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Feasibility and acceptability of the delivery of a group telehealth intervention for support persons of patients receiving buprenorphine for opioid use disorder



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ABSTRACT

Background: Opioid-related overdoses increased substantially during the COVID-19 pandemic, eliciting an urgent demand for accessible treatment for individuals with opioid use disorder (OUD) and those who support them (support persons). Support persons can improve treatment initiation and retention in their individuals with OUD. Additionally, support persons may have their own mental health needs related to their loved one's OUD. Unfortunately, few treatment options exist for support persons of individuals with an OUD. A support person-focused group telehealth intervention (referred to as eINSPIRE) that is accessible and feasible could help fill the treatment gap for support persons and bolster outcomes for individuals with OUD.

Methods: The study interviewed patients receiving buprenorphine (n = 9), their support persons (n = 12), and clinic staff members (n = 6) about their perceptions on a group telehealth intervention designed for support persons. Patient and support person dyads were recruited from two community health clinics to participate in a qualitative interview and/or focus group. Using classic content analysis, we then analyzed this data to evaluate the feasibility, acceptability, and usability of a group telehealth intervention for support persons.

Results: The eINSPIRE intervention was deemed generally acceptable, feasible, and usable. All support persons (n = 12) agreed that group telehealth was acceptable and those who completed an eINSPIRE demo session found it usable (IUS = 72.5). Patients indicated that eINSPIRE would be beneficial for support persons, and could provide services that are unattainable to them in their immediate community, but that groups sometimes lacked intimacy. Participants also found group telehealth to be more accessible than in-person alternatives and suggested how to improve the delivery of the intervention.

Conclusions: Group telehealth may be a feasible and acceptable option for delivering an intervention to support persons and could reduce barriers to treatment that this population often experiences due to competing demands. However, due to sample size limitations, more participant perspectives and future research are needed.

Introduction

The COVID-19 pandemic amplified the unique challenges (e.g., isolation, lack of treatment options) faced by individuals with opioid use disorder (OUD) and their families (Avena et al., 2021; Volkow, 2020 motivation). In 2021, over 100,000 people died of a drug overdose, a 14 % increase from 2020, and nearly 75 % of deaths involved an opioid (Hedegaard et al., 2021). The downstream effects of this epidemic reach beyond just the patient using opioids. A 2023 survey found that 125 million U.S. adults have lost someone to a drug overdose, and more than

1 in 8 U.S. adults reported that their lives have been disrupted by an overdose death (Athey et al., 2024). Despite opioid addiction and overdose deaths being a reality for family members and loved ones nationwide, very little research understanding the impact these events have on their mental health and other outcomes exists.

The negative impacts of OUD extend beyond the individual with OUD. Evidence suggests that OUD negatively impacts family members and support persons (e.g., a relative, romantic partner/spouse, friend) too. Support persons of those with OUD are at an increased risk for negative physical health, mental health, and quality of life outcomes

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Received 9 April 2024; Received in revised form 25 November 2024; Accepted 21 January 2025 Available online 23 January 2025 2949-8759/© 2025 Elsevier Inc. All rights are reserved, including those for text and data mining, AI training, and similar technologies. (Barnard, 2007; Daley et al., 2018; Lander et al., 2013; Velleman et al., 1993). The associated stigma, in addition to increased financial and interpersonal burden that these individuals may experience, can hinder treatment seeking and self-care (McCann & Lubman, 2018a, 2018b; Nebhinani et al., 2013). Further, stress experienced within the family system as a result of the COVID-19 pandemic was compounded for family members of individuals with an SUD (Gayatri & Puspitasari, 2023).

Existing treatment options for OUD focus on the patient, without considering the ways support persons can support and inform their loved one's treatment or their own increased risk for adverse outcomes (Dopp et al., 2022). This often leaves many families excluded from treatment (Lodge, 2022) and neglects the immense impact support person involvement can have in the recovery process. Prior research indicates that support persons can often facilitate behavior change and treatment entry, and patients in treatment often state that their support persons are the top motivator for pursuing care (Copello et al., 2005; Cusack et al., 2004). Behavioral therapy interventions demonstrate the ability to improve support person well-being, reduce adverse mental health outcomes, and increase their ability to provide effective support to their loved one with SUD. Community Reinforcement and Family Training (CRAFT) is an evidence-based approach in providing behavioral interventions to support persons (Roozen et al., 2010). CRAFT works directly with support persons to improve communication and support between the support person and the loved one with SUD by focusing on positive reinforcement and connection (Archer et al., 2019; Roozen et al., 2010; Smith & Meyers, 2023). CRAFT has been shown to increase treatment initiation for people with SUDs at greater rates compared to traditional group therapy interventions and peer support groups (such as Nar-Anon, Al-Anon, etc.) (Archer et al., 2019; Kirby et al., 2015; Roozen et al., 2010), but few studies have explored the utility specifically for OUD populations (Brigham et al., 2014).

With so many potential barriers to help-seeking for support persons, it is essential to investigate novel approaches that are responsive to the stigma, increased cognitive burden, as well as the emotional and fiscal impacts of OUD on support persons. A potential avenue to increase access to and decrease burden of care, especially in populations disproportionately impacted, is through telehealth delivery (Barbosa et al., 2021; Mahtta et al., 2021). Although disparities in both digital access and literacy exist, the feasibility of these modalities should be explored for this population to determine potential suitability. Since the expansion of telehealth after the COVID-19 pandemic, telehealth for mental health care has shown to be equivalent or better than in person care among patients (SteelFisher et al., 2023). Telehealth has the potential to increase accessibility to necessary and cost-effective supportive services for support persons. Online support groups for support persons have previously been utilized in the community (SMART Recovery, 2022) and previous research has successfully adapted interventions for families affected by substance use to telehealth (EEk et al., 2020; Peart et al., 2024; Rushton et al., 2024). Previous studies demonstrate the benefits of CRAFT via telehealth (Hogue et al., 2021; McCarthy et al., 2022) and inperson groups (Manuel et al., 2012), yet no known studies have examined the implementation of CRAFT in a group telehealth format for the support persons of patients on buprenorphine for OUD. A group telehealth CRAFT-based intervention for support persons of those with an OUD can provide effective and efficient support to support persons, while reducing barriers to attendance in those with competing demands (Friedrich et al., 2023; Tyo et al., 2023). Optimizing the delivery of a CRAFT-based intervention for support persons allows us to evaluate the effect of these approaches on support person-patient relationships, treatment initiation, treatment retention, and overall outcomes. This study works to contextualize our pilot study where we adapted CRAFT into a group telehealth program (eINSPIRE) for support persons affected by OUD. By collecting patient, support person participant, and clinic facilitator perspectives, we aim to identify potential barriers regarding eINSPIRE delivery and attendance in order to optimize eINSPIRE for this

underserved community (Osilla et al., 2024). The current study aims to evaluate the feasibility, acceptability, and usability of eINSPIRE delivery for support persons.

Methods

Study overview

To evaluate the feasibility, acceptability, and usability of the telehealth delivery of a CRAFT-based group intervention for support persons affected by OUD, we engaged three groups of participants (Clinic staff, OUD patients, and their support persons) to participate in qualitative interviews regarding their impressions of the delivery of the adapted intervention and attend a single demo eINSPIRE session. This study is part of a larger randomized clinical trial (Osilla et al., 2020, 2024), that adapted CRAFT to a group telehealth format (eINSPIRE). Clinic staff attended either a focus group (n = 5) or completed an individual interview (n = 1) about how their clinics have adopted group telehealth in their practices. The study recruited patients and their support persons from outpatient buprenorphine clinics. Individual interviews were conducted with patients (n = 9) and support persons (n = 8) to gather information on their current experiences with group therapy and treatment for OUD. We then adapted our eINSPIRE group telehealth protocol and invited a separate group of support persons to demo a single session and participate in a focus group (n = 4) to elicit their initial impressions of the adapted intervention and the overall feasibility and acceptability of the telehealth modality. The study used a usercentered design approach to evaluate the feasibility, acceptability, and usability of the eINSPIRE intervention (Lyon & Koerner, 2016). Demographic data was not collected from patients and support persons to protect anonymity and confidentiality.

Study setting

This study took place across two urban community primary care clinics with outpatient buprenorphine treatment programs in California. These primary care clinics serve predominantly low-income individuals. The study conducted focus groups and qualitative interviews between July 2020 and October 2021.

Participants

Clinic staff participants were recruited from collaborating clinics who had already adopted group-based telehealth. Clinic staff (three registered nurses, one family physician, and two therapists) were asked to participate in a focus group (n = 5) or in an individual staff interview (n = 1) to share how their clinics were adapting to group-based telehealth and to provide feedback on eINSPIRE's proposed implementation.

Both patients on buprenorphine for an OUD and their support persons were recruited for participation in this study. Patients were adults aged 18 years and older who were receiving buprenorphine treatment for an OUD at one of the two participating health centers. Patients were eligible if they: (1) had a support person who they were in frequent contact with (at least three times a week of one-on-one engagement) (2) the support person was not using heroin or misusing pain pills. Support persons were eligible if they were: (1) 18 or older; (2) in frequent contact with their patient (three times a week or more); (3) not concerned they would be physically hurt by the patient; (4) willing and available to attend sessions on how to better support their patient with OUD if assigned to eINSPIRE; (5) stable in their relationship with the patient over the next 90 days (no plans to move or change the relationship). Staff members at the clinics introduced the study to OUD patients, and 12 patients signed up to participate in the study, with 9 patients and 8 support persons attending the interviews. Support persons were nominated through patient-first recruitment, where the patients are contacted first and asked to identify a support person to participate in

CRAFT. This is a unique approach to recruiting participants, as most CRAFT studies recruit the support persons directly without consulting the patient (Archer et al., 2019). A total of 9 patients and 8 support persons participated in interviews. Four different support persons participated in a focus group.

Procedures

All procedures were approved by and conducted in accordance with both RAND and Stanford's Institutional Review Board (IRB). Using IRBapproved semi-structured protocols of open-ended questions to facilitate discussion, the study introduced all participants (staff, patients, and support persons) to the concept of eINSPIRE and asked for their general feedback about group therapy, OUD treatment options for support persons, and their impression of the eINSPIRE materials. Those participating in a single mock eINSPIRE session provided more specific feedback during focus groups on the delivery and format of the intervention. The study asked participants about their experience with telehealth, the pros/cons of a group format delivered via telehealth, suggestions for implementing group telehealth, and potential barriers that may arise. All interviews and focus groups probed the feasibility of eINSPIRE (defined as the interventions' practicality for this population), the appropriateness of the modality and format it was delivered in, as well as the acceptability (defined as the relatability and accessibility of the intervention content), and if it would meet their needs (Weiner et al., 2017). All interviews and focus groups were conducted via Zoom, audio recorded, and transcribed. Participants received \$50 for their participation in the study.

The study integrated feedback received during each interview into the intervention manual. This included implementing an orientation call prior to the first session, reviewing group expectations with all participants at the start of each session, mailing physical handouts prior to starting eINSPIRE, and asking participants to use their camera during sessions. We then conducted user testing of a single 60-minute eINSPIRE group session based on these iterations with a separate group of support persons (n = 4). Participation in the mock session also included a review of all eINSPIRE handouts across all ten sessions, and to provide insights on their own previous experiences with telehealth or in group settings to identify ways we can improve the delivery of eINSPIRE. All support persons received the same mock session, which was the first session of eINSPIRE. After they completed the mock eINSPIRE session with a facilitator, a different member of the study team led a focus group without the group facilitator present to reduce bias. After participating in the focus group, support persons (n = 4) completed a brief quantitative survey, administered by the interviewer, about the feasibility, acceptability, appropriateness, and usability of eINSPIRE (Lyon et al., 2021).

Clinic staff

The clinic staff focus group and interview focused on the logistics of facilitating group therapy in a telehealth format (e.g., "What are the pros and cons of doing the session via Zoom versus in-person?"), and group engagement techniques (e.g., "What supports do you think support persons will need to attend Zoom sessions?"). Clinic staff also provided feedback on their experience recruiting patients. Staff asked patients in their buprenorphine clinics about their interest in being involved in an interview and collected consent-to-contact for the study team. The study team then contacted the patient to further describe participation, obtain consent, and request consent-to-contact to contact their nominated support person.

Patients

Patient interviews focused on general perceptions and acceptability of group telehealth and involving support persons in treatment (e.g., "What do you think of the idea for eINSPIRE for your support person?" and "How might eINSPIRE help loved ones stay on Buprenorphine? How could it be unhelpful?"). Regarding feasibility, patients were asked "What are the pros and cons of doing the session via Zoom versus inperson?" and "What suggestions do you have for doing helpful video groups for other patients receiving OUD treatment?". Patients were also asked what type of information regarding OUD might be helpful to support persons (e.g., "What other information or tips do you think support persons would find valuable?" and "What other suggestions do you have for improving eINSPIRE?").

Support persons

In interviews, the study asked support persons questions about the feasibility of the study (e.g., "How does delivering eINSPIRE in video groups affect your view of it?" and "What are the pros and cons of doing the session via Zoom versus in-person?"). To capture acceptability, the study asked support persons questions regarding their general reactions to eINSPIRE and how impactful they thought the program would be (e. g., "What do you think of the idea for eINSPIRE for support persons?", "How helpful do you think eINSPIRE would be in helping others support persons?", and "How might eINSPIRE help loved ones stay on buprenorphine, or how could it be unhelpful?"). The usability of eINSPIRE was evaluated through both quantitative and qualitative items involving their current experiences and comfort with the technology used and what support may be needed for Zoom sessions (e.g., "How has it been using the technology? Getting connected?" and "What support do you think support persons will need to attend Zoom sessions?"). At the end of each interview, support persons participated in a brief quantitative survey, delivered by the interviewer, to assess the feasibility, acceptability, and appropriateness of eINSPIRE (see Measures below).

Measures

The study collected both qualitative data from the focus groups and interviews and quantitative data on feedback surveys to evaluate the feasibility, acceptability, and usability of eINSPIRE for group telehealth.

Feasibility

The Feasibility Intervention Measure (FIM) is a validated and reliable measure to test whether an intervention can be successfully applied to a variety of settings (i.e., real-world versus clinical) and evaluated eINSPIRE feasibility (Weiner et al., 2017). The FIM consisted of four items rated on a 5-point Likert scale (1 = Completely disagree, 5 = Completely agree). The FIM includes questions about how workable, possible, doable, and easy the group telehealth intervention would be for support persons.

Acceptability and appropriateness

The Acceptability of Intervention Measure (AIM) (Weiner et al., 2017), which is a validated measure of the degree to which an intervention is considered agreeable, palatable, or satisfactory among implementation stakeholders, evaluated eINSPIRE acceptability. Example items include whether group telehealth met their approval, was appealing/interesting, and was welcomed. The Intervention Appropriateness Measure (IAM) (Weiner et al., 2017), a validated and reliable measure for the perceived fit, relevance, or compatibility of an intervention, measured eINSPIRE appropriateness. Items included whether it was suitable, applicable, and a good match for support persons. Both measures consisted of four items rated on a 5-point Likert scale (1 = Completely disagree, 5 = Completely agree).

Usability

The Intervention Usability Scale (Lyon et al., 2021), adapted from the System Usability Scale (SUS) and validated for complex psychosocial interventions, assessed eINSPIRE usability. The IUS consists of eight items that assess the suitability of the intervention on a 5-point Likert scale (1 = Completely disagree, 5 = Completely agree). Items include questions such as whether group telehealth was unnecessarily complex or difficult, easy to use, or needed expert consultation to use. Items were reverse scored so that a higher score indicated greater usability. A score of 70+ was considered acceptable (Lyon et al., 2021).

Analytical and statistical approaches

Qualitative analyses

We used a grounded theory approach (Strauss & Corbin, 1998) to identify and group key themes related to the feasibility, acceptability, appropriateness, and usability of group telehealth. Reaching sufficient sample size was ultimately determined by thematic saturation for each participant sub-group, which is defined as the point at which data collection was redundant and themes began to repeat with no additional insights identified (Hennink & Kaiser, 2022). Two team members (KN, EU), both familiar with the intervention and with prior qualitative analysis and facilitation experience, coded the qualitative data. These coders had no prior contact with participants nor attended any of the interviews or focus groups. The coders separately read interview notes to identify themes across interviews. They developed an initial listing of themes within each category and then developed a codebook listing each theme with a detailed description, inclusion/exclusion criteria, and examples. Classic content analysis identified quotes that fit each of the themes (Krippendorff, 2019; Weber, 1990). As standard in qualitative approaches, coders met to discuss coding discrepancies and modify themes and sub-themes as appropriate until coders consistently identified and marked each theme. The study imported interview and focus group transcripts into Dedoose analysis software and the coders marked areas of text pertaining to each theme (Dedoose, 2024). The analytical process included discussions behind coding decisions and modifications to themes and sub-themes and continued until coders could consistently identify and mark each theme. Next, both coders worked on passages independently, after which we measured coder consistency (k = 0.71). We examined the distribution of themes separately for patients, support persons, and staff.

Quantitative analyses

The study collected quantitative data via self-report measures on feasibility (FIM), acceptability (AIM), and appropriateness (IAM), as well as usability (IUS). The study summarized this data by calculating the frequency with which participants endorsed each item. Mean scores and standard deviations from each global measure were also calculated. The study conducted no statistical testing on significance, as this study focused on both qualitative and quantitative reports of feasibility, acceptability, and usability.

Results

The study derived three main themes from the interviews and focus groups with clinic staff and support persons, as well as from individual interviews with patients: (1) eINSPIRE general impressions, (2) video telehealth modality, and (3) group format. For each theme, two to four sub-themes were identified (see Table 1). The interviews were on average 52.6 min per interview, and the focus groups were on average 75 min in duration. For all interviews and focus groups, we had strong inter-rater reliability (k = 0.79-0.89).

eINSPIRE general impressions

Staff, patients, and support persons predominantly reported positive perceptions of the eINSPIRE intervention, stating that it would be beneficial for support persons who have a loved one who recently started buprenorphine treatment and would help provide strategies on how to effectively support their loved ones (see Table 2). One staff member commented on the gap in services for support persons stating, "There's definitely a need because I've spoken to people in the past who say they do have some difficulties with their family and...how they can

Table 1

Qual	litative	themes.	
			1

Theme	Sub-theme
eINSPIRE General Impressions	eINSPIRE could improve support person understanding of how to support their loved one
Video Telehealth Modality	Facilitators should provide information and support regarding telehealth access barriers
	Facilitators should provide technical assistance and tips for those without digital access and/or literacy
	Ensuring a private location exists for support persons using video telehealth is important
	Group telehealth is convenient but may lack group cohesion
Group Format	Group member participation should be balanced respectfully
	Group telehealth can offer a sense of community, but group dynamics and engagement should be prioritized

Table 2

Sub-themes of eINSPIRE General Impressions.

Sub-theme	Participant quotes
eINSPIRE could improve support person understanding of how to support their loved one	 [SP101]: "Support groups are always helpful." [SP101]: "I think it's a good idea. Especially for newcomers if this is the support person's first time having their loved one in recovery." [SP104]: "It can help families actually heal better, if you give them more knowledge." [SP102]: "Well, it could be helpful for me and for the patient. Definitely, for the patient." [SP]: "If some people don't know how communication skills work, then this is the platform, this is what it's supposed to be about. It's a real good tool for families and loved ones." [P106]: "It sounds like something that could really help some people, especially when they first get on the buprenorphine, suboxone, and their loved ones." [P103]: "I think it's good to educate people that aren't too familiar with buprenorphine." [P102]: "I think it would be helpfulso, my mom could understand."
Addiction education is helpful for support persons	[SP104]: "I would think that they [SPs] need more information on just what they're dealing with and what the red flags are, because there's a lot that goes on with a person who does drugs or who is a recovering drug addict." [SP103]: "They [SPs] need to know how the drugs work, how to save somebody overdosing." [P108]: "Yeah, and maybe she might be able to learn everything that goes on underneath. Because specifically for opiate addicts and addicts in general, it's a really emotional process to get sober." [P101]: "So, I think education would be phenomenal—on the physiological response would be phenomenal for my brother."

NOTE: P = Patient, SP = Support Person, SM = Staff Member.

support them." Regarding the group content, participants agreed that it would provide benefits to both the support person and their loved one, especially in providing support persons with the tools to heal and improve their relationship. One support person voiced, "I think it's a good thing for us to be able to understand more of what the people that are using go through." Patient and support person recommendations included providing information on: (1) the pharmacology of on for opioid use disorder, (2) patient physiological responses to opioids, and (3) the underlying effects of opioid use.

Patients and support persons reported few negative perceptions of eINSPIRE, while staff members expressed concerns about adjustments to telehealth and how that might impact engagement. One patient voiced that the time commitment and engagement for their support person could be limited. When discussing concerns around the adjustment period for both facilitators and participants in developing telehealth competency, one staff member stated, "There's going to be a big ramp-up period and a long learning curve after you get there, everybody feeling comfortable."

Video telehealth modality

Support persons reported barriers to telehealth access indicating that most but not all participants would have reliable internet access and/or the necessary resources to join a telehealth group (see Table 3). This differed from patient perspectives, which indicated that a lack of resources and financial means for some participants could pose significant barriers to telehealth access. Patients and support persons viewed technical assistance needs for telehealth similarly, as both reported that direct and clear instruction would benefit participants. For example, one patient stated having "a sort of resource list about these things or where they can maybe use a computer," would be helpful, and another support person shared that they "work better hands-on. So, whether it's my mom or somebody from the clinic to just show me the ropes and how it works, I think that that would work best."

Participants were highly concerned about privacy while using telehealth. Patients and support persons mentioned specific challenges for participants in co-living communities or those with children, as well as concerns about the potential for someone to "intrude" on the telehealth video call. One support person stated, "there's nowhere to actually talk," and another emphasized the importance of having a "private place where they felt comfortable to share within their heart and mind." While most patients recognized potential privacy concerns, some patients did not express worries about privacy or meeting security and reported that they trusted the facilitators.

Finally, participants expressed moderate acceptability of telehealth groups. While some preferred in-person communication, others appreciated the convenience, ease of participation, and similarity to face-toface interaction offered by telehealth. A support person stated, "It's like if you were right here sitting there," and another support person stated, "Something is better than nothing. And it has been very convenient. I mean, it's better than going into the hospital." One patient stated, "I feel like I communicate better in person than over the Zoom," and another patient shared that they "find it easier to speak up in telehealth settings than in person." Staff overall viewed telehealth groups as acceptable but had concerns that the structure could lack intimacy and rapport building with other group members and that it might be difficult to maintain the attention of participants. A staff member shared that, "I think it would work. I look forward to seeing if you're able to hold people's attention on telehealth for 75 minutes." Regardless, clinic staff largely agreed that telehealth groups should continue even if in-person groups resume providing access for those who are sick, live far away, or lack the necessary resources to attend in person.

Group format

Participants responded positively about the group format of eINS-PIRE but also shared recommendations for improving group dynamics (see Table 4). Support persons and patients did not express concerns about the group telehealth format of eINSPIRE. Participants reported that having a support group with different types of people outside your immediate community would be beneficial. One support person stated,

Table 3

Sub-themes to video telehealth modality.

Sub-theme	Participant quotes			
Facilitators should provide information and support regarding telehealth access barriers	[SP105]: "There's always a place that you can go for internet, but I have it at mine." [SP101]: "I think it's [video telehealth access] 50/50." [SP]: "They may not even have a device,			
	so a lot of the population that may benefit from a program like that may not even have wi-fi."			
	[P105]: "I would not be surprised if some people are seeking this treatment after hitting rock bottom and they don't have			
w	anything, or they could be homeless."			
assistance and tips for those without	[SP104]: "But it's hard to say because everybody nowadays knows exactly about			
digital access and/or literacy	the phone. And it's pretty simple because			
	you can do Zoom from your phone."			
	[SP103]: "So, maybe if there was—I don't know how you would do a training class			
	to be able to—but I guess you just have to			
	keep playing with it until you got it."			
	[P107]: "Just maybe write down the			
	steps, like now to log in and first you've			
	told me all that before."			
Ensuring a private location exists for	[SP101]: "I think if they have children, it's			
support persons using video	a challenge."			
teleficiatii is important	platform, so everything would definitely			
	be confidential, but that [privacy] is also something to think about for sure "			
	[P108]: "Being confidential with just us in			
	the group, instead of other people getting			
	the information to just hop on there."			
	[P105]: "I can see it [privacy] being a concern, but it wouldn't keep me from			
	trying to get treatment."			
	[SM]: "The other issue is we always ask			
	folks to be mindful of their surroundings			
	every group, some children show up."			
Group telehealth is convenient but may	[SP102]: "You don't have to find			
lack group cohesion	transportation there or childcare if it			
	[SP]: "You miss out on a lot of other			
	nonverbal communication gestures."			
	[SP]: "Well, I think that because it is over			
	zoom, it makes it easier for you to be able to reach out to people all over, versus just			
	being in one specific area."			
	[SM]: "But you know, again, the energy is			
	totally different. There seems to also be			
	that are at risk, patients that are			
	unstable "			

NOTE: P = Patient, SP = Support Person, SM = Staff Member.

"You guys are already trying to do a support group for us to learn and know that...(support persons) aren't alone, either, that there's other people that they could reach out to, to be able to vent and keep going. Because it does get hard." Support persons reported that hearing about other support persons' experiences would be helpful, but that facilitation strategies including conversation moderation, individual check-ins, and time for questions were necessary to encourage participation. Staff provided several recommendations on how to conduct a group session via telehealth, including having a co-facilitator present to provide crisis management as necessary and utilizing icebreaker activities to promote group engagement.

eINSPIRE protocol adaptation

After conducting the interviews, the study adapted eINSPIRE

Table 4

Sub-themes of group format.

Sub-theme	Participant quotes
Group member participation should be balanced respectfully Group telehealth can offer a sense of community, but group dynamics and engagement should be prioritized	Participant quotes [SP101]: "I think you can learn from other people's emotions. The different groups I have been in, if somebody is having a hard time, the moderator just talks to them in front of everybody." [SP101]: "I just re-emphasize about no cross-talking. That's really important to me." [P108]: "I would say just try to pull them out the group into a separate group or ask them if they want to have a talk one-on-one [during a conflict]." [P105]: "At times I just don't feel like sharing, but if someone was to call on me, I would have something to say, you know?" [SM1]: "It's really important to have a cohost and a host." [SP104]: "So when someone says, Who would like to check-in before we open this meeting," it opens the doors for a wide variety, for people to hop in that are internalizing." [P105]: "But it was still nice to know that there's still that support group out there and numbers for people to call, if you just need to talk to anyone. If you can't talk to people that you know you want to talk to, and it just feels like there's a community of people out there." [P105]: "Honestly, they're [telehealth groups] pretty cool, like easy to talk to other people that are going through the same experiences you are. You just get to see the different people. It's all different people."
	box."

NOTE: P = Patient, support person = Support Person, SM = Staff Member.

protocol in response to support person concerns regarding lack of privacy as well as connection and engagement, and staff member concerns regarding group expectations and facilitation. We incorporated the following changes to the eINSPIRE protocol: including an orientation call before the sessions, reviewing group expectations at the start of the session, mailing group handouts before the session, and asking participants to turn their camera on during the session.

Survey feedback

Support persons (n = 12) rated the acceptability, appropriateness, and feasibility of group telehealth. All support persons agreed or strongly agreed that group telehealth was acceptable, and a majority (n = 10/12, 83 %) agreed or strongly agreed that it was appropriate for support persons (see Fig. 1). When asked the feasibility of the group telehealth intervention, all support persons reported that eINSPIRE seemed possible and feasible, and almost all (n = 11/12, 92 %) reported that it would be workable in the clinic and easy to use.

Support persons from the focus group (n = 4) rated the usability of the eINSPIRE group session after completing a user test. The overall IUS score was 72.5 out of 100, which exceeds the threshold score of 70 for an intervention to be deemed "adequately usable" (Lyon et al., 2021). Specifically, most support persons noted feeling very confident with

group telehealth (M = 3.8 on a 5-point scale, SD = 0.5), and some agreed the components of telehealth were well integrated (e.g., breakouts, chats; M = 3.0, SD = 0), and a few reported using telehealth frequently (M = 2.8, SD = 0.5). Support persons largely did not endorse that telehealth was complex or difficult (M = 0.5, SD = 0.6), that they would need the support of a consultant to use telehealth (M = 1.0, SD = 1.4), or that it was cumbersome/hard to use (M = 0.8, SD = 1.0).

Discussion

This study aimed to evaluate the preliminary feasibility and acceptability of the delivery of a group telehealth intervention for the support persons of patients with OUD. The study captured insights via semi-structured qualitative interviews, asking about participant perceptions of telehealth and group therapy, their reaction to the approach and format of eINSPIRE, and their feedback on the materials support persons would receive during each eINSPIRE session. Some support persons also participated in a single eINSPIRE demo session to provide further feedback on delivery. Our results indicate that the group telehealth aspects of eINSPIRE are moderately feasible and acceptable by support persons, patients with OUD, and the clinic staff who currently work with and recruit OUD patients and facilitate sessions. While group telehealth implementation barriers remain, this study offers insight into group telehealth recommendations for this specific population of loved ones affected by OUD. All participants agreed that this intervention filled a substantial need in providing support and educational resources for family members and support persons, and that the telehealth delivery could reduce common service access barriers (such as scheduling and transportation). Consistent with prior literature, participants believed that the telehealth format would also increase access for individuals who might not otherwise feel comfortable attending in-person care in a clinic or other community setting (Shah et al., 2022). The main concerns reported regarding the group telehealth format were related to privacy and engagement. Support persons and patients shared their concerns and the importance of identifying a safe and private location in their home prior to starting group sessions, and also noted how the level of connection with other group members might be lower than in person which is consistent with findings from a similar group video-conference intervention, SMART Family and Friends (Rushton et al., 2024). Although some participants expressed feeling more comfortable interacting with group members via telehealth, others were worried about feeling disconnected from the other participants. Future studies on the implementation of a group telehealth intervention should ensure that participants have consistent access to secure internet, a private space to attend group sessions, and provide guidelines on how one can identify an appropriate location. Facilitators should also consider incorporating engaging, group-based partner-share activities that allow the group members to get to know each other better and build the intimate connections that are so crucial for these interventions.

These findings suggest that telehealth has the potential to offer accessible alternatives for vulnerable populations, especially those with limited treatment options and high levels of stigma like loved ones affected by OUD (Peart et al., 2024). The telehealth modality may help bridge the gap in support services for support persons of those with a loved one with an OUD, while increasing utilization in underserved populations that are disproportionately impacted by opioid-related consequences and mortality. Our preliminary findings found that group telehealth can also provide a forum that allows individuals to build a sense of community among those seeking care that may not typically exist in their immediate surroundings, given the self-stigma and isolation that is associated with OUD (Judd et al., 2023; McCann & Lubman, 2018b). Especially when considering that stigma is exacerbated when the individual is considering medication for OUD, perceptions are often negative and the barriers for accessing this effective treatment option disproportionately impact disenfranchised and underserved populations (Madden et al., 2021; Mark et al., 2023; Witte



Agreed or Completely Agreed (%)

Fig. 1. Support person Ratings of eINSPIRE (n = 12).

et al., 2021). Despite the preliminary positive feedback about group telehealth delivery in this study and that eINSPIRE fills a clinical need for support persons affected by OUD, a subsequent pilot test of eINSPIRE demonstrated low attendance (Osilla et al., 2024). This discrepancy warrants further exploration of the factors that ultimately affect support person utilization and attendance to address challenges that support persons face in receiving support.

There are some limitations to note in this study. First, while typical of qualitative studies, our sample size was small in both the focus group and individual interviews, therefore limiting the generalizability and increasing the potential for selection bias. Secondly, we did not collect demographics of the participants, which also has the potential to limit the generalizability of these findings across age, gender, race, ethnicity, and geographic location. In addition, our sample may be biased towards those who are comfortable accessing telehealth. Although most participants noted having access to and an understanding of technology, additional instruction on accessing the online platform for the groups or granting access to necessary technology may be needed for closing the digital divide for this population. Moreover, the patient-first recruitment approach introduces the potential for selection bias, as support persons with stronger relationships with their patient may be more likely to participate than those with strained relationships who may have higher support needs. Lastly, the participant perspectives were collected at a single point in time and after a single eINSPIRE session, limiting our ability to understand how patient perspectives may change after their support person has completed more sessions or the possibility of a dosedependent response. Longitudinal mixed methods assessments of feasibility, acceptability, and usability of the intervention after a support person attends multiple sessions or to evaluate the sustainability of outcomes from participation longer term may provide a more comprehensive view of both participant and support persons' response to the intervention.

This study works to gauge and integrate unique participant and facilitator perspectives in developing group telehealth protocols supporting loved ones affected by OUD and to provide recommendations for those facilitating group telehealth in the future. As telehealth continues to expand into other areas of medicine, future research should evaluate what types of conditions and individual presentations for whom telehealth interventions are most feasible and effective. Researchers and facilitators should consider how to best optimize connection and engagement during telehealth sessions and among participants during group therapy, especially for those who are more comfortable in person. The impact of maintaining telehealth platforms and systems on clinic resources should also be further evaluated, so that the true cost efficiency of telehealth versus in-person care can be understood. More studies are needed that explore accessible treatment options to fill the gap in treatment for support persons and to determine the potential for CRAFT based group therapy for support persons to improve treatment retention for individuals with OUD and other SUDs. Support persons and family members affected by OUD are a hidden population often lacking in their own support and left behind in policy discussions surrounding the OUD epidemic, and the current study explores an option to increase support to these individuals through group telehealth.

CRediT authorship contribution statement

Elizabeth Ueland: Writing – review & editing, Writing – original draft, Formal analysis, Data curation. **Katherine Nameth:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jennifer K. Manuel:** Writing – review & editing, Supervision, Methodology, Investigation, Conceptualization. **Karen Chan Osilla:** Writing – review & editing, Validation, Supervision, Resources, Project administration, Methodology, Investigation, Funding acquisition, Conceptualization.

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Declaration of competing interest

None.

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