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GALLIPOLI MEDICAL RESEARCH

Peer-led Seeking Safety: translating an evidence-based practice model for veterans' support organisations

17 October 2025

Final Report

Peer-led Seeking Safety: translating an evidence-based practice model for veterans' support organisations

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Report: Version 2.1

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List of abbreviations

ADF – Australian Defence Force

AQoL-8D – *Assessment of Quality of Life Scale – 8 Dimensions*

BAM-R – *Brief addiction monitor – revised*

CAPS – *Clinician-administered PTSD scale*

CI – confidence interval

CPT – cognitive processing therapy

CSES – *Coping self-efficacy scale*

DASS-21 – *Depression Anxiety Stress Scale–21*

DVA – Department of Veterans' Affairs (Australian Government)

EMDR – eye movement desensitisation and reprocessing

ET – exposure therapy

GMR – Gallipoli Medical Research

ICER – incremental cost-effectiveness ratio

LGC – *Learning guide checklist*

'Open Arms' – Open Arms – Veterans & Families Counselling

PCL-5 – *PTSD checklist for DSM-V*

PE – prolonged exposure

PTSD – post-traumatic stress disorder

RCT – randomised controlled trial

SA – South Australia

SCS-SF – *Self-compassion scale – short form*

SD – standard deviation

SQLD – South Queensland

SSFQ – *Seeking Safety feedback questionnaire*

TAU – treatment as usual (evidence-based PTSD therapies; e.g. ET, CPT or EMDR)

Executive summary

Background and context

Seeking Safety is an evidence-based model consisting of 25 flexible topics designed to support individuals with trauma or addiction through a structured, strengths-based and present-focused coping skills approach. Originally developed in the United States by Treatment Innovations, it has been extensively researched and manualised to ensure consistency and reproducibility. The model provides structured training and optional certification for facilitators, fidelity assessment and supervision, enabling rigorous evaluation and high-quality delivery. Each session incorporates feedback opportunities to monitor client satisfaction to help guide service improvement. Research has also shown that Seeking Safety can be delivered effectively in partial-dose formats, with significant improvements observed even when only a subset of the original topics is delivered, producing outcomes comparable to the full model.

This Australian pilot project was the first to evaluate the implementation of the peer-led Seeking Safety model within Open Arms – Veterans & Families Counselling ('Open Arms'). The study assessed the model's preliminary feasibility in a real-world organisational setting, informed the development of an addendum to the Seeking Safety manual tailored to the Australian military context, and examined its cost-effectiveness.

Implementation journey

The pilot was delivered at 2 Open Arms sites – in South Australia and South Queensland – involving veteran clients, and Open Arms clinicians and community & peer workers (referred to collectively as 'staff'). Initially, the standard Seeking Safety training model was followed, but early implementation revealed that additional preparation and workforce support were required.

The revised training program integrated multiple supports to build confidence and readiness, including a *Learning guide checklist* (Najavits, 2024), information sessions, online experiential practice sessions across key Seeking Safety domains, optional one-on-one supervision, community of practice sessions and booster training sessions prior to program launch. Staff selection and feedback also drew on a 59-item questionnaire and focus groups. This intensive training and layered support sequence enhanced peer workforce capability, improved confidence and ensured consistent delivery across sites.

The partial-dose intervention was delivered weekly as eight 90-minute sessions over 8 weeks. The evaluation used a mixed-methods design, combining staff and client surveys (including psychosocial outcome measures), self-report fidelity assessments, focus groups and a health economic analysis.

Feasibility and outcomes

Preliminary findings from the pilot suggest that peer-led Seeking Safety is feasible – that is, practical to implement within existing resources and staffing – and acceptable – meaning well-received, relevant and suitable for participants – among Australian veterans, although further research is needed to confirm these results across diverse settings and to assess longer-term outcomes. Staff highlighted the model's unique value in creating a safe, recovery-oriented environment where peer lived-experience professionals could take on meaningful leadership roles that fostered trust and comfort among veterans. Having a peer worker in the room was described as particularly powerful, helping to normalise experiences and strengthen group connection. The combination of structured guidance and flexibility allowed facilitators from varied backgrounds to deliver sessions as intended, adapting content to client needs and group dynamics.

Clients reported positive engagement and satisfaction, and perceived the intervention as beneficial . Self-reported fidelity to the model was consistently high, and both qualitative and quantitative data showed positive trends towards improved psychosocial outcomes, including reduced post-traumatic stress disorder symptoms, stress, and substance use, and improved coping skills. While the small sample limited the drawing of statistical conclusions, the convergence of preliminary effect sizes, satisfaction

ratings and engagement suggests the potential of peer-led work to complement clinician-led care, expand service capacity and offer veterans an accessible, relatable and safe environment for recovery-oriented group work.

Economic evaluation

The economic analysis demonstrated that Seeking Safety was cost-effective across delivery scenarios, with the most favourable cost per unit of improvement, based on clinician-rated outcomes, observed at 6 months post-intervention. The outreach clinician-led approach offered the greatest savings, but peer-led and co-led formats also provided good value by expanding service reach and strengthening the peer workforce while maintaining clinical outcomes. These results align with international evidence of Seeking Safety's economic benefits and highlight its potential scalability within Australia.

Implications for policy and practice

The pilot demonstrated that peer-led Seeking Safety can be safely implemented within Open Arms, with preliminary acceptability and relevance for addressing trauma, post-traumatic stress disorder and substance use. For Open Arms, expanding the model has the capacity to diversify service offerings, while its structured flexibility supports a national rollout across varied contexts. For the peer workforce, the findings suggest that, with fit-for-purpose training, supervision and resources, peer workers can deliver a trauma-specific intervention with high self-reported fidelity, enhancing their roles and career development.

At a policy level, scaling up the model could improve accessibility and embed peer-led group work as a core option in veteran services, provided that robust support structures are in place. The positive engagement, satisfaction and cost-effectiveness observed in this pilot highlight peer-led Seeking Safety as a promising, scalable and sustainable component of veteran mental health care.

Overall, the project benefited from strong stakeholder engagement and adaptive management, providing valuable insights to inform future research and interventions in this area. Potential next steps include exploring telehealth delivery, family-inclusive and gender-specific groups, condensed or rolling formats, and enhanced peer worker training programs. Together, these initiatives have the potential to expand the reach, adaptability and long-term impact of peer-led Seeking Safety within the Australian veteran context, while offering transferable lessons for the broader health and social service sectors.

1. Introduction

1.1. Background and context

1.1.1. Peer workers: possibilities and challenges

In 2013, the Australian Government Department of Health launched the National Framework for Recovery-Oriented Mental Health Services (Department of Health, 2017), aiming to integrate recovery principles into practice by embedding peer workers in care teams. Accordingly, the peer workforce in the Australian mainstream health and social services sector has grown substantially over the last decade (Queensland Health, 2023). Consistent with changes in the broader service context, the number of peer workers employed by Australian veterans' support organisations has increased.

However, concerns remain about workplace health and safety risks to services, clinicians, peer workers and clients. In veterans' support organisations, peer workers are employed for their lived experience of military service and mental health recovery (Open Arms – Veterans & Families Counselling ['Open Arms'], n.d.), both of which are associated with greater exposure to trauma than the general population (Sweeney et al., 2018; Van Hooff et al., 2018). Moreover, peer workers can face risks of re-traumatisation and relapse when confronted with challenging material or scenarios shared by clients.

Research in the US demonstrates that peer workers can enhance the effectiveness of treatment-as-usual (TAU) service delivery, with randomised controlled trials (RCTs) reporting greater reductions in mental health symptoms, improvements in hopefulness and quality of life (Cook et al., 2012, as cited in Crisanti et al., 2016), and better treatment engagement for individuals receiving peer-led services compared with TAU (Sells et al., 2006, as cited in Crisanti et al., 2016).

In the Australian context, implementation of the peer worker role has been inconsistent, varying significantly across agencies (Queensland Health, 2019) and lacking adequate planning, support and structure (Department of Health, 2017). An audit of Queensland public mental health services found wide differences in peer workers' responsibilities, training and remuneration (Queensland Health, 2019). Over-reliance on 'lived experience' has contributed to poorly defined roles, insufficient preparation and mental health deterioration for some peer workers (Hurley et al., 2018).

1.1.2. The Seeking Safety model

Seeking Safety (Najavits, 2002) is a manualised, evidence-based model designed to support individuals with trauma or addiction through a structured, strengths-based and present-focused coping skills approach. Since 1998, 66 studies, producing a large number of peer-reviewed reports and professional publications have demonstrated strong outcomes for Seeking Safety across diverse clients presenting with a range of difficulties arising from trauma, addiction or impulse control problems (including male and female veterans; see the list of research on the Seeking Safety website: https://www.treatment-innovations.org/evid-all-studies-ss.html). Research has also demonstrated that Seeking Safety can be delivered effectively in partial-dose formats, with significant improvements reported even when only a subset of the 25 topics is delivered, having outcomes comparable to those of the full model (Sherman et al., 2023). Consistent with this literature, the present pilot delivered 9 of the 25 topics over 8 sessions.

This Australian pilot project was the first to trial the peer-led Seeking Safety practice model within Open Arms. The current research aims to provide the evidence required to successfully implement the practice model for community & peer workers[1] employed by Open Arms and to evaluate whether the model is associated with positive impacts for peer workers and veterans. Our pilot project:

- addresses strengths and challenges associated with embedding peer workers in care teams (e.g. clarify role requirements and the scope of practice)

[1] Community & peer workers will be referred to as 'peer workers' throughout the remainder of this report.

- improves consistency in service responses (within and across sites)
- reduces training and supervision burden (for team leaders)
- manages workplace health and safety risks (for service managers and executives).

This pilot project is an opportunity for the Department of Veterans' Affairs (DVA) to lead innovation in peer-led support. The preliminary outcomes from the selected Open Arms research sites suggest that peer-led Seeking Safety may offer a flexible and scalable model of care. With further implementation piloting, there may also be opportunities to explore the practice model's transferability to settings beyond Open Arms, helping to assess its broader applicability and strengthen the generalisability of results.

1.2. Research aims

The aim of the current study was to optimise the implementation of Seeking Safety for Open Arms peer workers supporting Australian veterans.

The specific aims of the pilot project were:

1. to determine the feasibility of implementing peer-led Seeking Safety within the Open Arms organisational setting, as specified by the following dimensions:
    a. recruitment capability and resulting sample characteristics
    b. data collection procedures and outcome measures
    c. acceptability and suitability of study procedures and peer-led Seeking Safety
    d. intervention fidelity (self-reported) and the degree to which the intervention was implemented as prescribed
    e. resources and ability to manage and implement peer-led Seeking Safety
    f. Open Arms clients' responses to the peer-led Seeking Safety intervention, assessed by validated psychological measures
2. to inform the development of an addendum to the Seeking Safety manual that would include adaptations that may be helpful for the successful implementation of peer-led Seeking Safety within the Australian military context
3. to estimate the cost-effectiveness of peer-led Seeking Safety in the Australian military context.

1.3. Research questions

The research questions were as follows:

1. Do the outputs and outcomes from the study demonstrate a sufficient level of acceptability and feasibility within the Open Arms organisational or site setting?
2. Which factors and processes (i.e. organisation, site, clinician, peer worker and client) promote or impede the successful translation and implementation of peer-led Seeking Safety?
3. What modifications (if any) are required to ensure the intervention is culturally appropriate for the Australian military context (i.e. aligned with its needs, values and preferences)?
4. What are the barriers to and facilitators for embedding the peer-led Seeking Safety practice model within the Open Arms model of care?
5. What is the ratio of costs to effectiveness for the peer-led Seeking Safety practice model when implemented in the Australian military context?

1.4. Project plan

1.4.1. Initial design and training approach

The initial pilot project was planned to be conducted at 5 participating Open Arms sites across 4 regions: Greater New South Wales, South Queensland (SQLD), South Australia (SA) and Western Australia. The group sessions would be delivered in a face-to-face format to 2 Open Arms client cohorts per region: ex-serving Australian Defence Force (ADF) members and their family members.

The original training involved 29 peer workers and clinicians (referred to collectively as 'staff') from the 4 regions. Treatment Innovations provided the standard Seeking Safety online training over two 3-hour sessions. This training plan was adapted from Crisanti and colleagues' (2016) study, which reported positive outcomes from a 1-day joint training for peer workers and clinicians.

Following this training, feedback from staff participants revealed concerns regarding their confidence and sense of readiness to deliver the intervention in a real-world setting, emphasising the need for more role-play opportunities, particularly for those new to group intervention delivery, implementing a manualised intervention and offering trauma-specific care. Some peer workers also wanted more guidance on how to adapt the clinical language in the Seeking Safety manual.

1.4.2. Addressing feedback and mitigation strategies

To meet the needs of Open Arms staff participants, Gallipoli Medical Research (GMR) coordinated 2 co-design focus groups (1 hour each) with participating staff to better understand their training needs and preferences. Focus group discussions revealed that staff desired more opportunities to observe session demonstrations, receive practical advice on group facilitation generally, receive guidance (for peer workers) on adapting clinical language from the Seeking Safety manual, and structured lesson plans.

1.4.3. Rationale for adaptation

The peer-led Seeking Safety pilot project was paused due to the need for additional preparation and workforce support, as described above, with agreement to hold a workshop. The workshop took place on 12 July 2024, with key representatives from DVA, Open Arms, the GMR research team and Prof Lisa Najavits in attendance. The objectives were to review the project's status and challenges, discuss the rationale for pausing the project and explore strategies to move forward.

1.4.4. Adaptation process and agreed changes

Although the research aims and questions of the pilot project remained unchanged, several adjustments to the initial pilot project scope were agreed upon at the conclusion of the workshop and in the subsequent weeks. Specifically:

- refinement of scope to involve a single ex-serving ADF group per research site (excluding families of ex-serving members) due to the greater availability of veteran peer workers and ease of scalability within this demographic
- establishment of an expert reference group to support pilot project planning and oversight, meeting at key decision points
- extension of the pilot project timeline as required to execute the research, including the co-design, development and delivery of supplementary training, and extended client recruitment and eligibility screening
- evaluation of staff willingness and suitability before continuing with further implementation
- review of the protocol for inclusion of clinical oversight and supervision
- review of Seeking Safety manual topics to ensure suitability for the Australian context, focusing on plain language and cultural appropriateness.

2. Methodology

2.1. Ethics approval and consent processes

An ethics application was submitted to the Departments of Defence and Veterans' Affairs Human Research Ethics Committee on 18 September 2023. The application was reviewed and approved by the committee on 21 December 2023 (Protocol no. #548-23).

The study involved 2 cohorts of participants: ex-serving clients and Open Arms staff (clinicians and peer workers). Open Arms staff who were interested in participating in the pilot project were provided with a copy of the *Participant information sheet and consent form*. Staff were informed that participation was voluntary and would in no way affect their current or future entitlements from DVA and that identifying information was strictly confidential. Prior to providing consent, staff were encouraged to contact GMR for further information. Open Arms staff managed the consent process for client participants, providing potential participants with the recruitment pack, which included the information sheet and consent form, a study poster and a *Client information and FAQ* handout. Aligned with the approved protocol, staff explained the pilot project, addressed questions and encouraged individuals to consider potential risks and discuss participation with a family member or health professional, if needed.

Participants who chose to proceed completed the information sheet and consent form online via Qualtrics. A signed copy of this was provided to participants (in person or by email), and the GMR research team retained the electronic record in the study's source documentation.

2.2. Study sites and staff participants

2.2.1. Site recruitment

The study was delivered within the clinical setting of Open Arms, the leading provider of mental health and wellbeing support to veterans and their families. The recruitment of Open Arms sites for the pilot project was refined to focus on 2 locations that expressed interest and willingness to implement the intervention at their site. Further, initial feedback indicated that staff at the SQLD and SA sites had greater comfort and knowledge with the Seeking Safety intervention and showed greater interest in participating in the pilot, compared with other sites.

2.2.2. Staff recruitment

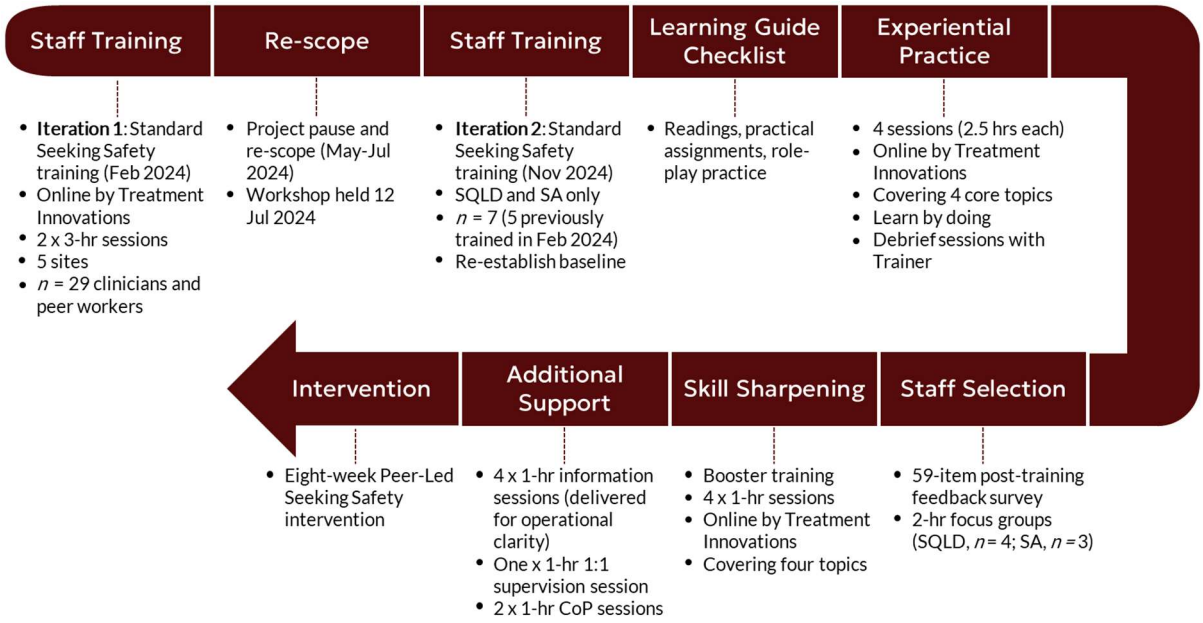
The selection of clinicians and peer workers at these sites was managed by the respective Open Arms site directors, who considered factors such as experience, current and future work commitments, interest in group facilitation and participation in the project, availability for training and the intervention period, and willingness to complete study outcome measures. Staff recruitment involved voluntary participation, with all staff informed that additional duties would be integrated into their regular work hours. Additional staff members were recruited to ensure adequate backup support at each research site for the re-scoped phase of the pilot project.

2.3. Staff training

Seeking Safety standard training was delivered in 2 iterations. In the first iteration (February 2024), Treatment Innovations provided online training across the 5 sites (two 3-hour sessions), which was attended by a total of 29 staff. Following the project pause and re-scope, a second iteration (November 2024) was delivered at SQLD and SA (7 staff, 5 of whom also attended the first iteration) to re-establish a consistent training baseline. To build confidence and readiness, the pilot integrated multiple supports: a *Learning guide checklist* (LGC; Najavits, 2024); information sessions (four 1-hour sessions); experiential practice (four online sessions across key Seeking Safety domains); optional 1-hour, one-on-one practice (role-play) sessions with the Treatment Innovations trainer; 2 optional community of

practice sessions; and four 1-hour booster sessions prior to the program launch. Staff feedback and selection drew on a 59-item questionnaire (see Section 2.7.1) and two 2-hour focus groups at each site (4 staff in SQLD and 3 in SA). See Figure 1 for the training and support sequence.

Figure 1. Training and support sequence for Open Arms staff



Note. SQLD = South Queensland; SA = South Australia; CoP = community of practice.

2.4. Client recruitment and eligibility screening

GMR supported Open Arms staff to recruit clients within their existing client base. To be eligible to participate in the study, clients were required to meet the following criteria:

- an Open Arms client
- over 18 years of age
- an ex-serving ADF member
- present with concerns related to trauma, stressors, substances or addiction
- willing and able to attend the peer-led Seeking Safety intervention
- willing and able to complete the peer-led Seeking Safety outcome measures via computer, laptop, smartphone or other device.

Once potential client participants were identified, Open Arms staff initiated informed consent and screening procedures.

2.5. Participant safety

Anticipated risks and mitigation strategies were considered for both veteran clients and Open Arms staff to ensure safety and wellbeing throughout the pilot.

2.5.1. Risks to veteran client participants

- **Mental health conditions**: As a substantial proportion of ex-military personnel experience mental health conditions, such as post-traumatic stress disorder (PTSD), substance use disorders, anxiety and depression (Van Hooff et al., 2018), it was anticipated that some participants may present with diagnosed mental health conditions. If a clinical marker was noted via standardised psychosocial measures in the course of the program, the client's treating

clinician would be engaged for both relevant treatments and protective risk management. If engagement with other health, mental health or community services was also indicated, clinicians had referral pathways to third-party providers in place.

- **Group sessions**: Participation in group sessions, which required open discussion of personal challenges, also carried the potential for discomfort or distress among participants.
- **Disclosure of sensitive information**: In the group-format setting, participants might choose to share personal information in front of others. However, as the intervention was skills-based, disclosure of sensitive details was not required. All group members were reminded of their privacy and confidentiality obligations.
- **Mandatory reporting**: There was a possibility that participants could disclose information (e.g. suicidality or threats of harm) necessitating mandatory reporting. In such cases, the co-facilitating Open Arms clinician would manage the situation according to standard clinical risk management procedures.

2.5.2. Risk mitigation for veteran client participants

To ensure the safety and wellbeing of participants, the following measures were adopted:

- **Informed consent**: Clients were informed, as part of the consent process, that they could withdraw from the study at any time, for any reason.
- **Clinical support**: Registered clinicians were present in the session and trained in assessing and managing participant distress.
- **Practice model boundaries**: The Seeking Safety model adopts a present-centred approach, designed to minimise the risk of re-traumatisation during group sessions. By limiting the discussion of trauma narratives to 'headlines, not details' (Najavits et al., 2014), the model emphasises stabilisation, psychoeducation, coping skills and service engagement, addressing unsafe coping strategies in each session.
- **Monitoring and referral**: Clinicians monitored participants for signs of distress or symptom escalation, conducted risk assessments and were able to develop safety plans if required. Clients could be withdrawn from the study if they developed unstable psychiatric conditions or posed risks to themselves or others. Where risks or concerns were identified, the Open Arms clinicians coordinated appropriate treatment, including referrals for individual psychological counselling or to external services if indicated.
- **Access to assessment results**: Participants and their healthcare providers could receive assessment results upon request, in line with Open Arms protocols.

2.5.3. Risks to staff participants

- **Facilitator wellbeing**: Staff participants could experience distress related to group dynamics, exposure to emotive content or their own mental health conditions.
- **Staff preparedness**: Staff participants may not feel prepared to facilitate group sessions or deliver the intervention to clients.

2.5.4. Risk mitigation for staff participants

The following measures were implemented to manage potential risks for Open Arms staff:

- **Clinical support**: Peer workers received support and supervision from Open Arms clinicians, who were present in sessions and registered with the relevant professional bodies.
- **Ongoing support**: Multiple support touchpoints were established throughout the study to assess staff comfort and willingness to continue and to gather feedback (see 'staff training' and 'additional support' in Figure 1). Direct supervisors monitored staff for signs of distress.

- **Model safeguards**: The present-centred, 'headlines, not details' (Najavits et al., 2014) approach was designed to minimise the risk of re-traumatisation among facilitators.
- **Access to counselling**: All facilitators had access to confidential counselling services through the Employee Assistance Program.
- **Routine supervision**: Facilitators maintained regular supervision arrangements for their existing caseloads and were provided opportunities to debrief about their pilot project involvement. Supplementary supervision and optional community of practice meetings were available to staff during the intervention.
- **Supervision and support**: Staff participants received fortnightly supervision from Treatment Innovations during the intervention period. Additional experiential practice sessions were provided, tailored to the learning style of ADF personnel.
- **Robust training**: Staff participants completed fit-for-purpose training in the Seeking Safety model, supported by Seeking Safety resources created by the model developer. Optional booster sessions and supplementary materials were made available.
- **Learning guide**: A structured Seeking Safety LGC (Najavits, 2024) was developed by Professor Lisa Najavits, in collaboration with GMR, to guide staff through supplementary training activities.

2.6. The peer-led Seeking Safety intervention

Seeking Safety is an integrated treatment for trauma or addiction based on cognitive behavioural therapy. The intervention focuses on present-focused coping skills and encourages coordination of wellbeing services (e.g. employment, finance, education, justice and safety, social connection, and housing). It is a trauma-specific, psychoeducational intervention that builds resilience, manages re-traumatisation risk in clients, and supports staff in relation to moral distress, secondary trauma and burnout (i.e. compassion fatigue). The model (Najavits, 2002) is highly structured and sequential, with each session following a consistent format.

Research on Seeking Safety has demonstrated its efficacy across a diverse range of client presentations, treatment contexts and populations (including male and female veterans; e.g. Barrett et al., 2015; Najavits et al., 2018). The practice model is safe (i.e. no reported adverse events across 66 studies) and structured (but flexible and scalable), and research has also demonstrated its effectiveness when delivered by peer workers (e.g. Crisanti et al., 2016; Crisanti, Murray-Krezan et al., 2019; Crisanti, Reno et al., 2019; Najavits et al., 2014). Peer-led Seeking Safety is identical to regular Seeking Safety in its format, content and training; however, peer workers may benefit from additional support as needed. For evidence on its RCT-based effectiveness, see Section 3.6.1 and the Seeking Safety website (https://www.treatment-innovations.org/seeking-safety.html), which has updated evidence and information on the model.

The peer-led Seeking Safety intervention in the current pilot project was conducted in a face-to-face, group format. An Open Arms peer worker facilitated the group session. A clinician co-facilitated the session and assisted the peer worker by:

- monitoring session time
- keeping the session true to the Seeking Safety format
- observing clients for signs of discomfort or psychological distress (e.g. agitation or dissociation; Najavits et al., 2014)
- initiating routine Open Arms duty-of-care processes for managing at-risk clients.

The partial-dose (8-session) intervention was delivered as 90-minute sessions, weekly for 8 weeks (i.e. up to 12 hours in total). The Seeking Safety topics selected for the intervention are presented in Table 1.

Table 1. Peer-led Seeking Safety topics for the partial-dose (8-session) intervention

Session no.	Session topic	Focus of intervention
Session 1	Introduction / Case management; Compassion	Combination
Session 2	Safety	Combination
Session 3	PTSD: taking back your power	Cognitive
Session 4	Detaching from emotional pain (grounding)	Behavioural
Session 5	Asking for help	Interpersonal
Session 6	Healing from anger	Interpersonal
Session 7	Coping with triggers	Behavioural
Session 8	Healthy relationships*	Interpersonal
Feedback	Focus group: staff participants only	Evaluation

Note. *The topic 'When substances control you' (cognitive) was initially selected for the intervention but was replaced with 'Healthy relationships' during the pilot project suspension and re-scoping. The decision was made by the expert reference group to omit the 'When substances control you' topic to avoid targeted discussions of substance use because Open Arms does not provide drug and alcohol services. The inclusion of 'Healthy relationships' was determined following expert advice from Professor Lisa Najavits.

Open Arms supervised their staff in line with Seeking Safety training and routine supervision processes. Specifically, supervision comprised the following components:

- **Preparation**: Prior to each Seeking Safety session, staff participants met to discuss the plan for the group session, drawing on the Seeking Safety training and treatment manual (Najavits, 2002).
- **Debrief and fidelity**: At the end of each session, staff participants individually completed the *Seeking Safety adherence scale – brief version* (Najavits et al., 2007), and discussed any discrepancies in ratings, to monitor fidelity to the treatment. They also discussed whether any duty-of-care concerns arose, and if so, the clinician initiated routine Open Arms processes for managing at-risk clients.
- **Supervision**: Staff participants received fortnightly supervision from Treatment Innovations during the 8-week intervention. The 1-hour sessions were delivered online in a group format. While attendance was not compulsory, staff were encouraged to attend. The supervision sessions were designed to provide ongoing support, reflection and shared learning opportunities to strengthen facilitator confidence and capability in delivering Seeking Safety.
- **Community of practice**: Finally, optional 1-hour community of practice meetings were coordinated by GMR, delivered online at Week 3 and Week 6 of the intervention. The meetings encouraged and supported Open Arms staff to share and discuss their experiences implementing Seeking Safety. A member of the GMR research team (an AHPRA-registered psychologist) coordinated the sessions and presented the following prompts to Open Arms staff to facilitate discussions:
  - How would you describe your experience so far implementing peer-led Seeking Safety?
  - What has been your experience managing group dynamics within the session?
  - Do you feel supported to deliver peer-led Seeking Safety intervention?
  - What has presented the greatest challenge for delivering the intervention?
  - What has presented the greatest facilitator for delivering the intervention?

2.7. Data collection

All measures and questionnaires completed across both cohorts are outlined in Table 2 below, including time points for completion.

Table 2. Peer-led Seeking Safety measures and time points for completion

Questionnaire	Pre	T1	T2	W1	W2	W3	W4	W5	W6	W7	W8
Demographics	✓	–	–	–	–	–	–	–	–	–	–
ProQOL (Staff only)	✓	–	–	–	–	–	–	–	–	–	–
SSTFQ (Staff only)	–	✓	✓	–	–	–	–	–	–	–	–
SSTNFQ-P2 (Staff only)	–	–	✓	–	–	–	–	–	–	–	–
SSP-LGC (Staff only)	–	–	✓	–	–	–	–	–	–	–	–
SSAS-BV (Staff only)	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓
Anon. feedback survey	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓
Client attendance log	–	–	–	✓	✓	✓	✓	✓	✓	✓	✓
SSFQ	–	–	–	–	–	–	–	–	–	–	✓
AQoL-8D (Clients only)	✓	–	–	-	-	-	✓	–	–	–	✓
BAM-R (Clients only)	✓	–	–	–	–	–	✓	–	–	–	✓
CSES (Clients only)	✓	–	–	–	–	–	✓	–	–	–	✓
SCS-SF (Clients only)	✓	–	–	–	–	–	✓	–	–	–	✓
PCL-5 (Clients only)	✓	–	–	–	–	–	✓	–	–	–	✓
DASS-21 (Clients only)	✓	–	–	–	–	–	✓	–	–	–	✓

Note. Time points – Pre = pre-intervention; T1 = Training 1: Seeking Safety training; T2 = Training 2: Experiential practice; W = week. Questionnaires – ProQOL = *Professional quality of life measure* (Stamm, 2009); SSTFQ = *Seeking Safety training feedback questionnaire* (adapted from Crisanti et al., 2016); SSTNFQ-P2 = *Seeking Safety training needs & feedback questionnaire – phase 2* (Najavits, Treatment Innovations et al., 2024); SSP-LGC = *Seeking Safety post-learning guide checklist survey* (adapted from Najavits, 2024); SSAS-BV = *Seeking Safety adherence scale – brief version* (Najavits et al., 2007); SSFQ = *Seeking Safety feedback questionnaire* (Najavits, 2002); AQoL-8D = *Assessment of quality of life – 8 dimensions* scale (Richardson et al., 2014); BAM-R = *Brief addiction monitor – revised* (Hallinan et al., 2021); CSES = *Coping self-efficacy scale* (Chesney et al., 2006); SCS-SF = *Self-compassion scale – short form* (Raes et al., 2011); PCL-5 = *PTSD checklist for DSM-V* (Weathers et al., 2013); DASS-21 = *Depression anxiety stress scale–21* (Henry & Crawford, 2005).

2.7.1. Open Arms staff participants

The following details the measures and instruments used to collect data from the Open Arms staff participants.

- **Demographic questionnaire**: Included brief demographics, ADF service information (if applicable) and mental health and treatment history.
- ***Professional quality of life measure*** (Stamm, 2009): Comprises 30 items across 4 subscales – *Compassion satisfaction*, *Compassion fatigue*, *Burnout* and *Secondary traumatic stress* (vicarious trauma). Higher scores reflect more of each construct.
- ***Seeking Safety training feedback questionnaire*** (adapted from Crisanti et al., 2016): A 16-item self-report questionnaire comprising 3 sections, assessing training content and delivery;

retrospective pre–post ability change, comfort and knowledge; and prior experience with Seeking Safety.

- *Seeking Safety training needs & feedback questionnaire – phase 2* (Najavits, Treatment Innovations et al., 2024): A 16-item questionnaire about experiential practice, additional training needs and preparedness to deliver Seeking Safety.
- *Seeking Safety post–learning guide checklist survey* (adapted from Najavits, 2024): A 38-item questionnaire closely replicating the original LGC, obtaining self-reported completion of various learning activities.
- *Seeking Safety adherence scale – brief version* (Najavits et al., 2007): A tool measuring the facilitators' session-by-session fidelity ratings (intervention and process).
- Client participant attendance log: Session attendance recorded by an Open Arms co-facilitator.
- Staff focus group: A post-intervention, in-person (up to 2 hours each) and audio-recorded focus group explored staff's delivery experience, barriers and enablers, and perceived acceptability and cultural fit of the peer-led Seeking Safety model.

2.7.2. Open Arms client participants

At 3 time points across the study (pre-intervention, mid-intervention and post-intervention), GMR supported Open Arms staff in administering the client measures described below by distributing online survey links, monitoring completion and providing staff with completion rates and non-completer IDs to facilitate follow-up.

The client battery was selected to balance relevance to veteran populations (PTSD, substance use, depression, anxiety, stress, coping capacity and self-compassion) with low respondent burden, strong psychometrics (validity and reliability) and sensitivity to short-term change in a pilot context.

- Demographic questionnaire: Included brief demographics, service information and mental health and treatment history.
- *Assessment of quality of life – 8 dimensions* scale (AQoL-8D; Richardson et al., 2014): A 35-item questionnaire over 8 domains (*Independent living*, *Happiness*, *Mental health*, *Coping*, *Relationships*, *Self-worth*, *Pain*, *Senses*) that produces health-related quality of life utilities.
- *Brief addiction monitor – revised* (BAM-R; Hallinan et al., 2021): A 17-item instrument indexing substance use, risk and protective behaviours for monitoring the recovery of patients in treatment for a substance use disorder.
- *Coping self-efficacy scale* (CSES; Chesney et al., 2006): A 26-item scale assessing coping self-efficacy for managing challenges and threats.
- *Self-compassion scale – short form* (SCS-SF; Raes et al., 2011): A 12-item scale measuring the capacity for self-compassion. Higher scores reflect greater self-compassion.
- *PTSD checklist for DSM-V* (PCL-5; Weathers et al., 2013): A 20-item questionnaire assessing the 20 symptoms of PTSD in the fifth edition of the *Diagnostic and statistical manual of mental disorders*.
- *Depression anxiety stress scale–21* (DASS-21; Henry & Crawford, 2005): A 21-item self-report questionnaire with 3 subscales (*Depression*, *Anxiety* and *Stress*), indexing symptom severity over the past week.

2.7.3. Open Arms staff and client participants

The following details the measures and instruments used to collect data from both the Open Arms staff and client participants.

- **Anonymous feedback survey**: An anonymous, voluntary feedback survey was made available to staff and clients via a QR code during each session. The brief survey included a free-text box to capture qualitative insights on each session topic's relevance and effectiveness.
- ***Seeking Safety feedback questionnaire*** (SSFQ; Najavits, 2002): This questionnaire assessed the acceptability and feasibility of the Seeking Safety intervention. Staff and clients provided feedback on the intervention, individual session topics and delivery. Clinicians also completed additional questions regarding their opinion about Seeking Safety related to their clinical practice.

2.8. Data analysis and interpretation

Both quantitative and qualitative data were analysed to evaluate the feasibility, acceptability and potential outcomes of the peer-led Seeking Safety intervention.

2.8.1. Quantitative analysis

Quantitative analyses were conducted using IBM SPSS Statistics. Prior to planned analyses, datasets were screened for missing values, data entry errors, outliers and violations of statistical assumptions. Initial exploratory data analysis included generating descriptive statistics and frequency distributions to assess data characteristics and identify anomalies. This process informed the decision to use non-parametric methods due to the small sample size and non-normal distributions. Descriptive statistics were calculated for all demographic variables and psychosocial outcome measures to profile the sample. Since feasibility was a primary focus, core indicators (e.g. average number of sessions completed, proportion completing all sessions) were analysed descriptively. Changes in psychosocial outcome measures across pre-intervention, mid-intervention and post-intervention time points were assessed using the Friedman test (per-protocol sample), with post-hoc Wilcoxon signed-rank tests used in the event that significant differences were found. Effect sizes (Kendall's W) were calculated, and moderate or larger effects (≥0.3) were explored descriptively. Analyses were conducted using both intention-to-treat and per-protocol datasets, with no imputation for missing data, given the small sample and exploratory design. The intention-to-treat dataset included all participants who enrolled and provided baseline data and was used primarily for descriptive feasibility analyses. The per-protocol dataset included participants who completed the intervention and all key outcome measures and was used for within-group analyses of change over time. Results were combined across sites due to the small sample size, which limited the interpretability of site-level comparisons.

2.8.2. Qualitative analysis

Qualitative focus group data were analysed thematically following Braun and Clarke's (2006) approach. Focus group recordings were transcribed verbatim and imported into the qualitative data analysis software NVivo for systematic coding. Transcripts were read multiple times to achieve familiarisation, and initial codes were generated independently by 2 researchers to capture meaningful features of the data. The researchers then met to compare and discuss their coding, resolve discrepancies and collaboratively collate codes into potential themes. Themes were reviewed, refined and named to reflect patterns across the dataset, with final themes supported by illustrative quotes. Open-ended questionnaire responses were not thematically analysed due to the small sample size. Instead, these responses were summarised descriptively, highlighting key points and ideas expressed by participants.

2.8.3. Data integration

Findings from quantitative and qualitative analyses were considered together to provide a more comprehensive understanding of the model's feasibility, acceptability and suitability for the target population.

2.8.4. Data management and security

All pilot project data were non-identifiable and stored using a unique participant ID (Veteran Electronic Record Application client ID, for client participants) assigned at enrolment. The link between participant IDs and personal details was retained only by Open Arms in secure records within the Veteran Electronic Record Application system. The GMR research team was provided only with de-identified datasets for analysis.

Electronic data files (e.g. Excel spreadsheets, Word documents, text files) were stored in secure, access-controlled folders on GMR systems. Data inventories were maintained to ensure traceability. All focus group audio files, transcripts and other qualitative materials were stored securely and in accordance with ethical and confidentiality requirements.

2.9. Economic evaluation

An exploratory economic evaluation was conducted to assess whether the benefits of Seeking Safety for veterans were achieved at a reasonable cost when compared with evidence-based PTSD therapies – that is, TAU, which can be either cognitive processing therapy (CPT) or exposure therapy (ET), with the latter encompassing both prolonged exposure (PE) and eye movement desensitisation and reprocessing (EMDR) therapy – to determine whether the intervention represented good value for money and supported decisions regarding broader implementation within veteran mental health services.

The modelled economic evaluation was conducted using effect sizes from international, peer-reviewed literature via systematic review and meta-analyses, alongside local cost data from the pilot. This took the form of a cost-effectiveness analysis from the healthcare provider's perspective.

2.9.1. Effectiveness of Seeking Safety

Systematic review

The review followed the *Preferred reporting items for systematic reviews and meta-analyses* guidelines (Page et al., 2021). Searches were run in PubMed, Google Scholar, the published library of Treatment Innovations and reference lists of identified studies, limited to the period 2004 to 2024 (corresponding to the development period of Seeking Safety). The last search was executed on 22 February 2024.

Studies were included if they were RCTs of Seeking Safety in adults that reported PTSD outcomes at baseline and follow-up, with sufficient data to calculate effect sizes. Data extracted from the selected articles included study identification and setting, participant demographics, intervention design (sample size and dose of Seeking Safety), means and dispersion measures (e.g. standard deviation [SD] and 95% confidence intervals [CIs]), PTSD outcome measures, and findings related to the PTSD-specific effectiveness of Seeking Safety.

Two researchers independently assessed the risk of bias for each included study using the revised Cochrane *Risk of bias tool for randomised controlled trials* (Sterne et al., 2019). Studies were classified as 'high risk', 'some concerns' or 'low risk' in accordance with the tool's decision algorithms.

Meta-analyses

To align with the pilot project's single-group design, intervention effects on PTSD were assessed using within-group standardised mean differences, defined as the change in PTSD scores within the intervention group from baseline to follow-up, standardised by the pooled SD. Standardised mean differences were used because they standardise changes across different PTSD measures, allowing results to be compared and combined across studies.

Meta-analyses reported effectiveness as 1-point improvements in PTSD symptoms (within-group standardised mean differences) following the Seeking Safety intervention, measured by clinician-rated measures (the *Clinician-administered PTSD scale* [CAPS]). Self-reported scales (e.g. PCL-5) were examined exploratively. Finally, meta-regression tested whether full versus partial delivery of Seeking Safety influenced the magnitude of treatment effects.

2.9.2. Costs of Seeking Safety delivery

The analysis focused on 2 main cost domains: training costs, specific to the Seeking Safety intervention, and treatment delivery costs, applicable to both the Seeking Safety intervention and TAU phases. For clarity, TAU is referred to as the baseline treatment cost, and Seeking Safety as the post-intervention cost throughout the analysis.

Of note, overhead costs (e.g. rent, utilities and general infrastructure) were excluded, reflecting the assumption that both Seeking Safety and other standard care treatments were delivered within the same organisational setting (Open Arms) and thus used shared infrastructure and facilities.

Training costs

Costs specific to the Seeking Safety training were derived from detailed project records and included trainer costs (fees paid to accredited trainers from Treatment Innovations); supervision costs (ongoing supervision provided throughout the implementation period, also performed by a Treatment Innovations trainer); training materials (DVD training series, e-books, the *Teaching guide* and participant recruitment); and participant time (time allocated to training).

Treatment delivery costs

Treatment delivery costs were estimated using the human capital approach (Drummond et al., 2015), valuing staff time based on their wages. For the Seeking Safety intervention, staff time estimates were drawn from project records, including the duration for preparation, session delivery and practice-based activities. Since the staff involved in delivering this Seeking Safety intervention were all Open Arms employees, their wage rates were sourced from the annual base salaries outlined in the *DVA enterprise agreement 2024–2027* (DVA, 2024). Clinicians and peer workers were assumed to be paid at Australian Public Service Level 6 or Level 5, respectively, using the average across the 5 steps within each band, based on the 4% incremental pay rise effective from 14 March 2024 (as per DVA and Open Arms expert opinion).

TAU costs were based on data provided by the Open Arms Program Insights and Technology team, including staff time and types of staff involved in therapies delivered to clients who self-reported PTSD. These therapies included CPT and ET (encompassing both PE and EMDR). Cost data included all available sessions, whether the episode of care was ongoing or had closed at the time of data extraction (July 2025), and were averaged over the 2024–25 financial year to reflect current clinical practice.

Wage rates for staff in the TAU cost estimates were sourced from the Open Arms *Outreach program counsellor – schedule of fees: psychologist and accredited mental health social worker*, which were in effect during the 2024–25 financial year, aligning with the pilot project timeline. All costs were calculated as lump-sum amounts and reported per client.

2.9.3. Base-case and sensitivity analyses

Base-case analysis

The reported outcome of the cost-effectiveness analysis is the incremental cost-effectiveness ratio (ICER), which represents the cost per 1-point improvement in PTSD symptoms from baseline to post-intervention. The base-case ICER was calculated as:

$$ICER = \frac{\Delta C}{\Delta E} = \frac{Cost_{Seeking\ Safety} - Cost_{baseline}}{Effect_{Seeking\ Safety} - Effect_{baseline}},$$

where ΔC is the difference in costs between the intervention (Seeking Safety) and the baseline or comparator, and ΔE is the difference in effects (outcomes) between the intervention (Seeking Safety) and the baseline or comparator. The former was calculated by subtracting $Cost_{baseline}$ (the total cost of TAU) from $Cost_{SeekingSafety}$ (the total cost of the Seeking Safety intervention). The latter was calculated by

subtracting $Effect_{baseline}$ (the symptom score before the Seeking Safety intervention) from $Effect_{SeekingSafety}$ (the score after the intervention).

Sensitivity analysis

To assess the robustness of the base-case ICER, multiple scenarios were tested. They included:

- **Effectiveness measured by raw PTSD scores**: As standardised mean differences are unitless and not always straightforward to interpret, raw PTSD scores were used (mean differences from baseline to post-intervention at multiple time points) from the original RCTs to calculate ICERs.
- **Effectiveness by different within-participant correlation values**: As PTSD scores were measured on the same individuals, pre-treatment and post-treatment scores are correlated. A conservative correlation (r value) of 0.3 was assumed, with sensitivity analyses using 0.5 and 0.7 to test robustness.
- **Costs under routine implementation of the peer-led Seeking Safety model**: Additional training (including experiential sessions, ongoing supervision, booster training and one-on-one role-plays) was excluded, as it is usually implemented internationally. Research-related costs (participant recruitment, focus groups, time spent completing outcome measures post-intervention, and communities of practice) were also excluded to reflect real-world practice. The staffing set-up for training and treatment delivery followed the pilot project, involving both peer workers and clinicians.
- **Costs under different staffing scenarios**: Three 3 hypothetical staffing scenarios for delivering Seeking Safety in future implementations were tested:
  - **Scenario 1 – clinician-led Seeking Safety (outreach only)**: Seeking Safety delivered exclusively by outreach clinicians. Outreach wage rates for psychologists and accredited mental health social workers were used. No training costs were included, as it is assumed that Open Arms would not be responsible for training outreach counsellors.
  - **Scenario 2 – peer-led Seeking Safety (Open Arms peer workers only)**: Seeking Safety delivered solely by Open Arms peer workers. Only peer worker wage rates were included in the costing, with no involvement from clinicians.
  - **Scenario 3 – co-led Seeking Safety (65% outreach clinicians, 35% Open Arms peer workers)**: Seeking Safety delivered by both outreach clinicians (65%) and Open Arms peer workers (35%), in line with the current service delivery model (Open Arms expert opinion). Outreach wage rates were applied for clinicians, and DVA Australian Public Service Level 5 wage rates were used for peer workers. Training costs were excluded for clinicians (as per Scenario 1).

  In all scenarios, research-related costs were also excluded, as in the 'Costs under routine implementation' scenario, while costs of additional training were retained to reflect the identified needs of the Open Arms workforce. It was also assumed that a total of 4 staff members were required to deliver Seeking Safety to 13 clients, as conducted in this pilot project.

3. Results

This section presents the findings of the feasibility evaluation of the peer-led Seeking Safety intervention. The evaluation drew on feasibility criteria adapted from Orsmond and Cohn (2015), who recommend assessing feasibility across 5 key domains:

1. recruitment capability and sample characteristics
2. data collection procedures and outcome measures
3. acceptability and suitability of the intervention and study procedures
4. resources and capacity to implement the intervention
5. participant responses to the intervention.

Findings are integrated throughout the results section and draw on both quantitative and qualitative data sources. Quantitative measures include participant recruitment and retention data, intervention self-reported fidelity rates, and pre-intervention mid-intervention and post-intervention psychosocial outcomes. Qualitative findings are derived from focus groups and staff feedback, offering deeper insight into participants' experiences, perception of relevance and suggestions for future refinement. Together, these data inform the feasibility and future potential of implementing the peer-led Seeking Safety model in an Australian veteran context.

Note: The data presented are limited to information collected after the project was re-scoped.

3.1. Staff participant characteristics

The clinician cohort was predominantly female (83%) and aged 35 to 54 years (66%). Clinicians had diverse professional backgrounds, with qualifications across psychology, nursing, social work and education, as well as additional certifications in mental health. Over 66% ($n = 4$) had been in their current roles for 5 or more years, and 50% ($n = 3$) had worked at Open Arms for 3 to 4 years. All clinicians had experience in group facilitation.

The peer worker cohort comprised entirely male Army veterans, with half aged 35 to 44 years, and all representing varied service durations, characteristics and discharge experiences. Half reported deployment to combat zones. Three (75%) were receiving individual mental health treatment, and 2 (50%) had received formal diagnoses of PTSD, depression or related conditions. They had between 3 and 5 years in their current roles, and half had worked at Open Arms for 3 to 4 years. Peer workers had a mix of formal training and lived experience.

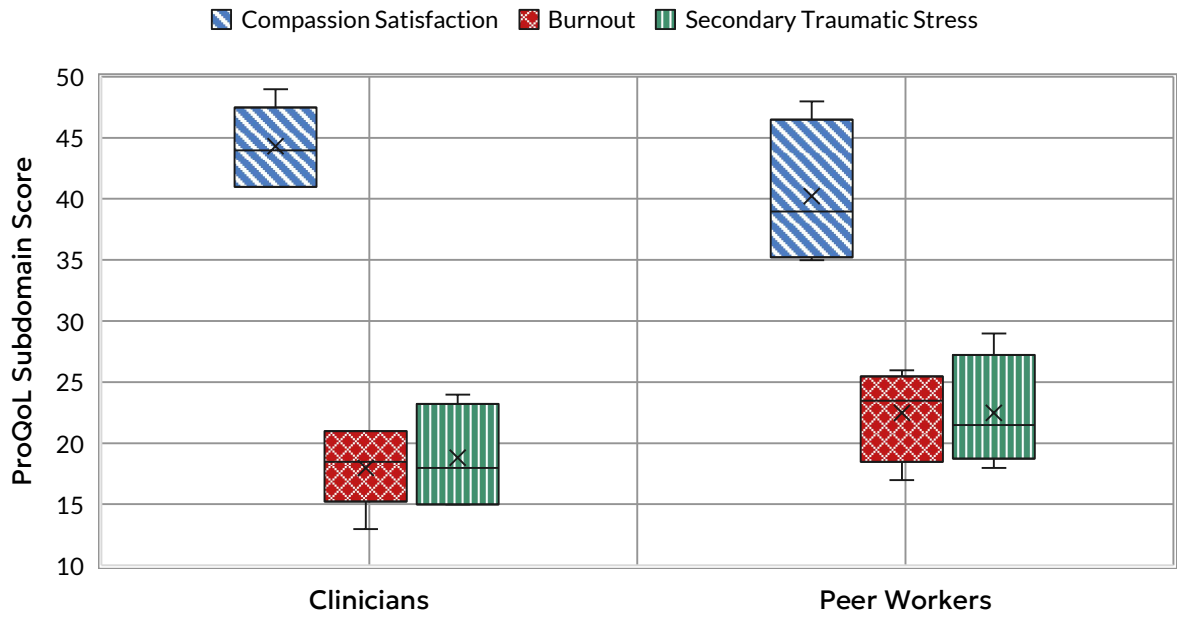
Staff participants completed the baseline *Professional quality of life measure* (Stamm, 2009) to assess work-related strengths and vulnerabilities. While the scale is not a diagnostic tool, it can be used to measure the impact of one's work on their wellbeing. Scores across each subscale (*Compassion satisfaction*, *Burnout* and *Secondary traumatic stress*) range from 10 to 50. Higher scores on the *Compassion satisfaction* subscale indicate greater satisfaction, and scores below 23 indicate a potential area of concern. Higher scores on the *Burnout* subscale suggest a higher risk of experiencing burnout, and scores above 41 are considered at-risk. Finally, scores above 43 on the *Secondary traumatic stress* subscale indicate a potential area of concern.

Figure 2 illustrates that staff participants reported moderate-to-high compassion satisfaction at baseline, with no participants scoring in the clinical concern range on any subscale. Peer workers tended to show slightly higher burnout and stress scores compared to clinicians, though still within the normal range. All staff completed the baseline measure with no missing data.

Overall, the baseline profile indicates that staff were well positioned to deliver the intervention, with no immediate risk signals. For broader implementation, the key consideration will be to proactively support peer workers, as even modestly elevated stress and burnout scores may become more pronounced

under increased service demand. Building in regular supervision and support mechanisms at the outset could mitigate this risk.

Figure 2. Baseline *Professional quality of life measure* subscale scores for staff participants at the South Australia and South Queensland sites (*n* = 10)



Note. *Compassion satisfaction*: higher scores indicate greater satisfaction, and scores below 23 indicate concern. *Burnout*: higher scores indicate greater risk of burnout, and scores above 41 are considered at-risk. *Secondary traumatic stress*: higher scores indicate greater risk, and scores above 43 indicate concern.

3.2. Staff training outcomes

Following recruitment, Open Arms staff participants received comprehensive training on Seeking Safety. Staff participants were asked to provide both quantitative and qualitative feedback following training.

3.2.1. Standard Seeking Safety training quantitative feedback

Participant feedback on the second iteration of standard Seeking Safety training content, before and after the training, is depicted in Figure 3 (clinicians) and Figure 4 (peer workers). Completed responses were provided by all of the participants in attendance. The results demonstrate a positive trend in perceived overall knowledge, comfort level and ability to implement the model after completing training. While the sample size was too small to support statistical comparison, descriptive results indicate that clinicians scored, on average, higher than peer workers across these domains following training.

Figure 3. Average Seeking Safety training content feedback scores (clinicians; *n* = 6)

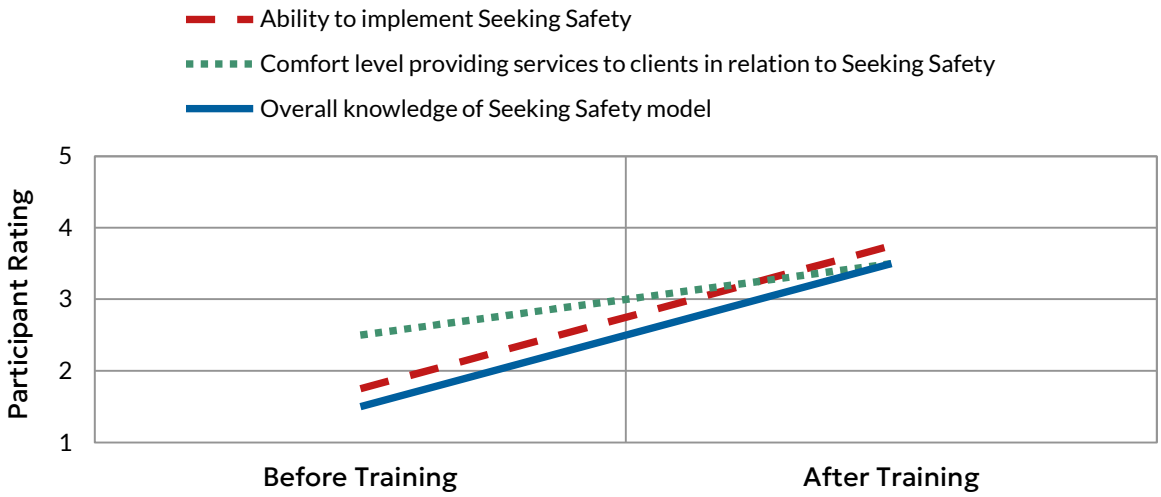


Figure 4. Average Seeking Safety training content feedback scores (peer workers; *n* = 4)

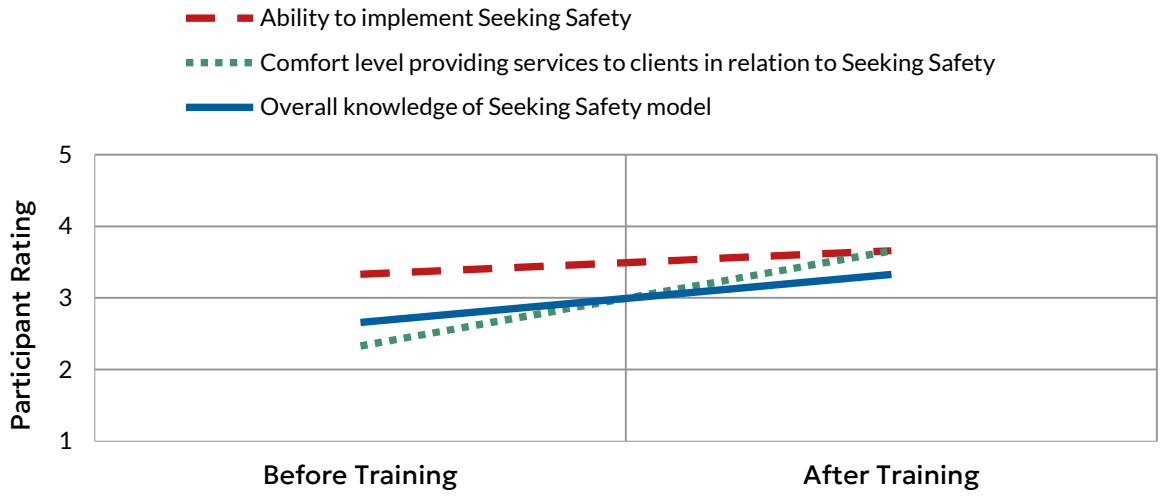


Table 3 summarises staff participant feedback regarding the delivery of the second iteration of Seeking Safety training. Overall, peer workers rated the training delivery lower compared to clinicians. Additionally, of the 7 participants that provided feedback, 50% (*n* = 2) of clinicians and 66.6% (*n* = 2) of peer workers reported having received Seeking Safety training in the past. No participants reported previously delivering the model to clients.

Table 3. Seeking Safety initial training delivery feedback

Training feedback question	Clinicians (*n* = 4) *n* (%)	Peer workers (*n* = 3) *n* (%)
How comfortable did you feel asking questions?		
Not at all	–	–
A little bit	–	–

Training feedback question	Clinicians (*n* = 4) *n* (%)	Peer workers (*n* = 3) *n* (%)
Moderately	–	–
Quite a bit	2 (50.0)	3 (100.0)
Extremely	2 (50.0)	–
To what extent did you feel you understood all of the material presented?		
Not at all	–	–
A little bit	–	1 (33.3)
Moderately	–	–
Quite a bit	3 (75.0)	1 (33.3)
Extremely	1 (25.0)	1 (33.3)
How satisfied were you with the material covered during the training?		
Not at all	–	–
A little bit	–	–
Moderate	–	1 (33.3)
Quite a bit	3 (75.0)	2 (66.6)
Extremely	1 (25.0)	–
Did you find the amount of material covered during the training…		
Too little	1 (25.0)	–
Just the right amount	3 (75.0)	2 (66.6)
Too much	–	1 (33.3)

3.2.2. Standard Seeking Safety training qualitative feedback

Of the 7 Open Arms staff members who provided feedback, 3 clinicians and 2 peer workers provided qualitative responses. The majority of feedback was operational in nature: for example, clarification on facilitator roles (i.e. clinicians vs peer workers), communication obstacles between the GMR research team and Open Arms staff, and obtaining physical access to supplementary training materials. Both peer workers also indicated that access to a local community resource sheet would be beneficial when facilitating Seeking Safety with real clients. Some clinicians highlighted the benefit of role-play practice and suggested that additional opportunities for in-person practice would be 'highly advantageous'. Further, one clinician highlighted their appreciation for the structured format of Seeking Safety, which 'ensures safety for all involved'.

3.2.3. Experiential practice quantitative feedback

Four supplementary experiential practice sessions were offered to staff participants. The sessions were delivered from November 2024 to February 2025, with a total of 7 out of 8 staff members attending at least 2 sessions. Session attendance ranged from 6 to 7 attendees per session. Staff participants were asked to provide both quantitative and qualitative feedback following the sessions. Completed responses were provided by 2 clinicians and 3 peer workers.

Participant feedback in relation to experiential practice content is shown in Figure 5 (clinicians) and Figure 6 (peer workers). The results demonstrate a generally positive trend in perceived overall knowledge, comfort level and ability to implement the model after completing experiential practice.

Of the 5 staff members who provided feedback, 3 respondents (1 clinician and 2 peer workers) provided qualitative responses. Similar to the initial training feedback, the majority of feedback was operational in

nature. However, participants described the experiential practice sessions as 'highly valuable' and the trainer as 'fun, energetic, passionate, and knowledgeable', and described greater familiarity with the Seeking Safety format and topics.

In addition, clinicians rated both their interest in delivering Seeking Safety to real clients and confidence in group facilitation as *quite a lot* ($n = 2$). Peer workers rated their interest in delivering Seeking Safety as *quite a lot* ($n = 1$) and *moderately* ($n = 2$). Peer workers provided mixed ratings of their group facilitation confidence as *extremely* ($n = 1$), *moderately* ($n = 1$) and *a little* ($n = 1$).

Further, participants were asked to indicate if they felt they needed further Seeking Safety training before delivering Seeking Safety to real clients. All clinicians reported not requiring additional training, and 66.6% of peer workers ($n = 2$) indicated additional training needs.

Figure 5. Average participant ratings before and after experiential practice (clinicians; $n = 4$)

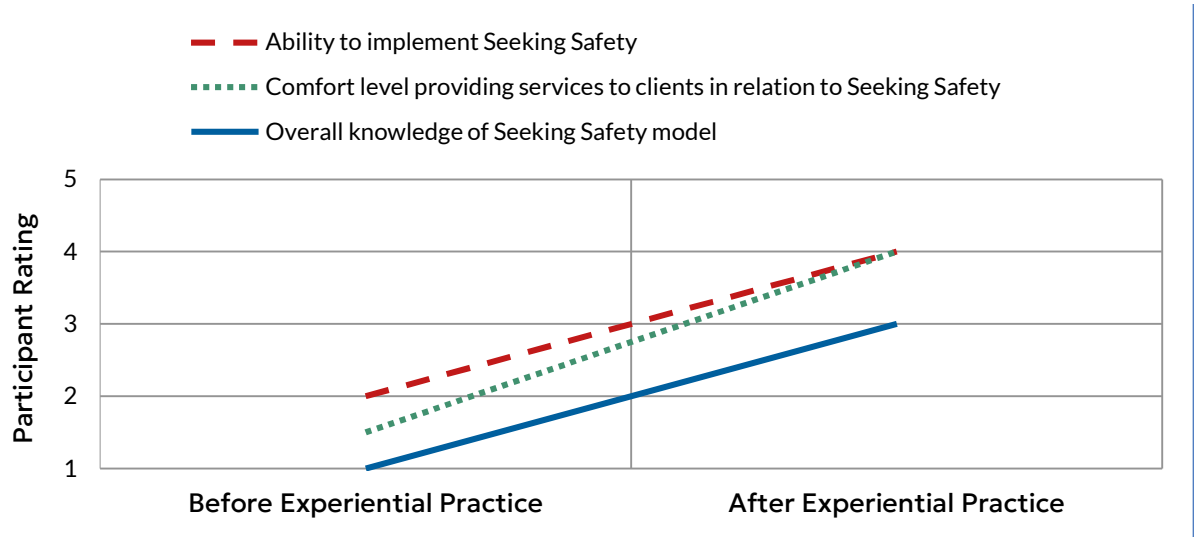
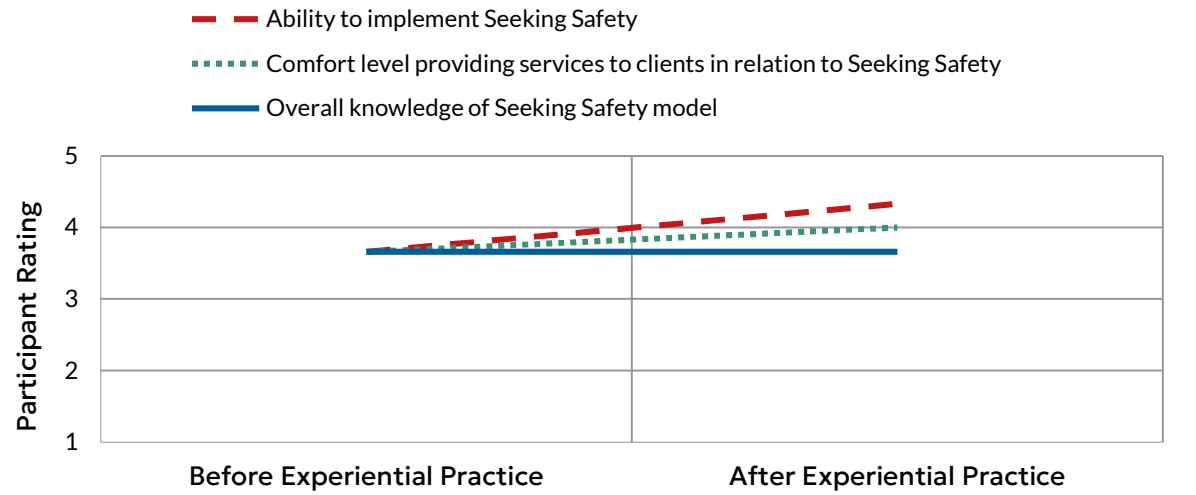


Figure 6. Average participant ratings before and after experiential practice (peer workers; $n = 3$)



3.2.4. Experiential practice qualitative feedback

Qualitative data from the focus groups were analysed thematically using the overarching thematic framework developed for the pilot project (see Section 3.5.2). While the full framework comprised 6 main themes, only 1 was represented in the post–experiential session discussions: facilitator preparation and support. Staff participants reflected on their current feelings about delivering Seeking Safety, framed by the overarching goal of experiential practice to enhance their knowledge, confidence and preparedness for real-world implementation.

Several participants expressed varying degrees of comfort and confidence, with some stating explicitly, 'I have no problems with delivering', or describing themselves as 'probably overconfident …'. However, some participants recognised that they still had room to develop their skills.

Experiential session quality and impact

Participants generally expressed positive experiences with the experiential sessions, noting that the hands-on elements contributed significantly to their knowledge and confidence. As one participant reflected, their confidence had risen:

> a lot higher than I suppose, when we originally began … but since … we've seen [the trainer] give examples of how it's presented … I would say if we're using a scale out of 10, initially I was a 1 out of 10 … and now I'm hovering around a comfortable 7.

Practice-based learning and observational opportunities were particularly valued:

> [As a] prospective facilitator for this program … I suppose watching it done in real-time gives me a lot of confidence.

Participants appreciated experiencing the program both as a facilitator and from the client perspective, noting that:

> as a participant, you get used to the format … [you are] part of the whole presentation, you've got a role to play in the Seeking Safety format … I can see value in it.

Interactive session elements, such as opportunities for reflection, discussion and clarification, were cited as strengths. For example, it was beneficial to:

> be able to take that second to kind of pause, check where we're at, rehash the check-in, rehash the check-out … check-in about where we're at and kind of go from that perspective.

Overall, these reflections underscore the value of experiential practice in building facilitator confidence, deepening understanding of the model and fostering the skills necessary for effective and flexible delivery of Seeking Safety.

Group facilitation as a distinct skill

Some participants consistently identified group facilitation as a distinct and learned skill that required ongoing professional development, reflection and dedicated practice. As one participant emphasised:

> the more you do it, the [better] you get at it, the more confident you are, and then you can deal with … a range of presentations.

External factors, particularly the needs and dynamics of the group itself, were seen as equally significant:

> I think often it comes down to the group sometimes … those notable bad days are when you just really have a group that doesn't want to engage and you can't really control that.

Facilitators described the complexity involved in managing group spaces, particularly when working with clients who had varied needs and personalities, noting the advanced skill required to adjust delivery in real time. Importantly, participants recognised the need to tailor session content and delivery style in response to the unique characteristics and needs of each group, with one stating:

> I just get the feeling that it just might take some reframing of the languaging [sic] in the facilitation space to help [veteran clients] make that connection.

These insights highlight that effective group facilitation is a dynamic and multifaceted skill, requiring continuous learning, adaptability and responsiveness to both individual facilitator capacities and the evolving needs of diverse client groups.

Additional experiential practice preferences and recommendations

Participants identified areas for improvement in the experiential practice. A common sentiment was the desire for more role-play opportunities. However, participants acknowledged that time constraints and competing work demands posed barriers. Additionally, the experiential practice sessions precluded opportunities to observe the management of difficult or emotionally heightened clients in real time. It was suggested that there would be value in:

> maybe giving a kind of example of what it would be like to manage a really distressed individual in the group. Say something pops up regarding their post-traumatic stress, anxiety, whatever … and just kind of see how that's managed in real-time.

Finally, participants expressed a desire for practical, skills-based training – such as role-plays with experienced trainers providing feedback – to strengthen their abilities and confidence:

> I think that's probably the next step, in terms of improving their confidence, actually delivering it with [the trainer] there to provide feedback.

This need was seen as especially critical for adapting facilitation style to different delivery formats, as in-person group facilitation was perceived as posing unique challenges in comparison with online formats.

Collectively, staff reflections highlight the importance of expanding experiential opportunities with focused, practical training to further build facilitator confidence and competence, particularly in managing complex group dynamics.

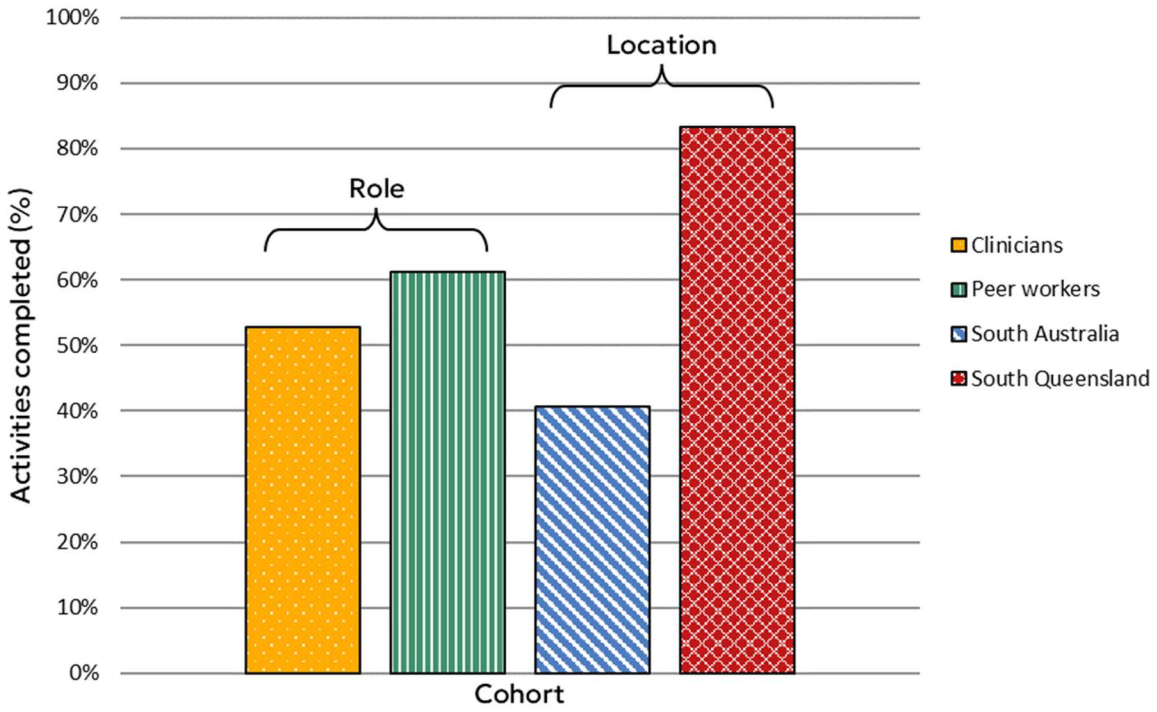
3.2.5. Seeking Safety *Learning guide checklist* feedback

Following experiential practice, additional feedback was obtained regarding the overall helpfulness of the LGC (Najavits, 2024), and qualitative feedback was obtained regarding which aspects of the LGC were most and least helpful, along with any obstacles that prevented staff from completing the learning activities. Finally, participants were asked to indicate how many hours of one-on-one optional role-play sessions they completed and which LGC activities they completed.

When asked to rate how helpful staff found the LGC (Najavits, 2024), 40% (n = 2) responded with *neutral*, 20% (n = 1) responded with *somewhat helpful*, and 40% (n = 2) responded with *greatly helpful*. Overall, peer workers rated the LGC as more helpful than clinicians.

Qualitative feedback indicated that the most helpful aspects of the LGC (Najavits, 2024) were its structure (n = 2), clear instructions (n = 1) and the inclusion of links and topic guides (n = 1). The least helpful aspect was the difficulty in accessing the LGC (n = 2). Time constraints was the most frequently reported barrier to completing LGC activities (n = 3). On average, clinicians and peer workers reported completing the same number of hours of one-on-one Seeking Safety role-play sessions (M = 2 hours). Figure 7 illustrates the total percentage of LGC activities completed according to cohort (clinicians vs peer workers) and research site (SA vs SQLD). The proportion of activities reported as completed ranged from 88.9% to 16.7%.

Figure 7. Proportion comparison of *Learning guide checklist* activities completed



3.3. Community resource book

For case management purposes, a user-friendly *Community resource book* was developed for both participating Open Arms sites to support the delivery of Seeking Safety. The book contained information related to local and national services that provide wellbeing support across domains such as housing, employment, justice and safety, finance, education, and social connection. The inclusion of community resources is a central component of the Seeking Safety model and is described in detail in 2 session topics: 'Introduction / Case management' and 'Community resources'. In the Seeking Safety book, some of the resources are specific to the US, and thus, one aspect of the tailoring on this project was to develop a list of local resources. Local supports – such as advocacy groups, non-profit organisations and self-help groups – play a vital role in case management and recovery. Consistent with the model's emphasis on practical supports, community resources aligned with each client's goals and needs are revisited during the check-in and check-out segment of every session (for example, a client experiencing domestic violence may be referred to a national domestic violence hotline). In the current study, these resources were circulated among staff participants and the research sites prior to commencing the intervention.

3.4. Client recruitment

Client recruitment outcomes across each Open Arms site are depicted in Figure 8. The outcomes suggest a generally good recruitment capacity and interest in the intervention across both sites. We were not able to recruit additional participants to meet our target sample of 16 due to the short time frame of this phase of the study and the closed group modality.

Figure 8. Client recruitment outcomes across research sites

Note. Enrolment target was 8 clients per site. Reasons for non-enrolment included medical reasons, current service member status, work commitments or no explanation provided.

The client cohort was predominantly male (77%) and aged 45 to 54 years (39%). Most participants reported past or current mental health diagnoses, with all 13 receiving individual treatment. Depression (85%), PTSD (69%) and anxiety (62%) were the most commonly reported conditions. Many were not currently working (39%) or classified as totally and permanently incapacitated (23%). All participants had previous ADF service, with 54% from the Army, 31% from the Air Force and 15% from the Navy. Most (85%) had been discharged for more than 5 years. More than half (54%) had deployed to combat zones, and 54% were medically discharged.

3.5. Peer-led Seeking Safety implementation

3.5.1. Acceptability and suitability of the intervention

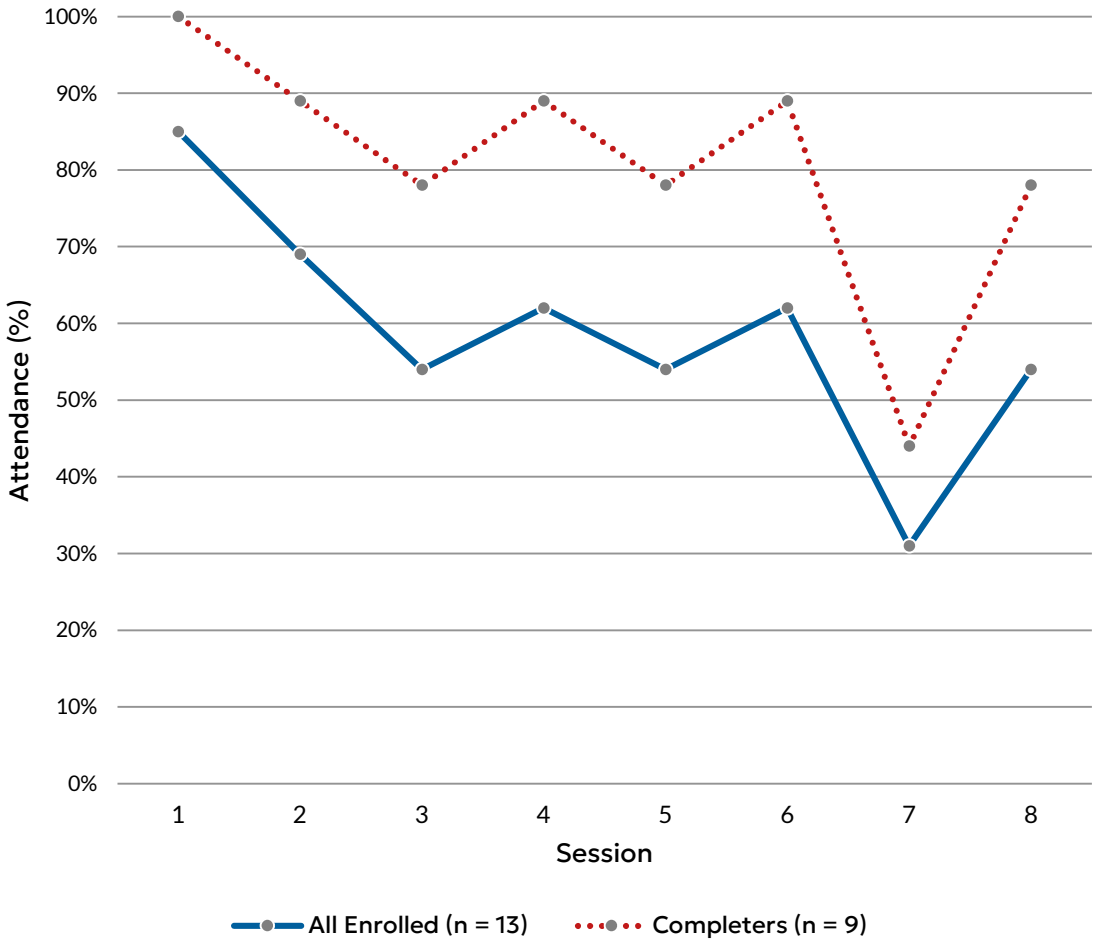
Clients' Seeking Safety attendance rates

A total of 13 clients enrolled in peer-led Seeking Safety (6 in SQLD, 7 in SA). Attendance across all participants averaged 58.6% of sessions (M = 4.69, SD = 3.01, range = 0–8 sessions). For analysis, 'completers' were defined as participants who did not formally withdraw and attended at least 3 sessions. Using this criterion, 9 participants were considered completers, with an average attendance rate of 80.5% (M = 6.44 sessions, SD = 1.51, range = 3–8 sessions).

Attendance among completers varied between sites: SQLD participants attended an average of 75% of sessions compared to 85% in SA. Two participants – one at each site – completed all 8 sessions. Reported reasons for non-attendance included illness (n = 8), competing priorities (n = 4), attending alternative treatment (n = 1) and being uncontactable before the session (n = 1). Overall, these attendance and retention rates are consistent with those reported in other Seeking Safety studies, according to which sustained participation can be challenging (e.g. Hien et al., 2012; Najavits et al., 2006).

Client session attendance across the 8-week intervention, both for all enrolled client participants and for completers, is shown in Figure 9.

Figure 9. Client participant attendance percentages per session across the 8-week intervention



Note. For analysis purposes, we considered 'completers' to be participants who did not officially withdraw and who completed at least 3 sessions.

Seeking Safety adherence scale ratings

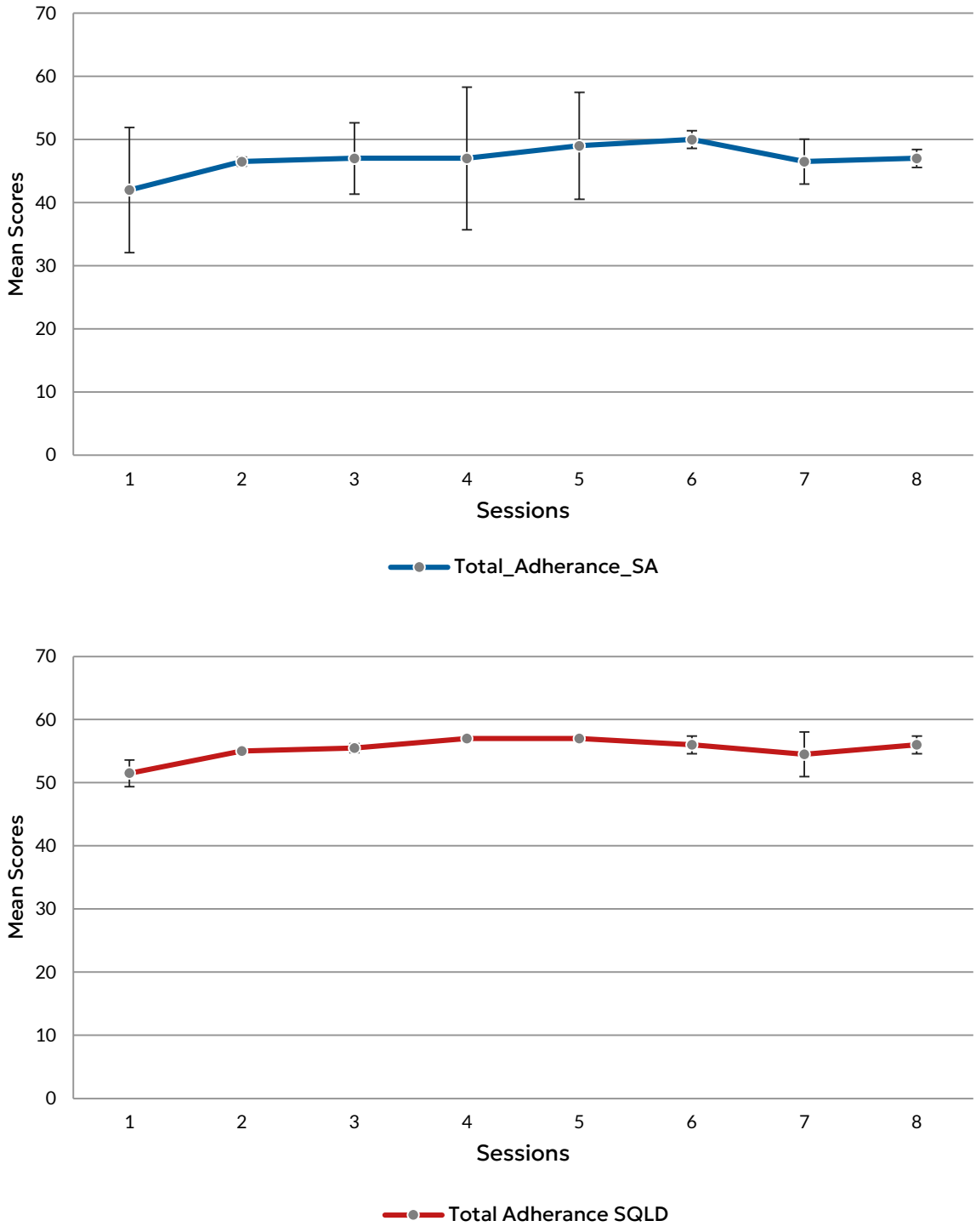
Self-reported session fidelity ratings were completed for 32 sessions (4 staff participants × 8 sessions). Subscale scores were computed from the *Seeking Safety adherence scale – brief version* by grouping items into the 2 parts of the scale: Part 1 (*Interventions*) and Part 2 (*Processes*). A total self-reported fidelity score was calculated by summing all 19 items per session, with possible total scores ranging from 0 to 57. The possible range is 0 to 27 for Part 1 and 0 to 30 for Part 2.

Across the 32 session ratings, mean self-reported fidelity was high (M = 51.09, SD = 5.84, range = 35–57). Site-level comparisons revealed slightly higher fidelity at the SQLD site (M = 55.31, SD = 2.09, range = 50–57) than at the SA site (M = 46.88, SD = 5.32, range = 35–55). The same trend was observed for Part 1 and Part 2 of the scale (Figure 10).

There is no published cut-off score for defining 'good fidelity' on the *Seeking Safety adherence scale – brief version*. Consistent with prior use (Najavits et al., 2007), a mean score of 2.0 or more per item indicates adequate fidelity. Based on this guideline, total fidelity scores of 38 and above (19 items), and subscale scores of 18 and above in Part 1 (9 items) and 14 and above in Part 2 (7 items), can be considered reflective of sufficient fidelity. All observed total and subscale scores met or exceeded these thresholds, indicating strong self-reported fidelity to the Seeking Safety model across both locations. Across the subscales (Part 1 and Part 2), scores for both sites were relatively stable over time, with

SQLD generally rating slightly higher than SA. Part 2 scores were consistently higher than Part 1 scores for both sites.

Figure 10. Mean self-reported fidelity and subscale scores by site across 8 sessions



Note. SQLD = South Queensland; SA = South Australia. Separate lines are used for total fidelity and both subscales for both sites. Standard deviation error bars are included for all scores to indicate session-level variability.

Seeking Safety feedback questionnaire – client participant feedback

Six client participants completed the SSFQ: 5 from SA and 1 from SQLD. Due to the small number of responses from SQLD, results are presented for the combined sample. Overall, the model was rated as highly helpful. The median rating for overall helpfulness was 6.0 (*SD* = 0.63, range = 5.0–7.0). Ratings for the model's helpfulness in addressing PTSD and substance use were similarly high (*Mdn* = 6.0, *SD* = 0.75, range = 5.0–7.0). Clients rated each of the 8 topics positively, with median ratings ranging from 6.0 to 6.5 across the board (Table 4).

Table 4. Client ratings on the topics delivered during the 8-week intervention

Topic	Mdn (SD, range)
Compassion	6.0 (0.75, 5.0–7.0)
Safety	6.5 (0.82, 5.0–7.0)
PTSD: taking back your power	6.5 (0.82, 5.0–7.0)
Detaching from emotional pain (grounding)	6.0 (0.63, 5.0–7.0)
Asking for help	6.0 (0.63, 5.0–7.0)
Healing from anger	6.0 (0.75, 5.0–7.0)
Coping with triggers	6.5 (0.82, 5.0–7.0)
Healthy relationships	6.0 (0.75, 5.0–7.0)

Note. Ratings from 6 client participants (1 in South Queensland and 5 in South Australia). Each topic was rated on a 7-point scale from 1 (*greatly harmful*) to 7 (*greatly helpful*), with higher scores indicating greater perceived benefit. Additional Seeking Safety topics not covered during the 8-week intervention were also rated by the client participants. As these topics were not part of the intervention, their ratings are not presented in this report.

Clients also rated specific components of the treatment's structure and delivery. Safety as the priority of treatment received a median rating of 7.0, at the top end of the scale (*SD* = 1.03, range = 5–7), and all other elements were also rated very highly. For example, other core elements – integrated treatment, focus on ideals and learning coping skills – each had a median rating of 6.5 (*SD* range = 0.55–0.98, range = 5–7). No treatment component received a median rating below 6.0 overall. Structural components of the model – such as the safe coping sheet, handouts, list of coping skills, written materials and core treatment concepts – also each had median scores of 7.0 (*SD* range = 0.84–1.30, range = 4–7), indicating strong engagement with the treatment content and format.

Participants rated 4 aspects of their experience with peer-led Seeking Safety using a scale from 0% (*not at all*) to 100% (*totally*). Overall, participants reported very high engagement. The median rating of how frequently they would use what they had learned in future was 85% (*SD* = 36.4, range = 10–100), and ease of understanding the treatment had a median rating of 99.5% (*SD* = 12.0, range = 70–100). Perception of the model's innovativeness had a median rating of 75% (*SD* = 34.0, range = 10–100), and the likelihood of recommending the model to others had a median rating of 100% (*SD* = 44.7, range = 0–100).

Open-ended questions

Several open-ended questions on the SSFQ invited participants to share their impressions of the model. While the small sample size (*n* = 6) and number of incomplete responses limit the potential for formal thematic analysis, the responses nonetheless offer insight into the overarching tone of feedback. Participants generally adjusted quickly to the treatment, with 50% of clients reporting they felt comfortable within the first week. Most participants appeared to value the structure and content of Seeking Safety.

When asked about the best and worst aspects of Seeking Safety, participants highlighted a range of positive aspects, including group connection, specific model components (such as the use of quotations)

and the practical coping strategies. Several participants commented on the need for more or longer sessions to better accommodate discussion and to cover the material in depth. This is addressed in regular clinical practice by conducting Seeking Safety topics over more than just one session, as described in Chapter 2 of the treatment manual; however, in the context of this pilot project, this was not possible.

The use of telehealth delivery was also suggested by some participants. Seeking Safety has been conducted in a telehealth format for over 20 years, but this was not part of the current study design. Views on whom the model may be especially helpful for were largely inclusive, with multiple respondents noting it could benefit anyone experiencing trauma or addiction.

Seeking Safety Feedback Questionnaire – staff participant feedback

Four staff members (2 clinicians and 2 peer workers, one of each from SA and SQLD) completed the SSFQ. Topic ratings are presented in Table 5. The overall helpfulness of Seeking Safety was rated extremely positively, with a median of 7.0 (*SD* = 0) across all 4 participants. Helpfulness in addressing PTSD and substance use was also highly rated, with a median rating of 7.0 (*SD* = 0.50, range = 6.0–7.0). All 8 topics were also rated extremely positively, with a median rating of 7.0 for each.

Table 5. Staff ratings of Seeking Safety topics

Topic	*Mdn* (*SD*, range)
Compassion	7.0 (0.00, 7.0–7.0)
Safety	7.0 (0.00, 7.0–7.0)
PTSD: taking back your power	7.0 (0.00, 7.0–7.0)
Detaching from emotional pain (grounding)	7.0 (0.50, 6.0–7.0)
Asking for help	7.0 (0.00, 7.0–7.0)
Healing from anger	7.0 (0.50, 6.0–7.0)
Coping with triggers	7.0 (1.50, 4.0–7.0)
Healthy relationships	7.0 (0.00, 7.0–7.0)

Note. Ratings from 4 staff (2 in South Queensland and 2 in South Australia). Each topic of the intervention was rated on a 7-point scale from 1 (*greatly harmful*) to 7 (*greatly helpful*), with scores of 1 to 3 indicating a level of harm, 4 being neutral, and 5 to 7 indicating a level of helpfulness. Nine topics in total were delivered. In addition to those in this table, the 'Introduction / Case management' topic was delivered in Week 1 alongside 'Compassion'; the *Seeking Safety feedback questionnaire* does not elicit ratings for this topic.

Other praised elements included safety as a priority, integrated treatment, focus on learning coping skills, community resources, use of quotations, handouts, the check-in and check-out structure, homework, the list of safe coping skills, the safe coping sheet, length of treatment, the amount of written material provided, and the structured approach. All were rated highly, with median scores of 7.0, standard deviations of 0.0 to 1.0, and score ranges from 6 to 7.

Staff participants rated 4 aspects of their experience with the Seeking Safety model using a scale from 0% (*not at all*) to 100% (*totally*). Feedback was positive across all items (most rated 90%, and one rated 80%). The median rating for how frequently staff would use what they had learned in the future was 80% (*SD* = 20.6, range = 50–100). The ease of understanding the treatment had a median rating of 90% (*SD* = 11.5, range = 80–100), and perceptions of the model's innovativeness were also high (*Mdn* = 90%, *SD* = 14.1, range = 60–90). Staff likelihood of recommending the model had a median rating of 90% (*SD* = 15.0, range = 70–100). The results suggest relevant professional acceptability of Seeking Safety.

Staff also reflected on how long it took them to feel comfortable delivering the model. Three staff indicated they became comfortable within 2 weeks; however, one clinician reported that it took around 6 months, attributing their eventual comfort to the valuable supervision and training. This suggests

quite a range of variability in the level of training and ongoing support needed to build facilitator confidence.

Open-ended questions

In answers to the open-ended questions, several strengths of the model were highlighted, including its clear structure, predictability and ability to foster group cohesion and mutual understanding. The format was viewed as empowering, with practical tools like the *Safe coping skills* checklist and quotations stimulating 'light bulb moments' for clients. No concerns were reported with the treatment content or delivery – reported challenges related to pre-intervention clarity and administrative burden, which may have contributed to attrition.

Recommendations for improving implementation included broadening the range of session topics to include those such as 'Setting boundaries in relationships' and 'Respecting your time' and extending session durations from 90 minutes to 2 hours to allow for deeper discussion and reflection. Staff emphasised the need for flexibility in intervention length and topic selection to meet diverse group needs, suggesting a core set of mandatory topics with optional additions. All of these suggestions fit within the inherent flexibility of Seeking Safety. The model was considered helpful for individuals with trauma and substance use issues. Staff highlighted that the model offered value to clients who lacked a sense of community or belonging or who would benefit from a safe and supportive space to explore trauma-related themes. While Seeking Safety is suitable for a wide range of groups, additional staff training may be required for use with individuals experiencing acute suicidality or high-risk concerns; nevertheless, the model was specifically designed for such clients, and efficacy studies have shown positive outcomes in high-risk populations (Najavits & Hien, 2013; Sherman et al., 2023). Additional feedback called for better promotion, enhanced communication between GMR and Open Arms leadership, and adapting resources to suit group preferences and dynamics.

3.5.2. Focus group feedback following intervention

Post-intervention qualitative feedback was gathered from staff focus groups in SQLD and SA, providing detailed insights into the delivery and perceived impact of peer-led Seeking Safety. Thematic analysis of the focus group data identified 6 overarching themes, as summarised in Table 6. Once these themes were established, further analysis was undertaken to explore which themes directly informed the acceptability and suitability of the intervention for veterans. This mapping process resulted in 3 cross-cutting domains:

1. acceptability and suitability of the intervention for veterans
2. implementation enablers and barriers
3. suggestions for adaptation.

We begin this section by presenting the findings within these 3 domains, as they provide targeted insight into the model's relevance, safety and engagement potential, along with practical considerations for future delivery. The findings within these domains highlight observations on client engagement, psychological safety in veteran peer groups, and ways the model could be refined to improve its relevance, delivery and sustainability. Following this, we detail the themes generated from the initial thematic analysis.

Table 6. Key themes and their descriptions from the reflexive thematic analysis

Theme	Description
Model design and fit	Examines how the model's structure, delivery and therapeutic framing meet veterans' needs and differentiates it from other interventions. Highlights the balance of structure and flexibility, the strengths-based and empowering approach, practical delivery considerations, relevance to veterans, and contrasts with typical peer worker programs.

Theme	Description
Client engagement and safety	Explores how clients engage with the model and the factors that support or challenge a safe, engaging group experience, including client-led participation, facilitator management of group dynamics and the importance of clear peer worker role boundaries.
Cultural and contextual appropriateness	Assesses the cultural suitability of Seeking Safety for Australian veterans, focusing on the influence of shared military experiences on group dynamics, the relevance of language and materials, and the cultural alignment of trainers or model developers.
Facilitator preparation and support	Examines facilitator preparedness, highlighting peer workers' skills, training, confidence and emotional readiness; perceptions of training quality; recognition of facilitation as a distinct skill; and dynamics of co-facilitation.
Implementation factors	Addresses organisational and structural factors influencing effective delivery of the model, including leadership support; facilitator capacity; training infrastructure; and supporting systems for coordination, communication, recruitment and safety.
Intervention reach and scalability	Highlights discussions on expanding, adapting and embedding Seeking Safety across diverse settings, formats and audiences, with an emphasis on future potential and strategic growth beyond immediate implementation logistics.

Acceptability and suitability of the intervention for veterans

Staff participants consistently highlighted Seeking Safety's structure and flexibility as features that aligned well with veteran preferences. The model's structured nature was seen as particularly helpful for ex-serving members, who are 'very oriented to structure … very oriented to process'. This structure, when combined with flexibility to adapt topics to client needs, was seen as a strength:

> I liked that each week, it was guided by the clients … depending on what was going on for each person, they could spend more time on this or less.

The model's recovery-oriented, strengths-based focus was also valued, particularly in validating trauma without dwelling on it, encouraging veterans to focus on coping. Others noted how the peer-led nature promoted engagement and made clients feel understood: 'it's coming from another person that has walked that line'. This peer worker context fostered a sense of mutual understanding, camaraderie and trust, which was seen to enhance safety and cohesion:

> … common link of service … everyone felt welcomed … the clients really supported each other.

There was mixed feedback regarding the cultural fit of materials. Some participants noted that elements of the manual required adaptation to better suit the Australian context. Despite these observations, the majority of the materials were viewed as culturally appropriate and relevant. From an implementation standpoint, staff participants felt the model fit well with existing services and added value: 'I think it's an awesome fit. I think it'll complement our suite of services already', and 'there's a whole bunch of new stuff that we can use in different ways'.

Overall, feedback across themes suggested that the Seeking Safety model – particularly its structured format, peer-led delivery, strengths-based content and adaptability – was considered acceptable and culturally suitable for the veteran population by staff members.

Implementation enablers and barriers

Several factors were identified as critical to the successful implementation of the Seeking Safety model, particularly around organisational support, screening practices and alignment with existing service structures. Organisational support was as an important enabler for implementation. Leadership engagement was seen as essential to ensure the model was prioritised and resourced appropriately:

> The key factor would be the organisational support and the time. I think prioritising that time will make this work.

The need for leadership to offer resources and structure was emphasised, in addition to clear messaging to reinforce the importance of the model, highlighting the need for sustained commitment, appropriate training and effective communication to support delivery.

Implementation was also hampered by administrative challenges; however, many of these were linked to the logistics and additional burden of the pilot project rather than the Seeking Safety model itself, highlighting the importance of refining project processes and communication structures in future pilots to support smoother implementation and greater engagement from staff and clients.

Finally, participants emphasised that, for the model to succeed in future implementations, it should be delivered to clients who are most suited to group-based programs and group dynamics, unless the model is delivered as individual sessions, which is also a regular format for Seeking Safety, especially those who are averse to groups or cannot attend for practical reasons such as scheduling. It would also be useful to offer clients the Seeking Safety '3-session tryout' that is emphasised by the developer as a strong engagement method; it allows clients to attend up to 3 sessions to see if they like the model without feeling that they need to continue beyond that. This 3-session tryout was not possible in our pilot study but is possible in routine clinical implementation. Importantly, participants suggested that pre-screening and clinician involvement should be incorporated to ensure that clients are adequately informed about the intervention and that group safety and cohesion are maintained. This was considered especially critical for groups held offsite, where participants may be more vulnerable and require immediate support:

> Offsite, definitely. I think we need to have 2 staff members, because sometimes clients just up and leave. And it's just too triggering for them, and they need space to get out. So, we need to ensure that they're okay and we're checking in on them.

Suggestions for implementing Seeking Safety within Open Arms

Open Arms considerations

Participants offered several suggestions to enhance the implementation of Seeking Safety within Open Arms. The importance of clients having access to clinical support during the intervention was noted. Several participants also noted the need for 'more flexibility with advertising', suggesting this could help in 'securing clients'. Widening the scope of participation to include others closely connected to the veteran experience – such as transitioning personnel or family members – while maintaining the core intent of veteran peer worker delivery, was also suggested. Regarding group dynamics, most participants agreed against mixing veterans and family members in the same group. However, others noted potential for expanding group participation with improved outreach and promotion:

> There is that potential there for some additional people to attend that group in the future with a bit more outreach of our marketing and getting the program out there to the wider community, and we'd probably have enough to fill a group.

There were also suggestions regarding adjusting the parameters that were constrained by the design of this pilot project. Alternatives to the 8-week format were proposed, including longer or more flexible delivery, such as rolling, drop-in format or 'a couple of days intensive program rather than once a week' to reduce attrition rates. Several participants also highlighted the need to deliver sessions in suitable venues: spaces that were both accessible and private. From a logistics standpoint, participants also emphasised the importance of contingency planning and flexibility in delivery, such as allowing clinicians to facilitate when peer workers are unavailable:

> I think having the flexibility that, if a clinician wanted to step up, they could, would be useful as well.

Finally, with regard to intervention reach and scalability, participants suggested implementing a wider range of delivery formats at Open Arms, such as telehealth or one-on-one sessions:

> using the same content, same structured sessions in [a] 1-on-1 setting, and treating that one participant as a group and not changing anything.[2]

Seeking Safety considerations

Some suggestions centred on alternative language and framing. This is consistent with the philosophy of Seeking Safety, according to which staff are encouraged to use examples and language specific to their population. Participants proposed altering the model's title to 'make it more approachable',[3] drawing upon examples from the US, where model names have been adapted to resonate with specific demographics. Use of 'some kind of … military slang to it … giving it a bit more familiarity' was suggested. Another suggestion proposed reframing material for veterans, including playful ideas like renaming exercises 'safe coping for switched-on digs'.

Staff participants called for a clearer definition of facilitation and for training and noted the importance of mock sessions and co-facilitation to build confidence. Suggestions included developing a robust training model, tailored to the needs of Open Arms staff – particularly with Australia-based trainers – and improving instructional resources, as existing videos were described as inadequate as a standalone training for peer worker facilitators. One peer worker expressed appreciation for having a model like Seeking Safety that allowed peer workers to contribute in meaningful ways:

> having something that's kind of peer-led really – it's something that I'm grateful for … something else that a peer can do within the organisation.

Six overarching themes from focus group feedback

In this section, a summary of the findings across the 6 identified themes is presented.

Model design and fit

Staff greatly valued the peer-led Seeking Safety model for its ability to foster a safe, supportive and recovery-oriented environment, empower peer workers in meaningful leadership roles, and offer accessible, well-structured sessions that provided predictability and flexibility to meet diverse client needs:

> It was so good to see peers stepping up and leading the group, and I think it really helped create safety of the group.

The model's strengths-based, recovery-oriented, focused approach was seen as empowering and highly relevant for veterans, supporting coping, resilience and present-focused safety:

> For ex-serving members, [it] would be that structure: being able to know what you're going to be going through that day.

Both staff and client feedback reinforced the model's positive impact, with some peer workers already integrating Seeking Safety skills into their broader practice.

Client engagement and safety

Staff described the client-centred design as empowering, flexible and effective in fostering engagement and recovery, with group members quickly taking ownership of sessions and benefiting from peer worker support and agency in their recovery journeys:

> just listening to them share their own ideas with each other, to help each other with things that they have tried … using the concepts that we'd learnt in the session to support each other.

---

[2] Telehealth and individual sessions are already established formats of Seeking Safety. The model was originally designed for either an individual or group modality, and its evidence base includes both. Telehealth delivery has also been implemented successfully for many years. Implementation at Open Arms would therefore not require adapting the model itself but rather supporting these delivery options within service processes.

[3] Alternative titles that are already established (e.g., part of the initial training slides) include 'Seeking strength' and 'Strength through safety', which may be especially relevant for veteran populations.

Facilitators described managing group behaviour as a complex but valuable skill that improved with experience. Effective management was linked to maintaining focus, redirecting sensitively and drawing on smaller group sizes to support safety and cohesion. Maintaining professional boundaries and ensuring careful pre-screening were seen as central to group safety and success.

Cultural and contextual appropriateness

Staff gave key insights into the implementation of Seeking Safety for Australian veterans. Some elements of the manual were seen as US-centric and in need of adaptation for Australian veterans. Suggested changes included reframing language, using military terminology and considering alternative titles for the intervention to improve resonance and acceptance. A shared military background among participants was identified as a powerful binding factor, fostering trust, cohesion, meaningful insights, openness and a sense of safety within groups:

> that rapport that's built through that lived experience has such great value in helping people to have that 'ah-ha' moment … I'm excited to see this move forward.

Facilitator preparation and support

Staff reported that training and ongoing support were essential for building confidence, particularly for peer workers, and valued the resources and experiential practice provided:

> I just had full confidence because I knew that … the training and support that was provided … any one of these other guys could've just stepped in

Challenges identified included unclear training structure, limited guidance on tailoring the model for Australian veterans and insufficient opportunities to observe sessions before leading them. Participants emphasised that facilitation is a distinct and underestimated skill requiring dedicated development and ongoing training, as quality facilitation is critical to client outcomes, and poor management of group dynamics could undermine the client experience.

Implementation factors

Staff highlighted several operational and structural factors affecting the delivery of Seeking Safety. Early challenges included communication difficulties, heavy survey demands and fluctuating group size, though these were expected to be less significant outside the research context. Flexible scheduling, enhanced recruitment strategies and leadership buy-in were seen as critical to successful implementation. Participants emphasised the value of organisational commitment and tailoring training for Australia to ensure sustainability, fidelity and national rollout:

> if it's expanded out and all the regions ran it … I think it could really open up some opportunities, and I think it would be well received, particularly by the clients and … by the peer workers.

Intervention *reach and scalability*

Staff reflected on practical barriers to scalability, such as the difficulty of sustaining an 8-week program, recommending alternative formats like shorter intensive programs or open groups with rotating topics. Group sizes of 6 to 8 were suggested, with careful attention to room selection and access for privacy. Extending the program to current-serving members and family was viewed as beneficial, though staff stressed the need for separate groups to ensure safety and relevance:

> I think it could be helpful to open it up a bit, see how it works with other family members.

3.5.3. Quantitative data on client outcomes

Preliminary client responses to the intervention data were collected at 3 time points – pre-intervention, mid-intervention (Week 4) and post-intervention (Week 8) – using a repeated battery of psychosocial measures: AQoL-8D, DASS-21, PCL-5, BAM-R, CSES and SCS-SF. At baseline, all 13 enrolled participants completed the full assessment battery. At mid-intervention, all 10 remaining participants

completed the survey battery, with no missing or unusable data. However, post-intervention, completion rates declined, with just 6 clients completing the full battery (all 5 clients in SA and 1 of 4 in SQLD). Given the small sample sizes, medians and interquartile ranges were reported to better capture central tendency and variability while minimising the influence of outliers.

Baseline profile of client participants

The AQoL-8D assessed multidimensional health-related quality of life, and participants recorded low utility scores (*M* = 0.38, *SD* = 0.15, range = 0.22–0.66) consistent with moderate-to-severe psychosocial impairment, particularly in the *Mental health* and *Self-worth* domains. Results of the DASS-21 indicated elevated symptoms (severe to extremely severe) across the subscales of *Depression* (*M* = 35.1, *SD* = 12.26, range = 18.0–54.0), *Anxiety* (*M* = 27.8, *SD* = 8.46, range = 16.0–40.0) and *Stress* (*M* = 33.8, *SD* = 7.94, range = 20.0–44.0). The PCL-5 showed high PTSD symptom severity (*M* = 63.2, *SD* = 19.30, range = 31–89), well above the commonly used cut-off score of 31 to 33 for probable PTSD (Weathers et al., 2013). BAM-R was used to gauge substance use, risk and protective factors, with substantial variability in use (*M* = 16.92, *SD* = 14.43, range = 1–44), risk (*M* = 50.2, *SD* = 16.97, range = 22–81) and protective factors (*M* = 27.5, *SD* = 13.93, range = 10–57). The CSES assessed participants' perceived ability to cope with distress, with higher scores suggesting stronger coping self-efficacy. Participants recorded a moderate level of coping self-efficacy (*M* = 123.5, *SD* = 67.79, range = 53–260). Finally, results of the SCS-SF suggested moderate levels of self-compassion (*M* = 2.83, *SD* = 0.98, range = 1.17–4.58; Neff, 2003). Overall, these baseline data indicated diverse clinical profiles within the sample and support the need for flexible intervention approaches.

Quantitative outcome measures

Note: Importantly, due to the small sample size and data loss over time – both of which are common in pilot studies – the results in this section should be viewed as indicative trends and preliminary effect size estimates to inform future, larger-scale studies

Descriptive statistics are presented to illustrate trends in outcomes across time points. Table 7 presents the median scores and interquartile ranges for each outcome measure across the 3 time points, based on the available sample at each stage. It is presented solely descriptively here but not formally interpreted for the reasons stated above. Note that the most meaningful information is pre-intervention to mid-intervention when the sample size was largest. The consistent pattern from pre-intervention to mid-intervention was a decrease in symptoms (all 3 subscales of DASS-21, and the *Substance use* and *Risk* subscales of BAM-R), accompanied by improvements in broader wellbeing and coping measures (AQoL-8D, CSES and SCS). No measure indicated worsening from pre-intervention to mid-intervention.

Table 7. Medians and interquartile ranges for outcome measures at each time point

Measure	Pre-intervention (n = 12)	Mid-intervention (Week 4; n = 9)	Post-intervention (Week 8; n = 6)
AQoL-8D utility	0.4 [0.3–0.5]	0.5 [0.3–0.6]	0.3 [0.2–0.6]
DASS-21 *Depression*	31.0 [25.0–44.0]	26.7 [19.5–43.0]	35.0 [16.0–40.0]
DASS-21 *Anxiety*	28.0 [21.0–36.0]	22.0 [19.0–31.0]	28.0 [20.0–36.0]
DASS-21 *Stress*	32.7 [28.0–41.0]	28.0 [21.5–31.0]	32.0 [26.0–38.0]
PCL-5 total	65.5 [46.0–80.5]	49.0 [35.5–71.5]	49.0 [33.0–78.0]
BAM-R *Substance use*	11.0 [4.67–22.0]	7.3 [1.7–16.5]	5.7 [3.3–20.0]
BAM-R *Risk*	51.0 [36.0–63.0]	38.0 [31.5–43.5]	42.0 [29.0–53.0]
BAM-R *Protective factors*	33.0 [14.0–36.5]	22.0 [13.2–43.2]	31.0 [18.0–37.0]
CSES total	102.5 [78.0–182.5]	156.0 [111.0–180.2]	132.5 [101.0–195.0]
SCS-SF total	2.6 [2.0–3.4]	3.0 [2.5–3.5]	2.9 [2.9–4.0]

Measure	Pre-intervention (n = 12)	Mid-intervention (Week 4; n = 9)	Post-intervention (Week 8; n = 6)
SCS-SF level	1.9 [1.2–2.6]	2.1 [1.5–2.7]	2.3 [–2.8]*

Note. AQoL-8D = *Assessment of quality of life – 8 dimensions*; DASS-21 = *Depression anxiety stress scale-21*; PCL-5 = *PTSD checklist for DSM-V*; BAM-R = *Brief addiction monitor – revised*; CSES = *Coping self-efficacy scale*; SCS-SF = *Self-compassion scale – short form*. Higher scores on the DASS-21 subscales, PCL-5 and BAM-R *Substance use* and *Risk* subscales indicate greater symptom severity or worsening. Higher scores on the AQoL-8D utility, BAM-R *Protective factors* subscale, CSES and SCS-SF indicate improvement in wellbeing, coping or protective factors.

* For the SCS-SF level at post-intervention, the 25th percentile could not be defined by SPSS due to the small sample size and limitations of grouped percentile estimation.

Estimation of effects (change over time)

In this section, statistical analyses are presented as indicative only and should be interpreted with caution, as the study was not powered to detect statistically significant effects.

Exploratory analyses using Friedman and Wilcoxon tests were conducted as illustrative indicators of potential change only. Effect sizes varied across measures. Of the 25 effect sizes that could be calculated (excluding the 2 that could not be computed), some fell in the medium-to-large range, with others in the small or negligible range.

Table 8. Changes in client outcomes across intervention time points (per-protocol sample; $n = 6$)

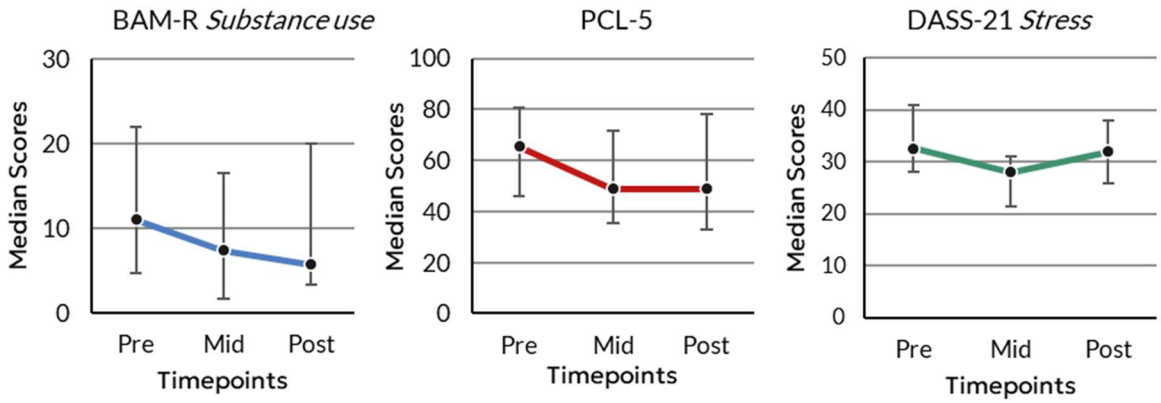
Measure	χ^2 (*df*)	*p*	Kendall's *W*	Wilcoxon *p*	*r*
AQoL-8D utility	0.61 (2)	0.738	0.051	Pre – Mid: 0.495 Pre – Post: 0.753 Mid – Post: 0.116	0.258 0.128 0.642
DASS-21 *Depression*	1.18 (2)	0.554	0.098	Pre – Mid: 0.031 Pre – Post: 0.916 Mid – Post: 0.416	0.815 0.043 0.364
DASS-21 *Anxiety*	0.12 (2)	0.939	0.010	Pre – Mid: 1.000 Pre – Post: 0.581 Mid – Post: 0.593	0.000 0.279 0.309
DASS-21 *Stress*	3.90 (2)	0.143	0.325	Pre – Mid: 0.072 Pre – Post: 0.647 Mid – Post: 0.109	0.736 0.171 0.926
PCL-5 total	4.00 (2)	0.135	0.333	Pre – Mid: 0.092 Pre – Post: 0.075 Mid – Post: 0.917	0.595 0.727 0.043
BAM-R *Substance use*	8.46 (2)	0.015	0.705	Pre – Mid: 0.012 Pre – Post: 0.043 Mid – Post: 0.893	0.892 0.905 0.060
BAM-R *Risk*	4.33 (2)	0.115	0.361	Pre – Mid: 0.069 Pre – Post: 0.248 Mid – Post: 0.115	0.644 0.472 0.644
BAM-R *Protective factors*	0.26 (2)	0.878	0.022	Pre – Mid: 0.574 Pre – Post: 0.891 Mid – Post: 0.463	0.199 0.061 0.300
CSES total	0.09 (2)	0.957	0.007	Pre – Mid: 0.575 Pre – Post: 0.916 Mid – Post: 0.686	0.198 0.043 0.181

Measure	χ^2 (*df*)	*p*	Kendall's *W*	Wilcoxon *p*	*r*
SCS-SF total	2.70 (2)	0.260	0.225	Pre – Mid: 0.670 Pre – Post: 0.345 Mid – Post: 0.344	0.161 0.385 0.386
SCS-SF level	1.00 (2)	0.607	0.083	Pre – Mid: 0.564 Pre – Post: 0.916 Mid – Post: 0.317	0.333 1.000* 1.000*

Note. AQoL-8D = *Assessment of quality of life – 8 dimensions*; DASS-21 = *Depression anxiety stress scale-21*; PCL-5 = *PTSD checklist for DSM-V*; BAM-R = *Brief addiction monitor – revised*; CSES = *Coping self-efficacy scale*; SCS-SF = *Self-compassion scale – short form*.
χ^2 *(df)* = Friedman statistic; Kendall's *W* = Friedman effect size; Wilcoxon *p* = post-hoc pairwise comparison *p*-value; *r* = Wilcoxon effect size.
* Where *r* = ±1.000, this reflects a very small number of non-zero pairs and is not considered a meaningful effect size. Conventional guidelines for effect sizes are as follows: small ≈ 0.10, medium ≈ 0.30, large ≈ 0.50.

The outcomes in Figure 11 were selected for visualisation due to large effect size changes over time, as indicated by the exploratory pairwise Wilcoxon signed-rank tests.

Figure 11. Median scores across intervention time points for BAM-R *Substance use*, PCL-5 and DASS-21 *Stress*



Note. BAM-R = *Brief addiction monitor – revised*; PCL-5 = *PTSD checklist for DSM-V*; DASS-21 = *Depression anxiety stress scale-21*. Error baris represent interquartile ranges, reflecting variability in a small sample.

In sum, the overall pattern of these results indicates possible benefits in the primary target areas of Seeking Safety (PTSD, addiction and coping skills), though these preliminary findings should be interpreted carefully.

3.6. Economic evaluation

An exploratory economic evaluation was conducted to determine if the benefits of the Seeking Safety program for veterans represented good value for money compared to standard evidence-based treatments (CPT, PE, and EMDR). This cost-effectiveness analysis, utilising effect sizes from a systematic review of international literature and local cost data, was performed from the healthcare provider's perspective to support implementation decisions.

3.6.1. Effectiveness of Seeking Safety

Characteristics of included studies

Fifteen RCTs, published between 2004 and 2023, met the inclusion criteria and were included in the meta-analysis. Based on the risk-of-bias assessment, the included studies were considered to be of reasonably good methodological quality.

Of these 15 RCTs, 12 were conducted in the US, while 1 study each was conducted in Germany, Australia and Canada. The majority of participants had co-occurring trauma-related conditions and substance use disorder, with some studies including related issues such as gambling. Eight studies focused on women, 4 on men, and 3 included both women and men. The mean age ranged from the 30s to the mid-50s.

CAPS was the most commonly used measure (8 studies), followed by the self-reported *PTSD Checklist for DSM-5* (PCL-5; 6 studies). Most studies assessed participants at baseline, end of treatment (typically 3 months) and follow-up periods ranging from 6 to 12 months from the start of treatment.

The intervention formats varied, encompassing both full and partial versions of Seeking Safety, delivered individually, in-group, via telehealth or through mobile apps. Common topics included safety, grounding, substance use, trauma recovery and interpersonal skills. Overall, the included RCTs reported that Seeking Safety was associated with meaningful reductions in PTSD symptoms over time. Adaptations of Seeking Safety – including condensed, peer-delivered, mobile-based and medication-assisted formats – also had positive outcomes.

Effectiveness of Seeking Safety on PTSD symptomatology

Of note, all instruments measuring PTSD symptoms, whether clinician-administered or self-reported, used in the included studies typically used higher scores to indicate greater symptom severity. Table 9 summarises the effects of Seeking Safety on PTSD severity, as measured by CAPS, at different time points. For PTSD measured by clinician-rated scales, the pooled effect size at 3 months indicated a moderate and statistically significant reduction in symptoms. Reductions were even greater at 6 and 9 months, showing that Seeking Safety remained effective at later follow-up periods.

Overall, these results provide robust evidence that Seeking Safety is effective in reducing PTSD symptoms over time, with consistent improvements observed from 3 to 9 months.

Table 9. Within-group effects of Seeking Safety on PTSD severity, measured by CAPS, across various time points

Time point	Pooled effect size	95% CI	*p*
3 months (6 studies)	−0.69	[−0.88, −0.51]	<0.001
6 months (7 studies)	−0.84	[−1.06, −0.61]	<0.001
9 months (4 studies)	−0.80	[−0.96, −0.64]	<0.001
12 months (2 studies)	−1.60	[−2.30, −0.91]	<0.001

Note. CAPS = Clinician-administered PTSD scale; CI = confidence interval; PTSD = post-traumatic stress disorder.

Dose–response analysis

Participants who received the full version of Seeking Safety had smaller improvements in PTSD symptoms at 3 months and 6 months, compared to those who received a partial version. By 9 months, there was no significant difference between the full and partial versions (Table 10).

In summary, partial-dose Seeking Safety was associated with greater improvement in PTSD at 3 and 6 months compared to full-dose Seeking Safety. However, there was no significant difference between them at 9 months.

Table 10. Effect of intervention dose (full vs partial) on PTSD severity, measured by CAPS, across various time points

Time points	Estimate (β)	95% CI	*p*
3 months (6 studies)	0.39	[0.08, 0.69]	0.013

9 months (4 studies)	0.43	[0.15, 0.71]	0.002
6 months (7 studies)	0.05	[−0.30, 0.41]	0.77

Note. The 12-month regression models were omitted due to collinearity.

3.6.2. Costs of treatments

Staff time for the Seeking Safety intervention totalled approximately 85 hours. This included 10.8 hours for training (with optional booster sessions), 40 hours for experiential practice and post-training activities, and 34.5 hours for delivering eight 90-minute sessions (including preparation, debriefs and assessments) and optional community meetings. For TAU, treatment sessions typically lasted between 60 and 85 minutes, with 1 to 6 sessions per treatment course, depending on the therapy type. When averaged across the 2 main therapy types – CPT ($1,283) and ET ($5,752) – the overall cost of TAU was approximately $3,517 per client.

The Australia-based costs of the Seeking Safety intervention and TAU are shown in Table 11. Delivering the Seeking Safety program cost more overall ($58,143) than TAU ($45,723), mainly because of the high upfront investment in training (about 88% of the total). Once training was complete, the actual delivery of Seeking Safety sessions was much cheaper than TAU. Spread across the 13 veterans who took part, the cost per person was $4,473 for Seeking Safety and $3,517 for TAU.

Table 11. Australia-based costs of the Seeking Safety intervention vs evidence-based PTSD therapies (i.e. treatment as usual)

Item	Seeking Safety (peer-led)	TAU (baseline)
Trainer costs		
Initial Seeking Safety training	$9,543.0	–
Booster training	$1,256.0	–
Experiential practice	$3,250.6	–
One-on-one role-play sessions	$1,300.2	–
Supervision costs	$3,250.6	–
Training materials		
DVD training series (4 DVDs)	$1,570.0	–
Teaching guide to introduce Seeking Safety to Open Arms	$1,816.1	–
Seeking Safety ebook manual	$3,371.7	–
Participant recruitment (marketing and communications)	$609.0	–
Participant time		
Clinicians' time costs for attending training (6 persons × 50.8 hours × $52.66 hourly wage rate)[a]	$16,062.5	–
Peer workers' time for attending training (4 persons × 50.8 hours × $45.82 hourly wage rate)[b]	$9,317.5	–
Subtotal – Seeking Safety training costs	$51,347.2	–
Clinicians' time cost		
Seeking Safety treatment (2 persons × 34.5 hours × hourly wage rate $52.66)[a,c] for 13 clients	$3,633.8	–
TAU treatment (average of CPT and ET costs), hypothetically applied to 13 clients	–	$45,723.3
Peer workers' time cost		
Seeking Safety treatment (2 persons × 34.5 hours × $45.82 hourly wage rate)[b,c] for 13 clients	$3,161.9	–

Item	Seeking Safety (peer-led)	TAU (baseline)
TAU treatment (average of CPT and ET costs), hypothetically applied to 13 PTSD clients	–	–
Subtotal – treatment delivery costs	–	$45,723.3
Total cost	$58,142.9	$45,723.3
Cost per client	$4,472.5	$3,517.2
Cost difference	$955.4	–

Note. TAU = treatment as usual; Open Arms = Open Arms – Veterans & Families Counselling; CPT = cognitive processing therapy; ET = exposure therapy; PTSD = post-traumatic stress disorder; APS = Australian Public Service.
[a] Hourly wage rate is converted from the DVA annual base salary for APS Level 6.
[b] Hourly wage rate is converted from the DVA annual base salary for APS Level 5.
[c] Four peer workers and 6 clinicians formally attended the Seeking Safety training. One peer worker and one clinician from each site were nominated to co-facilitate the 8-week Seeking Safety intervention.

3.6.3. Cost-effectiveness of Seeking Safety compared with treatment as usual

Base-case analysis

In the base-case analysis, using effect sizes from the meta-analysis, Seeking Safety showed steady improvements in PTSD symptoms from 3 to 9 months after starting treatment (see Table 9). Compared with TAU (ET and CPT), Seeking Safety cost $955 more per person (Table 11), resulting in ICERs between $1,143 and $1,381 per unit of improvement in PTSD symptoms (Table 12).

Seeking Safety was most cost-effective at 6 months, with an ICER of $1,143 per unit of improvement, representing the greatest value relative to the willingness to pay, which can be proxied by the baseline cost of $3,517 per client or $4,212 ($3,517 ÷ 0.84) per unit of improvement. Substantial symptom reduction and favourable cost-effectiveness were also maintained at 9 months, although with slightly smaller effect sizes and somewhat lower cost savings (higher absolute ICER).

These findings suggest that Seeking Safety achieves greater reductions than TAU (ET and CPT) in PTSD symptoms at a reasonable additional cost, showing the best value between 6 and 9 months after treatment.

Table 12. Base-case ICERs by time points

Time point	Pooled effect size	*p*	Incremental cost	ICER
3 months (6 studies)	−0.69	<0.001	$955.4	−$1,380.6
6 months (7 studies)	−0.84	<0.001	$955.4	−$1,142.8
9 months (4 studies)	−0.80	<0.001	$955.4	−$1,194.3

Note. ICER = incremental cost-effectiveness ratio ($ per unit symptom improvement). Effectiveness at 12 months is not presented due to the limited number of studies (n = 2) reporting outcomes at this time point. Negative values reflect symptom reduction, rather than cost savings.

Sensitivity analysis

Effectiveness measured by raw PTSD scores

When effectiveness was calculated using raw PTSD scores (pooled mean differences in CAPS), and the incremental cost was held constant at $955, Seeking Safety was associated with large and statistically significant improvements at all time points: −12.9 at 3 months, −17.1 at 6 months, and −16.0 at 9 months. The lowest cost per 1-point raw score improvement was at 6 months, making it the most cost-effective time point.

Effectiveness by different within-participant correlation values

Higher *r* values (0.5 and 0.7) resulted in slightly larger effect sizes and lower ICERs when intervention costs remain unchanged. With an *r* value of 0.3, the cost per 1-point raw score improvement, measured by CAPS, was about $75 (at 3 months) to $56 (at 6 months), showing good value. This lower *r* value is preferred because it gives more stable and realistic results, avoiding the overly optimistic estimates and high variability seen with higher *r* values, especially for clinician-rated outcomes.

Costs under routine implementation of the Seeking Safety model

Using the routine implementation model, with additional training and research-related costs excluded, training costs accounted for 62.4% of the total Seeking Safety intervention cost. Although this upfront cost was larger than the treatment delivery cost per patient, its proportion was substantially lower compared to the base case (88.3%). The total cost of delivering Seeking Safety intervention ($2,038) was thus lower than for TAU ($3,517), entailing an incremental cost of $1,479. Therefore, in this scenario, the Seeking Safety intervention was a more effective and lower-cost treatment option compared to TAU (ET and CPT) across all time points.

Costs under different staffing scenarios

All 3 Seeking Safety delivery models were less costly per client compared to baseline, with the (outreach) clinician-led model showing the greatest cost savings ($1,101 per client compared to $3,517 for TAU). The peer-led and co-led models, while requiring upfront investment in training (accounting for approximately 71.3% to 85.5% of the total cost), also had cost advantages, with estimated costs of around $2,683 and $3,021 per client, respectively. Overall, Seeking Safety appears to be cost-effective across all models and time points, with the outreach clinician-led model demonstrating stronger effects and greater savings, while the peer-led and co-led models also achieved savings and maintained clinical benefits, particularly at 6 and 9 months.

3.7. Peer-led Seeking Safety addendum

To support translation of the peer-led Seeking Safety model into the Australian veteran context, an addendum to the Seeking Safety manual was developed, building on international evidence and lessons from the Australian pilot to provide practical guidance for peer-led delivery and co-facilitation with clinicians in veteran settings. The addendum serves as a supplementary resource alongside the original Seeking Safety manual, offering additional strategies to strengthen confidence, cultural alignment and consistency in delivery. It includes guidance on co-facilitation, role clarity and maintaining boundaries to support safe and effective delivery. The addendum is designed to assist facilitators in session planning and delivery while maintaining the model's fidelity.

4. Discussion

4.1. Summary and interpretation of main findings

This study evaluated the delivery of peer-led Seeking Safety within Open Arms, focusing on both the implementation of an intensive, structured training and support framework for peer workers and clinicians and the intervention as experienced by veteran clients. The implementation component examined whether peer workers could be equipped – through formal training, supervision and practice opportunities – to confidently and competently deliver a manualised, trauma-specific intervention. The intervention component assessed the real-world delivery of Seeking Safety groups across 2 Open Arms sites, exploring client engagement, satisfaction and perceived benefits. By integrating quantitative measures with qualitative feedback from staff and clients, the study sought to determine whether it was positively received and yielded meaningful benefits for both facilitators and participants. The feasibility of the pilot project was also addressed. Overall, we evaluated the model's practical viability in the Open Arms context and its potential as a scalable, peer-led approach to trauma-specific care for veterans.

4.1.1. Research feasibility

Operational aspects of the pilot project were positive overall. Recruitment targets were nearly met, eligibility criteria functioned as intended, and both staff and clients reflected the target veteran population. At baseline and mid-intervention, all client participants enrolled in Seeking Safety at those time points completed the full assessment battery, demonstrating high engagement and the feasibility of administering comprehensive measures in this population. In SA, this high completion rate was maintained post-intervention. In SQLD, however, post-intervention completion was extremely low despite multiple follow-up attempts, suggesting possible survey fatigue towards the end of the intervention. Staff participants also demonstrated strong engagement, consistently completing required pilot project activities and providing timely feedback, which supported smooth delivery and adherence to project protocols. Overall, the tools, procedures and timing of data collection appeared appropriate and practical for this cohort. However, given the small sample size and limited number of sites, the findings should be interpreted cautiously and viewed as indicative rather than conclusive evidence of feasibility. It is worth noting that, outside the controlled conditions of a pilot, future recruitment would not be constrained by the same strict eligibility criteria, making it more likely that groups could operate successfully in routine practice. While focus group feedback highlighted that the volume of surveys and overall administrative requirements were perceived as burdensome, these factors did not undermine the project's feasibility. Nonetheless, simplifying future data collection and implementation initiatives may improve the staff's and clients' experience and reduce the perceived burden.

4.1.2. Seeking Safety feasibility

Although attrition was observed, the rates identified in this pilot are consistent with those reported in the broader Seeking Safety and trauma-focused intervention literature and with trauma-specific treatments more broadly, where dropout rates have been recognised as a challenge (Agarwal & Draheim, 2024; Hien et al., 2004; Molina & Whittaker, 2022). Nonetheless, attrition remains an important consideration for all treatments and limits the conclusions that can be drawn regarding overall feasibility from a pilot such as this. Since Seeking Safety does not prescribe a fixed number of sessions, allowing flexibility in attendance and completion, future evaluations should therefore explore how different delivery formats, session frequencies and attendance patterns influence engagement, outcomes and sustainability within veteran populations.

Despite these limitations, Seeking Safety was delivered successfully at both sites, suggesting that a structured, manualised, trauma-specific model such as Seeking Safety can be facilitated by peer workers within Open Arms. The staff's self-reported fidelity to the Seeking Safety model was consistently high across both sites, with all fidelity scores exceeding recommended adequacy thresholds. The stability of fidelity scores over time suggests that the intervention was implemented as intended. It is important to

note that the original training was not regarded as fully acceptable by staff, and as such, greater financial investment in training may pose a feasibility challenge in the future.

Delivery of the model was supported by the provision of high-quality resources, including the Seeking Safety manual, structured training materials, supervision sessions and optional one-on-one practice opportunities. These resources were beneficial in preparing peer workers to facilitate the intervention confidently.

4.1.3. Seeking Safety acceptability

The model was overall well received by both staff and clients. Staff valued the structure of Seeking Safety, reporting that it aligned with veterans' preference for sequential sessions while maintaining flexibility to tailor topics to client needs. Overall, in this pilot, the intervention was viewed as highly acceptable and engaging for most staff, although early steps in the training process indicated that additional preparation and support strategies were needed for peer workers in particular. The pivot to a more intensive staff training approach helped bolster staff confidence in conducting Seeking Safety.

Client feedback indicated strong acceptability and perceived relevance of the model, although as mentioned, this was a small pilot and larger studies would be needed for generalising this finding. Ratings of topics, treatment components and overall experience were highly positive, with most responses reflecting high engagement, perceived helpfulness and satisfaction with the model's format and delivery. These findings provide preliminary support for the model's suitability for clients with trauma, PTSD and substance use.

Staff feedback reinforced these findings, highlighting the model's structured and empowering format, its effective tools and the group cohesion it fostered. The model was described as easy to understand, innovative and valuable. Qualitative reflections noted that implementation challenges were largely logistical rather than due to the model itself. Suggestions for future implementation included tailoring content, topics and delivery for local contexts; expanding eligibility criteria; and exploring alternative delivery formats. These were not possible as part of the pilot project but are inherent to Seeking Safety, which emphasises the importance of making implementation decisions based on such elements. Together, the results suggest that the model was engaging, perceived as beneficial and well aligned with both client and staff expectations, supporting its suitability for delivery in veteran settings.

4.1.4. Seeking Safety training and intervention outcomes

Staff training outcomes indicated increased confidence and preparedness to deliver Seeking Safety. Staff participants reported that training, supervision and practice sessions equipped them with the skills to self-evaluate their fidelity and facilitate group sessions successfully.

From the client perspective, feedback indicated improvements in coping, emotional safety, connection and recovery-oriented outcomes. These qualitative impressions were generally aligned with quantitative results, with some effect sizes indicating promising signals. Some measures, including PTSD symptoms (PCL-5), perceived stress (DASS-21 *Stress*) and substance use (BAM-R *Substance use*), showed indications of positive impact, while others (BAM-R *Risk*, CSES and SCS) suggested trends in the expected direction.

Although the small sample size and the high attrition at follow-up limit the ability to draw definitive statistical conclusions, the combination of moderate to large effect sizes on key variables, positive qualitative endorsements and high satisfaction ratings is preliminary evidence that the model is likely to be relevant and beneficial for the veteran population.

Taken together, these findings indicate that, with appropriate training and support, peer workers in this small sample pilot were able to deliver Seeking Safety – a structured, trauma-specific intervention – in a manner that was feasible and acceptable within the veteran service contexts of the 2 Open Arms sites. However, the results are preliminary and further research on a larger scale is needed to confirm feasibility across diverse settings. The strong engagement from both staff and clients provides early

indications that the model holds promise for broader application within Open Arms and potentially other veteran mental health services. The preliminary effect sizes are suggestive of potential benefits: positive trends and outcomes in staff capability and client-reported benefits highlight the potential of peer-led work to complement clinician-led care, expand service capacity and offer veterans an accessible, relatable and safe environment for recovery-oriented group work.

4.1.5. Economic evaluation

The economic evaluation of the Australian pilot study examined the cost-effectiveness of Seeking Safety for individuals with PTSD symptoms using literature-based PTSD outcomes and local costs, across multiple time points and counterfactual delivery models. Seeking Safety was cost-effective across all scenarios, with the outreach clinician-led model offering the best value due to reduced delivery costs and sustained symptom improvements.

The base-case findings reflect consistent intervention impact under primary assumptions. Given limited Australian evidence on the cost-effectiveness of Seeking Safety, we drew on international studies of PTSD interventions. A cost-benefit model by the Washington State Institute for Public Policy (n.d.) estimated annual per-person benefits of US$23,606, mainly through increased earnings and reduced healthcare costs. Another US trial found tailored cognitive behavioural therapy to be more effective and cost-saving than a brief alternative in 28% of simulations, with an ICER of about US$36,893 per remission (Slade et al., 2017). Collectively, these studies highlight the economic value of PTSD interventions, though direct comparisons with this analysis are limited by differences in methods, outcomes and follow-up.

The meta-regression revealed nuanced effects of Seeking Safety dose intensity on PTSD symptom improvement. Notably, at earlier time points (3 and 6 months), partial-dose versions of Seeking Safety were associated with greater or comparable symptom reductions compared to the full version, particularly when assessed with clinician-administered measures. By 9 months, differences between full and partial doses diminished when measured using CAPS, indicating that partial versions may, from the patient's perspective, sustain or even enhance long-term recovery. These results challenge the assumption that longer or more intensive treatments necessarily yield better outcomes and highlight the potential for streamlined interventions to achieve meaningful clinical improvements.

The costing scenarios in the sensitivity analysis indicated that the actual cost of a Seeking Safety intervention would depend on how much Seeking Safety training clinicians or peer workers would receive. Seeking Safety does not require formal training, certification or prior experience – only one manual per provider. Additional training, certification or consultations are optional rather than mandatory. The peer-led and co-led models, while offering less cost savings than the outreach clinician-led model, may provide Open Arms with greater control by ensuring that peer workers are properly trained, engaged and supervised in delivering Seeking Safety intervention. These approaches align with broader mental health system strategies that advocate for task-shifting and alternative delivery approaches, such as community-embedded, scalable models, to provide meaningful care while alleviating pressure on specialist providers (Hoeft et al., 2018; Sangraula et al., 2025). The consistent pattern of the lowest ICERs observed at 6 months post-intervention, along with sustained cost-effectiveness compared to baseline and early follow-up (3 months), aligns with literature suggesting that the cost-effectiveness of PTSD treatments may improve with longer-term follow-up, as symptoms stabilise or continue to improve, thereby enhancing the long-term value of early intervention (Mavranezouli et al., 2020; Shearer et al., 2018). These findings highlight the importance of incorporating longer-term follow-up in future economic evaluations to enhance their relevance for decision-makers (Mavranezouli et al., 2020; National Institute for Health and Care Excellence, 2018).

4.2. Response to the research questions

1. Do the outputs and outcomes from the study demonstrate a sufficient level of acceptability and feasibility within the Open Arms organisational or site setting?

This pilot study indicated that the peer-led Seeking Safety intervention was feasible and acceptable within the Open Arms context and the limited methodology of our pilot. However, it is important not to generalise these findings without further research in other contexts and larger studies. Our recruitment achieved over 80% of the target, allowing the study objectives to be addressed and inform feasibility aims, but continued success would depend on replicating such engagement in future implementations. Eligibility criteria functioned as intended, and the sample included staff and clients consistent with the study's intended veteran focus. While the intervention was implemented as planned at both sites, and self-rated fidelity to the model was high across all sessions, it should be noted that the initial training needed enhancement in our project, particularly for peer workers who did not yet have group facilitation or trauma-specific intervention experience. For Seeking Safety to be considered for broader adoption by Open Arms, greater financial investment in training and facilitator support would likely be required. Staff and client feedback indicated positive engagement, high satisfaction and perceived benefit. Minor challenges – such as administrative burden and survey fatigue – do not undermine feasibility but point to opportunities for streamlining future evaluation processes. Additionally, our pilot study combined implementation with a level of research burden to staff; the latter would not be present in regular practice.

2. Which factors and processes (i.e. organisation, site, clinician, peer worker and client) promote or impede the successful translation and implementation of the practice model?

Several factors promoted the successful translation and implementation of peer-led Seeking Safety within Open Arms. Strong organisational and site-level commitment provided a solid foundation for delivery, supported by comprehensive training, ongoing supervision and ready access to Seeking Safety resources. The structured yet flexible nature of the model aligned well with veteran preferences for sequential sessions while allowing tailoring to client needs. Positive group dynamics and the relatability of peer worker facilitators fostered trust, engagement and a safe group environment.

At the same time, some factors presented challenges during early implementation, particularly the need for greater organisational investment in Seeking Safety–specific training and support to build peer workers' confidence and competence in delivering the model. Although this level of training intensity was not part of the initial pilot design, it became clear early on that additional guidance was needed, particularly as the peer workers had limited prior experience conducting group sessions, using manualised treatments or implementing trauma-specific interventions. Staff also did not receive personalised fidelity feedback (i.e. 'certification' in conducting Seeking Safety), and time was limited for staff to practise with real clients before implementing the topics, which may have contributed to some staff's lower confidence and comfort levels in the early stages of the implementation. These challenges were addressed during the pilot by adapting the training approach, which ultimately strengthened peer workers' capability and supported successful implementation. However, the majority of the training (experiential sessions, ongoing supervision, booster training, one-on-one role-plays) is not typical of the routine implementation of the model.

While the economic analysis indicated that Seeking Safety can be delivered at a lower cost than TAU (e.g. CPT, PE or EMDR) when established at scale, this may rely on maintaining adequate investment in facilitator training and supervision to ensure fidelity and program quality. That being said, the level of training provided in our project may or may not be needed in future implementation. Training level and cost depend on various factors, including staff selection, staff experience with group facilitation and trauma models, and the provision of performance-based fidelity feedback to staff (the latter, as mentioned, was not part of the current pilot but typically increases confidence in conducting the model). A second implementation barrier was that the 8-week duration of the pilot intervention was perceived as too short and presented recruitment challenges – particularly among veteran clients. To enhance

feasibility in future translation, adopting a longer-term, rolling intervention, incorporating rotating topics and a flexible, drop-in format may better accommodate client engagement patterns. In some instances, the standard 90-minute session length was perceived by some staff as insufficient – particularly when considering the potential for larger groups in future delivery – limiting opportunities for in-depth discussion and participant contributions. Furthermore, a small number of clients disengaged early in the intervention, suggesting that creating a tryout process and possibly offering enhanced preparation before group commencement might improve early engagement and retention.

3. What modifications (if any) are required to ensure the intervention is culturally appropriate for the Australian military context (i.e. aligned with its needs, values and preferences)?

Findings indicate that the peer-led Seeking Safety model is broadly culturally appropriate for Australian veterans. Cultural fit was supported by peer worker facilitation, the model's emphasis on safety and strengths, and flexibility to tailor content to group needs. Suggestions by participants included the following, all of which are inherently part of the model's flexibility. Thus, these represent pragmatic adaptation decisions that staff would make based on client needs and organisational structure:

- extending session duration to allow more sharing time
- increasing flexibility in topic selection and delivery sequence
- tailoring examples and discussion points to reflect Australian military culture and veteran experiences
- integrating references to local Australian veteran services, supports and community organisations into intervention materials
- adjusting language and terminology to better reflect Australian usage
- considering group composition to ensure comfort and trust, particularly in relation to gender mix and whether groups combine veterans with family members.

These suggestions highlight opportunities to further align the model with the lived experiences, cultural context and support networks of Australian veterans while maintaining fidelity to the Seeking Safety model. To support consistent, culturally responsive delivery, we developed an Australian veteran-specific addendum. It provides veteran-specific considerations and practical guidance on session length and sequencing, topic selection and ordering, Australianised language and examples, and references to relevant resources, enabling clinicians and peer workers to tailor delivery while maintaining fidelity.

4. What are the barriers to and facilitators for embedding the peer-led Seeking Safety practice model within the Open Arms Model of Care?

Facilitators included strong leadership buy-in, high-quality training and ongoing access to supervision. Staff valued the model's credibility, ease of understanding and relevance to veteran recovery needs. Barriers were primarily logistical, including competing service demands, session time constraints and the administrative load associated with the pilot project. Retention of clients is also an important consideration, as maintaining sufficient group numbers is critical to preserve the therapeutic value of peer interaction and group cohesion. Seeking Safety can be conducted in any size group but typically comprises 6 to 10 participants, although smaller or larger groups can also be used depending on the setting and client needs. (Najavits, 2002). Addressing these issues – particularly through streamlined processes, flexible scheduling and embedding ongoing peer worker support – may strengthen future scalability and sustainability within the Open Arms service model.

5. What is the ratio of costs to effectiveness for the peer-led Seeking Safety practice model when implemented in the Australian (military) context?

Seeking Safety demonstrated the greatest cost-effectiveness at 6 months follow-up, having the lowest ICER of approximately $1,143 per unit of PTSD symptom improvement. Sensitivity analyses supported these findings, showing consistently low ICERs, particularly for clinician-administered measures. In practical terms, this suggests that, based on international evidence, the program could deliver

meaningful improvements in PTSD outcomes at a relatively modest additional cost, suggesting good potential value for money in the Australian military context. Future research should evaluate the effectiveness of Seeking Safety in the Australian context through controlled, between-group comparisons to confirm and strengthen these findings.

4.3. Operational and logistical capacity

This section outlines the operational and logistical capacity of the team to implement and manage the research activities and intervention within the scope of this pilot project. While feedback from the SSFQ has already been discussed in earlier sections (see Section 3.5.1), the following elements address the remaining components of this criterion.

4.3.1. Evaluation of data collection, management and analysis processes

The research and implementation team coordinated data collection across 2 pilot sites (SQLD and SA) using structured tools administered at 3 time points (pre-intervention, mid-intervention and post-intervention). The team demonstrated adequate capacity to:

- design and distribute client and staff questionnaires tailored to the model's objectives
- manage secure storage and tracking of data in line with ethical requirements
- conduct quantitative and qualitative analyses using appropriate statistical and thematic approaches
- respond adaptively to real-time implementation challenges, including small sample sizes and differences in operational capacity across sites
- clean and analyse data following ethical and scientific standards and interpret findings to support program refinement and inform future implementation.

4.3.2. Adverse events monitoring

No adverse events or safety incidents were reported throughout the implementation of the Seeking Safety model. Facilitators were supported by local site supervisors and debriefed informally after sessions, with peer workers and clinical staff encouraged to report any concerns. The absence of adverse events suggests that the model was implemented safely and appropriately for the intended veteran population.

4.3.3. Estimated cost of intervention delivery

Cost analysis indicated that the total estimated time commitment per facilitator was 85.3 hours (51.3 hours required, 33.8 hours optional), covering training, experiential practice sessions, intervention delivery and evaluation activities. The total cost of delivering Seeking Safety was $58,143 for 13 clients ($4,473 per client), with training as the major cost driver (approximately 88.3%). Intervention delivery costs for Seeking Safety were substantially lower than for TAU (ET, CPT or PE), equivalent to approximately 15% of TAU's treatment delivery costs. While the intensive training used in this pilot was essential for achieving facilitator confidence and fidelity, it remains unclear what level of training would need to be repeated in future implementations to sustain peer confidence and program integrity. If similar, this would likely represent an ongoing upfront training cost for Open Arms. Nevertheless, future implementations may identify efficiencies through refined staff selection (e.g. facilitators with prior experience conducting groups, manualised models or trauma-specific interventions) and the potential for refresher rather than full initial training cycles. Accordingly, costs may be lower under routine implementation of the Seeking Safety model, as indicated by the sensitivity analysis. While training will remain a key cost driver, overall delivery costs are expected to decrease over time as the model becomes more established within Open Arms.

4.4. Comparison with existing literature

The findings from this pilot are broadly consistent with existing research on the Seeking Safety model and peer-led approaches in mental health and veteran contexts. International evaluations of Seeking Safety, delivered predominantly by clinicians, have demonstrated the model's feasibility, high fidelity, strong adoption and sustained use of the model, and positive outcomes for clients with trauma or substance use disorders (Hien et al., 2020; Rodriguez et al., 2018; Sherman et al., 2023). The present study provides preliminary evidence that Seeking Safety can be delivered successfully within an Australian veteran service context using a peer-led format, with self-rated fidelity scores exceeding recommended adequacy thresholds, and positive preliminary acceptability reported by both staff and clients. Session attendance was comparable to Seeking Safety studies and to studies of interventions for PTSD or substance use disorder and general counselling more broadly.

The results also align with the broader literature on peer-led mental health interventions, which emphasise the value of peer worker relatability, role modelling and the creation of psychologically safe spaces as drivers of client engagement and trust (Fortuna et al., 2018; Repper & Carter, 2011). Consistent with other studies, the shared lived experience of facilitators in this pilot was a key strength, enhancing group cohesion and cultural fit for the veteran population. Similarly, the structured yet flexible design of Seeking Safety is consistent with veteran-focused group programmes that combine predictable formats with flexibility to tailor delivery to individual needs (Najavits et al., 2014; Hurley et al., 2018; Sweeney et al., 2018).

This pilot contributes new insight by showing that a manualised, trauma-specific intervention like Seeking Safety may be translated successfully to a peer workforce with appropriate training, supervision and resource support. While Seeking Safety has been implemented in a range of settings internationally, there is limited published research on its peer-led delivery, particularly in veteran-specific contexts. This study therefore addresses a gap in the Australian literature by providing early, positive preliminary evidence of the feasibility, acceptability and cultural appropriateness of a peer-led Seeking Safety model for veterans.

The challenges observed in this pilot – including administrative demands and the need for robust support structures to help build intervention-related skills in peer workers – echo those reported in the literature on peer-led model implementation (Chinman et al., 2012). However, the high self-reported fidelity scores and positive client and staff feedback observed here suggest that these barriers can be managed effectively with targeted planning and adequate resourcing. Taken together, these findings reinforce the international evidence on the potential of peer-led interventions to complement clinician-led care, expand service capacity and offer accessible, culturally relevant support for trauma-affected veteran populations.

4.5. Practice and policy implications

The findings from this pilot have important implications for Open Arms, the broader peer workforce and the DVA. The successful delivery of peer-led Seeking Safety across 2 sites suggests that a structured, manualised, trauma-specific intervention can be implemented safely within veteran services through a peer-led model. Both staff and client feedback suggest that the model is acceptable, relevant and capable of addressing complex needs such as trauma, PTSD and substance use within a recovery-oriented group framework.

For Open Arms, the results suggest that the use of peer-led Seeking Safety could diversify service offerings with a complementary approach to clinician-led services, providing an alternative option that may reduce barriers to engagement for some veterans. Importantly, the model's structured flexibility allows it to be adapted to local contexts while maintaining fidelity, which could support national rollout across varied service environments.

For the peer workforce, the findings reinforce that, with adequate training, supervision and access to quality intervention resources, peer workers can deliver a structured trauma-specific intervention with

high self-reported fidelity and strong facilitation skills. The model offers an opportunity to enhance peer worker roles by equipping them with advanced group facilitation capabilities, supporting career development and increasing their contribution to service delivery.

From a policy perspective, scaling up this model could help to improve service accessibility by leveraging the capacity of trained peer workers. The model's demonstrated preliminary acceptability and safety in this study indicate it could be embedded as a core groupwork option within veteran services. However, successful scale-up will require a robust support structure, including:

- comprehensive, standardised training in Seeking Safety
- ongoing clinical and peer worker supervision to maintain fidelity and support facilitator wellbeing
- access to intervention materials, resources and administrative support
- clear integration pathways within existing service models.

The strong engagement, high satisfaction and perceived benefits reported in this pilot support the inclusion of peer-led Seeking Safety as a safe and acceptable format for trauma-specific group work in veteran settings. In regular implementation (outside of a research study), there would be a much lower administrative burden, and staff would be able to flexibly customise the model's delivery, according to the manual, to address organisational and client-centric needs, such as session length, dosage, client selection criteria and the order of topics, among others. Additionally, the economic evaluation offers positive findings and insights for DVA and Open Arms policymakers who are considering cost-effective, scalable responses to PTSD in community and veteran mental health settings.

4.6. Limitations

Several limitations in the current pilot study should be acknowledged. By design, this small-scale pilot project was not powered to evaluate statistically significant outcomes. Some staff and clients did not complete study measures, which resulted in an even smaller-than-planned sample (a well-known issue in intervention studies). The pilot project was re-scoped to involve only 2 sites, reducing the diversity of service contexts represented in the evaluation and potentially limiting the generalisability of findings to other settings. Participation was restricted to a single service provider (Open Arms), meaning results may not fully translate to other veteran service settings. Finally, while survey completion rates were generally high in the early stages of the project, some participants experienced survey fatigue, and the evaluation process was perceived by staff as administratively burdensome. These factors may have influenced engagement with the research components of the pilot and highlight the need to streamline evaluation processes in future research and implementation initiatives.

We also acknowledge several limitations of the economic evaluation. Seeking Safety's effectiveness was derived from international published data rather than being measured directly, potentially limiting applicability to the local context. Within-group standardised mean differences were used, which may be less intuitive for policymakers and could overestimate the intervention's effect relative to a control group. PTSD status in the TAU comparison (ET, CPT or PE) was based on self-report rather than formal clinical diagnosis, introducing potential heterogeneity in symptom severity and treatment pathways. Finally, assumptions of a fixed staff-to-client ratio and constant costs over time may not reflect real-world variation, potentially affecting ICER estimates and external validity.

4.7. Lessons learned and potential future directions

Several lessons were learned throughout the pilot project:

- **Communication**: Limited communication between GMR and Open Arms staff participants initially contributed to implementation challenges and added administrative burden on DVA staff. It became clear that operational details should be communicated with regional directors while decision-making remains centralised within the working group.

- **Site preparedness**: A preliminary site assessment would support gaining an early understanding of the peer workforce's availability and characteristics, such as preparedness for participation.
- **Peer workforce preparedness**: Additional training and communication were necessary to address gaps in group facilitation skills and research knowledge among peer worker participants. Tailoring training to veterans' learning styles and managing the demands on peer workers facilitating interventions alongside clinical staff were important considerations.
- **Change and risk management**: The complexities of the pilot project underscored the necessity of allowing sufficient time for ethical considerations and protocol adjustments. Unforeseen risks emerged as the protocol changed, highlighting the importance of regularly reviewing and updating the risk matrix.

Overall, the project benefited from strong stakeholder engagement and adaptive management, providing valuable insights to inform future research and interventions in this area. To build on the findings of the Australian pilot project and strengthen the evidence base for Seeking Safety within the Australian veteran context, several targeted projects could be undertaken:

- **Telehealth modality**: Conduct a pilot study implementing peer-led Seeking Safety via telehealth to assess feasibility, engagement and outcomes, including cost-effectiveness, compared to in-person delivery. This would expand access for veterans in regional and remote areas and those facing mobility, transport or scheduling barriers. A project of this kind would generate further evidence on whether telehealth delivery maintains fidelity to the model while increasing reach and accessibility.
- **Family-inclusive evaluation**: Conduct a pilot study to explore the feasibility and acceptability of adapting peer-led Seeking Safety for family members of veterans, with parallel groups designed for partners and adult children. Families of veterans often experience secondary trauma and stress, even without meeting clinical criteria. Using topics from Seeking Safety that are especially relevant to families (e.g. boundary-setting, managing anger, grounding and self-care) could strengthen family wellbeing while supporting veterans' recovery.
- **Gender-specific groups**: Conduct a pilot study to explore the feasibility and acceptability of gender-specific peer-led Seeking Safety groups, starting with female-only cohorts to address the unique challenges and high prevalence of military sexual trauma among women veterans. Tailoring could entail emphasising topics particularly relevant to women's experiences of trauma and recovery. Male-only groups may also be explored to assess whether single-gender settings improve comfort, openness and group cohesion for veterans.
- **Flexible 'drop-in' access**: Design and implement open-ended Seeking Safety groups with flexible 'drop-in' attendance. In this model, topics would be delivered on a rolling schedule, with each topic offered more than once across a set timeframe (e.g. a cycle of 6 to 12 months), allowing participants who miss sessions to catch up at a later date. This flexibility would enable veterans with unpredictable availability – or those initially hesitant to commit – to engage at their own pace, while still providing structure and continuity for regular attendees. An implementation pilot could evaluate whether this approach reduces attrition, supports re-engagement and increases early uptake of the program.
- **Standalone peer training program**: Develop a dedicated project to deliver Seeking Safety training as a professional development pathway for peer workers. The program would focus on strengthening preparedness, confidence and fidelity in facilitating structured, trauma-specific conversations with clients. Training could be tiered, with benchmarks or competency levels that recognise progression as peer workers acquire greater skills. Multimedia resources – such as short videos featuring Australian veterans demonstrating elements of the intervention – could further enhance learning and ensure the training is tailored to the Australian veteran context. An evaluation component should identify which training methods and materials are most effective in building peer worker capability.

All of these potential projects would include simplified data collection processes to reduce administrative burden while retaining key measures of feasibility, acceptability and cost-effectiveness.

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