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

HSR&D Cyberseminar 5/25/2022

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

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

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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

References:
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.
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

Mindfulness means paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally.

Kabat-Zinn 1982, 2009
Turner et al 2016
ACT: acceptance and commitment therapy

Acceptance
Be willing to experience difficult thoughts.

Commitment
Take action to pursue the important things in your life.

Cognitive Defusion
Observe your thoughts without being ruled by them.

Values
Discover what is really important to you.

Being Present
Focus on the here and now.

Self as Context
Notice your thoughts.

ACT
Psychological Flexibility

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?
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

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

Morris et al 2011
Any intervention has...

- **Adaptable Periphery**
  - Context-dependent
  - Can and often should be changed

- **Core Components**
  - Essential to efficacy
  - Can’t / shouldn’t be changed

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Damschroder et al. 2009
Damschroder & Hagedorn 2011
Figure: Adapted from Carney et al. 2016
Knowledge and beliefs, self-efficacy...

Damschroder et al 2009
Damschroder & Hagedorn 2011

Figure: Adapted from Carney et al 2016

Patient needs/resources
External policy/incentives...

Outer Setting

Inner Setting
Structural characteristics
Culture (norms, values, assumptions)...

Individuals Involved
Knowledge and beliefs, self-efficacy...

Adaptable Periphery
Core Components

Adaptable Periphery
Core Components

Intervention Un-adopted
Intervention Adopted

Process Cycles

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 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

<table>
<thead>
<tr>
<th>Topic/Description</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. INTERVENTION CHARACTERISTICS</td>
<td></td>
</tr>
<tr>
<td>D Adaptability</td>
<td>The degree to which an intervention can be adapted, tailored, refined, or reinvented to meet local needs.</td>
</tr>
<tr>
<td>E Trialability</td>
<td>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.</td>
</tr>
<tr>
<td>F Complexity</td>
<td>Perceived difficulty of implementation, reflected by duration, scope, radicalness, disruptiveness, centrality, and intricacy and number of steps required to implement</td>
</tr>
<tr>
<td>G Design Quality and Packaging</td>
<td>Perceived excellence in how the intervention is bundled, presented, and assembled</td>
</tr>
<tr>
<td>H Cost</td>
<td>Costs of the intervention and costs associated with implementing that intervention including investment, supply, and opportunity costs.</td>
</tr>
</tbody>
</table>
**II. OUTER SETTING**

<table>
<thead>
<tr>
<th></th>
<th><strong>A</strong> Patient Needs &amp; Resources</th>
<th>The extent to which patient needs, as well as barriers and facilitators to meet those needs are accurately known and prioritized by the organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>D</strong> External Policy &amp; Incentives</td>
<td>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.</td>
</tr>
</tbody>
</table>
### Consolidated Framework for Implementation Research (CFIR): Domains and Subdomains

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<td>B. Evidence strength &amp; quality</td>
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<td>C. Relative advantage</td>
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<td>D. Adaptability</td>
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<td>C. Peer pressure</td>
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<td>D. External policies &amp; incentives</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>III. Inner setting</th>
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<tbody>
<tr>
<td>A. Structural characteristics</td>
<td></td>
</tr>
<tr>
<td>B. Networks &amp; communications</td>
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<td>C. Culture</td>
<td></td>
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<tr>
<td>D. Implementation climate</td>
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<td>1. Tension for change</td>
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<td>2. Compatibility</td>
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<td>3. Relative priority</td>
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<td>4. Organizational incentives &amp; rewards</td>
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<td>5. Goals and feedback</td>
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<td>6. Learning climate</td>
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</tbody>
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<table>
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<tr>
<th>IV. Characteristics of individuals</th>
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<tbody>
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<td>A. Knowledge &amp; beliefs about the intervention</td>
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<td>B. Self-efficacy</td>
<td></td>
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<tr>
<td>C. Individual stage of change</td>
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<tr>
<td>D. Individual identification with organization</td>
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<tr>
<td>E. Other personal attributes</td>
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<table>
<thead>
<tr>
<th>V. Process</th>
<th></th>
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<tbody>
<tr>
<td>A. Planning</td>
<td></td>
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<tr>
<td>B. Engaging</td>
<td></td>
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<tr>
<td>1. Opinion leaders</td>
<td></td>
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<tr>
<td>2. Formally appointed internal implementation leaders</td>
<td></td>
</tr>
<tr>
<td>3. Champions</td>
<td></td>
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<tr>
<td>4. External change agents</td>
<td></td>
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<tr>
<td>C. Executing</td>
<td></td>
</tr>
<tr>
<td>D. Reflecting &amp; evaluating</td>
<td></td>
</tr>
</tbody>
</table>

Damschroder et al., 2009 and Damschroder and Hagedorn, 2011.
# Best-fit framework synthesis

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Define review question</th>
</tr>
</thead>
</table>
| 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**

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

Stokes et al 2016
Booth & Carroll 2015
# Best-fit framework synthesis

**Table 1** Summary of “best fit” framework synthesis approach

<table>
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<th>Step</th>
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<tbody>
<tr>
<td>1</td>
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| 2    | a) Systematically identify relevant primary research studies  
     b) Identify relevant (“best fit”) publications of frameworks and conceptual models/theories | 6    | Produce a new framework composed of a priori and new themes supported by the evidence |
| 3    | Extract data on study characteristics from included studies and conduct study quality appraisal | 7    | Revisit evidence to explore relationships between themes or concepts, in order to create a model |
| 4    | Code evidence from included studies into the a priori framework identified in step 2 |      |                                                                            |

Adapted from Booth and Carroll

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Stokes et al 2016  
Booth & Carroll 2015
Total Citations
N = 12,585

Abstracts screened
N = 7,295

Abstracts excluded
N = 6,789

Full-text reviewed
N = 506

Included articles
N = 20

Duplicates removed
N = 5,290

Ineligible articles N=439:
- Ineligible outcomes = 137
- Ineligible study design = 44
- Ineligible intervention = 179
- Ineligible population = 35
- Ineligible setting = 43
- Not in English = 1
<table>
<thead>
<tr>
<th>Approach</th>
<th>Total</th>
<th>High/mod. quality</th>
<th>Within RCT</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>US (VHA)</td>
</tr>
<tr>
<td>Cognitive Behavioral Therapy (CBT)</td>
<td>13</td>
<td>13</td>
<td>9</td>
<td>10 (6)</td>
</tr>
<tr>
<td>Mindfulness-based Stress Reduction (MBSR)</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>5 (1)</td>
</tr>
<tr>
<td>Acceptance &amp; Commitment Therapy (ACT)</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1 (1)</td>
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Mod, moderate; UK, United Kingdom; US, United States; VHA, Veterans Health Administration.
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C. Relative advantage
D. Adaptability
E. Trialability
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H. Cost

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B. Cosmopolitanism
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D. External policies & incentives

III. Inner setting
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C. Culture
D. Implementation climate
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   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
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Damschroder et al., 2009 and Damschroder and Hagedorn, 2011.
Consolidated Framework for Implementation Research (CFIR): Domains and Subdomains

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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

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<td>H. Cost</td>
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<tr>
<td>I. Group dynamics</td>
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<tr>
<td>J. Patient-therapist dynamics</td>
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<td>F. Other patient attributes</td>
<td></td>
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<tr>
<td>G. General practice climate &amp; patterns</td>
<td></td>
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</tbody>
</table>

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): 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
- **D.** Individual identification with organization
- **E.** Other personal attributes

### V. Process

Most studies were
- of patients
- within effectiveness RCTs

---

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# Studies with results addressing new CFIR subdomains

<table>
<thead>
<tr>
<th>New CFIR subdomains and definitions</th>
<th>Themes</th>
<th>CBT</th>
<th>ACT</th>
<th>MBSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outer Setting</strong></td>
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<tr>
<td><strong>Patient Knowledge and Beliefs</strong></td>
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</tr>
<tr>
<td>Individuals’ attitudes toward and value placed on the intervention; familiarity with facts, truths, and principles related to the intervention.</td>
<td>Pain-related knowledge &amp; beliefs</td>
<td>●●●</td>
<td>●●●</td>
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<tr>
<td></td>
<td>Therapy-related knowledge &amp; beliefs</td>
<td>●●●</td>
<td>●●●</td>
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<td>Study types:</td>
<td>Qualitative ●●●</td>
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<td></td>
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</tbody>
</table>
### Studies with results addressing new CFIR subdomains

<table>
<thead>
<tr>
<th>New CFIR subdomains and definitions</th>
<th>Themes</th>
<th>CBT</th>
<th>ACT</th>
<th>MBSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention Characteristics</strong></td>
<td></td>
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<tr>
<td><em>Group Dynamics</em></td>
<td></td>
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<tr>
<td>For group treatments, interactions between participants (or with facilitator) that impact patient experience and/or outcomes</td>
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<tr>
<td><em>Patient-Therapist Dynamics</em></td>
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<tr>
<td>Patient-therapist interactions during individual therapy that impact patient experience and/or outcomes</td>
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**Study types:** Qualitative ● Mixed ▶ Quantitative ▲
### Barriers and facilitators for uptake of CBT, MBSR, and ACT for chronic pain, by CFIR domains

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<tr>
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<th>Cognitive Behavioral Therapy (13 articles)</th>
<th>Mindfulness-Based Stress Reduction (5 articles)</th>
<th>Acceptance &amp; Commitment Therapy (4 articles)</th>
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<tr>
<td><strong>Evidence strength and quality</strong></td>
<td>- GPs interested in culturally relevant CBT for South Asian patients</td>
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<tr>
<td><strong>Design quality and packaging</strong></td>
<td>- Self-management materials helped understand principles, prompted use of skills; could be repetitive and unclear with dispiriting case studies</td>
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<td><strong>Cost</strong></td>
<td>- CBT cost-effective for improving quality of life; not significantly different from UC in health care utilization or productivity losses</td>
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<td><strong>Patient-therapist dynamics</strong></td>
<td>- Patients appreciated therapists for empathic, consistent, reliable care</td>
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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

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Barriers and facilitators for uptake of CBT, MBSR, and ACT for chronic pain, by CFIR domains

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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

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re-aim.org/learn/what-is-re-aim/
## Key findings: implementation evaluations

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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...

Adaptable Periphery

Core Components

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 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*
Meet Kyle from IN

Tell us about yourself. I am a veteran and served in the Army and Air Force National Guard and retired after 20 years. I was stationed in Germany as a young Soldier from 1986-1989. Most of my service was spent in operations, and as a veteran combat veteran, I have experienced first-hand the importance of chronic pain management and recovery. Why were you interested in serving on the VEP? I have managed chronic pain for years. Over the course of several years, I became interested in opioids and their impact. I am now married and have two beautiful children. I want to help others who are struggling with chronic pain and share my experiences and knowledge to help others.

Meet Ryan from WA

Tell us about yourself. I am a veteran and served in the Army and Air Force National Guard and retired after 20 years. I was stationed in Germany as a young Soldier from 1986-1989. Most of my service was spent in operations, and as a veteran combat veteran, I have experienced first-hand the importance of chronic pain management and recovery. Why were you interested in serving on the VEP? I was interested in joining the program because I want to help others who are struggling with chronic pain and share my experiences and knowledge to help others.

Meet Kathryn from CO

Tell us about yourself. I am a veteran and served in the Army and Air Force National Guard and retired after 20 years. I was stationed in Germany as a young Soldier from 1986-1989. Most of my service was spent in operations, and as a veteran combat veteran, I have experienced first-hand the importance of chronic pain management and recovery. Why were you interested in serving on the VEP? I was interested in joining the program because I want to help others who are struggling with chronic pain and share my experiences and knowledge to help others.

Meet Dave from WA

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

November 2021

Prepared for:
Department of Veterans Affairs
Veterans Health Administration
Health Services Research & Development Service
Washington, DC 20420

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

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Timothy J. Will, MD, MPH
Wei (Denise) Duan-Porter, MD, PhD

Thank you!

See report for citations of included articles:
www.hsrd.research.va.gov/publications/esp/Psychotherapies-Pain.cfm
References


Racine M. Chronic pain and suicide risk: A comprehensive review. Prog Neuropsychopharmacol Biol Psychiatry 2018;87(Pt B):269-280.


Thank you!

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