It takes a village:
A pragmatic trial of a group telehealth intervention for family members affected by opioid use disorder

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It really does takes a village

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Agenda

• Effects of substance use on the family
• Community Reinforcement and Family Training (CRAFT)
• eINSPIRE study
  • Reach and Exposure
  • Adoption and Feasibility
• Lessons Learned

Substance Use Stress on Family

• 40% know someone who died from overdose and one in eight say that death disrupted their lives
• Higher risk for chronic medical and psychiatric conditions
• High child displacement; higher family violence and aggression
• Financial and psychological costs
  • “Everybody is just divided. I argue with them all the time…”
  • “I couldn’t help myself because all of my energy …were going into get him help”
  • “… you can’t trust anyone… you have to be very selective on who knows about this… extremely selective. Because people are judging.”

Rationale for working with family

• #1 motivator for seeking care
• Can be a first-line responder
• Play an active role in supporting
• Typically motivated to “help”
• Can also perpetuate stigma

• Family members also need help (isolation, victims of violence, verbal assaults, $ problems, marital conflict, generational substance use, etc. etc. etc.)


Treatment Options for Family Members

Inclusive Approaches
• Family Therapy
• Johnson Intervention
• Behavioral Couples Therapy

Unilateral Approaches
• Al-Anon, Nar-Anon
• SMART Family and Friends
• Community Reinforcement and Family Training (CRAFT)
Community Reinforcement and Family Training (CRAFT)

• Cognitive Behavioral Therapy
• Motivational Interviewing
• Developed as 1:1 therapy (12 50-minute sessions)
• Designed for family in frequent contact w individual
• Goals:
  • Decrease individual’s (IP) substance use
  • Influence IP to enter treatment
  • Improve concerned significant other (CSO) functioning


CRAFT Procedures

1. Informing and motivating the CSO
2. Functional analysis of IPs substance use
3. Improving CSO’s communication skills
4. Rewarding non-using behavior
5. Withdrawing rewards for using behaviors
6. Allowing for natural, negative consequences of use
7. Problem Solving
8. Helping CSOs enrich their own lives
9. Inviting the IP to enter treatment
"The concept of letting their children hit bottom is not the best strategy," says Nora Volkow… because in hitting bottom they may die."

"I stopped feeling like I had to be a private investigator and controlling mom. I could … walk side-by-side with him on this journey, instead of feeling like I had to take charge of it."

"Families live with the undeniable truth that our loved ones could be taken from us at any moment…

If family members want to gain tools to support their loved one, why not educate and include them so that they complement and reinforce the treatment team's effort? We are on the same team. While we can't force a person to change, we can help motivate them to change.”
**CRAFT Evidence**

- Higher treatment initiation and engagement
- Improved CSO well-being
- Studies focus mostly on alcohol
- CSO relationship type (parents)
- 1:1, group, self-directed format (book)
- Telehealth*
- Persons experiencing early psychosis, PTSD, and gambling*

(Archer et al., 2019; Erbes et al., 2020; Hellum et al., 2022; Manuel et al., 2012; McCarthy et al., 2022; Nayoski et al., 2016; Roozen et al., 2010; Siljeholm et al., 2022)

*Preliminary evidence

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**Adapting CRAFT Pragmatically**

### Existing CRAFT studies

<table>
<thead>
<tr>
<th>Target Behavior</th>
<th>Alcohol</th>
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<tbody>
<tr>
<td>Setting</td>
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*CSO (Concerned Significant Other); MOUD: Medications for Opioid Use Disorder

Osilla et al., 2020 *Addiction Science & Clinical Practice*
Adapting CRAFT Pragmatically

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<td>Dyadic: Patient and support person</td>
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<td>Patient MOUD retention Support person well-being</td>
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<td>Modality</td>
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<td>10 rolling group telehealth sessions</td>
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Seven community health centers in California

![Map of California with certain counties highlighted]
Inclusion Criteria (N=323 dyads to date)

Patients:
• 18 and older
• Taking buprenorphine at the clinic
• Has an eligible SP that participates

Support Persons (SPs):
• 18 and older (family, partner, friend)
• Consents within one month of the patient
• Frequent contact (e.g., 3+ days in the past week)
• Not concerned they would be physically hurt by their loved one
• Willing and available to try CRAFT
• No expected change to their relationship in 90 days

Study Design
Sample Characteristics

- 960 screened (40% unreachable), 323 dyads randomized

- Patients*
  - Age (M=40, SD=11); 59% Male; 60% White, 40% POC; 82% established bup
  - 60% Never Married, 46% Cohabitating with SP
  - 48% Extreme Impairment from SUD; 40% with mod/more severe depression

- Support Persons (SPs)*
  - Age (M=49, SD=16); 71% Female; 59% White, 41% POC
  - 22% Parent, 32% Significant Other/Spouse, 46% Other Family/Friend
  - 17% Extreme impairment from pt SUD; 20% with mod/more severe depression

*Based on N=285 dyads
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Pause and Reflect – What were our stuck points?

- **Reach and Exposure**  – *Do SPs* attend the intervention and how many sessions do they attend if so?

- **Adoption and Feasibility**  – *Do staff use the intervention in their clinics, is the intervention feasible in community health clinics?*

*SPs=Support Person
Reach and Exposure

• 163 SPs randomly assigned to intervention
• 21% completed at least one session
  • More likely cohabitating with patient
  • No other differences by attendance
  • Averaged 7 of 10 sessions

“…after doing the program, her mind opened…her ideas about medically assisted treatment have changed.” (PT)

“Having the opportunity to be in a space where I could be candid and share my experience with others who were also having that experience was amazing …everything is different.” (SP)

Reasons for Low Attendance

• SPs are busy, competing demands
• Low intrinsic motivation (ready to leave, why me, pt already established on bup)
• They did not know about the group
• Technical issues
• Could not attend only group time

“I feel like the program assumed that the participants were in, living with the most extreme experience that we have when our partners are using, right. And I was not in that place.”

“I mean, even with that convenience, it’s hard to get everything to work out. A couple of times I was sick, a couple of times the internet just wasn’t working.”
Adoption and Feasibility

- Clinic staff are busy and often did not have the time to call SPs
  - “I only have time to contact them twice.”
  - Focus is on patients (crisis calls increased during COVID)

- At one health system, SP enrollment was challenging
  - Only 86 screened across 22 months
    - 31% of dyads screened ineligible (versus 6–22%)
    - 33% of eligible dyads refused participation (versus 13–23%)
    - 30% of patients reported not having a SP (versus 8–12%)
  - Low buy-in from frontline staff despite support from a champion (segmented team structure)

How we have been pivoting

- Spend a few minutes with patient on which SP to invite
- Remind, remind, remind (calendar invites, texts, postcards)
- Improve messaging about the group (free, helps all, check out one)
- Exploring joint patient-SP orientation session and in-person groups
- Open up more groups
- Try extrinsic motivation: Contingency management ($15/session)
- Build intrinsic motivation: Recruitment video
Future Implementation Considerations

• SP-first recruitment is ideal
  • Narrow in on spouses/parents
  • Works best with more contact/investment in relationship

• Feasibility in community health clinics?
  • OUD is more complex than AUD

• In-person is preferred
• Group vs. Individual
• Billing for family services is complex (Dopp et al., 2021)


Mis-Implementation of an EBP

There’s more to come…


Resources

- Partnership to End Addiction
- CMC: Foundation for Change
- NAMI Family Support
- SMART Family and Friends
- SAMHSA
  - Help for mil families and civilian families