Implementation of Evidence-Based Psychotherapies for Chronic Pain and Chronic Mental Health Conditions: a Systematic Review

HSR&D Cyberseminar 5/25/2022

Elizabeth S. Goldsmith MD PhD

Wei (Denise) Duan-Porter MD PhD

Discussants:

Alicia Heapy PhD, Jennifer Murphy PhD,

Walan Chang MS, Rebecca Keller MBA OTR/L

Evidence Synthesis Program

Implementation of Psychotherapies and Mindfulness-based Stress Reduction for Chronic Pain and Chronic Mental Health Conditions: A Systematic Review

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Prepared by:
Evidence Synthesis Program (ESP) Center
Minneapolis VA Medical Center
Minneapolis, MN
Timothy J. Wilt, MD, MPH, Director

Authors:
Elizabeth Goldsmith, MD, MS
Erin Koffel, PhD
Princess Ackland, PhD
Jessica Hill, MA
Adrienne Landsteiner, PhD
Wendy Miller, MD
Benjamin Stroebel, MPH
Kristen Ullman, MPH
Timothy J. Wilt, MD, MPH
Wei (Denise) Duan-Porter, MD, PhD

www.hsrd.research.va.gov/publications/esp/Psychotherapies-Pain.cfm

Disclosures

ESP

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Acknowledgments

Topic requested by VA HSR&D Pain/Opioid CORE
https://www.hsrd.research.va.gov/centers/core/pain-opioid.cfm

Technical Expert Panel (TEP):

Jennifer Murphy, PhD
Robert Kerns, PhD
Bradley Karlin, PhD
Amanda Midboe, PhD
Kristine Day, PhD
Hani Shabana, PhD

Objectives

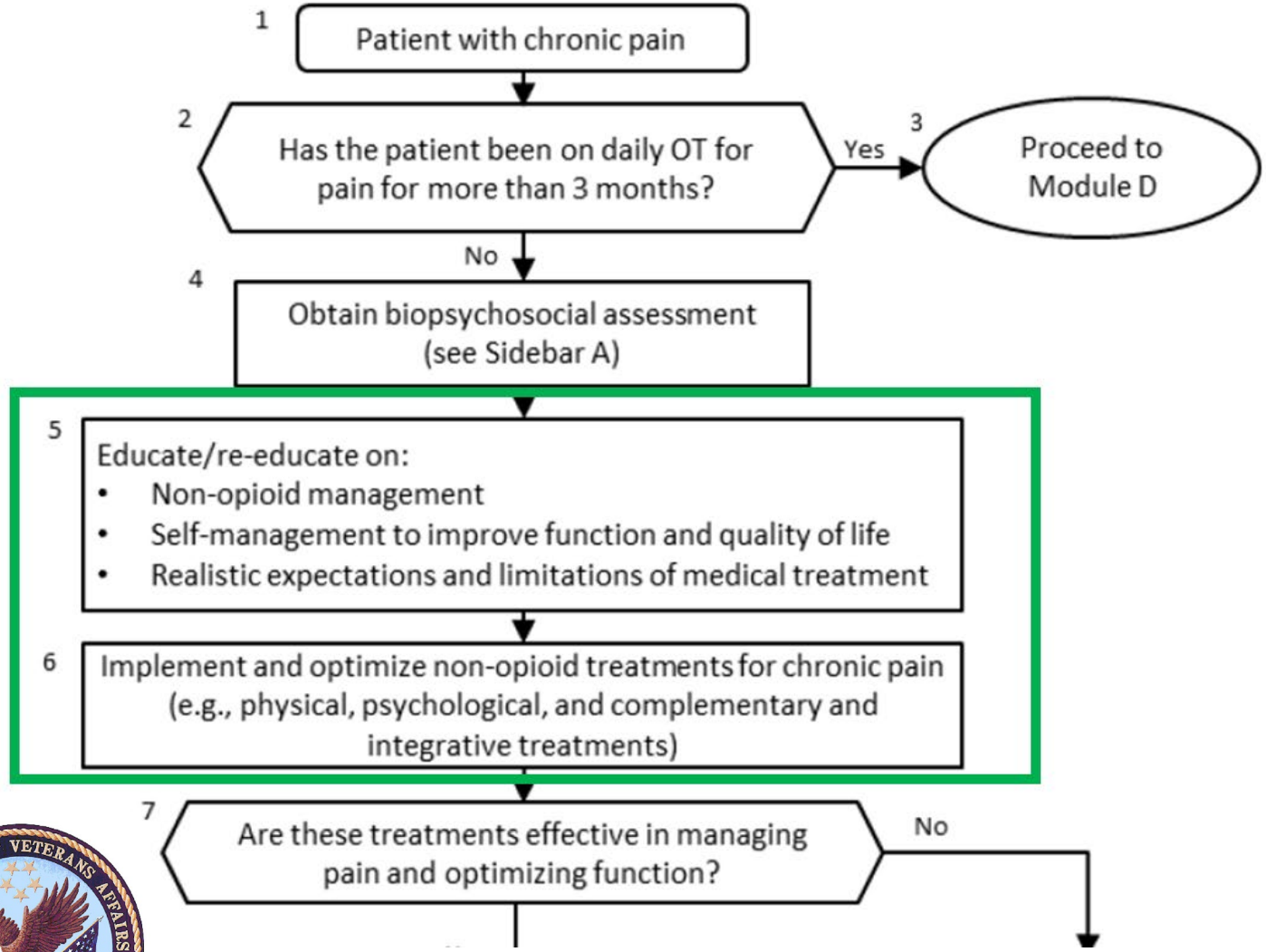
- Recognize Consolidated Framework for Implementation Research (CFIR)
- Summarize barriers, facilitators of evidence-based psychotherapies for treatment of chronic pain
- Highlight results from implementation evaluations of psychotherapies for chronic pain & chronic mental health conditions
- Explain implications for research, policy and practice

Chronic pain is bad and prevalent

- 3 of the top 5 causes of disability in the United States (US) and contribute to other disabling conditions, such as opioid use disorder
- In 2011-2012 estimated to affect at least 100 million US adults and to cost more than $600 billion in treatment and lost productivity
  - Prevalence has continued to increase
  - U.S. military Veterans have higher prevalence of chronic pain conditions compared to civilians
  - Associated with higher levels of psychological distress
- People with chronic pain have higher prevalence of mental health conditions
  - posttraumatic stress disorder (PTSD), depression, anxiety, insomnia

Banks et al 1996
Gaskin et al 2012
Goulet et al 2016
Haskell et al 2012
IoM 2011
McWilliams et al 2003
Nahin et al 2017
Racine et al 2018
Mokdad et al 2018
VanDen Kerkhof et al 2014
Zajacova et al 2021

Note: Non-pharmacologic and non-opioid pharmacologic therapies are preferred for chronic pain.



Sidebar A: Components of Biopsychosocial Assessment

- Pain assessment including history, physical exam, comorbidities, previous treatment and medications, duration of symptoms, onset and triggers, location/radiation, previous episodes, intensity and impact, patient perception of symptoms
- Patient functional goals
- Impact of pain on family, work, life
- Review of previous diagnostic studies
- Additional consultations and referrals
- Coexisting illness and treatments and effect on pain
- Significant psychological, social, or behavioral factors that may affect treatment
- Family history of chronic pain
- Collateral of family involvement
- Patient beliefs/knowledge of:
  - The cause of their pain
  - Their treatment preferences
  - The perceived efficacy of various treatment options

For patients already on OT, include assessment of psychological factors (e.g., beliefs, expectations, fears) related to continuing vs. tapering OT

VA/DoD Guidelines, 2017

CBT: Cognitive behavioral therapy

- Key principles include -
  - Problems relate to unhelpful ways of thinking and behaving
  - These can be changed (and/or better coped with)
  - Identifying and re-evaluating unhelpful thoughts and behaviors is part of change process
- Proposed mechanisms by which CBT helps with chronic pain
  - Decreased catastrophizing
  - Increased self-efficacy for pain management

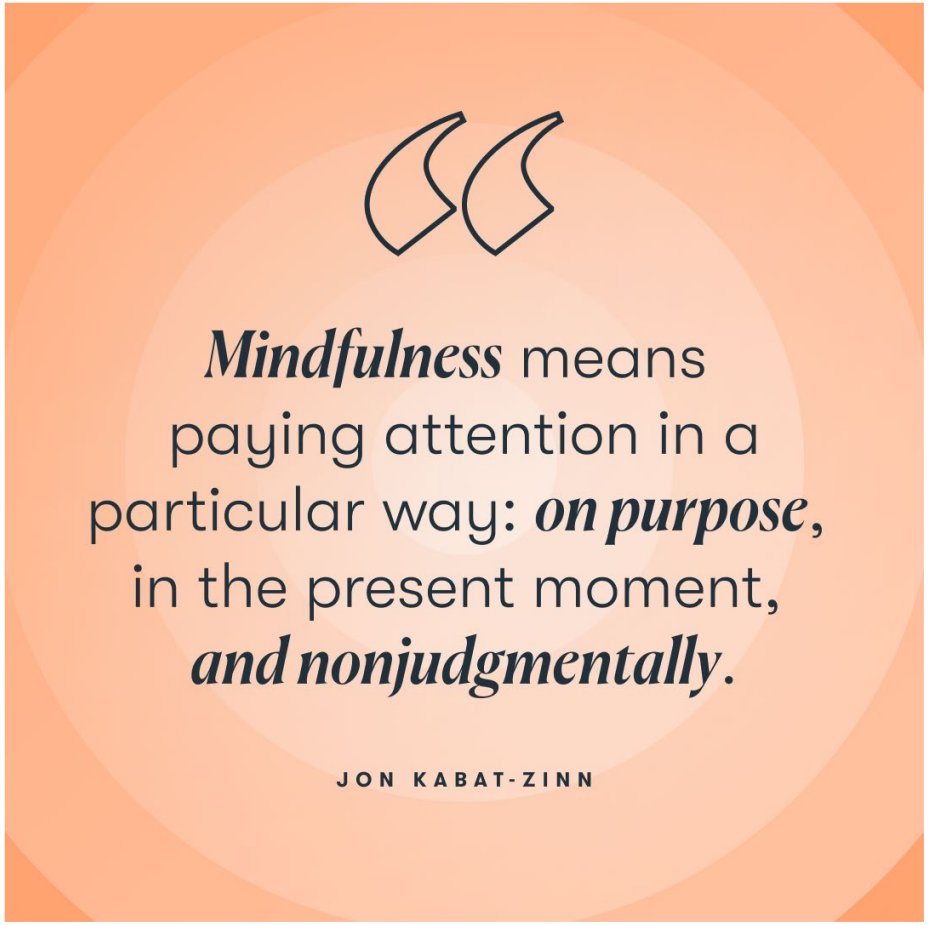
Beck 2021
Turner et al 2016

MBSR: Mindfulness-based stress reduction

- Mindfulness and meditation evolved across cultures and time
  - MBSR is a structured format adapted in the 1970s-80s by Jon Kabat-Zinn, a US researcher
  - Buddhist / Zen roots

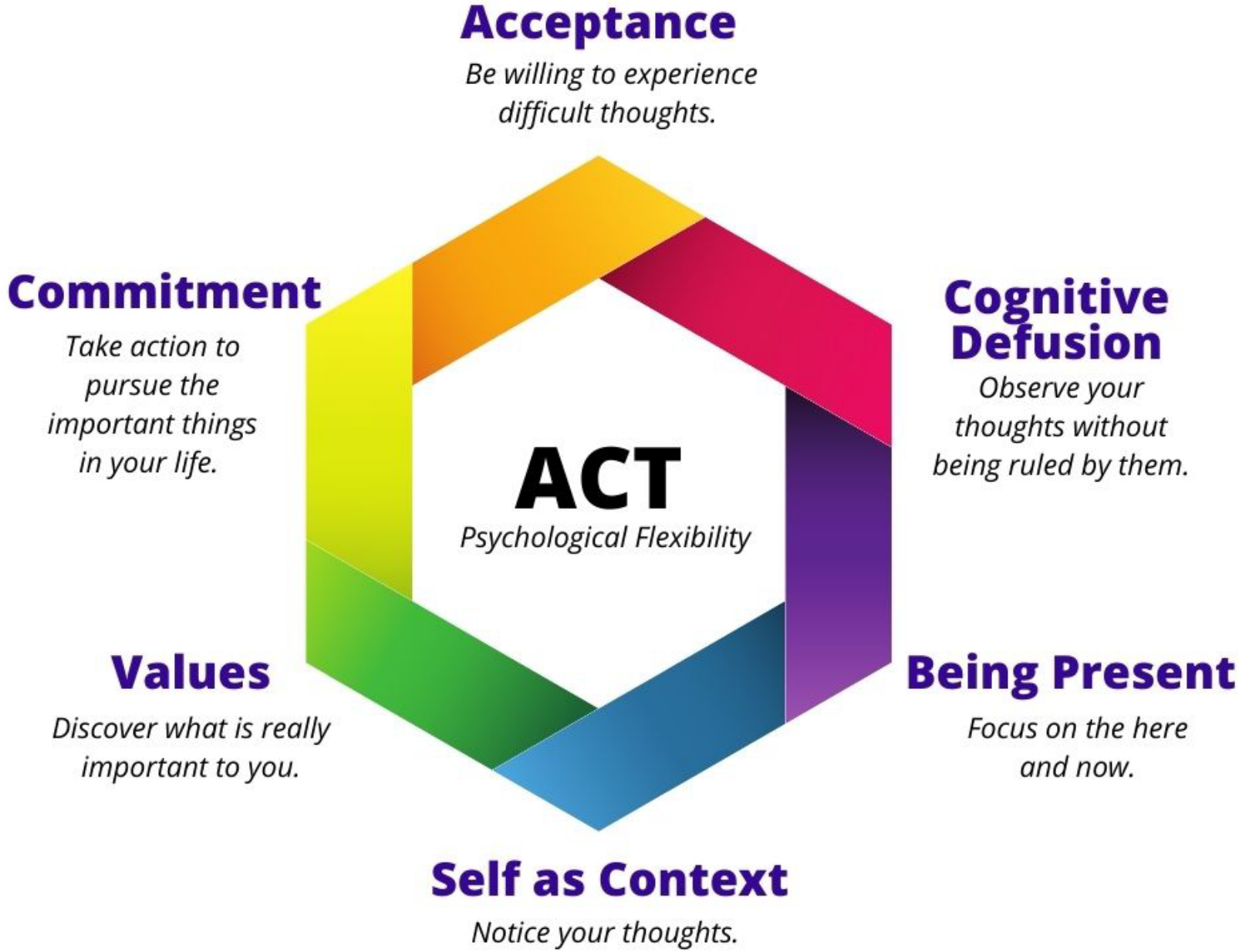
- Proposed mechanisms by which MBSR helps with chronic pain

  Increased mindfulness → increased pain acceptance and quality of life



Kabat-Zinn 1982, 2009
Turner et al 2016

ACT: acceptance and commitment therapy



Hayes et al 2013

Image credit: thrivetrainingconsulting

Effective for chronic pain, but underused

- CBT, MBSR and ACT are evidence-based psychotherapies (EBPs) for chronic pain
- VHA has developed national initiatives including CBT for chronic pain (2013)
- But limited uptake of psychotherapies for chronic pain
  - How to increase use?

Key questions

For CBT, MBSR and ACT:

What are patient, provider, and system-level barriers and facilitators for treatment uptake for chronic pain ?

What is the effect of implementation strategies to increase uptake for chronic pain and chronic mental health conditions?

Goldsmith et al 2021

Search strategy

- **Keywords/subject headings:** MeSH and free text
  - EBPs: CBT, ACT, MBSR
  - Chronic pain
  - Veterans
  - barriers and facilitators

- **Databases**
  - Medline, PsycInfo, Embase, CINAHL, AHRQ EPC, VA ESP

+ expert suggestions and referrals

Selection criteria

Inclusion

- Adults with chronic pain or mental health conditions
- Eligible EBP
- Implementation outcome or barriers & facilitators
- US, UK, Ireland, Canada, Australia

Exclusion

- Acute care settings, pain due to active medical treatments (*eg*, radiation)
- Yoga, t'ai chi, qigong (movement)
- Hospice or end-of-life care
- Reviews, editorials, etc.

Quality ratings, data abstraction

Quality ratings

- Quantitative Studies—Newcastle-Ottawa Scale (modified)
- Qualitative Studies—Critical Skills Appraisal Programme form (modified)
- 2 reviewers independently rate

Data abstraction

- Participant characteristics & setting
- Data sources & analytic methods
- Barriers & facilitators—code/ categorize by **Consolidated Framework for Implementation Research (CFIR); *best-fit framework synthesis***
- Qualitative studies—2 reviewers independently code results

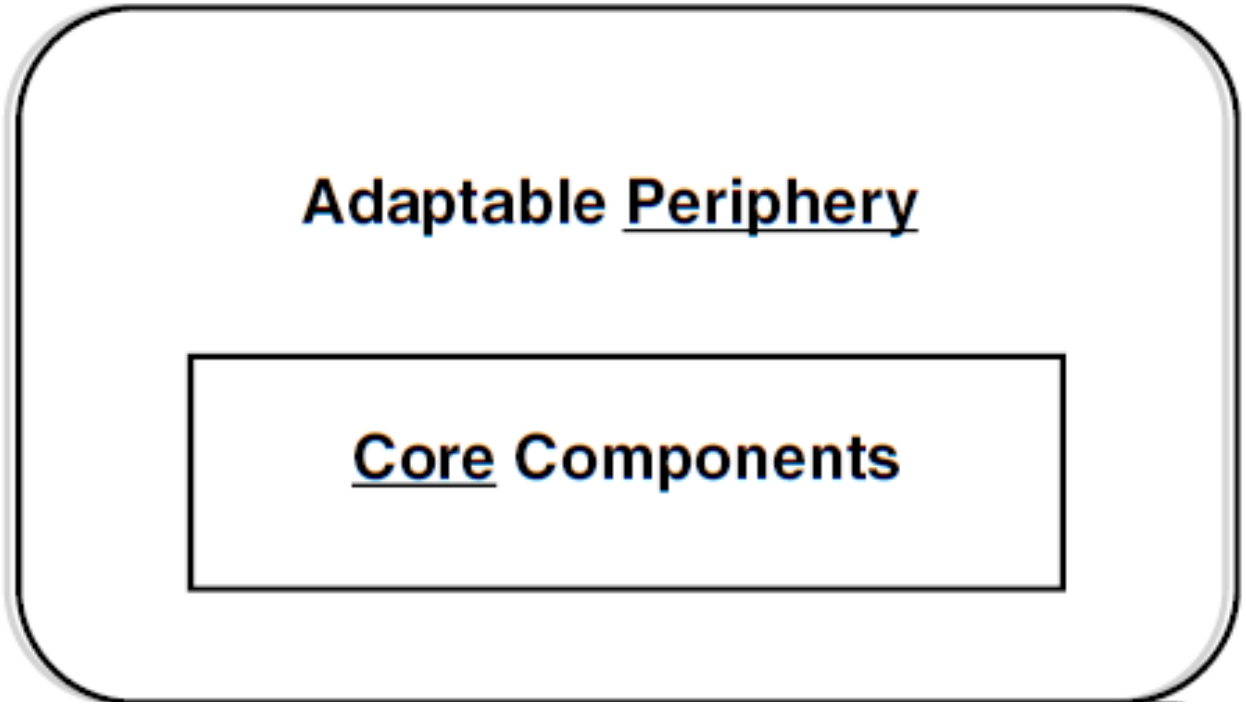
Implementation

REVIEW

The answer is 17 years, what is the question: understanding time lags in translational research

Morris et al 2011

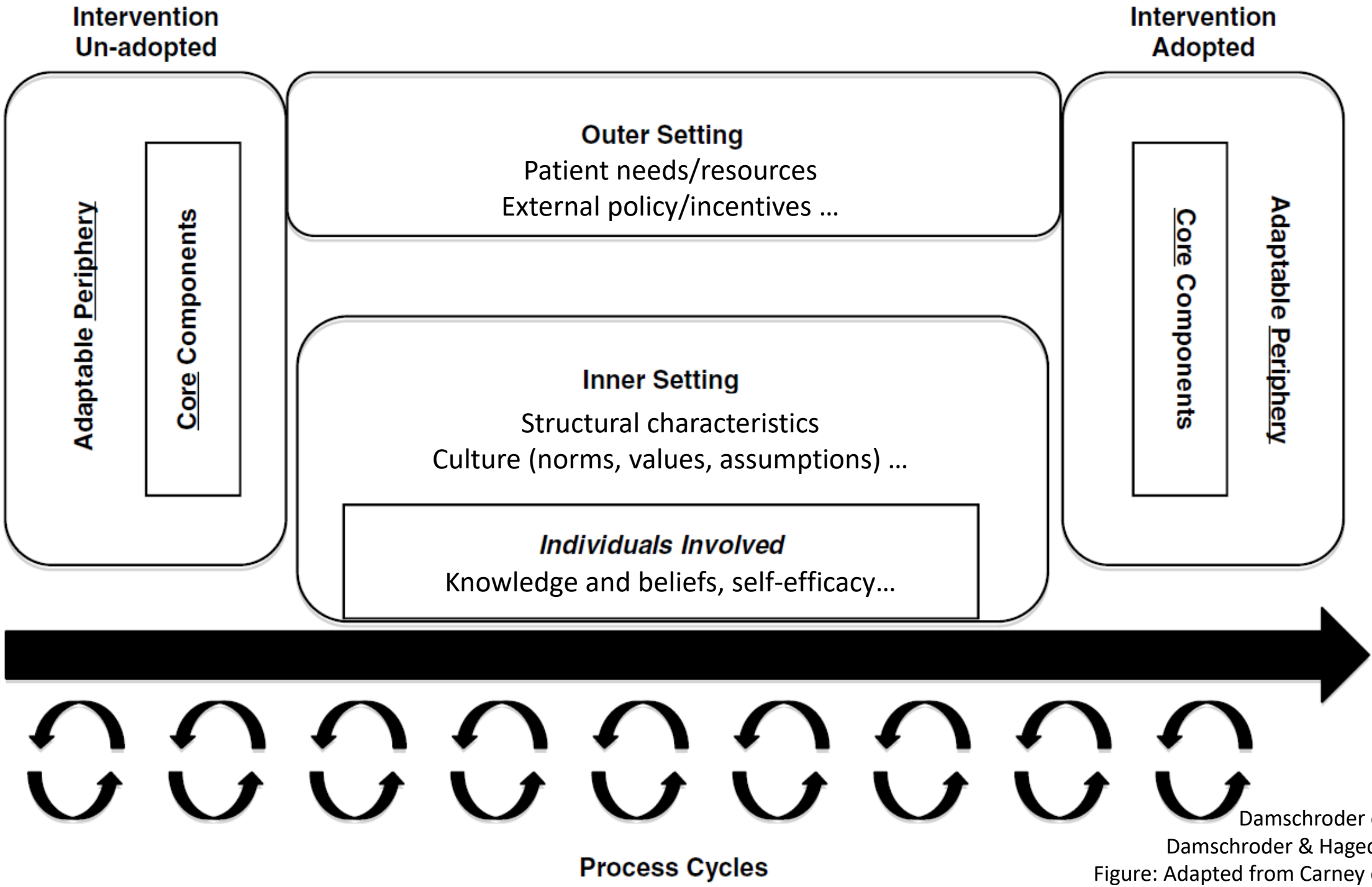
Any intervention has…



Context-dependent
Can and often should be changed

Essential to efficacy
Can't / shouldn't be changed

Damschroder et al 2009
Damschroder & Hagedorn 2011
Figure: Adapted from Carney et al 2016



Damschroder et al 2009
Damschroder & Hagedorn 2011
Figure: Adapted from Carney et al 2016

Implementation: developing models

Many models with overlapping constructs / mismatched definitions

- Process
- Explanatory

Consolidated Framework for Implementation Research (CFIR)

- **Typology**
- List of constructs relevant to treatment uptake, from published evidence
- Organization tool

Damschroder et al 2009
Damschroder & Hagedorn 2011

Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC: **Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science**

	Topic/Description	Short Description
I. INTERVENTION CHARACTERISTICS		
D	Adaptability	The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.
E	Trialability	The ability to test the intervention on a small scale in the organization [8], and to be able to reverse course (undo implementation) if warranted.
F	Complexity	Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement
G	Design Quality and Packaging	Perceived excellence in how the intervention is bundled, presented, and assembled
H	Cost	Costs of the intervention and costs associated with implementing that intervention including investment, supply, and opportunity costs.

Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander JA, Lowery JC: **Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science**

II. OUTER SETTING		
A	Patient Needs & Resources	The extent to which patient needs, as well as barriers and facilitators to meet those needs are accurately known and prioritized by the organization.
D	External Policy & Incentives	A broad construct that includes external strategies to spread interventions including policy and regulations (governmental or other central entity), external mandates, recommendations and guidelines, pay-for-performance, collaboratives, and public or benchmark reporting.

Consolidated Framework for Implementation Research (CFIR): Domains and Subdomains

I. Intervention characteristics
- A. Intervention source
- B. Evidence strength & quality
- C. Relative advantage
- D. Adaptability
- E. Trialability
- F. Complexity
- G. Design quality & packaging
- H. Cost

II. Outer setting
- A. Patient needs & resources
- B. Cosmopolitanism
- C. Peer pressure
- D. External policies & incentives

III. Inner setting
- A. Structural characteristics
- B. Networks & communications
- C. Culture
- D. Implementation climate
  1. Tension for change
  2. Compatibility
  3. Relative priority
  4. Organizational incentives & rewards
  5. Goals and feedback
  6. Learning climate
- E. Readiness for implementation
  1. Leadership engagement
  2. Available resources
  3. Access to knowledge and information

IV. Characteristics of individuals
- A. Knowledge & beliefs about the intervention
- B. Self-efficacy
- C. Individual stage of change
- D. Individual identification with organization
- E. Other personal attributes

V. Process
- A. Planning
- B. Engaging
  1. Opinion leaders
  2. Formally appointed internal implementation leaders
  3. Champions
  4. External change agents
- C. Executing
- D. Reflecting & evaluating

Damschroder et al., 2009 and Damschroder and Hagedorn, 2011.

Best-fit framework synthesis

Table 1 Summary of "best fit" framework synthesis approach

Step 1	Define review question
Step 2	a) Systematically identify relevant primary research studies b) Identify relevant ("best fit") publications of frameworks and conceptual models/theories
Step 3	Extract data on study characteristics from included studies and conduct study quality appraisal
Step 4	Code evidence from included studies into the a priori framework identified in step 2

Adapted from Booth and Carroll

Stokes et al 2016
Booth & Carroll 2015

Best-fit framework synthesis

Step 5	Create new themes by performing secondary thematic analysis on any evidence that cannot be coded into the a priori framework
Step 6	Produce a new framework composed of a priori and new themes supported by the evidence
Step 7	Revisit evidence to explore relationships between themes or concepts, in order to create a model

Stokes et al 2016
Booth & Carroll 2015

Best-fit framework synthesis

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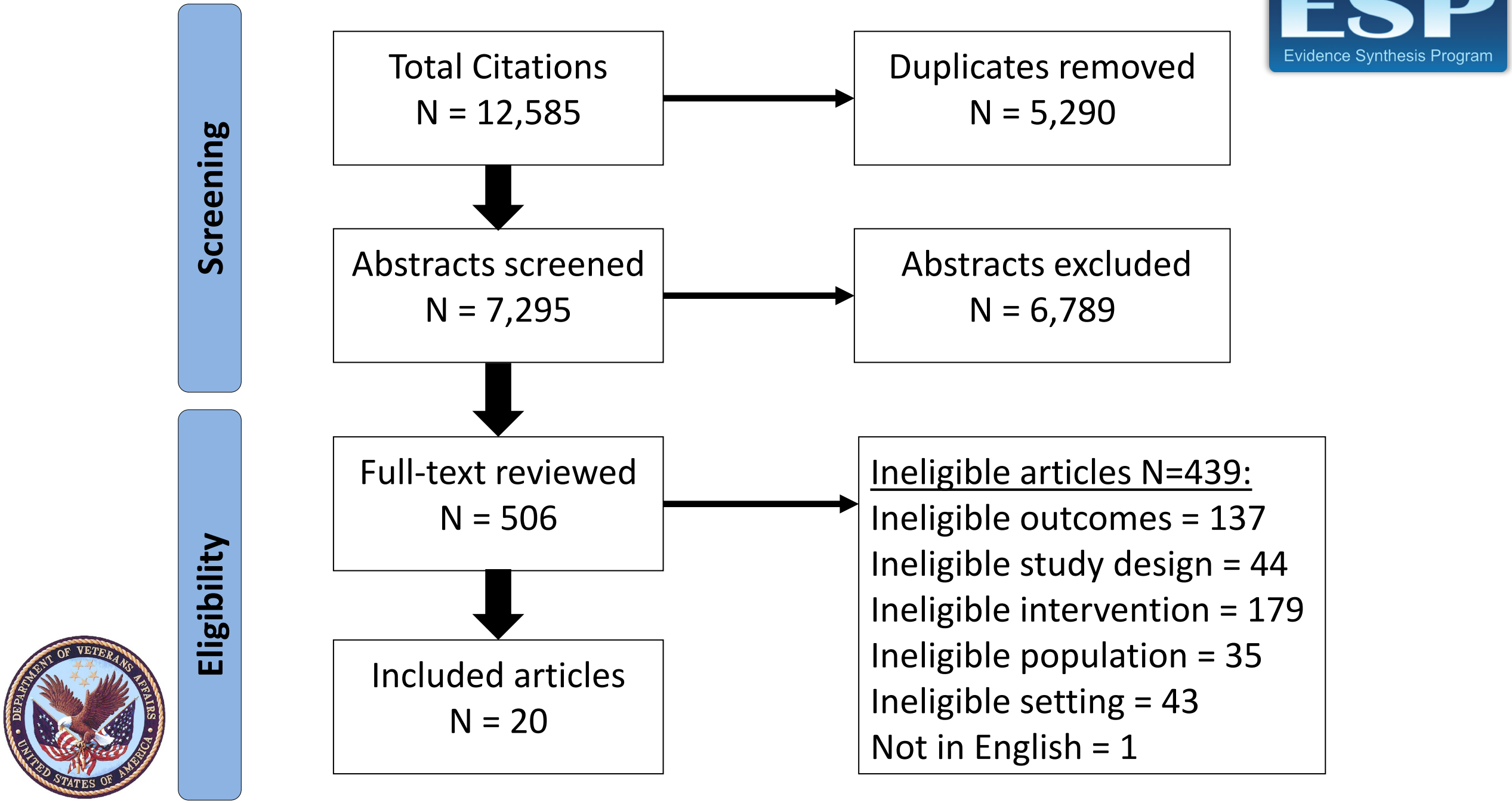
Screening
Eligibility
Total Citations
N = 12,585
Duplicates removed
N = 5,290
Abstracts screened
N = 7,295
Abstracts excluded
N = 6,789
Full-text reviewed
N = 506
Ineligible articles N=439:
Ineligible outcomes = 137
Ineligible study design = 44
Ineligible intervention = 179
Ineligible population = 35
Ineligible setting = 43
Not in English = 1
Included articles
N = 20
ESP
Evidence Synthesis Program
DEPARTMENT OF VETERANS AFFAIRS
UNITED STATES OF AMERICA

Article characteristics

	Total	High/ mod. quality	Within RCT	Country			
				US (VHA)	UK	Australia	Ireland
Cognitive Behavioral Therapy (CBT)	13	13	9	10 (6)	2	1	0
Mindfulness-based Stress Reduction (MBSR)	5	4	1	5 (1)	0	0	0
Acceptance & Commitment Therapy (ACT)	4	4	4	1 (1)	2	0	1

Mod, moderate; UK, United Kingdom; US, United States; VHA, Veterans Health Administration.

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Most studies within effectiveness RCTs

Damschroder et al., 2009 and Damschroder and Hagedorn, 2011.

Adaptation of the Consolidated Framework for Implementation Research (CFIR): Domains and Subdomains

I. Intervention characteristics

A. Intervention source
B. Evidence strength & quality
C. Relative advantage
D. Adaptability
E. Trialability
F. Complexity
G. Design quality & packaging
H. Cost
I. Group dynamics
J. Patient-therapist dynamics

II. Outer setting

A. Patient needs & resources
B. Cosmopolitanism
C. Peer pressure
D. External policies & incentives
E. Patient knowledge & beliefs
F. Other patient attributes
G. General practice climate & patterns

III. Inner setting

IV. Characteristics of individuals

A. Knowledge & beliefs about the intervention
B. Self-efficacy
C. Individual stage of change
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V. Process

Adapted from Damschroder et al., 2009 and Damschroder and Hagedorn, 2011; new subdomains noted in *italics*.

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D. Individual identification with organization
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V. Process

Most studies were
- of patients
- within effectiveness RCTs

Adapted from Damschroder et al., 2009 and Damschroder and Hagedorn, 2011; new subdomains noted in ***italics***.

Adaptation of the Consolidated Framework for Implementation Research (CFIR)

I. Intervention characteristics

B. Evidence strength & quality

…

G. Design quality & packaging

H. Cost

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II. Outer setting

A. Patient needs & resources

…

E. Patient knowledge & beliefs

F. Other patient attributes

IV. Characteristics of individuals

A. Knowledge & beliefs about the intervention

Adapted from Damschroder et al., 2009 and Damschroder and Hagedorn, 2011; new subdomains noted in ***italics***.

Studies with results addressing new CFIR subdomains				
New CFIR subdomains and definitions	**Themes**	**CBT**	**ACT**	**MBSR**
Outer Setting				
Patient Knowledge and Beliefs Individuals' attitudes toward and value placed on the intervention; familiarity with facts, truths, and principles related to the intervention.	Pain-related knowledge & beliefs	●●	●●	
	Therapy-related knowledge & beliefs	●●● ▲▲▲ ▲▲	●● ■	●● ■

Study types: **Qualitative** ● **Mixed** ■ **Quantitative** ▲

Studies with results addressing new CFIR subdomains				
New CFIR subdomains and definitions	**Themes**	**CBT**	**ACT**	**MBSR**
Intervention Characteristics				
Group Dynamics For group treatments, interactions between participants (or with facilitator) that impact patient experience and/or outcomes			●● ■	●● ■
Patient-Therapist Dynamics Patient-therapist interactions during individual therapy that impact patient experience and/or outcomes.		●●		
Study types: **Qualitative** ● **Mixed** ■ **Quantitative** ▲				

Barriers and facilitators for uptake of CBT, MBSR, and ACT for chronic pain, by CFIR domains		
Cognitive Behavioral Therapy (13 articles)	**Mindfulness-Based Stress Reduction** (5 articles)	**Acceptance & Commitment Therapy** (4 articles)
I. Intervention characteristics		
Evidence strength and quality • GPs interested in culturally relevant CBT for South Asian patients ***Design quality and packaging*** • Self-management materials helped understand principles, prompted use of skills; could be repetitive and unclear with dispiriting case studies ***Cost*** • CBT cost-effective for improving quality of life; not significantly different from UC in health care utilization or productivity losses ***Patient-therapist dynamics*** • Patients appreciated therapists for empathic, consistent, reliable care		

Barriers and facilitators for uptake of CBT, MBSR, and ACT for chronic pain, by CFIR domains		
Cognitive Behavioral Therapy	**Mindfulness-Based Stress Reduction**	**Acceptance & Commitment Therapy**
II. Outer setting		
Patient needs and resources • Need for culturally specific care, therapy in patient's language • Telephone CBT increased accessibility, eliminated time/geographical barriers • Pacing skills difficult to use at home ***Patient knowledge and beliefs*** • CBT increased understanding of pain triggers • Difficulty accepting mental health treatment for physical condition • Treatment acceptability predicted session attendance • Adherence related to stages of change ***Other patient attributes*** • Baseline pain interference, catastrophizing, opioid use a/w lower attendance in some but not all studies • Patient demographics generally not related to attendance		

Summary: barriers and facilitators

- Barriers and facilitators focused on patient-level findings
  - Adapted CFIR to expand patient-centered subdomains for evidence synthesis
- **Shared facilitators:** good match between patient knowledge and beliefs about pain and EBP principles, positive group or patient-therapist dynamics
- **Shared barriers:** variable patient buy-in to therapy rationale, competing responsibilities for patients
- One article showed that CBT and MBSR for chronic pain were cost-effective for improving quality of life

Key findings: barriers & facilitators in chronic pain

Patient demographics generally not related to EBP attendance

- Quantitatively assessed
- Demographic variables including race, ethnicity, sex and gender not clearly defined
- No studies assessed role of cultural and social factors in patients' views or experiences of EBPs

EBPs had widely variable formats

- Format, elements of sessions
- Length, number, spacing

Key findings: barriers & facilitators in chronic pain

- All articles assessing MBSR or ACT involved in-person groups
- Most articles assessing CBT involved individual therapy (via telehealth and in person)
- All ACT and most CBT studies were within RCTs
  - Limits assessment of factors related to inner setting, process, intervention adaptation

Key findings: implementation evaluations

- 12 eligible studies on CBT or ACT (none on MBSR)
  - Large integrated healthcare systems, 8 in VHA (4 were national VHA initiatives)
  - Strategies: education/training, audit/feedback, facilitation

re-aim.org/

Key findings: implementation evaluations

Reach	#, representativeness of participating individuals	Few results (none from VHA studies)
Efficacy	Impact on key outcomes	Moderate to large improvements in symptoms, function
Adoption	#, representativeness of willing providers, settings	Trained providers used therapies
Implementation	Provider fidelity and consistency; time & cost	Trained providers competent, but ongoing barriers to use
Maintenance	Extent to which intervention becomes part of practice	Limited evidence; providers using 3-12 months after training

re-aim.org/learn/what-is-re-aim/

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re-aim.org/learn/what-is-re-aim/

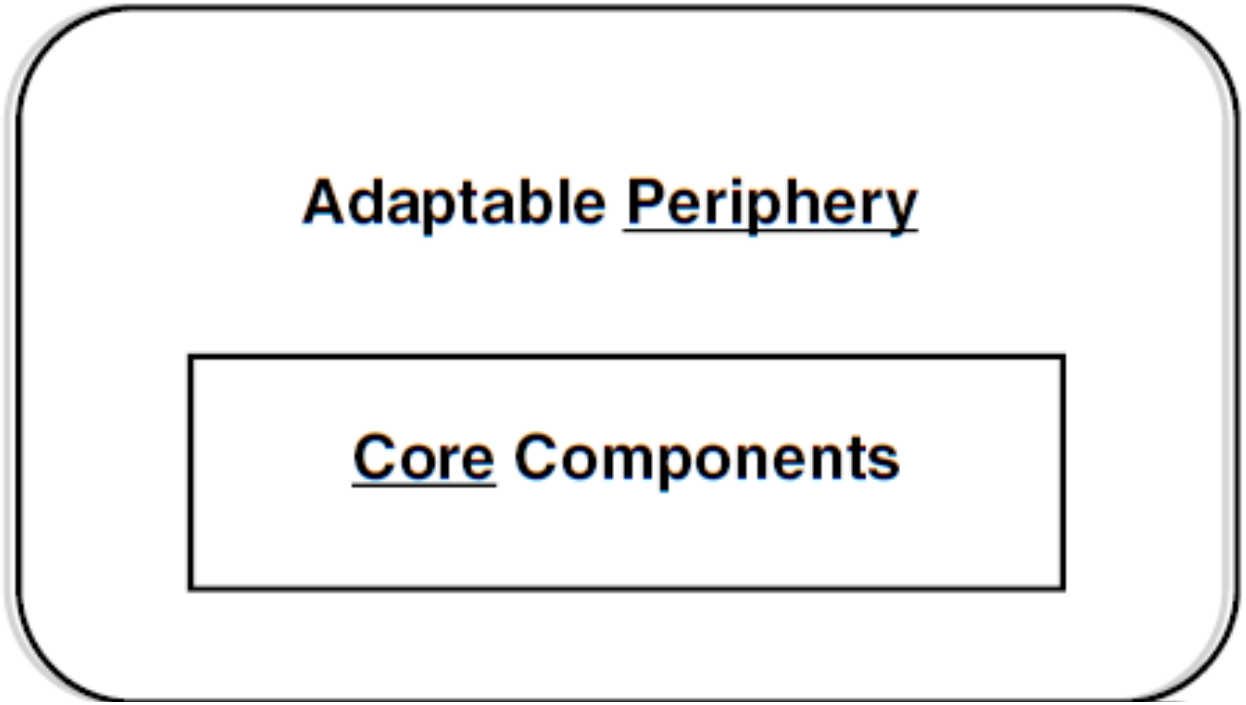
Recommendations: future research

- Examine provider- and system-level barriers and facilitators for CBT, MBSR, and ACT for chronic pain
  - using comprehensive frameworks
  - in clinical practice settings
- Evaluate patient-level factors contributing to heterogeneity of treatment effects and treatment uptake for EBPs for chronic pain
  - identify targets for future effectiveness and implementation work
- Evaluate patient-level sociocultural and demographic factors including sex, gender, race and ethnicity accurately and with clear analytic purpose
  - Recognize demographic indicators as limited proxies for sociocultural experience
- Evaluate implementation of MBSR (in large integrated healthcare systems)

Recommendations: policy and practice

- Support evaluation of provider- and system-level factors and implementation readiness
  - Local needs assessments, matching of strategies and resources
- Evaluate outcomes for alternative EBP delivery formats (individual vs group therapy, brief vs longer treatment duration)
  - where appropriate, support increased options for session formats
- Evaluate outcomes for telehealth versus in-person EBP delivery
  - where appropriate, support increased options for both formats and scheduling flexibility
- Develop and disseminate tailored patient-facing resources to increase awareness and buy-in

Any intervention has…



Context-dependent
Can and often should be changed

Essential to efficacy
Can't / shouldn't be changed

Damschroder et al 2009
Damschroder & Hagedorn 2011
Figure: Adapted from Carney et al 2016

Today's Discussants

Jennifer Murphy, PhD

Director, Behavioral Pain Medicine

Pain Management, Opioid Safety, & Prescription Drug Monitoring Program (PMOP)

Alicia Heapy, PhD

Co-Principal Investigator

HSR&D Pain/Opioid Consortium of Research (CORE)

Veterans, **Walan Chang, MS** and **Rebecca Keller, MBA, OTR/L**

from the Pain/Opioid CORE Veteran Engagement Panel

Operations Perspective

- An education campaign is necessary
  - Veterans want to hear about these treatments from multiple sources
  - Relieve burden from referring providers
- Solicit feedback on best wording instead of psychotherapies

Research Perspective

- Identification of system and clinician barriers is needed
- Examine implementation strategies to increase uptake
  - Self-referral
  - Direct outreach
  - Population-based education

Pain/Opioid CORE

Pain/Opioid Veteran Engagement Panel

- *Purpose*: Connect Veterans with VA investigators & facilitate Veteran-engaged chronic pain and opioid-related research
- Panel meets monthly with a different research team (n=20)
- Panel's work recently featured in Spring issue of HSR&D's publication, *Veterans' Perspectives*

VA HEALTH SERVICES RESEARCH & DEVELOPMENT SERVICE

Veterans' PERSPECTIVES

Pain/Opioid CORE Veteran Engagement Panel Brings Veterans' Perspective to HSR&D Research

HSR&D's monthly publication *Veterans' Perspectives* highlights research conducted by HSR&D and/or QUERI investigators, showcasing the importance of research for Veterans – and the importance of Veterans for research.

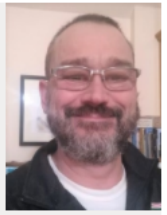
In the March-April 2022 Issue:

- Introduction – Veterans' chronic pain, the opioid crisis, and the Pain/Opioid CORE
- The Pain/Opioid CORE Veteran Engagement Panel – Bringing personal experience to research
- Making a Difference – Veterans' perspectives have improved several research projects
- Next Steps – Available for consultation. Meeting with CORE leadership.

Pain/Opioid CORE

Pain/Opioid CORE 12-Veteran Panel

Meet Kyle from IN



Tell us about yourself...I served in the Army and IN Army National Guard and retired after 26 years. I was stationed in Germany as a young Soldier from 1985-1987. Most of my service was spent in domestic response units with an emphasis on Disaster Response and Preparedness. I am a retired First Sergeant. The Veteran experience is multifaceted and incredibly varied. I believe it is critically important that the full spectrum of diversity of is represented in developing chronic pain management strategies.

Why were you interested in serving on the VEP...I have managed chronic pain for years. Over the course of several years, I became addicted to opioids and alcohol. I am in recovery now and place a very high value on sobriety. I am very interested holistic pain management strategies based on mindfulness and awareness as well as traditional medical and pharmaceutical approaches. I am very grateful to participate in the Veteran Engagement Panel because it gives me an opportunity to share experiences and offer unique perspectives to researchers.

Meet Ryan from WA

Tell us about yourself...I served in the Coast Guard for eight years and during that time I was stationed in LA, NC, VA and finally Portland, OR. I am now a Personal Trainer and attending nursing school. I currently reside in Washington and have two wonderful children.

Why were you interested in serving on the VEP...I was interested in joining this program because I wanted to help make a difference. I love applying what I can offer in new and helpful ways. I have personally struggled with finding other options besides using medications for chronic pain and I would love to be apart of the solution. Opioid abuse is a continuing problem and I look forward to finding alternative ways to help Veterans get the help they need.

Meet Kathryn from CO

Tell us about yourself...I'm an Army Veteran, and I served as a medic and had an opportunity to meet many people and travel many places. I loved my job, learned many rewarding lessons, and had a chance to offer the best part of me.

Why were you interested in serving on the VEP...Since I've experienced injuries and disabilities, I wanted to be a part of the VEP panel to share my point of view. I want to help shape policy, programming, and research surrounding Veteran health, chronic pain, and alternatives to pain management. I am excited to be a part of the panel. I simply want to make a difference and ensure that the lives of Veterans will improve from a mental, physical, and emotional standpoint. I am thankful that the VA, researchers, and the VEP panel are collectively working to address chronic pain and opioid use to improve the lives of both the Veteran and their families.

Meet Dave from WA

Tell us about yourself...I am a Veteran of 11 years and was stationed in both the United States and overseas with multiple deployments to the Far East and SW Asia. I currently work to serve Veteran students in a local community college.

Why were you interested in serving on the VEP...I was separated after my third major back injury, which led to years of over-medication and poor decision-making in my own pain management. Prior to my surgery on my back, I was told I had a low chance of walking again and that, if I was able to walk, I would have lifelong pain. Once I started taking responsibility for my pain management... I now walk and work and have found a rewarding path in life. I hope, through my work on this panel, to help other Veterans who are walking the path of pain management... to have a successful and healthy life without over-medication and through alternate treatments.

Meet Otis from WI

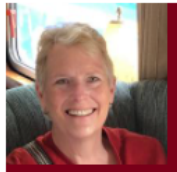
Tell us about yourself...I am a Vietnam Era Army Veteran and have served as a Veteran peer support specialist along with servicing my community in the same capacity for the past 10 years. I have struggled with opiate addiction for the better part of 30 years of my life. I serve as Executive Director of Dryhootch of America, a nonprofit organization that "helps Veterans who survived the war, survive the peace."

Why were you interested in serving on the VEP...My passion is working with fellow Veterans. As Nelson Mandela said, *"There is no greater a God's gift than giving one's time, empathy, and compassion to help their fellow man. What counts in life is not the mere fact that we lived. It is what difference we have made to the lives of others that will determine the significance of the life we lead."*

Meet Steve from CA

Tell us about yourself...I spent 8 years in the Navy. During that time I was deployed on 3 West Pac's, which took me to many other countries and ports. I learned a lot and experienced a lot. My biggest adventure was quitting smoking and then I climbed Mt. Fuji in Japan.

Why were you interested in serving on the VEP...I was interested in joining the group because of what I went through with medications. I wanted to see what was out there for the Vets and that I might be able to help them with input on the panel.



Meet Becky from MN

Tell us about yourself...I am a U.S. Air Force Veteran and retired after 26 years of service. During my career I spent 9+ years overseas, which included combat tours and hazardous duty. I retired from the Air Force in November 2014 and my husband and I settled back in MN, our home state. Upon retirement, I returned to school to become an occupational therapist and in June 2018 I passed the national boards, just 3 weeks after graduation. I have worked at Mayo Clinic ever since. Pre-COVID my husband and I enjoyed spending time with family and expanding our world-wide travels -- we hope to return to both of those activities when it is safe to do in the future.

Why were you interested in serving on the VEP...As with many Veterans involved in the VEP, I also suffer from chronic musculoskeletal pain, and have for many years. As a patient in the pain clinic at the Minneapolis VA, I learned of an opportunity to join my first VEP and thought of it as a way to "give back". As a VEP member, I was provided insight into the immense breadth and depth of research being done in support of Veterans across the country, and I quickly gained a profound appreciation for the dedication and passion of the researchers involved in VA programs. I feel blessed to participate and provide a voice for female Veterans.

Meet Evelyn

Tell us about yourself...Dr. Lewis earned her medical degree from the University of the Health Sciences, the Chicago Medical School and completed a residency in family medicine at Naval Hospital Jacksonville, Jacksonville, FL. She completed a faculty development fellowship at Madigan Army Medical Center and Pacific Lutheran University and earned a Masters degree in the Social and Behavioral Sciences. In 2003, Dr. Lewis retired from the United States Navy after 25 years of service. Currently, she serves as Chief Medical Officer for Warrior Centric Health, LLC; President and Chair, Veteran Health And Wellness Foundation; Adjunct Associate Professor, Department of Family and Community Health, Rutgers Robert Wood Johnson Medical School; Clinical Instructor, Rosalind Franklin University of Medicine and Science; appointee to the Department of Veterans Affairs Advisory Committee on Disability Compensation; and serves as the American Academy Family Physician's Delegate to the American Medical Association

Today's Discussants

Jennifer Murphy, PhD

Director, Behavioral Pain Medicine

Pain Management, Opioid Safety, & Prescription Drug Monitoring Program (PMOP)

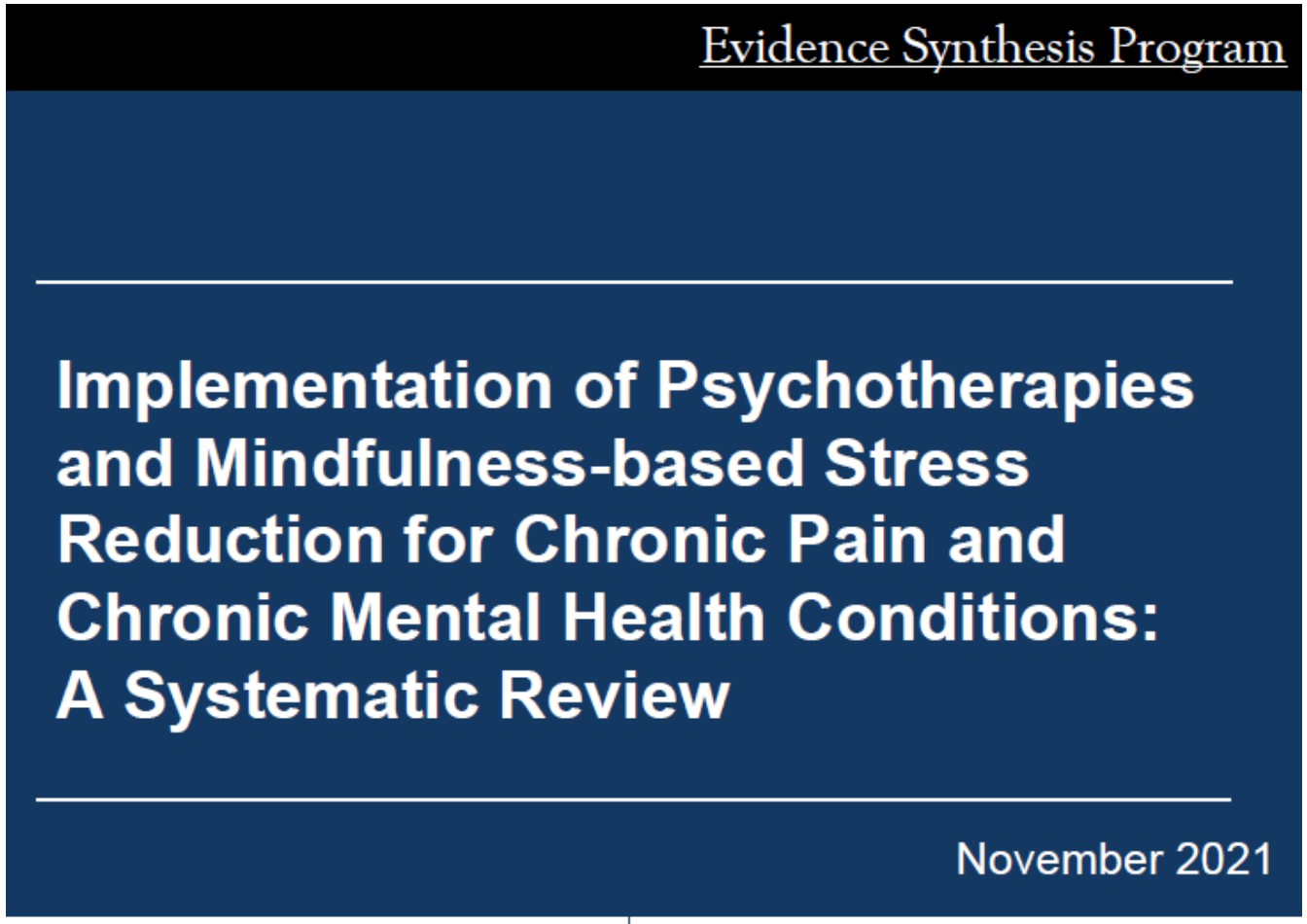
Alicia Heapy, PhD

Co-Principal Investigator

HSR&D Pain/Opioid Consortium of Research (CORE)

Veterans, **Walan Chang, MS** and **Rebecca Keller, MBA, OTR/L**

from the Pain/Opioid CORE Veteran Engagement Panel



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Thank you!

See report for citations of included articles:

www.hsrd.research.va.gov/publications/esp/Psychotherapies-Pain.cfm

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Thank you!

elizabeth.goldsmith2@va.gov