Dissemination and Feasibility of a Cognitive-Behavioral Treatment for Substance Use Disorders and Posttraumatic Stress Disorder in the Veterans Administration

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Abstract—This article describes a small dissemination effort and provides initial efficacy data for use of Seeking Safety, a cognitive-behavioral treatment for comorbid substance use disorders (SUD) and posttraumatic stress disorder (PTSD), in a VA setting. After providing a daylong interactive training in Seeking Safety to front-line clinicians, a cotherapist group practice model was implemented. Following 14 months of clinician training and an uncontrolled pilot study of four groups with 18 veterans, initial efficacy data indicate significant symptom reduction for patients and acceptability to clinicians. Findings are encouraging in that Seeking Safety treatment appears to have the potential to be beneficial for veterans with SUD-PTSD and also appeal to clinicians. Dissemination of Seeking Safety is feasible in the VA, yet there are likely barriers to sustaining it as a routine treatment. Recommendations for future dissemination are proposed, including ways VA administration can facilitate this process.

Keywords—posttraumatic stress disorder, PTSD, substance-related disorders, therapy, trauma

A recent priority in mental health services has been the dissemination and implementation of evidence-based treatments (EBTs) or "best practices" (Drake et al. 2001b; Schoenwald & Hoagwood 2001). However, there has been debate between mental health researchers and practitioners in regards to the appropriateness and practicality of implementing EBTs in "real-world" community settings. In a recent summary of the controversy, Chambless and Ollendick (2001) acknowledged practitioners' concerns—most importantly, that the randomized controlled trials on which EBTs are based define optimal treatment outcomes for narrowly selected patients not representative of those seen in actual practice.

One challenge to dissemination and implementation of EBTs is that of dual disorders (Drake et al. 2001a), particularly those for patients with comorbid substance use disorders (SUD) and posttraumatic stress disorder (PTSD). Individuals with SUD-PTSD frequently have poorer psychological, social and physical health than those with either

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disorder alone (for a review, see Ouimette & Brown 2003). These patients also use more costly inpatient services, tend to have more frequent relapses and are less likely to adhere to or complete treatment (Ouimette & Brown 2003). Additionally, it is generally accepted that PTSD complicates recovery from SUD and that substance use adversely affects the treatment of PTSD (Ouimette & Brown 2003).

Treatment of individuals with SUDs and co-occurring psychiatric disorders is typically delivered using one of three paradigms: parallel, sequential and integrated (Drake & Mueser 2000). Most VA and community based programs deliver parallel services, where patients receive treatment for SUD in one program and treatment for PTSD in another. Parallel treatment is prevalent in many PTSD special emphasis programs that provide highly specialized treatment for PTSD but make referrals for treatment of SUDs, leading to fragmented care and increased barriers to treatment. Many SUD-PTSD veterans may be unable to navigate the separate systems or make sense of the disparate messages about PTSD treatment and recovery.

Fewer programs use the sequential model, which focuses on first stabilizing the most acute disorder and then addressing the others, and even less use the integrated approach, which simultaneously addresses both disorders in a coordinated fashion. Consequently veterans with SUD-PTSD often find themselves in a situation where important symptoms and problems in functioning are not addressed. This may lead some veterans treated in abstinence-oriented SUD treatment programs that are not equipped to deal with PTSD to have worsening symptoms of PTSD at the same time that their substance abuse symptoms improve.

These problems can be addressed in an integrated model. One integrated cognitive-behavioral therapy (CBT) that has been acquiring empirical support is Seeking Safety (Najavits 2002). This 25-session manual-based treatment draws upon CBT for substance abuse (Beck et al. 1993; Carroll, Rounsaville & Gavin 1991; Marlatt & Gordon 1985), PTSD treatment (Herman 1992), and educational research (Najavits & Garber 1989). It is a first-stage therapy designed to teach "safe" coping skills that apply to SUD-PTSD. The general focus is on helping patients develop healthy coping skills that will reduce their symptoms and prepare them to engage in trauma-focused work as a part of later stages of therapy. Seeking Safety covers three coping skill domains: cognitive, behavioral, and interpersonal. Examples include: Recovery Thinking, Taking Good Care of Yourself, and Setting Boundaries in Relationships, respectively.

Initial efforts investigating Seeking Safety's treatment outcome in civilian outpatient and incarcerated women indicate significant improvements with respect to substance use and trauma-related symptoms (Zlotnick et al. 2003; Najavits et al. 1998). The treatment has been empirically evaluated in female samples from several other populations including inner city cocaine-addicted women and adolescent females (Morrissey et al. 2005; Hien et al. 2004). These studies all found that Seeking Safety is probably efficacious in reducing SUD and PTSD symptoms (a brief summary can be found at www.seekingsafety.org).

In an effort to bridge the gap between SUD and PTSD services and to promote the use of an integrated, probably efficacious CBT in clinical practice in the Veterans Administration (VA), front-line clinicians were trained and assisted in their implementation of Seeking Safety with male and female veterans. The overall goals of this project were to ascertain clinicians' acceptance of Seeking Safety and initially evaluate its efficacy in use with veterans.

RESULTS OF DISSEMINATION AND INITIAL EFFICACY

Although it is not often referenced in discussions of dissemination of empirically-based psychotherapies, a much broader literature documents the many difficulties inherent in attempting to influence clinician behavior in routine medical care. The medical literature is robust with studies showing how difficult it is to influence clinician behavior (Davis et al. 1999) indicating that traditional means (e.g., educational materials and workshops) without enabling or practice-reinforcing strategies (e.g., outreach visits such as academic detailing and opinion leaders or audit and feedback reminders) are not effective.

Training clinicians in EBTs or best practices typically involves traditional means such as requiring reading of manuals and relatively passive workshop attendance. The authors decided to take a more engaging and enabling approach in accepting the challenge of "Don't tell me, show me!" After providing a daylong interactive staff training in Seeking Safety, clinicians were informally surveyed on their willingness to colead groups with the first author (who had previously been trained in Seeking Safety). Four therapists immediately volunteered (one Ph.D., two psychiatric nurses, and one SUD counselor).

Subsequently, four Seeking Safety groups were initiated and completed at the Philadelphia VA Medical Center (PVAMC). Twenty-five outpatient veterans with clinician-diagnosed comorbid SUD-PTSD voluntarily began participating in the groups. Of those, 18 completed a series of 25 group treatment sessions (had attended at least 14 sessions and were still coming at the end of therapy). Of the completers, 72% were male. Ages ranged from 41 to 59 with a mean age of 50. Primary substance use disorders included alcohol abuse/dependence (78%; N = 14), cocaine abuse (61%; N = 11)and heroin dependence (33%; N= 6). The majority were receiving services in the SUD treatment program but were not receiving specialized PTSD care at the same time.

The veterans who completed Seeking Safety evidenced statistically significant improvements from pre- to post-treatment in self-report PTSD symptoms and quality of

life. PTSD symptoms decreased, as measured by the PTSD Checklist-Military (Weathers et al. 1993; pre M = 65.54, SD = 8.80, post M = 51.15, SD = 14.38, t (12) = 6.60, $p < .001$). Quality of life increased, as measured by the Quality of Life Inventory (Frisch et al. 1992; pre M = -15.43, SD = 20.82, very low; post M = .29, SD = SD = 18.38, low, t (6) = -2.46, $p < .05$). Qualitatively, the veterans reported increased ability to identify and manage PTSD and substance use triggers. They also endorsed improvements in their communication and problem solving skills. Regarding substance use, veterans did demonstrate continued abstinence from substances confirmed by urine testing. The veterans spoke of the value of having their own manual to refer to when they felt distressed (i.e., experiencing triggers or cravings) or were having difficulty employing a particular coping skill. Finally, the veterans indicated that the treatment made them feel valued and hopeful for the first time in years. This was an uncontrolled pilot study and thus there was no control group, no follow-up on dropouts, and no follow-up months after completion to see if there were lasting effects of treatment.

TECHNOLOGY TRANSFER OF SEEKING SAFETY IN VA

If EBTs are to be translated from science into service, an adjustment in the education, training and supervision of front-line clinicians is likely warranted. Our process of educating and training practitioners by coleading a group proved beneficial. Most clinicians reported that they were reluctant to jump in, try something new and become clinically responsible for a new group of patients alone. Easing in the process or "foot in the door" phenomena can help bolster the intrinsic motivation to learn a new technique. In marketing or managerial terms this strategy might be called "implementation support."

Although Najavits (2000) provides suggestions for how to learn Seeking Safety, we did not choose to audio or videotape the clinicians delivering the treatment and rating or providing feedback on adherence and competence. This would have been costly in terms of allocation of resources (e.g., equipment purchase, trainer time to watch tapes). A recommendation for future dissemination and implementation is to designate one or two influential clinicians, those seen as opinion leaders by the group, to be specifically trained and then require them in copractice to engage in training and supervision.

It was important for us to stress that although Seeking Safety was manual-based, there was flexibility in its delivery. For instance, it was highlighted that if clinicians learned Seeking Safety, they would have a new set of skills useful in group or individual format, in whole or in parts, in an inpatient or outpatient setting. It is a treatment model that appears readily translatable in VA settings without major modification. We recommend that the VA create incentives for clinician adherence to implementation.

Many SUD and PTSD clinicians in VA appear time-pressured to take care of large numbers of patient with complex emotional, medical and social needs. In many VA substance abuse and mental health settings, clinicians already are multitasking and are somewhat resistant to another responsibility in practice. In this dissemination and implementation process, we were continually aware of the importance of sustaining the treatment after the groups were completed. It is important to make new modalities intrinsically rewarding for the clinician by showing them that these complex SUD-PTSD patients with very chaotic lives can make significant treatment gains in symptom reduction and quality of life improvement.

One of the ways we "sold" the treatment to clinicians was to advocate belief that the Seeking Safety manual, technique, and philosophy would help increase clinicians' capacity to provide quality of care to patients and help with documentation and compliance. We continually promoted the idea that the strategies used in Seeking Safety (e.g., written patient handouts with non-technical terms) encourage sustained learning in a veteran population showing difficulties with concentration and memory.

Implementing change in clinical practice is a daunting task. Potential barriers include the clinician's skeptical or negative attitudes and beliefs about the treatment, patient characteristics (e.g., difficulties in willingness to engage and co-occurring problems) and deficiencies in systems factors such as communications, timing, and supports provided for the "buy-in" from leadership. Essential to the clinician's perception of the new treatment is whether or not it is relevant to day-to-day practice and has added value. Seeking Safety is an integrated treatment that is "user friendly" for both traditional mental health and substance use clinicians addressing the pertinent issue that confronts the field of how to best treat patients who present with this dual diagnosis. EBTs and best practices that require additional time in indirect clinical care and that are not patient-friendly tend to be perceived as burdensome. Seeking Safety provides "time and resource-strained clinicians" with structure and exercise supports that facilitate the practicing of patients' newly acquired skills both in and out of the treatment sessions. Generalized acceptance of EBTs is less likely to occur if the front-line clinician perceives the treatment to have been developed in a controlled environment and not with the complex multiproblem patients they work with on a daily basis. In the current environment clinicians are looking for proven interventions that reduce their burden related to documentation but also enhance the skill levels of their patients in clear, objective, patient friendly and measurable terms. Finally, how an EBT is introduced and maintained in a system is critical. One-time educational workshops and mandatory implementation

approaches are not effective (Davis et al. 1999). What does appear to be productive is the copractice model utilized at PVAMC in implementing Seeking Safety. Other supportive techniques include ongoing supervision and consultation between the provider and the scientist to enhance fidelity as well as trouble shoot problematic aspects of the treatment.

Though its clinical benefits have not yet been firmly established, Seeking Safety does appear to be an easily disseminated treatment in terms of clinician and veteran acceptability and veteran benefit.

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