**Abstract**

**Background:** Psychological interventions may assist in the management of bipolar disorder however few studies have assessed the use of group therapy programs using telehealth. **Aims:** The present study aimed to assess the feasibility and acceptability of a well-being group program for people living with bipolar disorder designed to be delivered via telehealth (Zoom platform) using a randomised-controlled pilot design.

**Method:** Participants were randomly assigned to either the 8-week well-being plan treatment condition or the wait-list control condition. They were administered a structured diagnostic instrument to confirm bipolar disorder diagnosis followed by a set of self-report questionnaires relating to mood, quality of life, personal recovery, and stigma.

**Results:** A total of 32 participants (16 treatment; 16 control) were randomised with 12 participants completing the intervention, and 13 the control condition. The program appeared acceptable and feasible (75% retention rate) with a mean attendance being reported of 7.25 sessions attended out of a possible 8 sessions attended. Participants reported high levels of satisfaction overall with the intervention, with a mean score of 9.18 out of 10.

**Discussion**: Preliminary evidence suggests that delivery of the group program online is feasible and acceptable for participants living with bipolar disorder. As the program was designed to prevent relapse over time, further research is needed to determine if the program may be helpful in improving symptom outcomes over a longer follow up period.

**Keywords:** bipolar disorder, cognitive behaviour therapy, group therapy, wellbeing plan, psychotherapy

**Introduction**

 Bipolar Disorder (BD) is a lifelong chronic mental health condition affecting 1-2% of the population worldwide (Merikangas et al., 2011). Although it is diagnosed based on mania or hypomania symptoms (American Psychiatric Association, 2022), depression is the most prevalent symptom experienced (Judd & Akiskal, 2003). Despite the use of medication, the risk of relapse over a five-year period is around 73% (Gitlin et al., 1995) and due to the chronicity of the condition, many people living with BD experience ongoing and multiple episodes of illness throughout their lifetime, often requiring hospitalisation.

 Psychological interventions are useful in assisting in the management of bipolar disorder as an adjunct to pharmacotherapy (Miklowitz et al., 2021). Interventions such as Family Focused Therapy (FFT) (Miklowitz & Chung, 2016) and Interpersonal Social Rhythm Therapy (IPSRT), a therapy targeting developing routines such as those around sleep (Crowe et al., 2016), have both shown to be helpful in the management of BD (Miklowitz et al., 2021). Other interventions that use Cognitive Behaviour Therapy (CBT) have also been found to be effective, with benefits being seen in a range of other target domains including medication adherence, symptoms reduction, and functioning (Chatterton et al., 2017).

 Given the chronicity of the illness, recovery-informed approaches are becoming increasingly popular as an approach to treatment for people living with BD with many programs indicating benefits (Hancock & Perich, 2022). Recovery models in BD posit that rather than symptomatic recovery being viewed as the ideal recovery, personal recovery may be important when considering overall outcome in the illness (Dodd et al., 2017). Personal recovery may be defined as an individual’s own interpretation of living well with illness and may include specific features in bipolar disorder such as purpose and meaning, hope and empowerment (Jagfeld et al., 2021). The concept of personal recovery may then vary from person to person, with the specific features of personal recovery then being dependant on how they are defined by the individual (Jagfeld et al., 2021).

 Well-being plans are a psychoeducation approach based on CBT that targets early warning signs, triggers and psychoeducation about symptoms. These have been utilised in mixed psychiatric samples in several studies (Canacott et al., 2019). The largest RCT assessing the use of a peer-led program with 519 participants found improvements in quality of life and reduced symptoms over a six month follow up period (Cook et al., 2012) showing support for this form of intervention. However, a recent meta-analysis of this program noted few improvements in symptoms, but instead showed support for specific benefits in self-reported personal recovery with some improvements in depression being found (Canacott et al., 2019).

 Well-being plans, often used as a component of psychological interventions, have been recommended in management of BD specifically for many years (eg Orum, 2012). Psychological interventions that incorporate features of well-being plans in BD, such as those that focus on relapse prevention, have reduced relapse and symptoms of depression for people living with bipolar disorder (Castle et al., 2010). In addition, psychoeducation overall has been found to lead to fewer mood episodes, shorter lengths of time in hospital and greater adherence to medication (Rabelo et al., 2021). However, many people living with bipolar disorder are not accessing psychosocial therapies such as psychoeducation programs due to a lack of availability of these services in their regions (Barbato et all., 2016).

During the COVID-19 pandemic, psychological services were delivered via telehealth platforms, with many of these services now continuing to be offered via telehealth in order to improve ongoing access to psychological treatment However, although telehealth programs have been shown to be as effective as face-to-face therapy in several studies (eg Poletti et al., 2020), few research studies (Sankar et al., 2021) have been conducted that have explored telehealth delivery for psychological therapy for people living with bipolar disorder The delivery of programs via telehealth to people living with bipolar disorder may be important in promoting access to group programs that otherwise may be difficult to access. One reported study that assessed individual telehealth delivered IPSRT therapy for young adults and adolescents with BD found that high retention rates were noted (77%) with high scores on measures of satisfaction with this platform (Sankar et al., 2021) suggesting that this may be a viable mode of treatment delivery for people living with bipolar disorder. However no studies have assessed the feasability and acceptablity of group therapy programs for adults living with bipolar disorder using telehealth platforms.

 The present study aimed to assess the acceptability and feasibility of a recovery-orientated well-being group therapy program for people living with bipolar disorder that was developed specifically to be delivered via telehealth (Zoom platform). Feasibility and acceptability were to be determined by at least a 70% retention in the treatment arm or higher (30% dropout or less) indicating a consistency with other group therapy studies in face-to-face settings with at least 6 out of 8 sessions attended during the program (eg Perich et al., 2020, Ellard et al., 2017). Corresponding qualitative data indicating acceptability of the content, zoom delivery and group processes were also aimed to be assessed, with data being collected using a semi-structured interview.

**Method**

**Participants**

 Thirty-six participants expressed interest in the study with 4 being excluded for reasons such as not meeting the inclusion criteria. The inclusion criteria were being over 18 years of age, having a confirmed diagnosis of BD, being under the care of a GP or psychiatrist. Exclusion criteria were being located outside of Australia. Groups were conducted from April 2021 to June 2022, with participants being located throughout Australia. As noted in Figure 1, 32 participants were randomized to the trial and were allocated to one of the two groups, with 12 participants completing all elements of the well-being plan intervention and 13 completing all elements of the wait list control condition, including completing all questionnaires.

 Four (13%) males and 28 (87%) females in total took part with 29 (91%) participants being born in Australia, 1 (3%) in Chile, 1 (3%) in Ireland and 1 (3%) in Czechoslovakia. Seventeen (53%) participants reported having a bachelor’s degree or higher, with 12 (38%) reporting a vocational qualification and 3 (9%) reporting other.

 Most participants 30 (90%) were currently taking medication for BD symptom management, with 3 (10%) not currently taking medication. Of those who reported medication use, 27 (93%) reported the use of more than one psychiatric medication with 11 (38%) using lamotrigine, 8 (28%) lithium, 4 (14%) quetiapine, 3 (10%) sodium valproate, 3 (10%) Epilim. All participants were confirmed as being under the care of a GP or psychiatrist. Remaining demographic and clinical characteristics of participants are presented in Table 1.

[Insert Table 1 here]

 Participants were recruited from the community via social media (Facebook, Instagram advertising) and existing research participant databases, directed to people who were located within Australia. Trial was listed with Australian New Zealand Clinical Trials Registry (ACTRN12623000043639).

 Participants allocated to the wait list control condition were offered the program at the end of the 8 weeks. Completion of the treatment was defined as attendance at a minimum of four sessions over the 8-week period.

**Procedure**

 Participants were provided a link to the study’s participant information, online consent and directed to a set of questions regarding eligibility (under the care of a GP or Psychiatrist, over 18 and previously diagnosed with bipolar disorder). After participants consented to be contacted and to take part in the study, they were contacted via email to book in a phone interview to confirm their bipolar disorder diagnosis.

 Participants then undertook a telephone interview confirming their diagnosis of bipolar disorder using the SCID-5 (Research Version) (First, 2015), with current symptom severity assessed using the MADRS and YMRS. The interview was conducted by a psychologist or clinical psychologist trained in the administration of the SCID V. After confirmation of the diagnosis, participants were enrolled into the study and asked to complete questionnaires which included demographics questions, mood symptoms (ASRM, DASS), quality of life (Brief QoL. BD), personal recovery (BRQ) and internalized stigma (ISMI) administered online via Qualtrics.

 Participants were then randomly assigned to either the treatment condition or the wait list control condition (under the care of a GP or psychiatrist) as a parallel trial design. Randomization was undertaken by a researcher who was not associated with the research study. The researcher used a computer-generated randomization list to conduct the randomization where the participants were then randomly allocated to a condition using a block randomisation sequence with 16 participants in each group (eight per condition). The researcher conducting the randomisation was blind to the conditions.

 Participants allocated to the treatment condition then attended an 8-week well-being planning group telehealth delivered via the zoom platform. Each session lasted for approximate 1.5 hours. The program contained elements of CBT, psychoeducation about bipolar disorder, stigma and coping (Table 2).

 Those in the treatment allocation were required to complete a mood chart and journal throughout the 8-week period as part of the intervention and to complete one component of the well-being plan each week along with some questions at the end of each weekly session. At Week 7, a five-minute time was allocated to each individual participant to review their well-being plan with the facilitator on. one-to-one basis in a Zoom breakout room. At the completion of each group therapy session, participants were asked questions about the program content that week.

 Those allocated to the wait list control condition were not required to complete a mood chart or journal and completed the self-report measures listed in the measures section at baseline and then at 8 weeks. The group therapy was conducted by a registered psychologist with a research assistant/Master of Clinical Psychology trainee students attending throughout the trial. The research assistant/student assisted with the delivery of the content, noted attendance and any technical issues with Zoom during each session every week.

 Any adverse events that may have occurred during the session were recorded by the research assistant/student whilst the daily journal was reviewed for any adverse events that may have been related to the intervention during the trial at completion. Participants were invited to stay at the completion of the program each week in the zoom room to report any adverse events or other experiences that may have occurred with the facilitators.

 At the completion of the 8-week program, participants in the wait list control and treatment conditions completed the same battery of self-report questionnaires listed under measures. Those who completed the treatment were invited to complete a telephone qualitative interview and were asked to return their mood chart and final well-being plan for further assessment of any potential adverse events. Participants in the wait list control condition were invited to take part in the well-being plan intervention if they chose.

Researchers conducting the interviews were not blinded to the treatment allocation and all interviews were conducted by phone.

 Informed written consent was obtained from all participants and the study was approved by the Western Sydney University Human Research Ethics Committee (H14254). The research was conducted conforming to the Declaration of Helsinki.

**Measures**

*Self-report measures*

*Demographics*

 These included gender, marital status, age, education, country of birth, receipt of government benefits and employment. Questions relevant to bipolar disorder illness course were also asked, including age of onset of depression and hypo/mania, age at diagnosis, number of prior episodes, other psychiatric diagnoses, medication use and type, and previous hospitalisations.

*Depression, Anxiety and Stress Scales (DASS-21)*

 The DASS-21 (Lovibond & Lovibond, 1995) scale assesses past week symptoms of depression, anxiety and stress with 21 items overall and 3 subscales. Participants indicate on 4-point scale from 0 to 3 for each item with 3 indicating greater frequency of symptoms. Previous research has found it to have good reliability for each of the three subscales (α=0.95 ‘Depression’; α=0.90 for ‘Anxiety’; α=0.93 for ‘Stress’) (Crawford & Henry, 2003) with this study noting lower levels of relability with α=0.90 ‘Depression’; α=0.71 for ‘Anxiety’; α=0.90 for ‘Stress’.

*Altman Self-Rating Mania Scale (ASRM) (Altman et al., 1997)*

 This scale measures past-week self-reported mania symptoms. It contains 6 items assessing symptoms of mania and is scored from 0 to 4 with 4 representing greater frequency. It has previously reported good reliability with α=0.79 reported in the original study (Altman et al., 1997), however in this study the reliability was α=0.57. Scores 6 and over denote clinically significant symptoms of mania.

*The Bipolar Recovery Questionnaire (BRQ)*

 The BRQ (Jones et al., 2013) measures self-reported personal recovery in bipolar disorder over the past week. It is a bipolar disorder specific measure that contains 36-items. Items are scored from 0 to 100 on a VAS scale. In the initial validation study, the scale has reported good to excellent internal consistency (α =.875; test-retest reliability after four weeks =.866) (Jones et al., 2013). Reliability in this study was α=0.79.

*Brief version of Quality of Life in Bipolar Disorder (Brief QOL.BD)*

 The Brief QOL.BD (Michalak & Murray, 2010) is a self-reported 12-item measure of quality of life designed for bipolar disorder populations over the previous seven days. Items are rated from ‘strongly disagree’ to ‘strongly agree’ on a range of domains such as sleep, mood, physical, leisure, cognition, social, independence, finance, household, self-esteem, spirituality and identity. The scale has indicated good reliability, with previous research indicating the Cronbach alpha for this scale as ranging from α=0.87 to 0.89 (Michalak & Murray, 2010). Reliability in this study was α=0.88.

*Internalized Stigma of Mental Illness Inventory (ISMI)*

 The ISMI (Ritsher et al., 2003) is a 29-item self-report scale that measures internalised stigma in mental illness. Participants endorse items on a scale from 1 to 4 with 1=strongly disagree to 4 = strongly agree. The measure comprises five subscales: alienation, stereotype endorsement, perceived discrimination, social withdrawal, and stigma resistance which may be used to comprise a total self-stigma score. Higher scores indicating greater levels of internalized self-stigma. ISMI has reported good internal consistency in prior research α=.90 (Ritsher et al., 2003). Reliability in this study was α=0.89.

**Clinician-Administered**

*Structured Clinical Interview for DSM-5 – Research Version (SCID-5-RV)*

 The SCID-5 (First MB, 2015)is a semi-structured interview designed to assess diagnostic criteria for major psychiatric disorders as defined in the DSM-5 (APA, 2022). The past month and lifetime modules of depression, hypomania and mania were used in this study. Internal consistency on the SCID-5 have also shown good results (Shankman et al., 2018). For the SCID-5, diagnostic sensitivity/specificity has been reported as high as >0.70 with kappa values reported as being >0.70 for most diagnoses (Osório et al., 2019).

*Young Mania Rating Scale (YMRS)*

The YMRS (Young et al., 1978)is an 11-item scale which assesses mania symptoms and their severity over the past week. Previously it has reported good reliability in the original study (Young et al., 1978) with a cut-off score of less than 4 suggesting remission for mania in bipolar disorder (Berk et al., 2008).

*Montgomery-Åsberg Depression Rating Scale (MADRS)*

The MADRS (Montgomery & Åsberg, 1979) assesses depressive severity over the past week using a 10-item clinician-administered scale. Scores are rated from 0 to 10. It has reported good internal consistency (α=0.85) (Hermens et al., 2006) and inter-rater reliability (0.76) (Davidson et al., 1986). Suggested cut off for severity are 0-8 (no to mild symptoms), 9-17 (mild symptoms), 18-34 (moderate symptoms), 35 and over (severe symptoms) (Müller et al., 2000).

*Weekly measures*

*Treatment program*

*Modified Mood Chart*

Based on National Institute of Mental Health prospective Life Chart Methodology (Denicoff et al., 2000). Daily mood charting asks participants to rate their mood on a scale from ‘High’ Severe to ‘Low’ Severe on 12-point scale. The chart also included monitoring of functioning severity and medication adherence. Brief journaling was added to the chart for participants to record life stressors or other daily events if they chose.

*Weekly group measures*

At the completion of the group treatment every week, participants were asked on a Likert scale from 0-10: ‘How helpful did you find the content discussed today?’ - 1=Not helpful:10=Very helpful; ‘How useful did you find engaging with the other participants today?’ - 1=Not useful:10=Very Useful; ‘How satisfied were you overall with the program today?’ - 1=Not at all satisfied:10=Very satisfied. Participants were further asked a qualitative question - ‘Please write any additional comments you would like to share about today's session’.

*Qualitative interview*

At the treatment completions, participants were asked a series of qualitative questions via phone interview. Questions included, ‘What other aspects of the program did you find most useful?’, What, if anything, would you change or improve about the program?’,

‘What about the program had the most impact on you?’, ‘What aspects of the program did you find least useful?’.

**Well-being plan treatment program**

The well-being plan group was developed based on principles of well-being planning previously described in prior research and literature (Orum, 2012). Previous studies have included a focus on symptoms, triggers and relapse signatures, social support as well as a focus on personal recovery goals for well-being more broadly for SMI populations (Cook et al., 2012) whilst in this program, BD-specific information was added. This included sessions which included content such as sleep and maintaining routines, circadian rhythms, hypo/mania and depression symptoms and BD medications.

 Further additions to the program included discussion of stigma, acceptance, and personal identity and how stigma may play a part in well-being planning. The principles of CBT employing both active and passive coping strategies were also included as a feature of this program, with participants drawing on these strategies to enhance their well-being plan. A session-by-session outline is presented in Table 2.

[Insert Table 2 here]

 A brief optional mindfulness practice was also conducted at the conclusion of each session to complete the session, along with the option to debrief with the therapists if needed. Additional feasibility and acceptability relating to the zoom mode of delivery of the program has been reported elsewhere (Perich et al., 2023).

**Data Analyses**

 Data on feasibility and acceptability (number of sessions attended, completion of well-being plan, dropout rates) were collected throughout the trial by research assistants in session and recorded into SPSS V 28 (SPSS for Windows).

 Descriptive data (mean score calculations) were conducted for mood symptoms (DASS, ASRM), quality of life (Brief QoL. BD), personal recovery (BRQ) and internalized stigma (ISMI). Chi-square analyses were conducted comparing group allocation on demographic and clinical features of gender, sexuality, employment status, country of birth, receipt of govt benefits, bipolar subtype, rapid cycling history, seasonal mood history, diagnosis of an additional mental health condition.

 Due to pilot nature of the study, statistical analyses to determine significant differences between groups were not conducted. Effect sizes were reported from pre to post treatment for both conditions using intention-to-treat principle where the last data point assessed was used in the final analysis (n=7). As an analysis of the measures was not the primary outcome, this method was chosen due to the small sample size and preliminary nature of the study.

 All quantitative data was analysed calculated using SPSS V 28 (SPSS for Windows). Qualitative data was analysed using a content analysis framework employing a directed approach (Hsieh & Shannon, 2005). This process involves coding data in a structured process, using existing ideas leading to then identifying key concepts for initial coding categories. For this study, data relating to discussion of the therapy content was extracted for inclusion in this study. Data was then coded into the broad categories as ‘helpful’, ‘unhelpful’ or ‘areas for improvement’. . KK coded the initial data which was then reviewed in collaboration with TP to determine the final data for inclusion in these themes. Further details of the full qualitative dataset and coding is described elsewhere (Perich et al., 2023). All interviews were conducted by phone, recorded and transcribed verbatim by research assistants/students working on the project.

**Results**

 A total of 12 out of 16 participants (10 female; 2 male) who were allocated to the treatment condition competed all aspects of the baseline, group therapy program and post-treatment questionnaires, with 13 out of 16 (12 female; 1 male) participants completing all elements of the waitlist control condition assessments. Further demographic characteristics of the participants at baseline are listed in Table 1. Chi square analysis indicated no significant differences between the groups on any demographic or clinical variables assessed (gender, sexuality, employment status, country of birth, receipt of govt benefits, bipolar subtype, rapid cycling history, seasonal mood history, diagnosis of an additional mental health condition).

 Retention rates were similar across the two group conditions with 75% completing in the treatment condition and 81% completing in the control condition. Reasons for dropouts are listed in Figure 1 at each stage of the study.

[Insert Figure 1 here]

 The mean number of sessions attended in the treatment group was 7.25 out of 8 sessions (91%, SD 1.21; range 4 – 8 sessions), with 7 (58%) participants attending the full 8 sessions, 3 (25%) attending 7 sessions and the remaining participants 8 (16%) attending less than 6 sessions.Of the treatment group participants who reported weekly satisfaction ratings after completing each weekly group session, the overall mean scores for all sessions for helpfulness was 9.02 (SD 1.27; range 5-10); engagement with others 8.95 (SD 1.41; range 5-10); satisfaction 9.14 (SD 9.14; range 5-10). See Table 5 for individual session mean scores.

 No serious adverse events were reported by participants or observed in direct response to the intervention during the Zoom group. One participant reported becoming increasingly symptomatic after commencing the group program and one reported some distress at attending the zoom sessions and interacting with other participants. A review of the mood diary and journal noted no serious adverse events self-reported by participants throughout the trial that were related to the intervention. However, four participants reported feelings of stress on some evenings after the group, and one participant reported difficulty sleeping after the group on two evenings early in the program.

 No significant technical issues were noted with Zoom during the program’s delivery, with participants being able to attend or resolve any technical issues with the platform that arose. No participant reported discontinuing the program due to the use of Zoom.

**Symptom Measures**

Participants mean self-reported symptom scores at baseline and post-treatment for the DASS (Depression, Anxiety, Stress), ASRM (mania), quality of life (Brief QoL. BD), personal recovery (BRQ) and internalized stigma (ISMI) are reported in Table 3.

 The study was not powered to report on group differences on measures. Pre to post treatment effect sizes were calculated for each condition. See Table 3 for reported effect sizes (See Table 3).

**Content Analysis**

 A directed content analysis was conducted on the questions asked in the qualitative interview. Data from 10 interviews of those who completed the treatment (both those allocated to the treatment and those from wait list control who chose to undertake the intervention) was analysed and content discussion was coded into areas of ‘Helpful’ or enjoyed, ‘Unhelpful’ or needing improvement.

Out of the 12 participants who completed the treatment program, 11 (92%) participants completed and returned the well-being plan and mood chart. As noted in Table 4, the majority reported that this was a helpful aspect of the program. Most participants who attended our program reported that they found the mood charting and journaling aspect of the chart helpful in the development of the plan and in terms of understanding their moods.

[Insert Table 4 here]

 Most participants (n=9) reported that they found the content helpful/enjoyable overall, with the well-being plan and stigma content being worthwhile. The most common reported unhelpful content was recovery (N=5) where participants reported it was not discussed enough or described well in the program, and others stating they were not resonating with the semantics of the word and the language used. The description of bipolar disorder symptoms was also reported as the most unhelpful aspect of the program, with some participants describing that this was content that they were already familiar with, with this content being reviewed by their clinician. See Table 4.

 Weekly session written qualitative content was analysed. Example comments from each session are presented in Table 5 along with mean scores of the Likert scale satisfaction items of helpfulness, participant engagement and overall satisfaction. The highest scores for each were reported for Session 7 (the individual well-being plan discussion and resource sharing) and the lowest scores for each were reported in Session 3 (discussion of symptoms of bipolar disorder).

[Insert Table 5 here]

**Discussion**

The aim of this study was to pilot feasibility and acceptability of a telehealth-delivered recovery-orientated well-being group program for BD. Retention rates were similar across the two group conditions with 75% completing in the treatment condition. There was a high overall attendance rate noted throughout, with more than half of participants attending the full program of 8 sessions and the majority attending between 7-8 sessions out of 8 sessions. The well-being plan, which is the key outcome of the program, appeared to be acceptable and feasible, with 11 out of 12 participants in the treatment condition completing this as part of the program.

 This study also found that the telehealth platform, Zoom, appeared feasible and acceptable to participants. There were no significant technical issues noted throughout the delivery of the program and any technical issues were able to be resolved by the participants taking part during the program. No dropouts were reported to have occurred due to technical issues, suggesting that this is a viable form of delivery for this group of participants. However, it is worth noting that this program was advertised as a telehealth-delivered program specifically, and it is unclear how many participants chose not to take part in the study due to this. Although telehealth has been argued to increase equity, there is still limited research in this area and it is unclear if telehealth may decrease access for some members of the community (Jonnagaddala et al., 2021), for example, those who have limited access to technology or lower levels of technology literacy.

 The retention rate of 75% found was consistent to other bipolar disorder group therapy programs, including previous research which noted a retention rate of 71% for face-to-face group therapy for anxiety (Perich et al., 2020). However, it was slightly lower than other telehealth programs for young people with BD, with a 77% rate noted in this study (Sankar et al., 2021). This suggests that telehealth delivered programs are similar to or higher than face-to-face programs in participant retention.

 Where our prior face-to-face anxiety group noted a mean session attendance of 6.9 sessions or 77% (Perich et al., 2020), here the mean was 7.25 sessions or 91%. This may be seen as preliminary evidence that telehealth delivered programs may be more accessible for participants, increasing session attendance rates. Further research with a larger sample size is needed to determine if this is the case.

 Scores on the measures did not change because of the intervention, however, this is not unexpected, given that the study was not powered to detect these types of group differences. Also, the focus on the well-being plan program is not to reduce symptoms in the shorter term, but rather to reduce the risk of relapse over a longer period. Results reported are consistent with previous research of peer-led wellbeing plan interventions where no changes in mean scores were noted from pre to post treatment, but significant reductions in symptoms were noted at 6-month follow up (Cook et al., 2012).

 The qualitative data noted that most participants reported that they enjoyed the program overall and that they found the content useful. Most participants further indicated that they would use the well-being plan. The most useful or helpful aspects participants reported in the program were in the areas of developing the well-being plan itself, and discussion around stigma. Given that stigma is a significant issue for people living with bipolar disorder (Perich et al., 2022), it is unsurprising that participants engaged with this element of the program and demonstrates that discussion around stigma and stigma-related issues may be useful and helpful for people living with BD.

 The qualitative data also noted that unhelpful aspects included discussion around symptoms and the use of the word ‘recovery’. Future versions of the intervention should consider minimising this and deliver information regarding symptoms that is more targeted towards adding to existing knowledge.

 There were several limitations noted in this study. Firstly, there was a small sample size and a larger pilot RCT would need to have been conducted to review any potential changes in symptoms. However due to the pilot nature of the project, an 8 week wait list control condition was utilised to match the treatment length. Another limitation is the low representation of people who identified as male taking part in the study. More work is needed to recruit male participants to ensure that this program is also feasible and acceptable to this population. Results at this stage suggest that this program may not be acceptable for male participants.

 A standardised instrument to assess technical issues was not utilised in this study, which is a significant limitation and future research should add this to the assessment battery. Additional limitations include that therapist engagement with the platform was not assessed. The self-perceived level of therapist skill in delivering via zoom was also not considered in this program. Given that this was found to have an impact on therapist engagement with treatment during COVID-19 (Lin et al., 2021), more research is needed in this area. In addition, a treatment fidelity measure was not utilised in this study, and this is a significant limitation when considering the findings.

 Preliminary evidence suggests that the telehealth-delivered recovery-orientated well-being plan group program was acceptable and feasible for participants living with bipolar disorder. Retention rates were similar to other face-to-face group programs, with slightly a higher session attendance rate being found. Although most participants completed the well-being plan as part of the program, further research is needed to determine if the bipolar-specific well-being plan group program is helpful in reducing symptoms and improving outcomes over a longer follow up period. The small sample size makes it difficult to draw firm conclusions regarding effectiveness and a larger scale trial is needed.

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| **Table 1** *Demographic and Clinical Characteristics of the sample (n=32)* |  |  |  |
|  |  |  |  |  |  |  |
|   |   | Treatment (n=16) | % |  | Control (n=16) | % |
| Bipolar type (SCID-5-RV) |  |  |  |  |  |  |
| Bipolar I  |  | 11 | 70 |  | 8 | 50 |
| Bipolar II |  | 5 | 30 |  | 8 | 50 |
|  |  |  |  |  |  |  |
| Marital Status  |  |  |  |  |  |  |
| Married / de facto |  | 7 | 44 |  | 9 | 56 |
| Divorced/separated |  | 5 | 31 |  | 3 | 19 |
| Never married |  | 4 | 25 |  | 4 | 25 |
|  |  |  | 100 |  |  | 100 |
| Sexual identity  |  |  |  |  |  |  |
| Heterosexual  |  | 11 | 69 |  | 11 | 69 |
| Homosexual  |  | 0 | 0 |  | 2 | 12 |
| Bisexual  |  | 3 | 19 |  | 3 | 19 |
| Other |  | 2 | 12 |  | 0 | 0 |
|  |  |  |  |  |  |  |
| Employment type |  |  |  |  |  |  |
| Full time |  | 7 | 44 |  | 4 | 25 |
| Part time |  | 2 | 13 |  | 1 | 6 |
| Casual  |  | 0 | 0 |  | 3 | 19 |
| Not in current employment |  | 7 | 44 |  | 8 | 50 |
|  |  |  |  |  |  |  |
| Government benefits |  |  |  |  |  |  |
| Yes |  | 7 | 54 |  | 6 | 46 |
|  |  |  |  |  |  |  |
| Other diagnosed mental health condition |  |  |  |  |  |  |
| Yes |  | 11 | 69 |  | 15 | 94 |
|  |  |  |  |  |  |  |
| Rapid Cycling (SCID-5-RV) |  |  |  |  |  |  |
| Yes |  | 7 | 44 |  | 10 | 63 |
| Seasonal Mood (SCID-5-RV) |  |  |  |  |  |  |
| Yes |  | 5 | 31 |  | 6 | 38 |
|  |  |  |  |  |  |  |
|   |   |   |   |  |   |   |

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| **Table 2** *Description of the content of the program* |  |
| Session  | Content description  |
| 1. Introduction to the program  | Introduction to the well-being plan, concept behind the plan, goal setting and mood charting.  |
| 2. Symptoms and illness course | Symptoms of bipolar disorder and other symptoms; discussion of common symptoms of depression, hypomania and common co-occurring conditions. Discussion of symptoms over the life course.  |
| 3. Early warning signs and triggers | Discussion of early warning signs and how to identify these through mood charting, discussion of common triggers and the role that alcohol and drug use or other substances may plan as both an early warning sign and a trigger. |
| 4. Sleep and routines in bipolar disorder, medications | Describe the role that sleep and other routines can play in maintaining wellness in bipolar disorder. Discussion of the common medications used to treat bipolar disorder and barriers to medication adherence. |
| 5. Stigma/internalised stigma, identity and acceptance | Description of the different types of stigma and how these can impact well-being. Discussion of the role that the diagnosis has had on acceptance, personal identity and how self-stigma may play a role. |
| 6. Building skills and social support | How to identify social supports and how to involve them in well-being planning.Family and friends and review how this can form part of the plan itself. Discuss the role that that GP, psychiatrist and other mental health support services can also play here. Skill building through using coping strategies. Discussion of active and passive coping strategies. |
| 7. Individual whole plan review and discussion  | Discuss mood chart overall and what has been noted. Individual discussion about what triggers were noted and what stressors have been identified over the course of the past week, daily well-being activities and what has worked and what hasn’t worked, group sharing of helpful resources.  |
| 8. Implementing the plan and barriers | Discuss plans with participants and discuss how the plans will be implemented. As part of the plan, stressors and barriers should be taken into consideration. Discuss potential stressors that may arise when implementing the plan and how they should be managed. |
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| --- | --- | --- | --- | --- | --- |
| **Table 3***ITT Pre and Post intervention scores for treatment and control conditions* |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |   | Treatment (N=16) |   |   |   |   |   | Control (N=16) |   |   |   |   |   |
|  |  | Pre |   | Post |   |   | 95% CI |   |   | Pre |   | Post |   |   | 95% CI |   |
|   |   | Mean | SD | Mean | SD | d | Lower | Upper |   | Mean | SD | Mean | SD | d | Lower | Upper |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Depression | 11.13 | 10.25 | 12.75 | 12.65 | -0.1 | -0.603 | 0.38 |  | 15.88 | 8.91 | 18.63 | 8.12 | -0.4 | -0.904 | 0.116 |
| Anxiety |  | 8.5 | 7.81 | 9.13 | 6.73 | -0.1 | -0.63 | 0.355 |  | 15.75 | 7.9 | 17.5 | 10.77 | -0.2 | -0.701 | 0.29 |
| Stress |  | 14.88 | 12.77 | 15.75 | 11.52 | -0.1 | -0.625 | 0.36 |  | 21.75 | 22.88 | 22.88 | 8.82 | -0.1 | -0.635 | 0.351 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mania |  | 3.38 | 3.44 | 2.94 | 2.91 | 0.1 | -0.405 | 0.576 |  | 2.13 | 2.03 | 3.69 | 2.85 | -0.5 | -0.997 | 0.042 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Quality of Life | 40.31 | 9.68 | 38.06 | 9.55 | 0.2 | -0.293 | 0.698 |  | 30.31 | 6.03 | 31.94 | 6.9 | -0.4 | -0.988 | 0.121 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Recovery | 2221.69 | 256.9 | 2229.88 | 272.27 | <0.1 | -0.531 | 0.449 |  | 2029.13 | 387.79 | 2106.63 | 250.26 | -0.2 | -0.727 | 0.267 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Stigma | 57.69 | 9.71 | 60.06 | 10.95 | 0.3 | -0.821 | 0.185 |  | 68.69 | 11.06 | 71.5 | 11.7 | -0.5 | -0.981 | 0.054 |
|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Table 4** *Content analysis results of well-being program content* |
|  |  |  |  |  |  |
|   |   | N | % |   | Example  |
|   |   |   |   |   |   |
| Helpful/Enjoyed |  |  |  |  |
|  | Content overall | 9 | 90 |  | I mean I really enjoyed the course and I really like having the contact with the people and the majority of the time it was fantastic. So, I mean, I haven't got a bad word to say about anything |
|  |  |  |  |  |  |
|  | Well-being plan | 9 | 90 |  | Yeah I think like a lot of it is like stuff that I already had like, with my psychiatrist or like just through like psychoeducation I've had, like, from him and from like psychologists as well…but um having it like collated and written down is something I haven't done before and I think that that that process was helpful… |
|  |  |  |  |  |  |
|  | Stigma | 7 | 70 |  | The stuff about stigma and essentially self stigma like no one really discusses that…it was very worthwhile |
|  |  |  |  |  |  |
|  | Mood chart | 6 | 60 |  | That was brilliant. That was, that was so good. And that was, I've had a bit to do with a lot of mood charts, and definitely, yeah, maybe I was in a good headspace for it, you know, the group supported it.  |
|  |  |  |  |  |  |
|  | Medication description | 4 | 40 |  | I love the meds one. Because I love that kind of stuff. |
|  |  |  |  |  |  |
|  | Triggers/warning signs | 3 | 30 |  | I think writing down the symptoms of unwellness of how that looks like and about your triggers and early warning signs. I think that for me I had to write them all down, I think that was very helpful.  |
|  |  |  |  |  |  |
|  | Journaling | 2 | 20 |  |  I found that period of self-reflection with the journal being quite good, very good. |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Unhelpful/needs improvement |  |  |  |  |
|  |  |  |  |  |  |
|  | Recovery | 5 | 50 |  | Recovery… it's almost like remission, you know, like you say, oh somebody’s in recovery from cancer, they’re in remission or whatever. And recovery from bipolar…and not sure recovery is the word. |
|  |  |  |  |  |  |
|  | Symptom description | 3 | 30 |  | What the symptoms are…I like personally have heard that spiel a lot from a lot of different doctors and people...it's not so much that it's unhelpful it's just that like it's content that I already knew  |
|  |  |  |  |  |  |
|  | Well-being plan | 2 | 10 |  | I mean, I didn't really engage with the work. And I can't give you a clear articulate reason why other than I just really find it compelling.  |
|  |  |  |  |  |  |
|  | Journaling | 1 | 10 |  | ... it just seemed that it was that we were looking more at the, at the negatives rather than the positives.  |
|  |  |  |  |  |  |
|  | Other treatments | 1 | 10 |  | ... it's not just medication but treatments that are available |
|   | Content overall | 1 | 10 |   | It wasn't anything that I didn't already know. It was just like, really confirming it all.  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

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| --- | --- | --- |
| **Table 5***Session by session scores on Likert scale items and qualitative feedback examples* |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
|   | Helpfulness |   |   | Participant engagement |   |   | Satisfaction overall |   |   | Qualitative feedback |
| Session | M | SD |   | M | SD |   | M | SD |   |   |
| 1. Introduction to the program  | 8.86 | 1.35 |  | 8.36 | 1.69 |  | 9.07 | 1.14 |  | An amazing experience (slightly overwhelming) being part of a specific bipolar group. |
| 2. Symptoms and illness course | 9.1 | 1.29 |  | 9.2 | 1.03 |  | 9.1 | .99 |  | It was great hearing other's experiences and feeling understood by others also when sharing my own. Thank you. |
| 3. Early warning signs and triggers | 8.27 | 1.79 |  | 8 | 1.95 |  | 8.18 | 1.72 |  | we needed 4 hours.......each !! LOL, absolutely great hearing other peoples live discussions. |
| 4. Sleep and routines, medications | 9 | 1.18 |  | 9 | 1.18 |  | 9.09 | .94 |  | more awareness and understanding of different effects |
| 5. Stigma/internalised stigma, identity and acceptance | 9.2 | 1.03 |  | 9.1 | 1.45 |  | 9.4 | .97 |  | The content and discussion has helped me to see hope in the possibility of reframing my own self stigmatising of living with bipolar - that is, “to date I have survived despite it”. |
| 6. Building skills and social support | 9.11 | 1.36 |  | 9 | 1.32 |  | 9.22 | 1.09 |  | A gentle approach towards coping styles such as we enjoyed tonight is so welcome and quite rare.  |
| 7. Individual whole plan review and discussion  | 9.44 | 1.01 |  | 9.78 | 0.44 |  | 9.78 | 0.44 |  | Today it was really good to discuss things and sort of discuss things that weren't on the list of things to discuss and aren't really a focus but are concerns we all share but don't have somewhere to talk about really as a whole.  |
| 8. Implementing the plan and barriers | 9.5 | 0.76 |   | 9.75 | 0.46 |   | 9.63 | 0.52 |   | Discussing how we can individualise sections of our plans for implementation and review has given me ideas of how to get greater benefit from it. |
|  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

Figure 1 CONSORT 2010 Flow Diagram

Allocated to treatment as usual control (n= 16)

 Received allocated control (n=15)

 Did not receive allocated intervention:

 No response to contact requests (n=1)

Allocated to intervention (n=16)

 Received allocated intervention (n=14)

 Did not receive allocated intervention:

No response to contact requests (n=1)

Self reported symptoms (n=2)

## Follow-Up

## Enrollment

## Allocation

Randomized (n=32)

Excluded (n=4)

  Not meeting inclusion criteria (n=2)

  Other reasons (n=2)

Assessed for eligibility (n= 36)

Completed treatment as usual control (n=13)

Discontinued treatment as usual control:

Lost to follow up (n=2)

Completed intervention (n=12)

Discontinued intervention:

Family responsibilities (n=1)

ITT Analysed (n= 15)

## Intent to treat Analysis

ITT Analysed (n= 16)