Brown, V.B., Najavits, L.M, Cadiz, S., Finkelstein, N., Heckman, J.P, Rechberger, E. (2007). Implementing an evidence-based practice: Seeking safety group. *Journal of Psychoactive Drugs, 39*, 231-240.

Implementing an Evidence-Based Practice: Seeking Safety Group†

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Abstract—This article presents findings from a multisite study on adopting and implementing an evidence-based practice, Seeking Safety, for women with co-occurring disorders and experiences of physical and sexual abuse. It focuses on what implementation decisions different sites made to optimize the compatibility of Seeking Safety with the site's needs and experiences and on issues posed by Rogers (1995) as relevant to successful diffusion of an innovative practice. A total of 157 clients and 32 clinicians reported on satisfaction with various aspects of the model. Cross-site differences are also examined. Results show that Seeking Safety appears to be an intervention that clinicians perceive as highly relevant to their practice, and one that adds value. Clients perceive the treatment as uniquely touching on their needs in a way that previous treatments had not.

Keywords—adoption of innovation, group interventions, mental health, substance use/abuse, trauma

Studies of the diffusion of technology have identified factors that may contribute to the adoption of new practices (Gustafson et al. 2003; Simpson 2002; Rogers 1995). Diffusion theory suggests that adoption of innovation depends in part upon: (1) the perceived relative advantages of the new practice; (2) compatibility with values, experiences, and needs; (3) low complexity or simplicity of use; (4) potential to try on a limited basis; and (5) the extent to which results

†This study was funded under Guidance for Applicants (GFA) No. TI 00-003 entitled Cooperative Agreement to Study Women with Alcohol, Drug Abuse and Mental Health (ADM) Disorders who have Histories of Violence: Phase II from the Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration's three centers: Center for Substance Abuse Treatment, Center for Mental Health Services and Center for Substance Abuse Prevention (March 2000). The authors are indebted to Stephen Banks for his consultation and advice on the statistical methods employed in the WCDVS. The assistance of project staff at the following participating sites (listed in alphabetical order by state) is also gratefully acknowledged: Los Angeles, CA: PROTOTYPES Systems Change Center, Vivian Brown, Principal Investigator; Stockton, CA: Allies: An Integrated System of Care, Jennie Heckman, Principal Investigator; Thorton, CO: Arapahoe House–New Directions for Families, Nancy VanDeMark, Principal Investigator; Washington, DC: District of Columbia Trauma Collaboration Study, Roger Fallot, Principal Investigator; Avon Park, FL: Triad Women's Project, Margo Fleisher-Bond, Co-Principal Investigator, Colleen Clark, Co-Principal Investigator; Boston, MA: Boston Consortium of Services for Families in Recovery, Hortensia Amaro, Principal Investigator; Cambridge, MA: Women Embracing Life and Living (WELL) Project, Norma Finkelstein, Principal Investigator; Greenfield, MA: Franklin County Women's Research Project, Rene Andersen, Principal Investigator; New York, NY: Portal Project, Sharon Cadiz, Principal Investigator. The Coordinating Center is operated by Policy Research Associates (PRA) located in Delmar, NY, in coordination with the National Center on Family Homelessness of Newton, MA and the Cecil G. Sheps Center for Health Services Research, University of North Carolina (UNC) at Chapel Hill, NC. The interpretations and conclusions contained in this publication do not necessarily represent the position of the WCDVS Coordinating Center, participating study sites, participating consumer/survivor/recovering persons, or the Substance Abuse and Mental Health Services Administration and its three centers.

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are observable (Rogers 1995). Other factors that are important are staff skills and knowledge, as well as leadership. With regard to substance abuse treatment, Simpson (2002) reviewed the literature on technology transfer and described factors that are needed to implement evidence-based practices in particular settings. He stresses that innovations must be brought to the attention of organizations and be made accessible; in addition, there must be evidence of effectiveness and feasibility, as well as adequate resources. Wandersman (2003) suggests a number of solutions in closing the gap between research and practice, including participation and control by practitioners and communities in tailoring interventions and monitoring their success under local conditions.

This article describes an example or prototype of studying the innovation-development process described by Rogers (2003, 1995). This process consists of a series of choices and actions over time through which an individual, organization, or system evaluates a new idea/practice and decides whether or not to incorporate the new practice into ongoing practice.

It also describes the adoption and implementation of Seeking Safety, a manualized treatment designed for trauma/PTSD and substance use disorder (SUD) (Najavits 2002). It was implemented in group format as part of a multisite national study on women with co-occurring substance abuse and mental health disorders and histories of violence and trauma (WCDVS; McHugo et al. 2005).

PTSD and SUD have consistently been found to co-occur (Ouimette & Brown 2003). Reports on rates of PTSD among women receiving treatment for substance abuse range from 20% to as much as 59% (Kessler 2000; Najavits, Weiss & Shaw 1997; Triffleman et al. 1995). Current research shows that 48% to 90% of women with co-occurring mental health and substance abuse disorders also have histories of interpersonal violence (Perkonigg et al. 2000; Lipschitz, Kaplan & Sorkenn 1996). Most clinical programs treat PTSD or SUD, but rarely both. Fewer than half of the women with co-occurring disorders and trauma will receive treatment that addresses all of these issues (Timko & Moos 2002).

In 1996, Najavits introduced "Seeking Safety," an integrated intervention for substance abuse and trauma/PTSD which has since had several completed outcome studies (Najavits 2007;Cook et al. 2006; Najavits et al. 2005, 1998; Hien et al. 2004; Zlotnick et al. 2003; Holdcraft & Comtois 2002). The intervention was designed as a first-stage treatment for each of the disorders. The treatment offers 25 topics and covers four content areas: cognitive, behavioral, interpersonal, and case management. Seeking Safety was designed to be highly adaptable to different contexts. In research studies, it has shown positive results in individual and group formats; for both women and men; in sessions of one hour and 1.5 hours; in outpatient, day treatment, and prison settings; in open and closed groups; and with solo and co-led groups (Najavits 2004).

The number of sessions in research studies has typically been 25 over three months (twice-weekly treatment). As all of the Seeking Safety topics were designed to be conducted in any order and independently of each other, clients do not have to be available for the entire treatment, but can use whatever time is available to them. While Seeking Safety is highly adaptable and flexible, it nonetheless asks the interventionist to follow a structured session format.

The present report describes implementation of Seeking Safety in four settings that were part of a multisite intervention study, focusing on what decisions different sites made in order to optimize the compatibility of Seeking Safety with the site's needs and experiences, and on the issues posed by Rogers (1995) as relevant to successful diffusion of an innovative practice.

It addresses the following questions: (1) What decisions did the different sites make in order to optimize the compatibility of Seeking Safety with the site's needs and experiences? (2) How satisfied were the clinicians/facilitators and consumers/clients with Seeking Safety, and were there differences between sites and between clinicians and consumers? and (3) What may be important factors that contribute to the adoption of new practices?

METHODS

Sites

The Women, Co-Occurring Disorders and Violence Study (WCDVS) was a quasi-experimental nine-site longitudinal outcome study. Eligibility criteria included a substance use and mental health disorder, experience of physical and/or sexual abuse, and at least two previous treatment episodes. Women in the experimental condition had access to comprehensive, integrated, and trauma-informed services; these services also involved consumer/survivor/recovering (CSR) staff. Women in the comparison condition had access to treatment as usual, which usually meant nonintegrated and nontrauma-specific services. Each of the nine sites chose or developed a trauma-specific treatment to add to their programs. Four of the sites chose Seeking Safety. These four sites—PROTOTYPES (Los Angeles), WELL Project (Cambridge, MA), Palladia/Portal (New York City), and Allies (Stockton, CA)—are the focus of the present study.

Participants

Consumers and clinicians from three sites—PROTOTYPES, WELL Project, and Palladia/Portal—provided anonymous ratings of the Seeking Safety groups. Additional data were obtained from consumers who participated in focus groups at two of the sites (PROTOTYPES and Allies) or who answered the same questions used in the focus groups in written form (WELL Project). A total of 157 clients and 32 clinicians responded. Average age of the clients who responded was 36.6 years. There were no differences between sites on age or on whether the client had a history of trauma,

TABLE 1
Characteristics of Clinician Respondents*

	Site		
	PROTOTYPES	WELL Project	Palladia/Portal
Total number responding	17	9	6
Average age	40	---	27
Average years of experience	6	12.6	2
Professional background			
Social work	8	1	4
Psychologist	1	---	1
Certified alcohol and drug counselors	2	3	---
Other training in alcohol and drug	6	---	---
Mental health counselor	---	5	---
No professional training	0	1	0
Experienced trauma (%)	80	---	50
Experienced PTSD (%)	50	---	50
Experienced substance abuse (%)	60	---	25

*Data not available for Allies.

PTSD, or substance abuse. These 157 clients represent a subset of 743 clients who participated in the interventions at these four sites. Sites showed racial and ethnic variety: in two sites the majority was Caucasian, at one site the majority was African American, and one site had a more balanced ratio. Two of the sites had significant percentages of Hispanics/Latinas. Note that identifying information on the consumer respondents was not collected for this study, as the measure was administered anonymously in order to obtain as accurate and honest a dataset as possible on their views of Seeking Safety. Table1 summarizes demographic information on clinician respondents for the current study.

Measures

The Seeking Safety Feedback Questionnaire (Najavits 2002) and the Protocol Implementation Questionnaire (Najavits 1996) were administered at three sites at the conclusion of the Seeking Safety groups and at the end of the study. At the WELL site, the forms were administered either at the end of Phase I or Phase II. At PROTOTYPES additional questionnaires were collected in conjunction with a focus group about the trauma-specific intervention. The questionnaire contains several parts:

- four questions about how harmful or how helpful the treatment is, rated on a Likert scale from -3 (greatly harmful) to +3 (greatly helpful);
- a rating of each separate session on the -3 to +3 Likert scale;
- a rating of each part of the manual on the -3 to +3 Likert scale;
- an estimate from 0% to 100% about how frequently the material will be used, how understandable the treatment is, how innovative, and whether the woman would recommend the treatment to someone else;
- an open-ended question about how long it took to get comfortable with the treatment;
- a space for open-ended comments about best and worst aspects of the treatment, recommended modifications, people for whom the program would be especially helpful or unhelpful, and any general comments.

For clinicians, there were additional ratings on a -3 to +3 Likert scale of the materials provided to therapists and a list of views about the Seeking Safety treatment on which comments were solicited.

An additional feedback form was administered at the WELL site. It asked in what ways the group had been helpful, which sessions were best, what additional material would be useful, and whether there were too many or too few sessions. These questions corresponded to the focus groups conducted at Allies and at PROTOTYPES.

RESULTS

Adaptations

The Seeking Safety manual was, by design, intended for flexible use in different clinical settings. Thus, for example, it explicitly states that there is no particular order to the topics (after topic 1a, Introduction/Case Management); that there is no required length, pacing, or frequency of sessions (but rather that these decisions should be made by the clinician and/or site); that topics can be run over multiple sessions; and that examples for particular populations be woven in (e.g., based on ethnicity, gender, setting; see Najavits 2004, 2002). Table 2 illustrates the way each of the four sites implemented the Seeking Safety manual. It is important to discuss some of the decisions in more detail.

Number of sessions. At PROTOTYPES, Allies, and the WELL Project, the Seeking Safety intervention was pilot tested and implemented based on feedback from the pilot groups. At PROTOTYPES, the number and sequence of sessions were suggested by mental health professionals and substance abuse counselors who co-facilitated the pilot groups. These decisions primarily revolved around arranging the order of the sessions to reflect clients' most prominent

TABLE 2
Implementation of Seeking Safety

	Site			
	PROTOTYPES	**WELL Project**	**Palladia/Portal**	**Allies**
Number of sessions	31	24	12	24
Duration	1 1/2 hrs	1 1/4 hrs	1 1/2 hrs	1 1/2 hrs
Frequency	2/week	1/week	1/week	1/week
Where	Chiefly residential; some outpatient	Residential and outpatient	Residential (some residential)	Community agencies
Leaders	Co-led by mental health professionals and substance abuse counselor (typically C/S/R)	Substance abuse or mental health professionals; substance abuse counselors in recovery	Mental health professionals	Mental health professionals, peer substance abuse counselors
Training	Najavits1-day workshop; all other training by site staff (2.5-month training for leaders; pilot groups)	Najavits 1-day workshop; all other training by site staff (2-hour introduction locally; cofacilitate with trained staff)	All training by site staff (e.g., trauma conferences, dual diagnosis trainings, readings, videotapes)	Najavits half-day workshop; other training by site staff, including co-led 12 session groups
Fidelity	Audiotape; use of Najavits' Seeking Safety Adherence Scale	Audiotape; use of Najavits' Adherence Scale	Adherence scale	Audiotape; case management logs; Adherence Scale

NOTE: C/S/R = consumer, survivor, recoverer

treatment needs and increasing the time spent on some of the sessions. For example, clients frequently struggle with anger issues; therefore, the Healing from Anger session was covered early in the sequence (it was the ninth topic). Furthermore, because the topic involves an important client treatment need, staff advocated for covering it in two sessions. As a result of these staff contributions, PROTOTYPES' Seeking Safety treatment was 31 sessions, since a number of topics were discussed over several sessions.

Palladia/Portal used 12 sessions as the core of the clinical intervention. The selected topics focused primarily on developing self awareness and safety strategies. Palladia/Portal covered the themes of safe coping, personal power, compassion, exploration of symptoms, and the links between substance abuse and trauma.

At Allies the decision was made to offer all 25 topics provided in the manual, but to split the 24 topics (after the Introduction) into two series of 12 sessions each. The first series involved open groups; the second, closed groups. The purpose of this "open/closed" combination was to provide an opportunity for serving the maximum possible number of women (during the first 12 sessions), but then to allow greater safety and trust to build for those women interested in continuing in the second series. In general, the topics were implemented per the manual; however, the content for a topic was sometimes split across two sessions.

At the WELL Project the basis for the ordering was to have clinicians identify the topics that they believed might be most "triggering" or difficult for clients later in the sequence, when trust would be more established and the group more cohesive. Seeking Safety was then divided into two phases: Phase I had 12 topics, and Phase II had 12 topics, conducted in total across 24 sessions. This was done for two reasons. Since the groups were usually closed to new members after Session 3 in outpatient settings, it allowed two Phase I groups to be combined into a single Phase II group so that groups would retain sufficient numbers of women to maintain adequate clinical interaction and financial viability. In residential settings, splitting Seeking Safety into two phases also enabled women to complete at least Phase I before leaving and continue with Phase II in their outpatient treatment. With regard to this adaptation, the topics covered across sessions, whether the sessions were divided 12 and 12 or were given as a continuous sequence of 31 sessions, were similar. However, the sequence of topics were diverse.

Cultural adaptations. For a number of the sites, the facilitators working with African-American and/or Latina groups specifically added examples from their lives, incorporating cultural elements to which clients could relate and add their own examples. Examples of racism were raised as traumatic events. Some sites matched facilitators with the ethnic populations being served. Palladia/Portals opened sessions with a reading connected to the women's sense of spirituality and their faith-based beliefs. Affirmations, poems, art, and quotations that referred to healing, creativity, and womanhood were used to help to anchor the women.

Implementation for clients with low reading skills. When programs knew that a number of the clients had low reading skills, facilitators read handouts out loud in group and/or other clients would spend additional time reading to these clients outside of the group. In some cases, where there were two facilitators, the second facilitator sat with

TABLE 3
Average Ratings of Helpfulness of Seeking Safety

	PROTOTYPES				Site							
					WELL Project				Palladia/Portals			
	N	Mean	SD	% Rating Greatly Helpful	N	Mean	SD	% Rating Greatly Helpful	N	Mean	SD	% Rating Greatly Helpful
Consumers												
Overall	77	2.83	0.44	86	39	2.36	0.81	51	33	2.82	0.53	88
For PTSD and substance abuse	77	2.70	0.80	78	39	2.28	0.89	51	33	2.67	0.69	76
For PTSD alone	76	2.59*	0.70	70	39	1.81 *	1.05	31	32	2.28*	1.08	56
For substance abuse alone	77	2.77	0.43	77	39	1.90*	1.25	38	32	2.34*	0.70	44
Clinicians												
Overall	11	2.91	0.30	91	---	---	---	---	3	2.67	0.58	67
For PTSD and substance abuse	11	3.00	0.00	100	---	---	---	---	3	2.33	0.58	33
For PTSD alone	11	2.82	0.40	82	---	---	---	---	3	2.33	0.58	33
For substance abuse alone	11	2.91	0.30	91	---	---	---	---	3	2.67	0.58	67

NOTES: Neither consumers nor clinicians from Allies completed the questionnaire. Only one WELL Project clinician completed this form; therefore these WELL Project data are not included. Rating scales ranged from -3 (greatly harmful) to +3 (greatly helpful), with zero as neutral. "Greatly helpful" refers to the highest rating of the scale, which was +3; the percentage refers to the number of people who gave this highest rating to that variable.

*Indicates that the ratings for PTSD and substance abuse, PTSD alone, or substance abuse alone, respectively, were significantly different from the overall rating using a matched t-test to compare the means. T-tests were not conducted for clinicians due to small samples.

TABLE 4
Consumers vs. Clinicians on Satisfaction with Topics of Seeking Safety

How helpful is the following topic?	Consumers (N = 118-147)		Clinicians (N = 12-15)		
	M	SD	M	SD	*t*
Healthy Relationships	2.64	0.77	3.00	0.00	-5.03**
Self-Nurturing	2.63	0.72	2.91	0.30	-2.49*
Honesty	2.62	0.69	3.00	0.00	-6.46**
Setting Boundaries in Relationships	2.59	0.73	3.00	0.00	-6.61**
Recovery Thinking	2.59	0.63	2.80	0.63	-1.03
Coping with Triggers	2.56	0.67	3.00	0.00	-7.30**
Safety	2.54	0.73	3.00	0.00	-7.74**
Compassion	2.52	0.70	2.92	0.29	-3.85**
Taking Good Care of Yourself	2.52	0.76	2.92	0.28	-4.00**
When Substances Control You	2.50	0.91	2.69	0.75	-0.74
Healing from Anger	2.50	0.79	2.73	0.91	-0.89
Detaching from Emotional Pain (Grounding)	2.49	0.93	2.83	0.39	-2.54*
Taking Back Your Power	2.48	0.84	2.92	0.28	-4.32**
Commitment	2.45	0.80	2.75	0.62	-1.28
Creating Meaning	2.44	0.82	3.0	0.00	-7.41**
Respecting Your Time	2.42	0.87	2.64	0.67	-0.82
Red and Green Flags	2.42	0.94	3.0	0.00	-6.58**
Getting Others to Support Your Recovery	2.42	0.83	2.73	0.65	-1.18
Asking for Help	2.39	0.85	3.0	0.00	-8.43**
Discovery	2.35	0.91	2.64	0.51	-1.02
Community Resources	2.33	0.95	2.27	1.01	0.20
Termination	2.32	1.09	2.85	0.38	-3.67**
Integrating the Split Self	2.30	1.14	2.18	0.87	0.35
Life Choices Game (Review)	2.29	0.96	2.92	0.29	-5.06**

Note: Analysis was conducted using independent samples t tests. Rating scales ranged from -3 (greatly harmful) to +3 (greatly helpful), with zero as neutral.
* $p < .05$.
** $p < .01$.

an individual client with low reading skills and explained the forms and worksheets to her.

Treatment program refinements. To optimize participation, PROTOTYPES' administrative and clinical staff conjointly decided to structure the treatment program schedule so that Seeking Safety groups were held consistently on the same days and at the same time each week. At the WELL Project, all Seeking Safety groups were also held at the same day and time each week, whether in residential or outpatient treatment. At Palladia/Portals, the group sessions were bolstered by: (1) carefully orchestrated pregroup introductions; (2) "gentle reminders" about group meeting times; (3) individual sessions after every group as needed; (4) trauma-specific service plans; and (5) introduction of peer educators at the final sessions to link the women to the next level of service.

Another implementation decision made by a number of the sites was replacing the word "PTSD" with the word "trauma," (consistent with Najavits 2004, 2002) where that was appropriate in the manual. The WELL Project also added the words "mental illness" in a number of places and included additional examples related to mental illness in some of the exercises.

Protocol Implementation Questionnaire

Consumers. The women who participated in Seeking Safety were strongly positive about the treatment. Table 3 shows the mean ratings of the helpfulness of treatment at each site. All ratings were very high, and most of the sample gave the highest possible rating to the Seeking Safety intervention. Women saw the treatment as most helpful for combined PTSD and substance abuse. For each disorder alone, the ratings tended to be lower than the overall ratings of helpfulness, but varied by site.

PROTOTYPES and WELL participants rated 24 separate session topics, while Palladia/Portal rated five. These results are shown in Table 4. There were also 24 separate aspects of the manual that received ratings. These are shown in Table 5. Complementing the ratings, consumers at all four sites offered opinions about the best and worst sessions in writing and/or in focus groups.

TABLE 5
Consumers vs. Clinicians on Satisfaction with Elements of Seeking Safety

How helpful is this aspect of the model?	Consumers (N = 112-149)		Clinicians (N = 10-14)		
	M	SD	M	SD	*t*
Learning coping skills	2.63	0.73	3.00	0.00	-6.19**
Safe coping list	2.60	0.81	2.80	0.56	-0.94
Safety as priority of treatment	2.59	0.75	2.93	0.27	-3.58**
Focus on ideals	2.52	0.81	2.73	0.59	-1.00
Structured approach	2.50	0.92	3.00	0.00	-6.22**
Focus on behavioral skills	2.49	0.84	2.93	0.26	-4.59**
Integrated treatment	2.48	0.83	3.00	0.00	-7.38**
Patient session handouts	2.47	0.86	2.93	0.26	-4.60**
Safe coping sheet	2.47	0.85	2.67	0.72	-0.87
Focus on abstinence	2.43	0.92	2.73	0.70	-1.26
Use of quotations	2.40	0.89	2.27	1.03	0.54
Focus on interpersonal skills	2.37	0.93	2.67	0.62	-1.21
Amount of material provided	2.35	1.15	2.58	0.90	-0.70
Length of treatment	2.28	1.17	2.17	0.84	0.33
Focus on cognitive skills	2.27	1.03	2.67	0.49	-2.62*
Core concepts of treatment	2.27	1.00	2.71	0.47	-2.90**
List of further resources	2.27	1.03	2.33	0.89	-0.22
Check in/check out	2.25	1.28	2.87	0.35	-4.40**
Commitments	2.24	1.08	2.40	0.63	-0.58
Community resources	2.17	1.04	1.40	1.60	2.56*
Empirical basis of treatment	2.17	1.13	2.50	0.67	-1.00
How frequently will you use this treatment again in the future?	84.12	23.09	88.38	18.72	-0.65
[How innovative is this treatment?	84.04	25.63	87.69	18.89	-0.50
[Would you recommend this treatment?	91.03	20.92	92.86	12.04	-0.32

Note. Analysis was conducted using independent samples t tests. Rating scales ranged from -3 (greatly harmful) to +3 (greatly helpful), with zero as neutral. For the last three items results are percentages.

* $p < .05$.

** $p < .01$.

Average ratings were all highly positive. Sessions that received the highest ratings at PROTOTYPES were Self-Nurturing, Honesty, and When Substances Control You; at WELL, Setting Boundaries, Safety, Healthy Relationships, Detaching from Emotional Pain, and Discovery; at the Portal project, Safety; at Allies, Setting Boundaries, Coping with Triggers, Taking Good Care of Yourself, Detaching from Emotional Pain, Asking for Help, and Integrating the Split Self. The sessions about which consumers expressed slightly less enthusiasm at PROTOTYPES were Respecting Your Time, Discovery, and Integrating the Split Self; at WELL, Compassion, Asking for Help, and Community Resources; at the Portal project, Termination.

Parts or aspects of the manual rated highest across sites included learning coping skills, the safe coping list, and safety as a priority of treatment. At PROTOTYPES, check-in/check-out and the structured approach also received positive ratings; while at WELL, the part of the manual rated lowest was check-in/check-out. Parts of the manual rated lower, but still in the positive range included, for PROTOTYPES and the Portal project, commitments, and for the Portal project, community resources. Women stated clearly that they intended to use what they had learned, that they could understand the treatment, and that they would recommend it to others.

When women were asked how long it took to feel comfortable with the treatment, 51.3% of them said that they were comfortable by the end of two weeks or sooner; only 19.3% said that it took over one month. Across sites, 38.6% of PROTOTYPES women, 51.4% of the WELL women, and 80.0% of Portal women reported feeling comfortable within two weeks.

Statistical analyses compared sites on the 46 rating variables. On twenty-nine Portal and PROTOTYPES scored higher than the WELL Project, on three, PROTOTYPES scored higher than the WELL Project with Portal not different from either, on four variables all three sites differed significantly from one another. In one instance PROTOTYPES scored higher than Portal, with the WELL Project not different from either; on nine variables PROTOTYPES scores were greater than both Portal and WELL. In sum, the WELL Project had significantly lower ratings than the

other sites, with PROTOTYPES providing higher ratings. However, all three sites provided very high satisfaction data, with no variables in the negative or even neutral range.

Consistent with the ratings, comments in the women's own words reflected that the three most important parts of the treatment were: (1) the group experience—feeling safe, bonding with other women who had similar experiences; (2) learning about coping skills; and (3) receiving information about PTSD and substance abuse.

The women in the focus groups provided articulate descriptions of how important these concepts were for their treatment. Analyses of the transcripts from Allies consumers showed that the women had incorporated the session concepts into their daily language, and apparently to a great extent, into their lives. For example, the women talked about what triggered them, setting boundaries in relationships, coping skills, grounding techniques, and "that's a red flag, that's a green flag." They indicated that having a term or label for different experiences was helpful (e.g., "It's labeled and I have stored it away so I can use it again. In times when I am overwhelmed, this gives me something to draw from").

Consumers described Seeking Safety as uniquely touching on their needs in a way that previous treatments had not. For example, one woman from Allies said, "Seeking Safety was one of the best tools I could have had for [healing from] the trauma and my recovery with my drug addiction. It is one of the best things that happened to me." One woman at PROTOTYPES put it, "It tripped me out, it just related to me. I never knew how much a class could relate to a person."

The chief modification requested was to lengthen the treatment (consistent with Najavits et al. 1998, where clients reported the same comment). A few women mentioned particular topics that might be covered in more depth. At one site, check-in/check-out was perceived as an aspect that needed improvement, as the women commented that it occupied too large a proportion of the group's time.

Clinicians. Therapists were uniformly enthusiastic about the treatment. Favorite sessions included Healthy Relationships (PROTOTYPES), Honesty (PROTOTYPES), Setting Boundaries (PROTOTYPES, WELL), Coping with Triggers (PROTOTYPES), Safety (WELL, Palladia/Portal), Taking Good Care of Yourself (Palladia/Portal), Detaching from Emotional Pain (WELL), Red and Green Flags (PROTOTYPES, WELL), Asking for Help (WELL). Open-ended comments from PROTOTYPES clinicians indicated that Integrating the Split Self and Discovery were somewhat difficult for low-functioning women to understand. Allies facilitators found the Community Resources session of somewhat less value than the other sessions. Aspects of the manual rated as "greatly helpful" by clinicians included integrated treatment (PROTOTYPES and Portal), safe coping list (PROTOTYPES and Portal), Safety as a priority (Portal), patient session handouts (Portal), and the structured approach (PROTOTYPES, WELL).

Statistical analyses compared consumers to clinicians on satisfaction with the topics and elements of Seeking Safety. As can be seen in Tables 4 and 5, the clinicians' ratings are significantly higher on most items than consumers. However, both clinicians and consumers consistently gave very high ratings to all aspects of the treatment. On the scale, which ranged from -3 to +3, all results were above 2.0, and most were above 2.5. No scores were in the negative or even neutral range.

When asked how long it took them to feel comfortable with the treatment, about 60% of clinicians at both PROTOTYPES and WELL indicated that it took less than a month (typically three weeks), with the balance stating that it took longer. Most clinicians at PROTOTYPES and WELL thought that the length of the group was fine, and PROTOTYPES clinicians liked the twice per week format. The main modifications recommended by PROTOTYPES, WELL, and Allies clinicians were allowing more time for some of the topics and either lowering the reading level of the materials or providing the materials in audio format. The consensus among PROTOTYPES and WELL clinicians was that Seeking Safety should be run as a closed group. However, one problem was dropout, in that a group could begin with 12 women and end up with three to six members.

PROTOTYPES and WELL respondents very much valued having cofacilitators with complementary skills. There were several open-ended comments among PROTOTYPES clinicians about the importance of training and supervision. Palladia/Portal clinicians felt that a knowledge base in trauma was needed to conduct the groups as well as skills with running groups and good personal boundaries.

DISCUSSION

This is the first study to report detailed feedback from both clients and clinicians on Seeking Safety. Particularly notable is the large sample size, the ability to compare results across four geographically diverse sites, the front-line nature of the programs (i.e., these were not research-based university programs), and the minimal amount of training or decision-making carried out directly by Najavits and her team (i.e., three sites had an initial one-day or half-day training, but all other training, supervision, and implementation decisions were made by the sites themselves). Results were quite consistent in indicating highly positive views of the group treatment by both clients and clinicians. Clients' open-ended comments described Seeking Safety as a unique experience of having an intervention that reflected their special needs in a way that had not happened in previous treatment episodes.

As providers think through adopting Seeking Safety, they may be reassured that the number of topics suggested (25) does not appear to be a difficulty for the women. In fact the women reported wanting more sessions. However,

it is possible that there are differences in this issue between women who completed and women who dropped out of treatment and between those in residential and outpatient settings. A limitation of this study is that the consumers were mostly those who completed treatment. The adaptations regarding low reading skills do appear to be important, particularly to the clinicians, who felt that the reading level of handouts was too advanced. The women participants did not report this.

Several findings were particularly notable. The first was that, for both clinicians and consumers, satisfaction ratings were consistently high. However, another limitation of the study is that the consumer satisfaction cannot be connected to outcomes. We did find however that on virtually all variables where consumers and clinicians showed a significant difference, clinicians reported higher satisfaction. It is important when considering a new treatment model to remember that in addition to client satisfaction and outcome, the clinician's own wish to adopt a treatment is also important. Second, we could find differences between sites, with PROTOTYPES generally rating higher in satisfaction and the WELL project relatively lower when there were differences. All three were highly positive on all variables, but such site differences suggest that there likely are factors that influence satisfaction ratings—in this case, unknown factors.

By using Seeking Safety as a test of diffusion theory, the findings and lessons learned have important implications for the overall theory of diffusion. Many innovations with proven effectiveness are never adopted. In this large-scale study investigating promising practices for women with co-occurring disorders and trauma, a number of important overarching features were present that appear to have facilitated adoption. WCDVS began with a two-year (Phase I) study to increase knowledge and awareness of both the need for trauma-specific interventions and of what curricula were available with what outcomes. This phase also allowed staff to make decisions to decide among a number of interventions, and then try out/implement the chosen group curriculum. Unlike studies in which one intervention is imposed upon all funded sites, this study allowed for differences in interventions chosen. In this way, sites had some power and control over the decision of which intervention to implement. One of the factors in the selection process for the four sites was that Seeking Safety had a strong focus on substance use and trauma, and these four sites had strong histories of providing substance abuse treatment in contrast to some of the other sites in the study. Many of the group topics echoed themes that clients and staff worked with throughout substance abuse treatment and recovery. These steps all preceded full implementation of the more rigorous study of outcomes (Phase II).

We also know that individuals do not evaluate an innovation only on the basis of scientific studies of its consequences. Instead, most people depend mainly upon a subjective evaluation of an innovation that is conveyed to them from other individuals like themselves (near peers) who have already adopted the practice (Rogers 1995). This is extremely important when we look at the results of this subset study. The heart of the diffusion process consists of interpersonal network exchanges. Thus, the high ratings by the clinicians/providers may not just reflect the early adopters being satisfied with their selection, but may demonstrate the behavior that assisted in the diffusion of the preferred intervention. The high ratings of the providers may be a good application of the "opinion leader" concept in dissemination of programs and ideas; i.e., community providers who have implemented innovative programs and who see the advantage of the innovations may be better at marketing these programs to their peers than researchers. At the time of writing this article, all four sites have not only sustained Seeking Safety in their programs, but also have disseminated it to others within and beyond their own agencies.

Relative advantage has been found to be one of the strongest predictors of an innovation's rate of adoption. Relative advantage can be seen as a ratio of expected benefits to the costs of adoption of the new practice. This article is not a study of outcomes of the Seeking Safety intervention (see Gatz et al. In press) for one of the four site's local outcomes). As the four sites looked for trauma-specific interventions that could be incorporated into integrated programs for women with co-occurring disorders and trauma, it was clear that there were existing effectiveness studies of Seeking Safety. When the sites participated in the trainings and piloted the intervention, the staff and managers experienced the beginning benefits of adding this new group to the programs. The clients were extremely positive about the group, even at the pilot stage, and clients and staff then had the opportunity to recommend the adaptations.

With regard to *compatibility*, the four programs adopting Seeking Safety had extensive experience in substance abuse treatment in which group interventions play a major focus. It was a good fit to embed a group curriculum within the treatment programs. The addition of the group was not disruptive of usual practice. Secondly, the adaptations made reflected each site's making the innovation compatible with its unique characteristics. Another dimension of compatibility is the degree to which a new practice is perceived as meeting the needs of the clients. Seeking Safety was rated by clients as not only meeting their needs, but enhancing treatment in a number of ways: e.g., teaching them new coping skills, assisting them in understanding the links between their substance use and their trauma experiences, and helping them share their experiences in a safe environment. The client's satisfaction with the group led to more enthusiasm for the intervention by other staff.

Trialability allows the user to dispel uncertainty about a new idea. Trying a new idea may involve reinventing it so

as to customize it more closely to the adopter's system. In the four agencies, pilot tests allowed the staff to "know" the intervention, to change it after the trial to fit client's needs, and to "own" the new practice before full implementation.

With regard to *observability*, the comments and enthusiasm of the clients in the focus groups and their open-ended comments about their participation in Seeking Safety were strong observed results for staff, facilitators, and administrators. One woman at PROTOTYPES told the Principal Investigator of the study site that she had stayed in treatment only because of Seeking Safety.

Another critical thread in the implementation of the new practice was the consideration of consumer input at all stages. In addition, consumer/survivor/recovering or peer women who served as cofacilitators had a special advantage of "safety credibility" (Rogers 1995). These peers are perceived as trustworthy and less likely to have selfish motives.

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