their views and experiences. When therapeutic communities were separated from each other, the professionals in one therapeutic community were separated from those in other communities. This led to a situation in which professionals did not necessarily have the means to provide certain services for patients that usually have been provided to all patients in the treatment unit. Thus, the quality of treatment was to some extent impaired. When patients are isolated in their own groups instead of getting peer support from a larger group of patients, from family members, and from the other significant others, some essential social elements of the treatment are lost. Professionals also described their feelings of stress and lack of clear instructions, especially at the beginning of the COVID-19 pandemic, and this affected their work and relationships with patients. The relationship between patient and worker is one of the key elements in treatment, and the interviewees felt that the communication with patients had suffered. Overall, the drastic reduction in support, supervision, and communality may have impaired the patients' commitment to treatment and motivation, which in turn could lead to poorer outcomes in rehabilitation. While it is natural that professionals' skillsets vary, it is necessary to either educate professionals in different treatment methods or relocate professionals in such a way that therapeutic communities can apply all the necessary methods even when isolation of therapeutic communities is needed. Opportunities to learn new therapeutic methods or tools may enhance professionals' well-being at work [35] and also improve treatment quality.

Table 2. Challenges, solutions, and their consequences.

Challenges	Solutions	Consequences
Prevention of COVID-19	Using personal protective equipment (PPE)	Ethical consideration Physiological and psychological affects Communicational challenges
	Sanitation of surfaces	Sharing increased workload
	COVID-19 testing and quarantine protocol	Dealing with mixed emotions
	Social distancing	Changes in daily practices and treatment methods
Applying social distancing in inpatient treatment based on therapeutic communities	Limiting treatment methods and group sizes	Unequal opportunities Greater dependence on own therapeutic community
	Telecommunication in peer support groups and other meetings	More possible groups and members
Communication and co-worker support among professionals	Clear guidelines	Fewer negotiations and feelings of injustice
	Creating supportive telecommunication practices	Better information flow
	No solution for ways to enhance co-worker support among professional	Lack of unity

Previous research has revealed that a combination of professional treatment and peer support is more effective than either alone [36,37]. Thus, the limitations of peer support groups during COVID-19 may also impair the effectiveness of treatment provided in inpatient units. The opportunity to take part in online peer support groups in inpatient treatment enhanced patients' chances to share experiences and opinions with people outside treatment, even abroad.

The third challenge, communication and co-worker support among professionals, also arises from social distancing regulations. In the midst of the COVID-19 pandemic, professionals were in a situation where patients' circumstances deteriorated, treatment methods were curtailed, work-related practices changed, and life in general was overshadowed by COVID-19. Inpatient treatment organizations need to create new ways to enhance support-

ive communication between professionals and different therapeutic communities. Even in normal settings, professionals in substance abuse treatment may feel emotional exhaustion, stress, burnout, and wish to quit the job (e.g., [18–22]). Thus, overall, rewarding, positive, and respectful work is needed in supporting professionals with their workload [22,23]. Informational and emotional supports are commonly provided concurrently in jobs with high emotional labor [38]. To achieve better communication and unity during the isolation of the therapeutic communities and the professionals within them, new measures such as telecommunication etiquette are needed. This helps in disseminating information to all professionals and therapeutic communities, leading to similar practices and fewer negotiations with patients feeling they are being treated unfairly. Professionals also voiced a need for unofficial communication for sharing personal issues with each other. However, they did not propose any solutions to this challenge. Perhaps this is something that is as yet unresolved and requires necessary actions.

COVID-19 has compelled workers to adjust to new modes of action consistent with health safety. Some of these, for example, the increased use of distant connections and digital tools, proved useful by introducing flexibility into scheduling meetings and reducing the need for travel. Management, however, should be alert to the constant need for technological support as workers, tools, and software change from time to time [15].

There are some limitations in this study: it is important to note that this study was conducted with a relatively small number of professionals in two inpatient substance abuse treatment units in Finland. As not all professionals in the organization were interviewed, our sample may not be representative. However, we included in our study members of the administrative staff, professionals conducting the treatment, and supporting professionals. Thus, we elicited information on COVID-19 related challenges from different points of view.

Further research is still needed in challenges in inpatient substance abuse treatment due to COVID-19. As the pandemic is like a recurring wave phenomenon [39], further research could focus on how addiction professionals and treatment organizations have evolved the level of preparedness for future disruption during pandemic waves. Future research could examine which of the new working methods and ways of communicating have proven viable in the usual daily routines. In this article, we examined professionals' views. The next step could also be to hear from the patients: how has the treatment changed from their point of view? What is the best practice and what should be avoided in the future if such a pandemic as COVID-19 should hit us again?

Author Contributions: Conceptualization, T.K., A.R., K.K.; methodology, E.E., T.K., A.R., K.K.; formal analysis, E.E.; investigation, T.K., A.R.; data curation, E.E., K.K.; writing—original draft preparation, E.E., K.K.; writing—review and editing, E.E., T.K., A.R., K.K.; supervision, K.K.; project administration, K.K.; funding acquisition, K.K. All authors have read and agreed to the published version of the manuscript.

Funding: This research was funded by The Finnish Foundation for Alcohol Studies, PI: Kuusisto, 2019–2020.

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Data may be made available upon reasonable request from Katja Kuusisto.

Conflicts of Interest: The authors declare no conflict of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

References

1. Andersson, H.W.; Otterholt, E.; Grawe, R.W. Patient satisfaction with treatments and outcomes in residential addiction institutions. *Nord. Stud. Alcohol Drugs* **2017**, *34*, 375–384. [CrossRef]
2. Orford, J.; Kerr, C.; Copello, A.; Hodgson, R.; Alwyn, T.; Black, R.; Slegg, G. Why people enter treatment for alcohol problems: Findings from UK alcohol treatment trial pre-treatmentinterviews. *J. Subst. Use* **2006**, *11*, 161–176. [CrossRef]

3. Ekqvist, E.; Kuusisto, K. Changes in clients' well-being (ORS) and state hope (SHS) during inpatient substance abuse treatment. *Nord. Stud. Alcohol Drugs* **2020**, *37*, 384–399. [CrossRef]
4. Larimer, M.E.; Palmer, R.S.; Marlatt, G.A. Relapse prevention: An overview of Marlatt's cognitive-behavioral model. *Alcohol Res. Health* **1999**, *23*, 151–160.
5. Thombs, D.L.; Osborn, C.J. *Introduction to Addictive Behaviors*, 4th ed.; Guilford: New York, NY, USA, 2013.
6. Columb, D.; Hussain, R.; O'Gara, C. Addiction psychiatry and COVID-19: Impact on patients and service provision. *Ir. J. Psychol. Med.* **2020**, *37*, 164–168. [CrossRef]
7. DeJong, C.; DeJong-Verhagen, J.; Pols, R.; Verbrugge, C.; Baldacchino, A. Psychological impact of the acute COVID-19 period on patients with substance use disorders: We are all in this together. *Basic Clin. Neurosci.* **2020**, *11*, 207–216. [CrossRef]
8. Marsden, J.; Darke, S.; Hall, W.; Hickman, M.; Holmes, J.; Humphreys, K.; West, R. Mitigating and learning from the impact of COVID-19 infection on addictive disorders. *Addiction* **2020**, *115*, 1007–1010. [CrossRef]
9. Johannessen, D.A.; Nordfjærn, T.; Geirdal, A.Ø. Substance use disorder patients' expectations on transition from treatment to post-discharge period. *Nord. Stud. Alcohol Drugs* **2020**, *37*, 208–226. [CrossRef]
10. Mäkelä, K.; Arminen, I.; Bloomfield, K.; Eisenbach-Stangl, I.; Helmersson Bergmark, K.; Kurube, N.; Zielinski, A. *Alcoholics Anonymous as a Mutual-Help Movement: A Study in Eight Societies*; University of Wisconsin Press: Madison, WI, USA, 1996.
11. Enns, A.; Pinto, A.; Venugopal, J.; Grywacheski, V.; Gheorghe, M.; Kakkar, T.; Orpana, H. Evidence-informed policy brief—Substance use and related harms in the context of COVID-19: A conceptual model. *Chronic Dis. Inj. Can.* **2020**, *40*, 342–349. [CrossRef]
12. Kaitala, I.; Partanen, A.; Kuussaari, K.; Heiskanen, M.; Kesänen, M.; Viskari, I. Koronaepidemian ensimmäisen aallon vaikutuksia päihdepalveluiden toimintaan, asiakkaisiin ja henkilöstöön. *Yhteiskuntapolitiikka* **2021**, *86*, 606–614.
13. Melamed, O.C.; Hauck, T.S.; Buckley, L.; Selby, P.; Mulsant, B.H. COVID-19 and persons with substance use disorders: Inequities and mitigation strategies. *Subst. Abus.* **2020**, *41*, 286–291. [CrossRef]
14. Pagano, A.; Hosakote, S.; Kapiteni, K.; Straus, E.R.; Wong, J.; Guydish, J.R. Impacts of COVID-19 on residential treatment programs for substance use disorder. *J. Subst. Abus. Treat.* **2021**, *123*, 108255. [CrossRef]
15. Lin, C.; Clingan, S.E.; Cousins, S.J.; Valdez, J.; Mooney, L.J.; Hser, Y.I. The impact of COVID-19 on substance use disorder treatment in California: Service providers' perspectives. *J. Subst. Abus. Treat.* **2022**, *133*, 108544. [CrossRef]
16. Oksanen, A.; Oksa, R.; Savela, N.; Mantere, E.; Savolainen, I.; Kaakinen, M. COVID-19 crisis and digital stressors at work: A longitudinal study on the Finnish working population. *Comput. Hum. Behav.* **2021**, *122*, 106853. [CrossRef]
17. Harrikari, T.; Romakkaniemi, M.; Tiitinen, L.; Ovaskainen, S. Pandemic and Social Work: Exploring Finnish Social Workers' Experiences through a SWOT Analysis. *Br. J. Soc. Work* **2021**, *51*, 1644–1662. [CrossRef]
18. Butler, M.; Savic, M.; Best, D.W.; Manning, V.; Mills, K.L.; Lubman, D.I. Wellbeing and coping strategies of alcohol and other drug therapeutic community workers: A qualitative study. *Ther. Communities* **2018**, *39*, 118–128. [CrossRef]
19. Elman, B.D.; Dowd, E.T. Correlates of Burnout in Inpatient Substance Abuse Treatment Therapists. *J. Addict. Offender Couns.* **1997**, *17*, 56–65. [CrossRef]
20. Gallon, S.L.; Gabriel, R.M.; Knudsen, J.R. The toughest job you'll ever love: A Pacific Northwest Treatment Workforce Survey. *J. Subst. Abus. Treat.* **2003**, *24*, 183–196. [CrossRef]
21. Knight, D.K.; Becan, J.E.; Flynn, P.M. Organizational consequences of staff turnover in outpatient substance abuse treatment programs: Organizational Dynamics Within Substance Abuse Treatment. *J. Subst. Abus. Treat.* **2012**, *42*, 143–150. [CrossRef]
22. Knudsen, H.K.; Johnson, J.A.; Roman, P.M. Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *J. Subst. Abus. Treat.* **2003**, *24*, 129–135. [CrossRef]
23. Skinner, N.; Roche, A. R-E-S-P-E-C-T: Psychosocial Factors Outdo Employment Conditions in Predicting Job Satisfaction and Turnover Intentions for AOD Nurses and Counsellors. *Int. J. Ment. Health Addict.* **2021**, 1–16. [CrossRef]
24. Aarons, G.A.; Sawitzky, A.C. Organizational Climate Partially Mediates the Effect of Culture on Work Attitudes and Staff Turnover in Mental Health Services. *Adm. Policy Ment. Health Ment. Health Serv. Res.* **2006**, *33*, 289–301. [CrossRef]
25. Bakker, A.B.; Demerouti, E. The Job Demands-Resources model: State of the art. *J. Manag. Psychol.* **2007**, *22*, 309–328. [CrossRef]
26. Ducharme, L.J.; Knudsen, H.K.; Roman, P.M. Emotional Exhaustion And Turnover Intention In Human Service Occupations: The Protective Role Of Coworker Support. *Sociol. Spectr.* **2007**, *28*, 81–104. [CrossRef]
27. Barocas, J.A.; Blackstone, E.; Bouton, T.C.; Kimmel, S.D.; Caputo, A.; Porter, S.J.; Walley, A.Y. Prevalence of COVID-19 Infection and Subsequent Cohorting in a Residential Substance Use Treatment Program in Boston, MA. *J. Addict. Med.* **2020**, *14*, e261–e263. [CrossRef]
28. EMCDDA Trendspotter Briefing—Impact of COVID-19 on Drug Services and Help-Seeking in Europe. Lissabon. 2020. Available online: https://www.emcdda.europa.eu/publications/ad-hoc/impact-of-COVID-19-on-drugservices-and-help-seeking-in-europe_en (accessed on 10 December 2021).
29. Responsible Conduct of Research and Procedures for Handling Allegations of Misconduct in Finland. 2012. Available online: https://www.tenk.fi/en/tenk-guidelines (accessed on 8 December 2021).
30. The Ethical Principles of Research with Human Participants and Ethical Review in the Human Sciences in Finland. 2019. Available online: https://www.tenk.fi/fi/eettinen-ennakkoarviointi-suomessa (accessed on 8 December 2021).
31. The European Code of Conduct for Research Integrity. 2017. Available online: https://allea.org/code-of-conduct/ (accessed on 8 December 2021).

32. Krippendorff, K. *Content Analysis: An Introduction to its Methodology*, 4th ed.; Sage Los: Angeles, CA, USA, 2018.
33. Volkow, N.D. Collision of the COVID-19 and Addiction Epidemics. *Ann. Intern. Med.* **2020**, *173*, 61–62. [CrossRef]
34. Veluri, N. Are masks impacting psychiatric inpatients' treatment? *Psychiatry Res.* **2020**, *293*, 113459. [CrossRef]
35. Watson, D.; Tregaskis, O.; Gedikli, C.; Vaughn, O.; Semkina, A. Well-being through learning: A systematic review of learning interventions in the workplace and their impact on well-being. *Eur. J. Work Organ. Psychol.* **2018**, *27*, 247–268. [CrossRef]
36. Fiorentine, R.; Hillhouse, M.P. Drug treatment and 12-step program participation: The additive effects of integrated recovery activities. *J. Subst. Abus. Treat.* **2000**, *18*, 65–74. [CrossRef]
37. Kaskutas, L.A.; Bond, J.; Avalos, L.A. 7-year trajectories of Alcoholics Anonymous attendance and associations with treatment. *Addict. Behav.* **2009**, *34*, 1029–1035. [CrossRef]
38. Mathieu, M.; Eschleman, K.J.; Cheng, D. Meta-analytic and multiwave comparison of emotional support and instrumental support in the workplace. *J. Occup. Health Psychol.* **2019**, *24*, 387. [CrossRef]
39. Lai, J.W.; Cheong, K.H. Superposition of COVID-19 waves, anticipating a sustained wave, and lessons for the future. *BioEssays* **2020**, *42*, e2000178. [CrossRef]