Innovation and implementation in integrated care

trauma, PTSD and addiction

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Disclosures

- supported by a National Health and Medical Research Council Investigator Grant
- member of the Royal Australian & New Zealand College of Psychiatrists Steering Committee on Psychedelic Assisted Therapies; and immediate past chair of the RANZCP Faculty of Addiction Psychiatry
- received speaker honoraria from Camurus, Indivior, Gilead, Janssen and Servier unrelated to this work


I acknowledge with deep
respect all First Nations People
and traditional owner groups
across Australia

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Recognition

I recognise the lived and living experience workforce and all people accessing our services, as their expertise, partnership, and generosity of sharing experiences help us shape services that are safe, accessible, and inclusive.

I would like to acknowledge and thank community who participated in this research, including people who inject drugs & participants with a lived experience of mental health & substance use problems.

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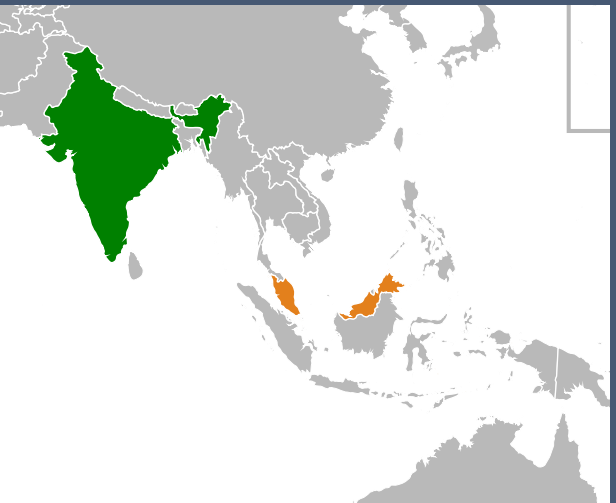
overview

context - PTSD + substance use disorder

- **implementing integrated treatment**
- **building a road map for translation**
- **innovation in integrated treatment psychedelic-assisted therapy**

context


Maharashtra
Warangal
Hyderabad
Vishakhapatnam
Yanam
Andhra
Paradesh
Vijayawada
Bay
of
Bengal
Goa
Karnataka
Tirupati
Port Blair
Arabian
Sea
Coorg
Bangalore
Chennai
Kanchipuram
Mahabalipuram
Mysore
Ooty
Tamil Nadu
Pondicherry
Lakshadweep
Islands
Kavarati
Trichy
Kodaikanal
Thanjavur
Munnar
Kumarakom
Madurai
Alleppey
Thekkady
Rameshwaram
Kovalam
Thiruvananthapuram
Cochin
Kanyakumari
Indian Ocean

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PTSD + substance use disorder

Prevalence of PTSD in Australia

- Nearly 3 in 4 Australians will experience some form of trauma in their lifetime
  Approx 4.5% go on to develop PTSD
- Twice as common in women than men



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Trauma is a major risk factor for mental health problems and is implicated as both
a causative factor *and*
a perpetuator of substance use disorders

Nearly **1 in 2** individuals in Australian substance use treatment report some symptoms of trauma—related MH disorders

Kingston, Marel and Mills. 2017

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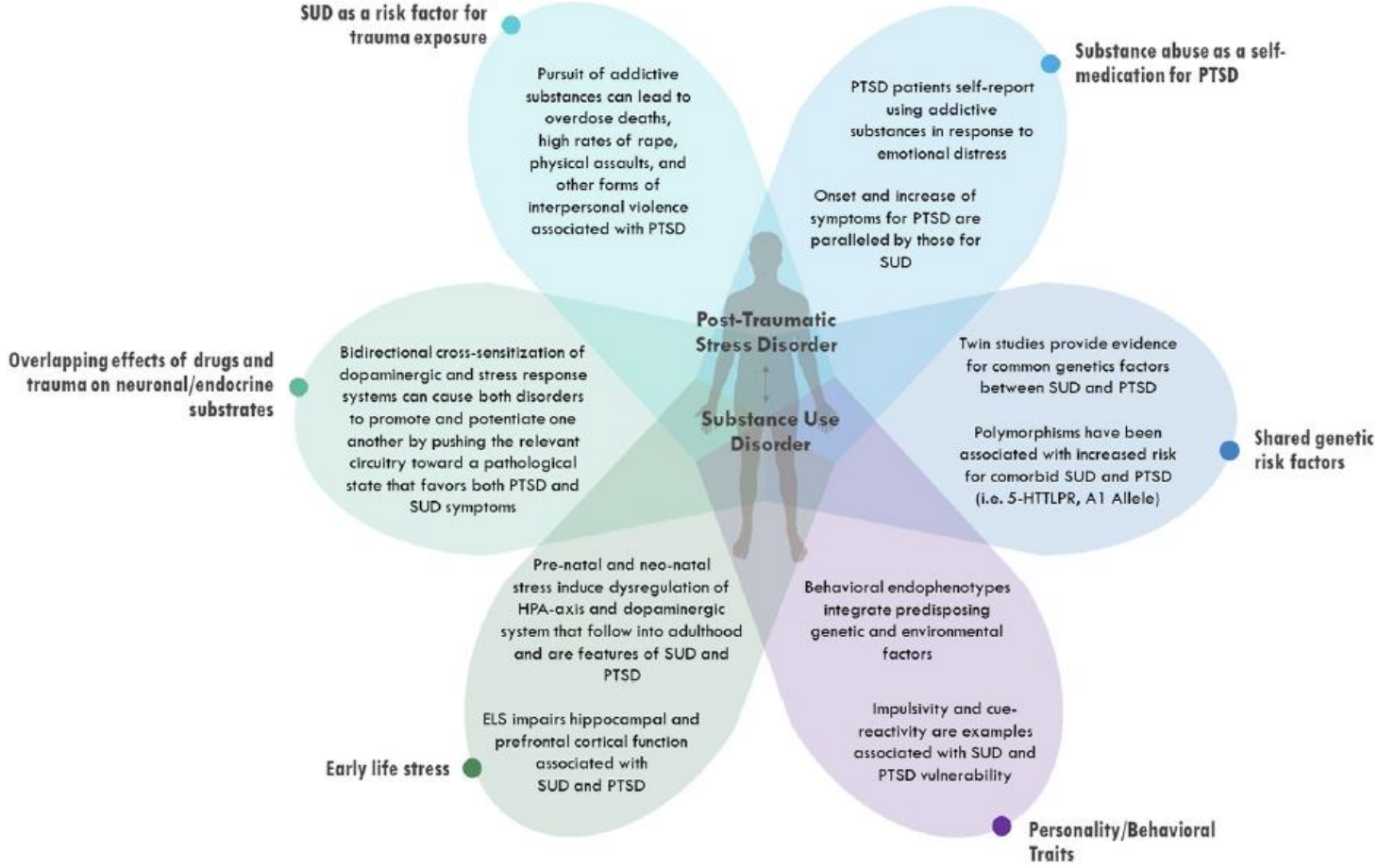
PTSD and Substance Use Disorder

PTSD can be debilitating, and its clinical course is worsened by co-occurring SUD:

- Poorer physical & psychological health
- Poorer psychosocial functioning
  e.g. more interpersonal and legal problems
- Poorer treatment response
- More inpatient hospitalizations

Brady KT, Back SE, Coffey SF; 2004

Why do PTSD and SUD co-occur?

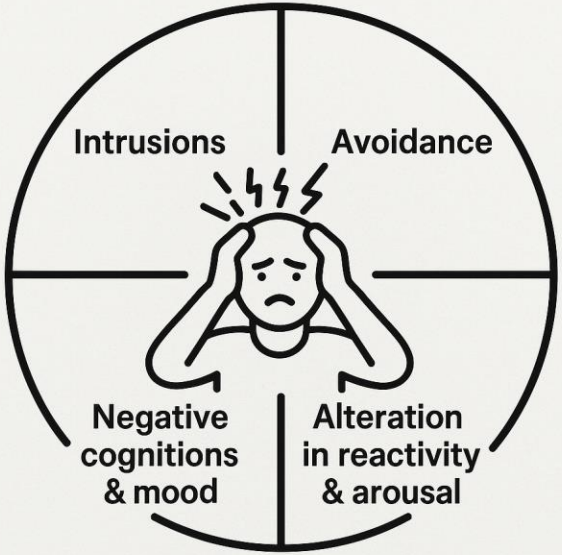


Maria-Rios & Mo Front. Behav. Neurosci. 2020

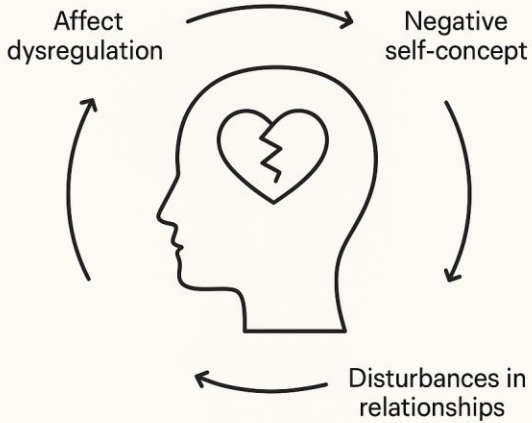
"It is not the event that determines whether something is traumatic to someone, but the individual's experience of the event"

(Jaffe, Segal & Flores Dumke, 2005)

Core PTSD symptoms

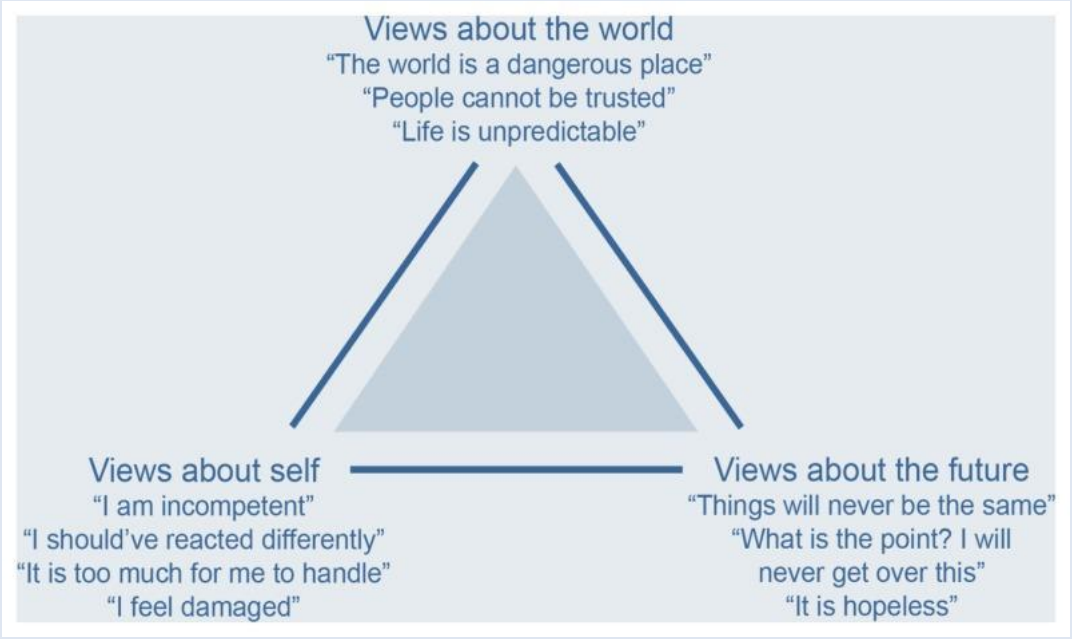


DSM-5



Complex PTSD symptoms

ICD-11



Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57

Symptoms for each diagnoses

ICD-11 PTSD	ICD-11 CPTSD	DSM-IV BPD
Re-experiencing	Re-experiencing	
Flashbacks	Flashbacks	
Nightmares	Nightmares	
Avoidance	Avoidance	
Thoughts	Thoughts	
People, places, activities	People, places, activities	
Sense of threat	Sense of threat	
Hypervigilance	Hypervigilance	
Startle	Startle	
	Emotion regulation	
	Anger	
	Hurt Feelings	
	Negative self-concept	
	Worthless	
	Guilty	
	Interpersonal problems	
	Not close	
	Feel disconnected	
		Frantic
		Unstable relationships
		Unstable sense of self
		Impulsiveness
		Self-harm
		Mood changes
		Empty
		Temper
		Paranoid/dissociation

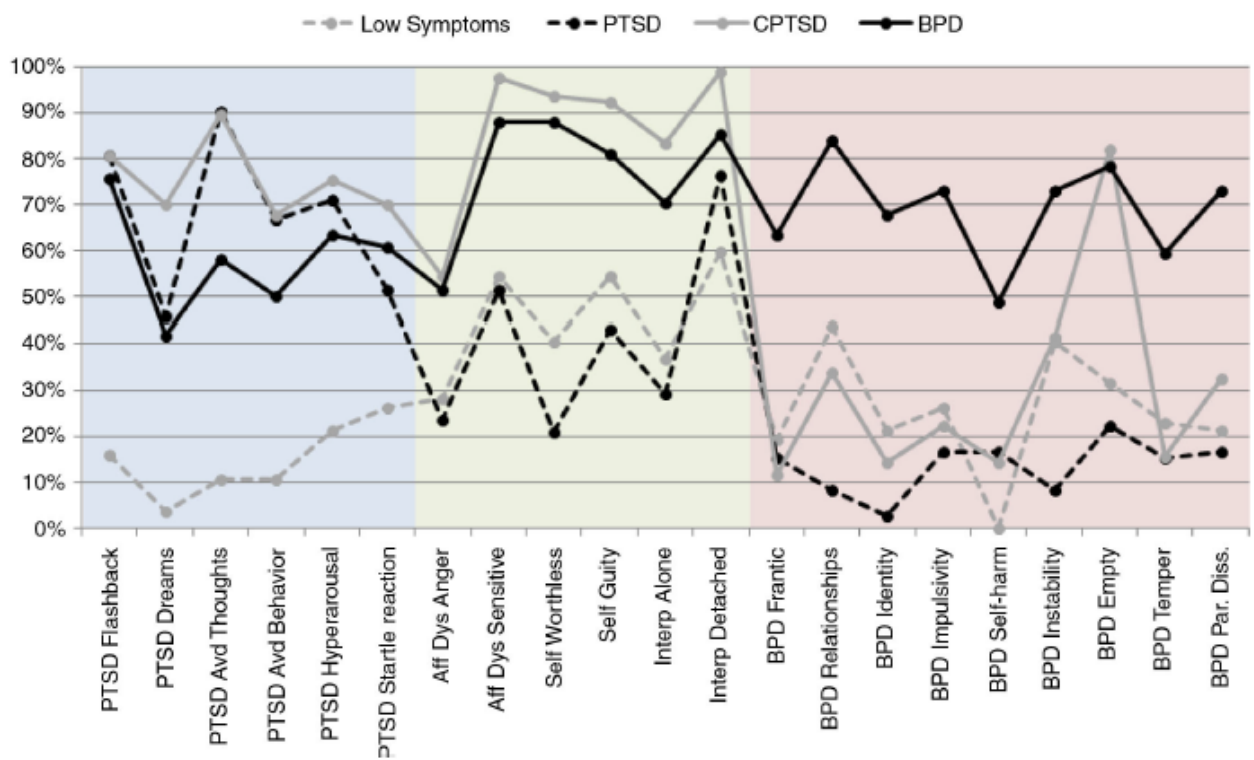


Fig 1. Symptom endorsement of Complex PTSD and BPD items by class.

Cloitre et al, 2014 Eur Journal of Psychotraumatology

Complex trauma and perceived barriers to treatment among people accessing a supervised injecting facility

- 102 PWID attending MSIR
- 89% experienced at least one potentially traumatic event
  - 23% >10 event types
- 29% past 30-day PTSD
- 83% of this group had symptoms that also met criteria for C-PTSD
- Consistent with other studies in treatment settings
  ~40% PTSD prevalence w
  CPTSD higher prevalence than PTSD

eetham... Nielsen and Arunogiri, 2025. Eur Journal of Psychotraumatology
rvey, Slade, Marel and Mills, 2025. Psychological Trauma: Theory, Research, Practice and Policy

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integrated treatment

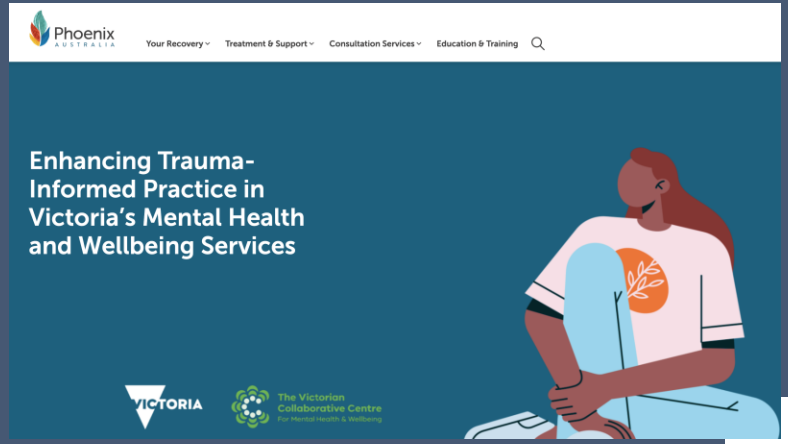
Trauma informed care

Trauma informed care

- Talking safely about trauma: sensitive questioning, not pursuing information if client does not want to talk about it

Principles to guide clinical and organizational practice; overarching framework for sector

Does not *treat* trauma, but does support safe care during treatment for other problems


Phoenix
AUSTRALIA
Your Recovery
Treatment & Support
Consultation Services
Education & Training
Enhancing Trauma-Informed Practice in Victoria's Mental Health and Wellbeing Services
VICTORIA
The Victorian Collaborative Centre
For Mental Health & Wellbeing

bitly


Available Tools and Resources
Understanding Trauma-Informed Practice
Organisational Audit of Trauma-Informed Practice
Trauma-Informed Reflective Practice
Supporting Safe Disclosures of Trauma
Trauma-Informed Approach to Risk
Minimising Impacts of Vicarious Trauma

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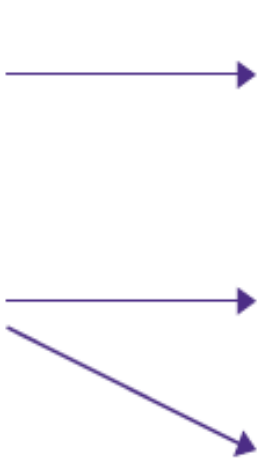
Trauma treatment

Non Trauma Focused	Trauma Focused
Present focused	Past focused- trauma memory
No revisiting or re-processing of memory	Revisit & reprocess
Stress management, skills building, somatic	Cognitive (e.g., cognitive processing therapy, prolonged exposure), EMDR

Integrated trauma treatment

AOD clinicians can do significant work at Phase 1

With extensive professional training and clinical supports AOD clinicians could work at all three phases



Three phases of trauma treatment

Phase 1: Safety, stabilisation and symptom reduction

Includes actual and perceived safety, development of emotional awareness, emotion regulation, distress tolerance and therapeutic alliance.

Phase 2: Processing of trauma memories

Involves revisiting and re-examining the traumatic events and the associated relational cognitions.

Phase 3: Intergration and reconnection

Involves establishment of a new way of seeing the self, improved self-esteem and repair enlargement of interpersonal and social connections.

Adapted from Rothschild (2000)

So what works?

Decades of research supports safety and efficacy of integrated, trauma focused treatments[1]

Trauma-focused integrated approaches have the strongest evidence base

COPE- Integrated CBT-relapse prevention with Prolonged Exposure- is gold standard *(APA PTSD Guidelines 2025)*

Medications can play a role in symptom management[2]

Medications for substance use (e.g., alcohol pharmacotherapy)are effective and should be routinely prescribed

However- translation and implementation gap

1 Hien, Psychological Bulletin 2024; 2 Arunogiri, JSAT, 2025

Implementing and evaluating integrated treatment

- Integrated, evidence-based treatment program for PTSD and SUD
- Synthesis of 2 treatments – Prolonged Exposure and CBT
- ↓ Sx of PTSD using prolonged exposure (imaginal & in vivo)
- ↓ substance use using cognitive behavioural techniques
- American Psychological Association (2025) Firstline treatment – strong recommendation

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Original Contribution FREE

August 15, 2012

Integrated Exposure-Based Therapy for Co-occurring Posttraumatic Stress Disorder and Substance Dependence

A Randomized Controlled Trial

Katherine L. Mills, PhD; Maree Teesson, PhD; Sudie E. Back, PhD; et al

Author Affiliations | Article Information

JAMA. 2012;308(7):690-699. doi:10.1001/jama.2012.9071

2012

JAMA Network Open

RCT: Concurrent Treatment of Posttraumatic Stress Disorder and Alcohol Use Disorder in Women

POPULATION

90 Women

Women with posttraumatic stress disorder (PTSD) and moderate-to-severe alcohol use disorder

Mean age, 44.7 y

INTERVENTION

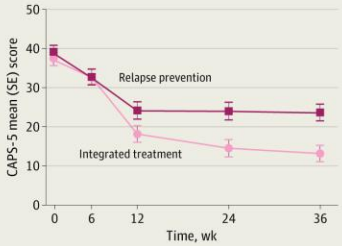
90 Patients randomized
Participants were randomized to receive
12 individual sessions of treatment

45 Integrated treatment
Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)

45 Relapse prevention
Treatment guided by the Project MATCH Cognitive-Behavioral Coping Skills Therapy Manual

FINDINGS

Compared with relapse prevention, integrated treatment significantly reduced PTSD; alcohol use also decreased in both groups, but with no significant between-group difference



Alcohol use
Integrated intervention: 144.41 (95% CI, 104.66-184.15) g/wk at baseline, 92.65 (95% CI, 48.81-136.48) g/wk at 9-mo
Relapse prevention: 133.45 (95% CI, 93.71-173.19) g/wk at baseline; 77.80 (95% CI, 31.65-123.95) g/wk at 9-mo

SETTINGS / LOCATIONS

3 Addiction services in Sweden

PRIMARY OUTCOME

Change from baseline to 9 mo in PTSD symptom severity, measured by the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; range, 0-80; higher scores indicate greater severity) and weekly alcohol use, measured by Timeline Followback self-report (g/wk)

Persson A, Axén Å, Capusan AJ, Magnusson Å, Helig M. Concurrent treatment of posttraumatic stress disorder and alcohol use disorder in women: a randomized clinical trial. *JAMA Netw Open*. 2025;8(7):e2521087. doi:10.1001/jamanetworkopen.2025.21087

2025

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implementing integrated treatment

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Could we offer this in a ‘routine’ clinical setting?

'Know-do’ gap- how do we implement this?

Set up in collaboration with Prof Katherine Mills and Prof Sudie Back in 2020
Supported by Northwest Melbourne PHN in Victoria

Learning curve

Skills base; Capacity & confidence; Supervision

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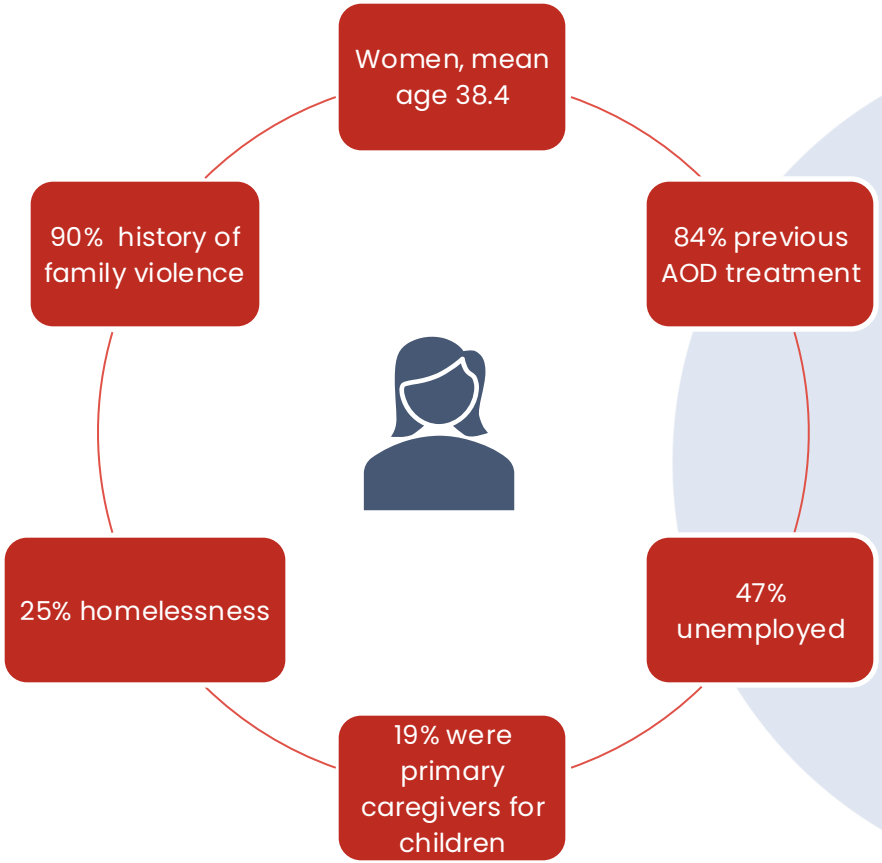
Preliminary data 372 clients

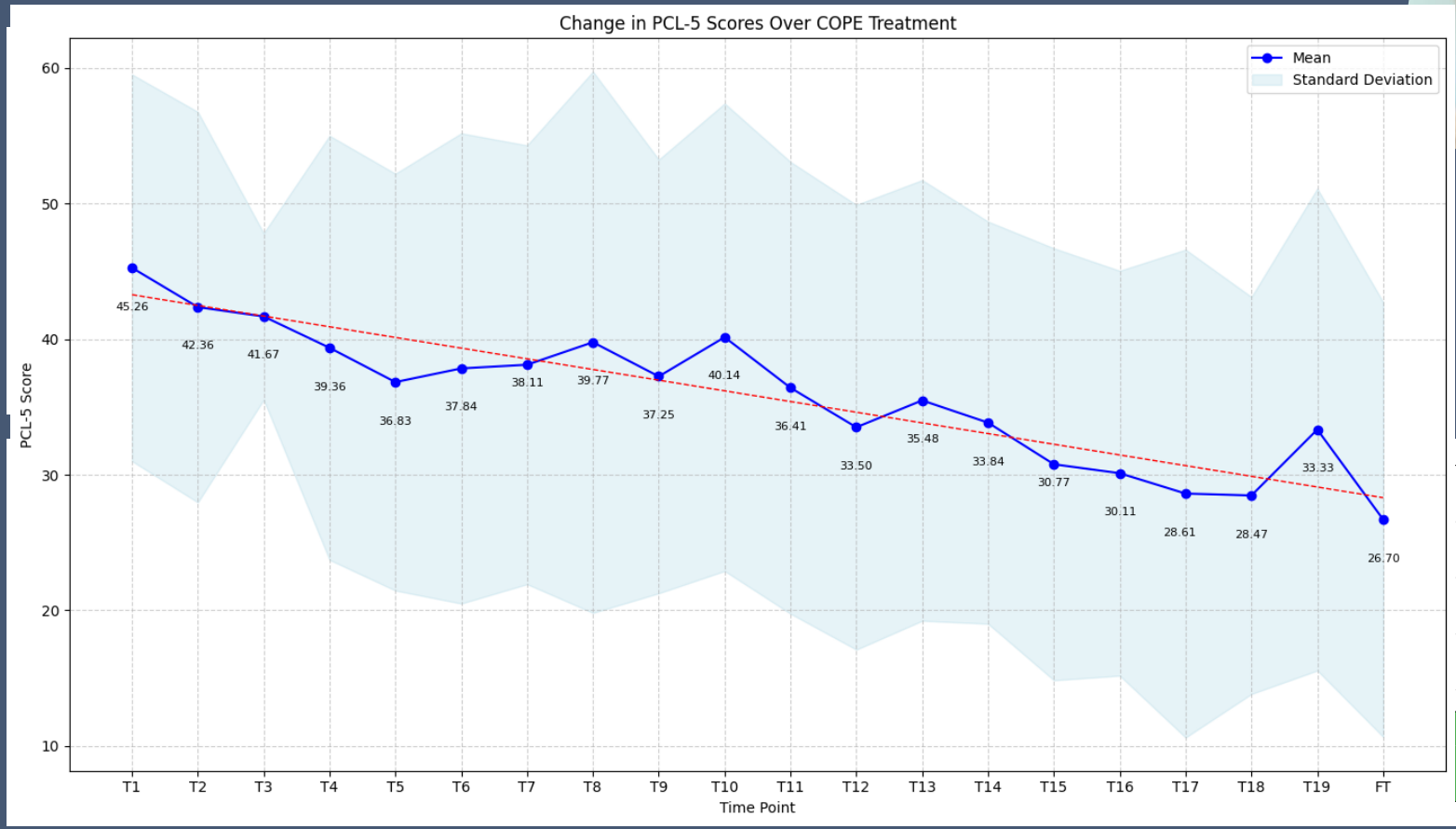
Descriptive characteristics

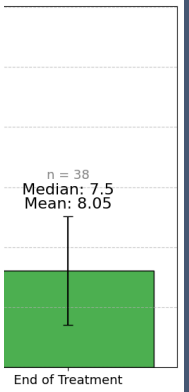


Primary drug of concern
Alcohol (41%)
Methamphetamine (28%)

COPE Clinic at Turning Point

Tooba Fatima





Manuscript in prep

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translation to practice

Integrated care capacities for co-occurring trauma/PTSD and SUD

India Read, Sara Daly, Troy McGee, Leah Heiss; Anne Laure- Couineau, Cathryn Pilcher, Irina Hart, Katrin Oliver, Ali Cheetham, Shalini Arunogiri
2025

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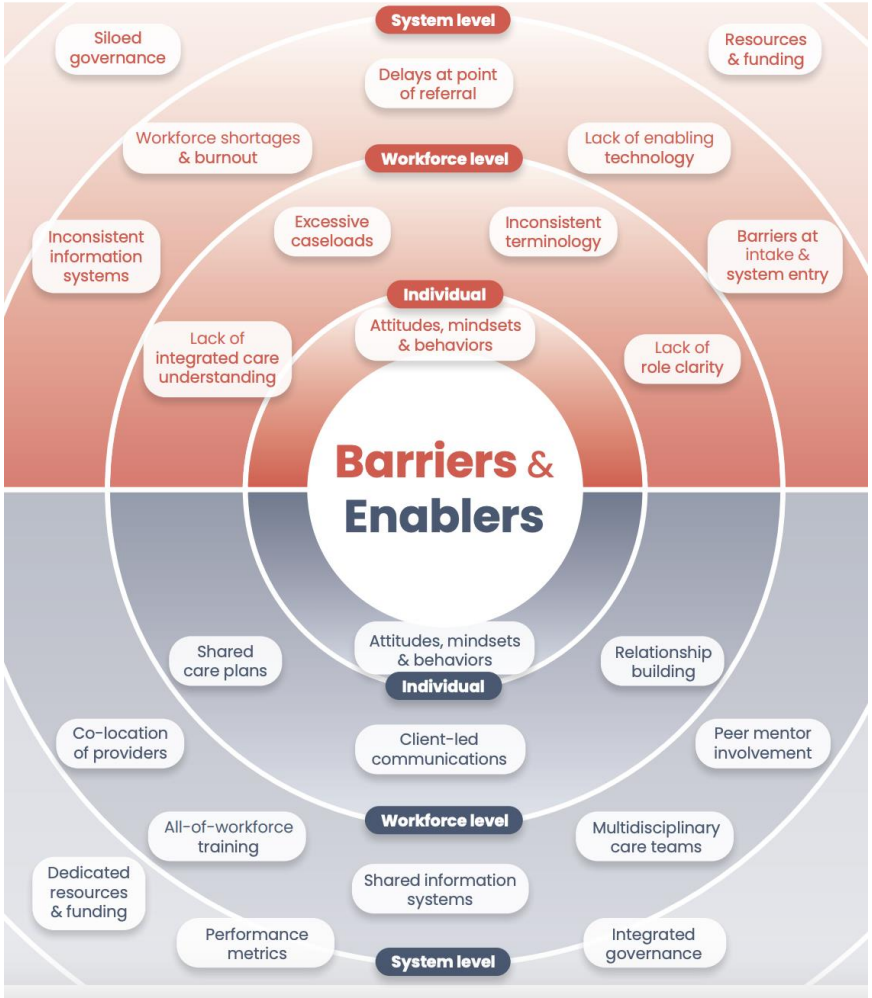

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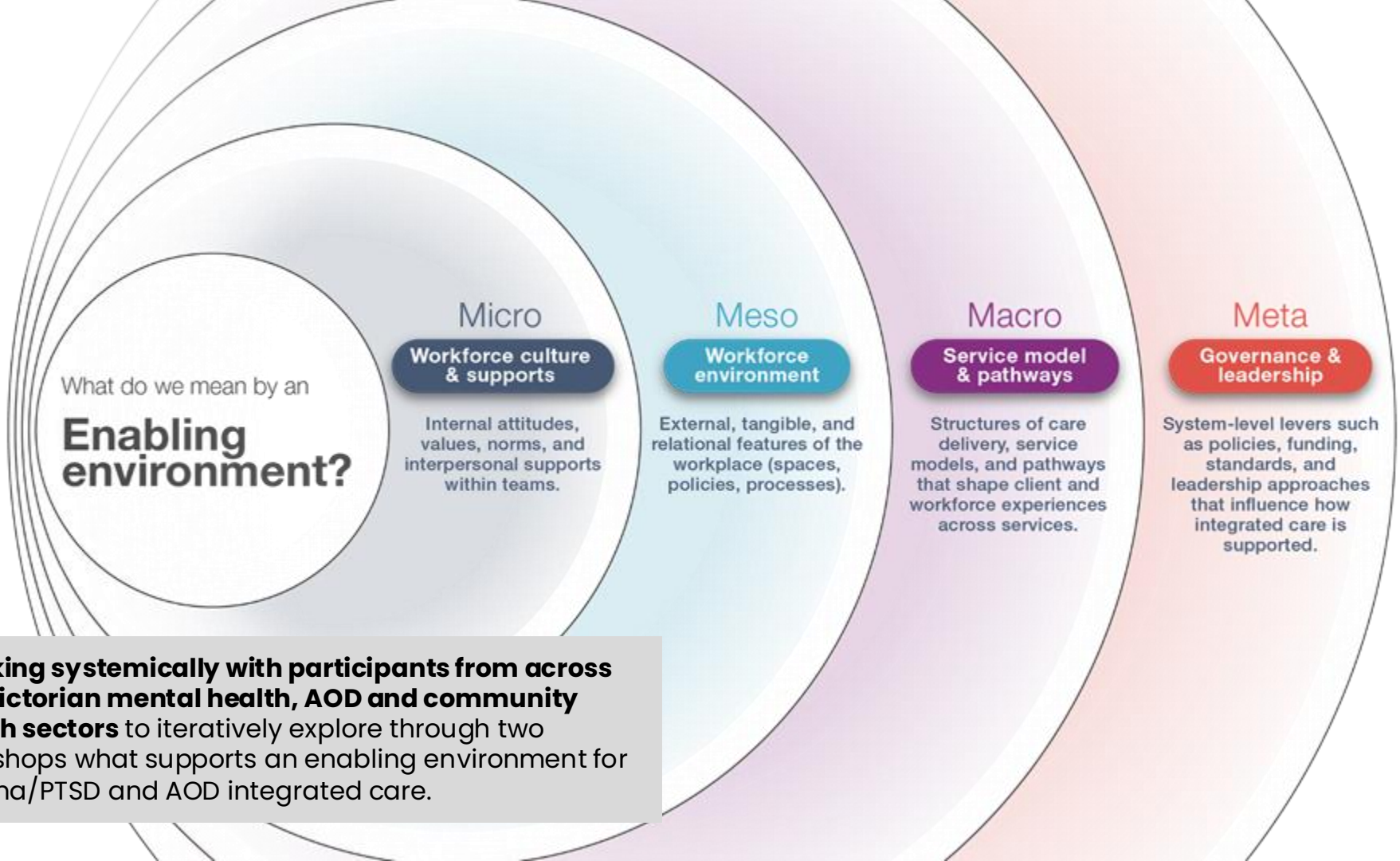


Thinking systemically with participants from across the Victorian mental health, AOD and community health sectors to iteratively explore through two workshops what supports an enabling environment for trauma/PTSD and AOD integrated care.

Co-design with

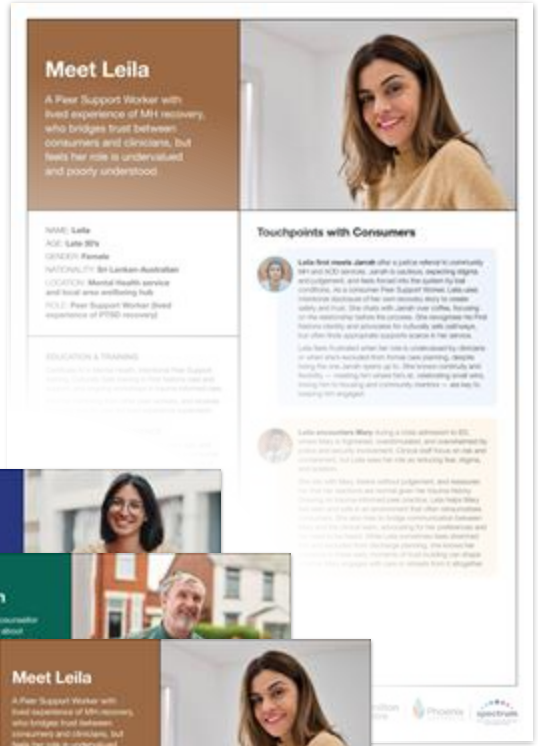
people with lived experience

service providers

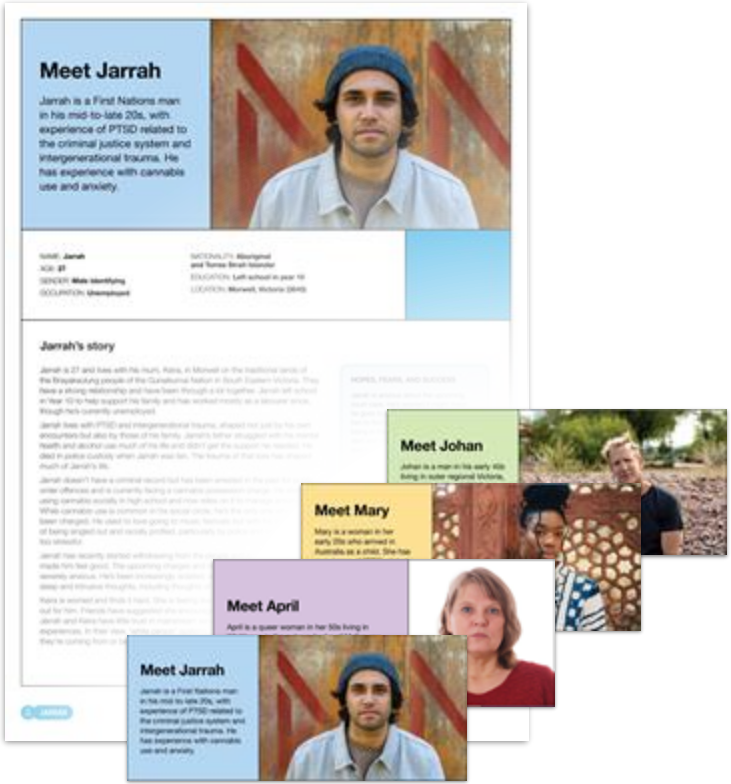
peer workers, AOD clinicians, MH clinicians

Exploring what constitutes an enabling environment in practice
by anchoring workshop activities in the experiences and needs of consumers and workforce using personas

Workforce personas



Consumer personas



Each square represents a finding from one of the two workshops, mapped to the enabling environment framework

Key

WS1 WS2

What do we mean by an Enabling environment?

Micro
Workforce culture & supports
Internal attitudes, values, norms, and interpersonal supports within teams.

Meso
Workforce environment
External, tangible, and relational features of the workplace (spaces, policies, processes).

Macro
Service model & pathways
Structures of care delivery, service models, and pathways that shape client and workforce experiences across services.

Meta
Governance & leadership
System-level levers such as policies, funding, standards, and leadership approaches that influence how integrated care is supported.

Training and embedding learning into practice
- Discipline specific skills & approaches.
- Access & awareness of Trauma-Informed Tools & resources
- Access to Training
- Rhetoric and confidence gap : Trauma
- Access to training
- Embedding training
- Discipline-Specific Mentoring & Debriefs
- Reflective Practice
- Mentoring, supervision
- Reflective practice

Worker supports
- Healthcare Worker Practice Supports
- Personal Supports
- Employment supports

Trauma/PTSD and AOD Care model
- Challenging Stigma
- Trauma - Informed Trust &
- Understanding of consumer
- Models shape care
- Trust & Rapport Building
- Flexibility of approaches
- Supporting and supportive families
- Cultural and contextual gaps
- Culturally-safe and inclusive approaches to
- Strength-based Engagement
- Culturally safe care
- Strength-based engagement

Worker confidence
- Worker hesitancy & confidence gaps
- Confidence & Know-How
- Worker strengths and confidence

Roles, coordination and cohesion within team
- Multidisciplinary Care Coordination
- Breaking down territorial behaviours
- Collaborative coordination practices
- Team inclusion, cohesion and equity
- Learning across disciplines/ roles
- Role Clarity
- Disciplinary role Drift & Scope Creep
- arity ope

Current IC challenges
- Variability and inconsistency
- Time and resource constraints
- Poor fit with trauma & addiction
- Time and resource constraints
- Difficult environments
- Stigma and shame
- Access and navigation barriers
- Process-centered vs person-centered
- Entry barriers
- Process-centered vs person-centered

Care model enablers
- System Literacy & Navigation Support
- Appropriate Service Referrals & Access
- Continuity of Care
- Referrals & Access
- Access to lived experience
- Transition support
- Space for healing
- Protected time
- Transport and tools

System level enablers
- KPIs and evaluation
- Implementation and change-management
- Governance and funding

The findings have informed the development of 7 x pathway principles as well as 25+ actions for achieving enabling environments for trauma/PTSD and AOD integrated care.

Example actions responding to the findings:

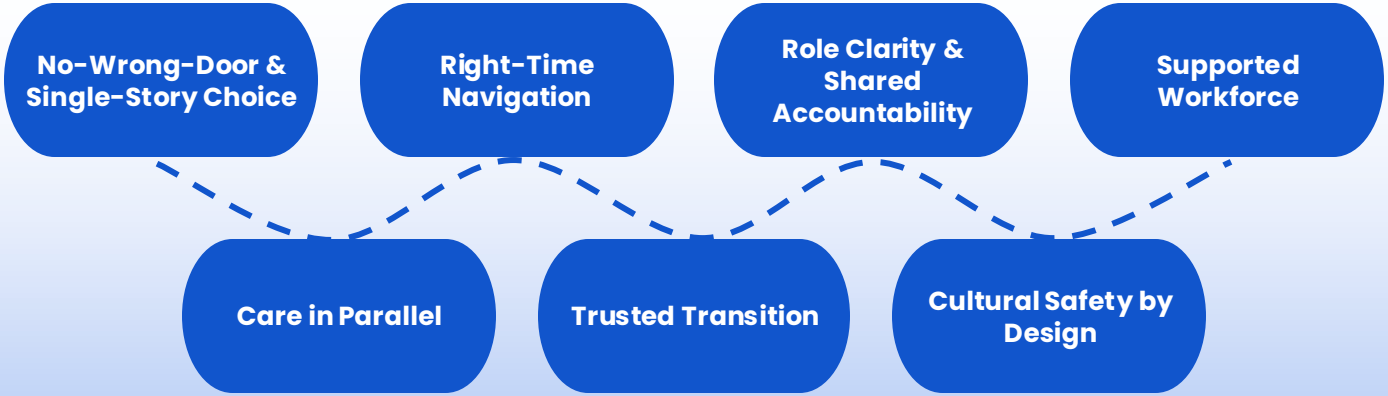
Micro
Connective activities to support confidence through learning, team-building, e.g reflective practice, supervision

Meso
Structured multidisciplinary team ways-of-working to support coordination e.g case-conferencing, debriefs

Macro
Time frames that support flexibility, rapport-building, and prioritise consumer readiness and needs

Meta
Recruit lived experience at senior and leadership levels

7 x pathway principles to follow for integrated, trauma-informed treatment



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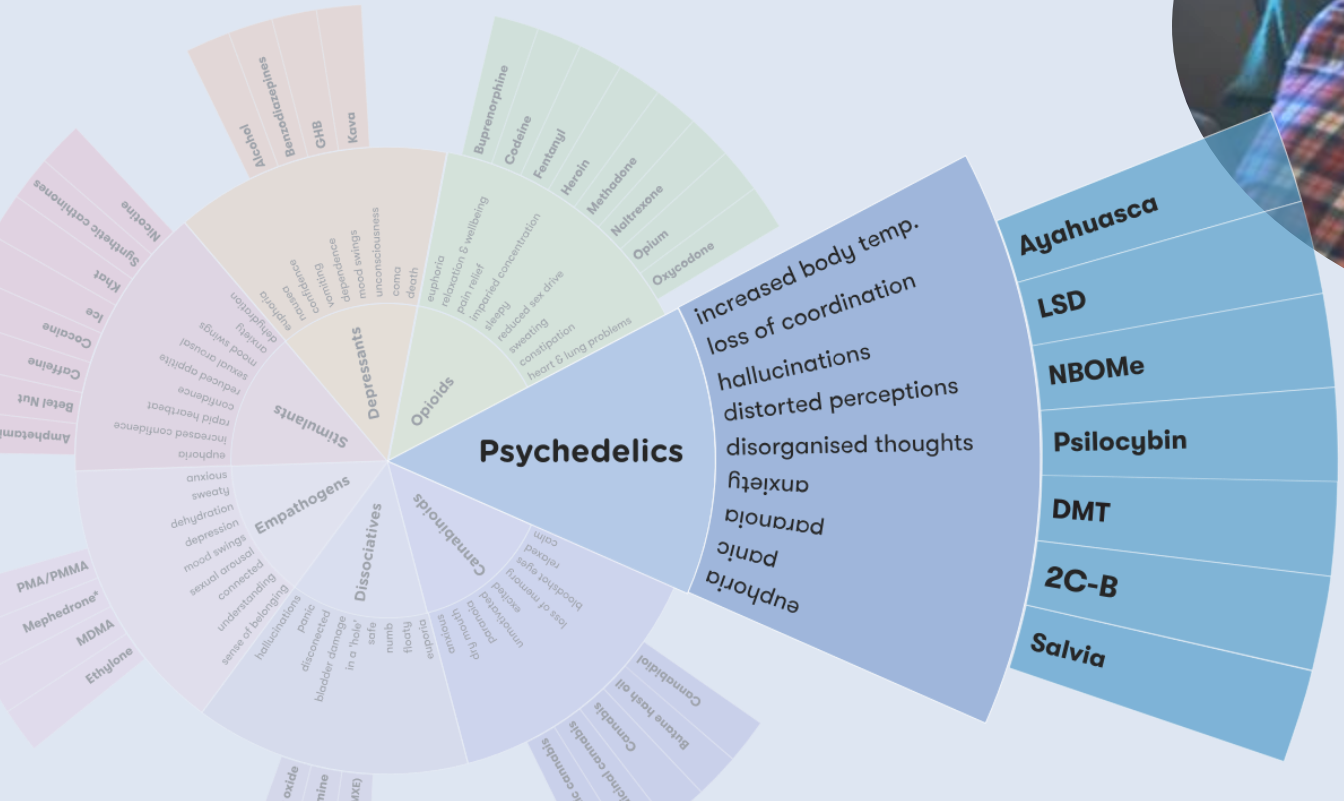
innovation in integrated treatment

psychedelic assisted therapies



Psychedelic assisted therapies

- Australia – first international jurisdiction for a psychedelic therapy medicalised model
- Growing evidence base for PTSD and depression
- Clinical Practice Guidelines- MDMA for PTSD (Monash University) public consultation to 31 Aug 2025 and now available
- People with co-occurring substance use and/or SUD have not been included in most of the existing trials (there is no evidence)

Alene Sze Jing Yong, Sue E Brennan, Suzie Bratuskins, Aimée Freeburn, Shalini Arunogiri, Gillinder Bedi, Rimona Burke, Terry Haines, Mary Hollick, Kimberley Ann Jones, Andrew J Lawrence, Yong Yi Lee, Alexander C McFarlane, Ernst Meyer, Stephen Parker, Nicholas Procter, Andrew A Somogyi, Liam Spicer, Simon Stafrace, Clare Walton, Stacey Watts, Kay Wilson, J Simon Bell. Clinical Practice Guidelines for the Appropriate Use of MDMA-Assisted Psychotherapy for Post-traumatic Stress Disorder. Parkville: Monash University 2025.

MDMA-Assisted therapy for PTSD and Alcohol

Lead investigator

Kirsten Morley
University of Sydney

Two clinical sites
Sydney (RPAH)- PI Paul Haber
Melbourne (Turning Point)- PI Shalini Arunogiri

Our investigator team
Katherine Mills, Dan Lubman, Andrew Baillie, Maree Teesson, Alyssa Morse, Yong Yi Lee, Sudie Back

https://clinicaltrials.gov/study/NCT05709353

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Model of psychotherapy

Extended eligibility- screening & assessment process (typically over 3-4 sessions over 4-6 weeks, including medication taper where indicated)

Dosing model

Dosing sessions are 6 hours, 2 co-therapists

Unstructured and non-directive/ supportive in orientation

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so what next…

- Trauma treatment is not currently accessible for people living with substance use disorders
- Major gaps in translating research into practice
- Barriers – funding, workforce training, sustainability
- Opportunities to design implementation of interventions to meet the needs of the communities they serve, and the workforce and services that support them

Practical tips for clinicians

- Screening for PTSD can be easily done using the PCL-5, a 20-item questionnaire available online, and also through the PTSD Coach Australia app - *www.openarms.gov.au/ptsd-coach-australia-app*. The app supports individuals to self-screen for PTSD and also to track their symptoms over time.
- In community health, AOD and general practice settings, a brief 5-item screener may be more appropriate. The PC-PTSD-5 Primary Care PTSD Screen can be used for this purpose. Available at: *www.phoenixaustralia.org/disaster-hub/wp-content/uploads/2023/01/Primary-Care-PTSD-Screen-for-DSM-5-PC-PTSD-5.pdf*
- For clinicians working with clients who are unable to access evidence-based psychological treatment in-person, online options may be helpful. *This Way Up* operates a self-directed program for PTSD for clients who are managed by a clinician (e.g., their counsellor or their GP). Available at: *www.thiswayup.org.au/programs/post-traumatic-stress-program*
- Trauma-informed care is central to the delivery of mental health and substance use care. For more information on trauma-informed care, clinicians can refer to the *Victorian Mental Health Capability Framework*, and the Network of Alcohol and Other Drug Agencies (NADA) guide available at: *www.nada.org.au/wp-content/uploads/2022/12/Trauma-informed-practices.pdf*
- For clients, *Blue Knot Foundation* hosts a range of resources, factsheets and self-help tips that can assist with managing PTSD symptoms.

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thank you for listening

With thanks to the courageous clients who access our services and participate in our research

Acknowledgements to our amazing team
Sarah Catchlove, Ali Cheetham, Katrin Oliver, Tooba Fatima, Anna Bough, Trudi Mckenzie, Liron van Heerden, Taya Grainger, Dominique Jones, Emily Bove, Maddy Willis, Temika Mu, Michelle Sharkey, Adam Milne, Vanessa Wilson, Daniel Pham, Catrin Gabriel, Dan Lubman

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