Factors in Utilization of Telehealth Treatment by Rural African-Americans with Opioid Use Disorder and Disabilities

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Abstract

This study explored factors that impact telehealth service utilization for treatment of African Americans with disabilities with opioid use disorder in rural communities. A focus group was conducted involving 12 different mental health, substance use, and rehabilitation counseling professionals. The analysis was completed using NVivo (Version 12). The results identified critical barriers that included historical distrust of technology and healthcare systems, digital divide/unavailability of Internet modems, fear of losing confidentiality, and agency non-approval. The benefits were improved communication, reduction of stigma, continuity of care, and convenience of collaboration. The findings indicate the need for additional research in this topic area.

Keywords

Rural; Barriers; Access; Telehealth; African Americans with Disabilities; Opioid Use Disorder

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Understanding barriers to access and successful outcomes among African Americans with disabilities has been an explicit focus of rehabilitation research since the adoption of Section 21 of the Rehabilitation Act Amendments of 1992. However, to date there has been limited attention given to rural African-American residents with disabilities, specifically those with opioid use disorder (OUD), in accessing and utilizing telehealth treatment in order to achieve such outcomes. Access to effective treatment has been a long-range goal of the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDLLRR) since the agency established priorities for research aimed at enhancing the field's understanding of effective services authorized by the Rehabilitation Act of 1973 (NIDILRR, 2018).

Telerehabilitation or telehealth is a relatively new modality that has been added to the treatment landscape in recent years. The COVID-19 public health emergency brought an unprecedented change and advancement of health care, federal and state health care systems rapidly changed their delivery of services, as many assessments and treatment protocols changed to an online format (Drake et al., 2020; Oesterle et al., 2020; Zhou et al., 2020). During the recent global pandemic (COVID-19) many substance use and mental health clinics decreased their traditional face to face contacts, which widened the treatment gap for African Americans in rural communities with OUD (Drake et al., 2020; Gruber, et al., 2020; Oesterle et al., 2020; Zhou et al., 2020). Telehealth assessment and treatments contained all elements as a face to face visit would encompass (Drake et al., 2020). Many aspects of treatment changed for individuals coping with OUD in which aspects such as access to laboratory services for urine testing became difficult (Oesterle et al., 2020). Many studies began exploring the strategies and monitoring of substance use and mental health treatment, but few discussed the access of rural African American residents with OUD. This recent pandemic has presented an opportunity to use technology to advance and improve the quality of health care, as well as further research to be conducted within rural community health care systems (Drake et al., 2020; Gruber et al., 2020; Oesterle et al.,2020; Zhou et al., 2020).

Maximizing the health and functioning of rural African-American residents with disabilities and OUD is a critically important foci, as this population is at great risk of poor health outcomes due to inadequate access to healthcare and functional limitations, which negatively impacts full participation in employment and community living (NIDILRR, 2018). Furthermore, due to elevated health risks, adverse outcomes and substantive needs, persons with disabilities still experience poor access to healthcare services (NIDILRR, 2018). The capacity to meet the healthcare needs of persons with disabilities in rural communities encompasses developing and advancing rehabilitation research, service delivery, and treatment strategies. Specialized treatment and resources are a necessity for rural African-American residents with disabilities and OUD (George et al., 2012; Hilty et al.,2018; James et al., 2017).

The World Health Organization (WHO) describes barriers as being more than just physical. For example, some barriers are described as negative attitudes towards people with disabilities, as well as, services, systems, and policies that limit or prohibit their inclusion (WHO, 2011). Literature has emphasized that several barriers to specialized care for rural

residents are transportation and providers trained in specialized healthcare (Gilmore et al., 2017; Jackman et al., 2019; Johnston et al., 2019; Klein & Anker, 2013; Lin et al., 2019; Molfenter et al., 2018; Smith & Kelly, 2002; Titus & Guthmann, 2010; Usher-Pines et al., 2020; Young et al., 2015).

Telehealth services have been recognized within the literature as being an effective and innovative solution to alleviating these healthcare barriers. Substance use treatment and interventions, such as cognitive behavioral therapy (CBT) delivered using telehealth modalities have demonstrated the same amount of effectiveness as face-to-face services (Arnedt et al., 2021; Khatri et al., 2014). Although telehealth treatment services have shown to be effective, there are still general concerns regarding limited access for rural African-American residents with disabilities. Many of these concerns are related to regulations and policy standards that vary by state (Keyes et al., 2014; Lerman et al., 2018) and impact telehealth treatment services implementation.

Issues with implementation shown that there are unique barriers and needs to consider while adopting telehealth as a service delivery model and strategy in disability settings. Although there is an abundance of RSA-911 data analyzing racial and ethnic differences in treatment outcomes, such data are void regarding telehealth services and practices. There is also a need to increase understanding via research of what directly impacts access and utilization of OUD treatment delivered via telehealth to rural African-American residents with disabilities.

Apart from general concerns of rural access to telehealth for many groups, there is a more specific concern for cultural considerations that may hinder this population from utilizing these services. For example, historically, African Americans have displayed a distrust towards formalized healthcare systems and treatment. Some of this apprehension is related to unethical medical research practices historically and the lack of culturally relevant interventions (Sun et al., 2016; Tillotson et al., 2015). These aforementioned researchers and others have documented a myriad of factors that impact African Americans' full participation in substance use disorder (SUD) treatment.

Currently, there is a dearth of knowledge and empirical data pinpointing and emphasizing the specific needs and concerns of rural African-American residents with disabilities and OUD, as evidenced by limited studies in the extant literature on this topic. Also, having more data on the efficacy of telehealth as a treatment modality generally is imperative towards creating and testing culturally competent and responsive interventions within rural healthcare systems, and especially those focused-on OUD treatments for minority populations. To decrease barriers of access for this population, it is critical to understand the specific needs from a rural, disability, and culture-specific perspective. Relatively little information is known about the efficacy of culturally relevant telehealth services for persons with disabilities and OUD living in rural communities. The lack of knowledge in this area must be limiting the profession's ability to strategically plan and implement services among this population of consumers. Lack of knowledge also limits the development of a culturally responsive telehealth model for OUD that could enhance disease management and treatment success.

Researching the cultural relevancy of a telehealth model for OUDs could ultimately move in the direction of more effective OUD treatment outcomes for rural African-American residents with disabilities. As such, the purpose of this study was to discover the factors (barriers and benefits) to the utilization of OUD treatment via telehealth services for rural African-American residents with disabilities. This study intended to understand those factors (barriers and benefits) as they pertain to utilization from the perceptions of clinical services professionals. Research questions were derived from literature regarding accessibility and utilization for rural communities in deploying telehealth delivered healthcare services. The following research questions were addressed:

1. What are the perceived barriers and benefits in relation to access and usage of telehealth services rural African-American residents with disabilities and Opioid Use Disorder (OUD)?

2. What challenges do healthcare providers encounter when providing OUD services to rural African-American residents with disabilities and OUD?

Methodology

This qualitative study used focus group discussion (FGD) in an attempt to understand and identify key factors (barriers and benefits) that impact usage and accessibility of OUD treatment via telehealth for rural African-American residents with disabilities. Qualitative methods, including FGD, have been widely used techniques to explore experiences and perceptions associated with disability and health studies with similar topics of interest (Aref et al., 2017).

Selection of Focus Group Participants

We used a purposeful and convenient approach to select the participants for this study. The targeted pool of study participants consisted of rehabilitation counselors, substance use counselors, and mental health therapists who have provided treatment and vocational services to African-American service recipients with disabilities and opioid use in rural communities.

Profile of Participants

The focus group cohort (N =12) was drawn from a developed pool of professionals. They included vocational rehabilitation, substance abuse, and mental health service providers (e.g., counselors, clinicians) from four different agencies in the state of Oklahoma that provide outpatient or inpatient services to African Americans with OUD. To participate in the study, they were required to meet the following inclusion criteria: (a) currently working at an organization or agency that provides mental health and substance use treatment services for persons with disabilities and (b) must be at least 18 years of age. Participation in the study was voluntary, and participants were able to withdraw from the study at any time. Participants completed an informed consent prior to the focus group discussion.

Of the 12 participants in the study, 75% were female and 25% were male having an average of 18.5 years of human service experience per provider, and 8.9 years of experience in OUD

services. The majority or 59% identified as African American, 33% identified as Native American, and Whites represented 8% of the sample. In terms of educational levels, 58% of participants had a master's degree, 9% had a bachelor's degree, and 33% possessed an earned doctorate degree. Other participant descriptive and characteristic information is provided in Table 1.

Procedures

The study protocol was approved by the Institutional Review Board (IRB) at Langston University. The research team created the 15-question protocol designed to elicit participants' experience and perspectives on factors that influence utilization of telehealth. We provided information to participants concerning the purpose of the study, confidentiality, and benefits prior to beginning the FGD. The study co-investigator and one other research team member facilitated the FGD, as three other research team members took copious observer notes about the discussion content, focus group dynamics, and other factors that contributed to the FGD process. The FGD was recorded by an audio-tape recorder. Verbatim transcripts, the observer notes, and the demographic profiles were the primary data for analysis.

Data Analysis

Data collected on participants' demographic profiles were collected via PsychData.com, which is a platform to conduct surveys in social sciences. Qualitative data analysis used NVivo (Version 12), and included reading the transcripts, creating codes, triangulating data, reducing to essential points, and interpreting data. Initially, an open-coding approach was employed to allow themes to emerge from the data. Next, the investigators generated significant categories and codes through a thematic analysis process, including open coding, memo writing, and data comparison. These codes were reviewed for reliability by three investigators. The research team completed manual coding and developed an agreed upon code-book. Data comparison and the perspective of a fellow researcher was used when there was disagreement upon the research team. Codes were agreed upon by all investigators to increase trustworthiness and validity. Participant verbatim quotes served to validate the coding, investigators' interpretations, and conclusions.

Results

NVivo identified themes that emerged from the data. Three of the eight factors/themes identified by the focus group participants, were barriers with the balance being benefits. The main themes were (a) improved communication/crisis response, which was articulated as a benefit (b) historical distrust, (c) decrease in stigma (d) digital divide (e) isolation of community (f) continuity of care – a benefit, and (g) opportunity and convenience for collaboration – also a benefit and (h) agency approval and authorization. The identified barriers from the FGD are below in Table 2.

Improved Communication/Crisis Response

Many of the participants identified improved communication as an advantage of utilizing telehealth services with African Americans with disabilities and OUD. These results

reinforced previous findings (Au-Yeung et al., 2019; Cucciare & Timko, 2015; Egan, 2021) regarding the benefits of telehealth for improved quality of healthcare services and diminished substance use by improving the quality of communication between the providers and clients. Participants further identified specific benefits as using telehealth when transportation is an issue, and how this modality assisted with isolation and reconnecting to the community. Telehealth was described overall as a supportive tool to help African Americans with disabilities in rural communities with prescription refills, and having the flexibility to speak with a medical provider. As explained by one participant:

> "They can also use it [telehealth] when transportation is an issue to get to their therapy appointments, not just for their medications and their doctor refills, but to be able to talk to somebody when they really need it"

Another participant described improved communication as allowing African Americans with disabilities in rural communities to participate in community elements and reconnect back with their community. As one participant explained: ***"it [telehealth] puts that community element back into it so whatever it is that you're dealing with, you're not on an island anymore."*** As reflected in this individuals' detail, telehealth provides the opportunity to provide holistic and specialty care. Several participants also identified telehealth as being a tool that helps with crisis intervention communication. One participant stated, ***"They can also use this [telehealth] to be able to talk to somebody when they really need, there's a way that they can contact their person through that iPad system, that they have set up, to be able to get the help they need when they need."*** Participants also identified the benefit of reaching out to those within the rural communities. One participant stated, ***"We have been giving out iPads so that we can communicate with clients that are in rural areas."*** Participants also felt that clients were appreciative of telehealth, ***"the majority of them really use them [iPads] and appreciate having them [iPads], and it's not like where they can do a lot of things with it [iPads], but they can talk to the doctor and get medication refills and a therapist"***

Historical Distrust and Stigma

Nearly all participants identified fear and distrust as a barrier to providing OUD treatment via telehealth for African Americans with disabilities in rural communities. They mentioned lack of trusting the system, historical mistrust of a "closed community", identity protection, and fear of their confidentiality being violated. The following quotes from participants illustrate how the distrust among African-Americans rural residents with OUD manifested:

> "Fear and distrust of the system, and especially, "On this thing [iPad] that I'm looking at, I don't trust this process."

> "They may feel like they're being recorded, or it's going to be stored and kept and then brought up like," Hey we saw you saying this."

> "I totally agree with the mistrust and the access. Our agency hasn't started using it [telehealth]yet. But some of my clients, they distrust filling out the application. So just thinking about having to use technology, they're like, "What is this?" And a lot of mine, they're like, "What is this?" And a lot of mine, they're just now using

the cell phone. They don't even have an email address, like "set yourself an email address so we can communicate."

The African-American community has a historical distrust of formal systems, such as the healthcare system, which is largely attributable to the Tuskegee Syphilis Experiment (James & Jordan, 2018; Saberi et al., 2013; Sun et al., 2016). Similar findings were reported in how African Americans and Latinx individuals feel about telemedicine; George et al. (2012) reported that technology issues with confidentiality and privacy were concerns of African-American participants. The concern among these study participants was that personal information shared via e-technology would be stolen or accessed by unauthorized individuals. African-American participants perceived that aspects of the internet and technology are "insecure" and "for anybody". Some participants felt concern about their identity possibly "floating around"; participants seem to not trust that their health information would be kept confidential.

Privacy issues related to the infrastructure of telehealth include the transmission of tapes, patient record data, phone calls, all of which raise concerns of possible privacy violations for professionals. Schopp et al. (2006) implied that clients may have concerns with confidentiality as well as privacy due to not being familiar with technical infrastructure and operations of videoconferencing. It is likely that these concerns of telehealth may cause hesitancy and refusal to utilize services. Educating rural clients concerning the appropriate usage of telecommunications and equipment, could likely assist with alleviating the overall concern of risk of privacy loss (Schopp et al., 2006).

Participants also discussed fear held by African-American rural residents with disabilities and OUD because of a concern of exposing their self-information. Many of the participants identified that this population had a legal concern for their confidentiality being threatened in the telehealth process. As one participant highlighted:

> "Whenever you started saying that I even got a moment of like, okay now some people try to use those, the legalities against you. So even as a professional, it's like, "Hold on, you're recording me? And are you trying to get me back?" So, there's a barrier too. So, there's an interest for the barrier not to be there."

Participants also identified their concerns with legalities, in regards to legal standards for clinicians, especially for the associate level clinical professionals. Standards and guidelines for providing services across state lines are also inconsistent and appears to be a reason of hesitation in implementing telehealth services to PWD in rural communities. This was identified as a barrier to providing services due to non-existent licensure, insurance policies and guidelines on reimbursement, payments, and authorization of associate level clinicians (i.e., LCSWA, LMHCA).

Historical Distrust and the Digital Divide

The overall concept of distrust for this community, are concerns for confidentiality and the "fear of exposure of self-information", which are barriers for both consumers and professionals. Having access to internet modems was also a barrier to accessing health care

via telehealth. Participant 1 highlighted the unavailability of internet modems in the rural communities:

> "Being able to get a modem is really difficult for a lot of people. We've had to try and find some resources to get some modems for some rural clients of ours."

> "And they did buy a modem, and their modem broke. And they were trying to figure out how do I get another one in order to continue my services, and there just aren't any modems out there that people will donate to you that we've found."

> "So, there were some fundraising things going on in order to get these people a modem. So maybe Cox Cable or AT&T or some of the others would be willing to donate modems to people for this service. That would be helpful."

It is a critical matter for accessibility to technology modems to be considered for the overall adoption of telehealth services for African-American rural residents with OUD and disabilities.

Isolation of Community

Arguably, factors of isolation are complex and represent a specific concern of clinicians in implementing telehealth for OUD services for this rural population. Participants identified the following key concerns of community isolation:

> "I think it can kind of keep that person more isolated. You know, they don't get to leave their community.

> They don't know what else is out there"

> "So, I think using that telehealth medicine is a good deal, but on the other side, making sure that they're not isolated, that they're still on track with everything, that they're actually doing what they're discussing and things like that"

> "They don't know what is out there. They don't get to experience other things and meet new people that might have different ideal from them. So, they're a little bit more isolated, I think."

Agency Approval and Authorization

Additional factors identified as barriers to the adoption of telehealth were agency approval and authorization. When asked the question of reasons the participants and/or their agencies have for not using telehealth, the participants indicated limitation within agency policies, approval and authorization from senior leadership and administration. Licensure limitations are a factor; no agency or clinician needs to use telehealth services, lack of compensation, prohibition, and regulatory issues were all factors that influenced utilization. Clinicians indicated that a barrier to implementing clinical services via telehealth was difficult due to the inconsistencies and lack of guidelines and policies supporting use. As one participant expressed:

> "One of the agencies that we contract with has not approved for us to do it [telehealth) yet. They keep saying 'Nope you can't do it." No, we don't' want that." So, we haven't implemented [telehealth] for that reason."

> "At my agency that [use of telehealth] is al lowed, but not when you're candidate. So, if you're a candidate, you're not allowed to use it [telehealth]. And I haven't really researched it to see if there's an Oklahoma-regulation, like as far as Oklahoma doesn't allow it, for the candidate to use."

> "My agency is using tele mental health, and had social workers available Monday-Friday from 8:00 to 5:00, to set up appointments with veterans that were not in a 50-mile radius."

> "They could go in and access and talk to a therapist through their smart phone or even at a satellite clinic, if that was closer. And then they would connect with the therapist that way.

Other participants indicated that their agencies were in the stage of considering adoption of telehealth in their organization., ***"but I did hear them speak about it [telehealth] and say that they're in the works of getting it [telehealth] approved."*** Rural health care systems' adoption of telehealth is a critical contribution for the rural community to have access to specialty providers. Technology serves to break certain barriers to transportation and scarcity of specialty care, but the utilization of telehealth has been reported to be low, so these perceptions are not surprising (Cassity-Caywood, 2019).

Continuity of Care

Although barriers were identified, several benefits were noted by the participants related to implementing OUD services via telehealth for African Americans with disabilities in rural communities. When asked the question of, if telehealth could improve the continuity of care for OUD in this population, participants identified consistency of care provisions, the ability to reach out to the community, convenience, compliance, and making access easier as factors that benefit the overall continuity of care. One participant cited easier access as a contribution to the continuity of care and compliance: ***"It gives continuity of care, and so if it makes access to healthcare easier by calling in or messaging, then that can hopefully improve compliance to treatment in general."***

Others in the FGD described continuity of care as facilitating consistency, as evidenced by the remark: ***"not only the continuity of care, but just ensuring that the level of care is consistent. Even in times where they may not have the means to get to the doctor, be it transportation or whatever issue arises, the fact that you would be able to just connect with a provider at that point would allow you to have, I mean they just, it's really a convenience to have, especially when you're far out and when there's no access and there's limited resources."***

Improved care was described as an advantage for this specific population, this included the ability for the consumers to meet with their specialty providers with ease. Consistency of care is easier with telehealth due to consumer's ability to connect with providers with convenience and ease of technology. Consumers are more likely to have access to sessions due to the convenience of being able to connect to their provider from anywhere. One participant indicated: ***"I think that it would improve not only the continuity of care, but just ensuring that the level of care is consistent. Even in times where they may not have***

the means to get to the doctor, be it transportation or whatever issue arises, the fact that you would be able to just connect with a provider at that point would allow you to have, I that would be great if I could go and see my doctor and be like "Hey, need to go and can you refill this one real quick."

The factors of convenience have been cited in literature as being a positive outcome (i.e., benefits) in telehealth services with OUD and mental health treatment (Au-Yeung et al., 2019; Cucciare & Timko, 2015; Egan, 2019). Another benefit raised in the discussion was the reduction of stigma related to OUD and mental health services, as it provides reliable choices for the consumer (i.e., not having to drive to appointments and not being seen going into an actual clinic to receive help). Participants indicated that telehealth provided an advanced level of anonymity as consumers would not have the need to travel to a physical office. The reduction of stigma is afforded by consumers having the convenience to attend sessions from the comfortability of their own homes and not having to physically attend appointments. ***"Speaking to African Americans as well as the disability portion of that question, maybe there are some things regarding stigma, so you don't have to deal with the stigma like I'm walking to a mental health facility and there's a stigma and pride, or, you know, angst against that, as well as there's the comfort of being in your own home. That's how telehealth can improve."*** This statement implies that the convenience of engaging in a telehealth session at home also reduces the likelihood of clients feeling ashamed and reluctant to participate in services. Historically, stigma has been a factor that has impacted the health seeking behaviors of African Americans with OUD and mental health services (George et al., 2012).

Opportunity and Convenience for Collaboration

Although there were external and cultural factors that impact barriers and benefits of OUD telehealth services, participants who reported use indicated that telehealth provided the opportunity to implement a community-based approach to treatment, which is an additional benefit. When asked the question of whether telehealth improved integrated health, participants highlighted a treatment team approach, multidisciplinary health team, holistic care, and making coordination easier in care. From their perspectives, it was more of a unified voice, and inclusive of persons with disabilities.

The ability to provide multiple types of treatment for OUD would be enhanced, whereas it would be difficult with traditional face-to-face organizational behaviors, and this, too, was voiced as a benefit. Telehealth is unique in how participants identified inter-agency collaboration possibilities due to the convenience of communication. One participant described it as: ***"We can use it [telehealth] with other agencies. If we have someone that stays at my facility, and they just showed up there for a bed, and they need to be detoxed, and maybe the detox crisis center is full, I can then correspond with the referral center. Or, if we have someone that maybe they have a kid that's in crisis and they need to go to St. Anthony's, so you can use it for other places. I mean that's a great benefit."*** Another positive aspect of collaboration articulated was the treatment team approach, as another participant stated: ***"Having the person at the table who needs the services. And so, say you're working with an interdisciplinary team, but they can't get to***

you, but all of your medical people are there at the same place, then it could be possible to coordinate a meeting where they're all in the same room and you can come in with me, via telehealth, have all of your providers in the same room and get opinions and advice or form a treatment plan with all of those voices together instead of just well you know, "My counselor said this and then my primary said this and my pain doctor said this. And then my whoever else said this over here", and nobody's speaking the same language, but we're all talking about the same person." A final benefit articulated was that this modality of providing OUD treatment to the African-American rural communities was cited by participants as an opportunity to centralize services and have stakeholders (i.e., persons with disabilities) present in one room to discuss prognosis and treatment needs versus the lapse of time in services due to the need of scheduling appointments and seeing providers based upon their availability in the traditional manner, which is less than optimal.

Discussion

This study offers findings that begin a path of knowledge that could ultimately, once replicated in quantitative investigations, contribute to what we know about the likelihood that African-American rural residents with disabilities and OUD will embrace treatment services delivered via telehealth. Findings also contribute to the existing knowledge base on important factors in providing specialized telehealth services. In spite of some studies indicating that telehealth provides the opportunity for quality and specialty care in rural communities, it appears that not all rural healthcare agencies have adopted this practice of providing OUD treatment. To date, there is limited research available in this area concerning rural health care systems' adoption of telehealth, which is vital in understanding factors that impact accessibility and utilization (Shulver et al., 2017; Usher-Pines et al., 2020). Ample literature and research about the specific cultural factors that may impact African-American rural residents with OUD and other disabilities engagement with telehealth services was also unavailable.

The FGD supported the identification of the following main themes as telehealth utilization barriers; digital divide and isolation of community. Participants communicated that the benefits were improved communication/crisis response, historical distrust/stigma, continuity of care, opportunity and convenience of collaboration. Our research found that participants' (clinical service professionals) perceptions were consistent and formed a direct consensus around factors that constitute barriers and benefits to providing telehealth services. Within this context, there are several factors mentioned in the FGD that might be actionable. First, the barrier of the digital divide and having access to telehealth services were discussed as being resolvable by making Internet modems more available to consumers residing in the rural communities. This action supports the need for first understanding the nature of the digital divide for rural healthcare agencies and African Americans with disabilities. Resolution should focus on what specific equipment, personnel, training, and policies are needed to implement this service for use by target population members. There may be specific multigenerational, gender, family, and community needs that should be highlighted from the perspectives of the service recipients that might be worth noting.

Literature has generally encouraged an increase in research activities to support the overall adoption of telehealth from the healthcare and organizational aspect. The policies and behaviors that create barriers should also be further explored to discover the professional and training needs. A review and audit of telehealth policies specifically within the rural health care system should be a priority to understand what recommendations are needed to achieve full integration. In other words, policymakers should be made aware of the limitations of agency and statewide standards of telehealth that limit accessibility.

The literature has supported the critical need for further examination of standards that are currently sending contradictory messages across states. These factors are causing prohibition of telehealth utilization for OUD treatment in rural communities (Keyes et al., 2014) Future research should solidify recommendations that would actionably address barriers for healthcare organizations and African Americans with disabilities in rural communities.

Additionally, fear and distrust among African-American rural residents with disabilities and OUD is a barrier related to telehealth services. The historical distrust of formal healthcare systems was identified as a contributing barrier. Such barriers have been described as fear of information being lost and confidentiality being compromised in the telehealth process. These results are consistent with what other researchers have found (George et al., 2009; George et al., 2012). There may be a need for technology platforms that promote education concerning telehealth that could be provided to the clients and the community overall, so that the level of apprehension would decrease.

Increasing knowledge of telehealth and how it has similar benefits and the same ethical responsibility of maintaining privacy as face-to-face services should be shared with the community. Also, sharing the education of HIPPA compliance within the applications and platforms used for telehealth could help ease worries. Advocates would need to reach out to rural healthcare agencies, OUD professionals, and African Americans with disabilities in rural communities to create a culture of transparency and understanding with presentations providing education and awareness of telehealth services. Effective training and education will not only impact consumer utilization, but based upon this study's results, i.e., the perspectives of clinical professionals as well.

Finally, issues with preventing community isolation were identified as a concern with implementing telehealth for this population. The findings on community isolation are inconsistent with the views of scholars who noted that telehealth brought more of a convenience for alleviating isolation of specific communities (Benavides-Vaello et al., 2013; McGinty et al., 2006; Zhou et al., 2022). Creating models for OUD treatment via telehealth could perhaps assist with eliminating isolation of consumers in time. The literature has supported an increase of healthcare research in this area to ensure quality service prevents such factors (i.e., isolation) from contributing to non-adoption (James et al., 2016; Shulver et al., 2017; Usher-Pines et al., 2020). An increase in empirically-driven research will assist with expanding telehealth services and creating models that address the concern regarding isolation in this community.

Limitations and Future Research

This study has three limitations. The first limitation is that it is an initial, exploratory study of this topic and so major conclusions drawn from the results may not be plausible. Secondly, the FGD participants in this qualitative investigation represent only part of the relevant perceptions (i.e., those of clinical service professionals) needed for a complete perspective. A complete perception would necessarily require the views of African Americans with disabilities in rural communities as well. Also, while qualitative research is valid and meaningful, in this study the data collection process consisted of only one FGD. An additional limitation is that though the clinical service professionals provided their perceptions, most are based on speculation about barriers and benefits to usage of telehealth in the target population, since many have no firsthand experience actually working in an OUD telehealth service delivery program.

Nevertheless, this study offers a starting contribution to the literature on this new topical area of exploration. Therefore, the opportunities for follow up studies are plentiful. For example, there may be a need for additional, larger qualitative inquiries as well as quantitative investigations, and mixed methods studies examining this topic. Such subsequent investigations would advance the burgeoning knowledge in the general topic area of telehealth, how this service delivery modality applies to OUD, and how it applies to underserved people of color with disabilities.

Conclusion

Researchers and rural healthcare delivery systems should analyze policies and organizational behaviors that may precipitate or sustain barriers or offer benefits to implementing OUD telehealth services to African-Americans residing in rural communities. The findings from this study identify key preliminary concerns and insights on barriers and benefits of rural telehealth delivery in providing OUD services to members of this target population. Launching more research investigations that specifically address this topic would be important. Such subsequent research efforts should be comprehensive and focus on the perspectives of African Americans with disabilities from rural communities, as well as leadership and administration from healthcare agencies. Increased research will also provide the opportunity to begin to understand the effectiveness of telehealth OUD services in the rural areas; and ultimately promote this service delivery modality as a viable alternative to traditional face-to-face services.

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Table 1

Descriptive Profiles of Profiles

Number	Gender	Ethnicity/Race	Profession	Type of Service
1	Female	African Amercan	Mental Health	Mental Health Treatment (Outpatient)
2	Female	African American	Licensed Counsellor, Licensed Alcohol and & Drug Counsellor	Substance Abuse (Inpatient)
3	Male	African American	CRC, LPC-S	Vocational Rehabilitation
4	Female	African American	CRC	Vocational Rehabilitation
5	Female	African Americans	LPC Candidate	Vocational Rehab Substance Abuse (Outpatient/Inpatient) Mental Health (Inpatient/Outpatient)
6	Female	African American	LPC/CADC	Substance Abuse (Outpatient/Inpatient) Mental Health (Outpatient/Inpatient)
7	Male	Native American	Consultant/Mental Health Researcher	Mental Health (Inpatient/Outpatient)
8	Female	Native American	LCSW, LADMH-S	
9	Female	Native American		Vocational Rehabilitation
10	Female	Native American		Vocational Rehabilitation
11	Male	African American	Licensed Social Worker	Social Worker Substance Abuse (Inpatient/Outpatient)
12	Female	White	Licensed Alcohol and & Drug Counsellor	

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Table 2

Barriers and Benefits in Utilization of Telehealth for OUD Services of PWD

Barriers	Benefits
• Isolation of community	• Improve communication and crisis response.
• Agency approval	
• Agency authorization	• Decrease in stigmatization
• Licensure approval across state line	• Convenience for collaboration of providers
	• Continuity of care
• Digital divide	