Hamilton Centre

Understanding competencies: Integrated Care for Co-occurring Trauma/PTSD and Substance Use

Prepared by:
Monash University Art, Design and Architecture (MADA)
Monash University
900 Dandenong Road
Caulfield East VIC 3145
Australia

Correspondence:
Associate Professor Leah Heiss
Eva and Marc Besen International Research Chair in Design
Emerging Technologies Research Lab
leah.heiss@monash.edu

MONASH University

Turning Point
TREATMENT · RESEARCH · EDUCATION

Photography by
Adam R. Thomas.

Acknowledgement of country

Monash University Art, Design and Architecture (MADA) and Hamilton Centre acknowledge the First Nations peoples of Australia, the traditional custodians of the lands on which this research was conducted. We pay our respects to ancestors and Elders, past, present, and emerging.

MADA and Hamilton Centre are committed to honouring First Nations peoples' unique cultural and spiritual relationships to the land, waters and seas, and their rich contribution to health and wellbeing.

Our respect also extends to all Traditional Custodians of the lands, waters, animals, forest, and skies where this report is read, and we are grateful for the cultural wisdom that may teach us in guiding our shared health futures.

We extend this acknowledgement to people with lived and living experience of co-occurring trauma, addiction, and their recovery journey. We also acknowledge the experience of people who have been carers, families, or supporters. We recognise their vital contribution to this research, and value the courage of those who shared their unique perspectives for the purpose of this project.

Monash Art, Design and Architecture
Monash Art, Design and Architecture (MADA) is a connected community of creative thinkers, makers, researchers and professional practitioners. Through our research, MADA academics play a prominent role in Australia's creative culture, as well as in addressing pressing global challenges. Read more at monash.edu/mada.

Turning Point
Turning Point is Australia's leading addiction treatment, research and education centre, providing support for people adversely affected by alcohol, drugs, and gambling.

The **Hamilton Centre** came from renewed investment by the Victorian Government into integrated care for people living with mental illness and substance use or addiction. This was a recommendation of the Royal Commission into Victoria's Mental Health System (2021), recognizing that many people with co-occurring problems had difficulties accessing holistic care and navigating a complex treatment system.

Read more about Turning Point's work at turningpoint.org.au/

Read more about the Hamilton Centre's work at https://www.hamiltoncentre.org.au/#the-hamilton-centre

Monash University Team
Associate Professor Leah Heiss
Dr Troy McGee
Dr Sara Daly
India Read

Hamilton Centre team
Associate Professor Shalini Arunogiri
Dr Katrin Oliver
Dr Ali Cheetham

Co-design Partners
Anne-Laure Couineau
Cathryn Pilcher

Funding
This research was commissioned and funded by Turning Point.

Ethics approval
Ethics approval for this research was provided by the Monash University Human Research Ethics Committee (Project ID 48074), approved 29th July 2025.

Suggested citation
Understanding competencies: Integrated Care for Co-occurring Trauma/PTSD and Substance Use, (2025), Monash University and Hamilton Centre.

Some quotes have been edited for clarity and to preserve anonymity.

A note on content

This research acknowledges the strength of people living with co-occurring trauma/PTSD and addiction, their families, carers, supporters and the staff who care for them. We thank the people who have contributed their lived and living experience to this research.

This report contains information that could be distressing. It explores and discusses aspects of mental health and addiction, including substance use, addiction to alcohol and other drugs, trauma, post-traumatic stress disorder and complex clinical mental health presentations. These discussions are important to ensure that integrated care service delivery meets the diverse needs of the Victorian community. You may want to consider how and when you read this report. Please read with care.

If you are upset by the content of this report, or if you or a loved one need support, the following services are available to support you:

- For crisis support, contact Lifeline on 13 11 14.
- Beyond Blue on 1300 224 636
- National Suicide Callback Service on 1300 659 467 or visit their website suicidecallbackservice.org.au/
- For alcohol and other drug support contact the National Alcohol & Drug Hotline 1800 250 015
- For assistance in an emergency or life-threatening situation, contact emergency services immediately on Triple Zero (000).

Contents

Executive Summary

Context

In 2025, the Hamilton Centre and Monash University Art, Design and Architecture (MADA) formed a partnership with Spectrum (Victoria's Specialist Centre for Personality Disorder and Complex Trauma) and Phoenix Australia (Australia's National Centre of Excellence in Posttraumatic Mental Health) to identify the workforce capabilities and service supports needed to improve care for people with co-occurring trauma or post-traumatic stress disorder (PTSD) and substance use disorder (SUD). This work aims to develop practical, evidence-informed guidance to strengthen integrated and trauma-informed care delivery across tertiary, community health, and emergency care settings for people with co-occurring trauma/PTSD and SUD.

Project Method

MADA worked collaboratively with the Hamilton Centre team and partners Spectrum and Phoenix to develop and facilitate two workshops. These workshops used a sequenced co-design approach (Heiss et al. 2025) - an applied, practice-based method for bringing interdisciplinary teams together to address complex healthcare and service challenges. Workshop participants (n=28) included peer workers and consumers with lived experience, Alcohol and Other Drug (AOD) practitioners, and Mental Health and Wellbeing practitioners offering diverse perspectives. A detailed breakdown of participant expertise, organisations, roles and professions from each workshop can be found in Appendix A. The first workshop focussed on understanding how care is currently delivered to people with co-occurring needs across various health settings, and the second workshop focussed on the experiences and needs of healthcare workers in providing care to consumers with co-occurring needs. In particular, the sessions sought to understand what factors at different system levels contribute to an enabling environment for supporting people with co-occurring trauma/PTSD and SUD. In the context of this work an enabling environment encompasses the micro (workforce culture and supports); meso (workforce environment); macro (service model and pathways); and meta (governance and leadership) (see Fig. 2). Following the workshop, MADA researchers undertook a qualitative thematic analysis of the workshop data, to translate participant contributions into insights that could support integrated and trauma-informed treatment.

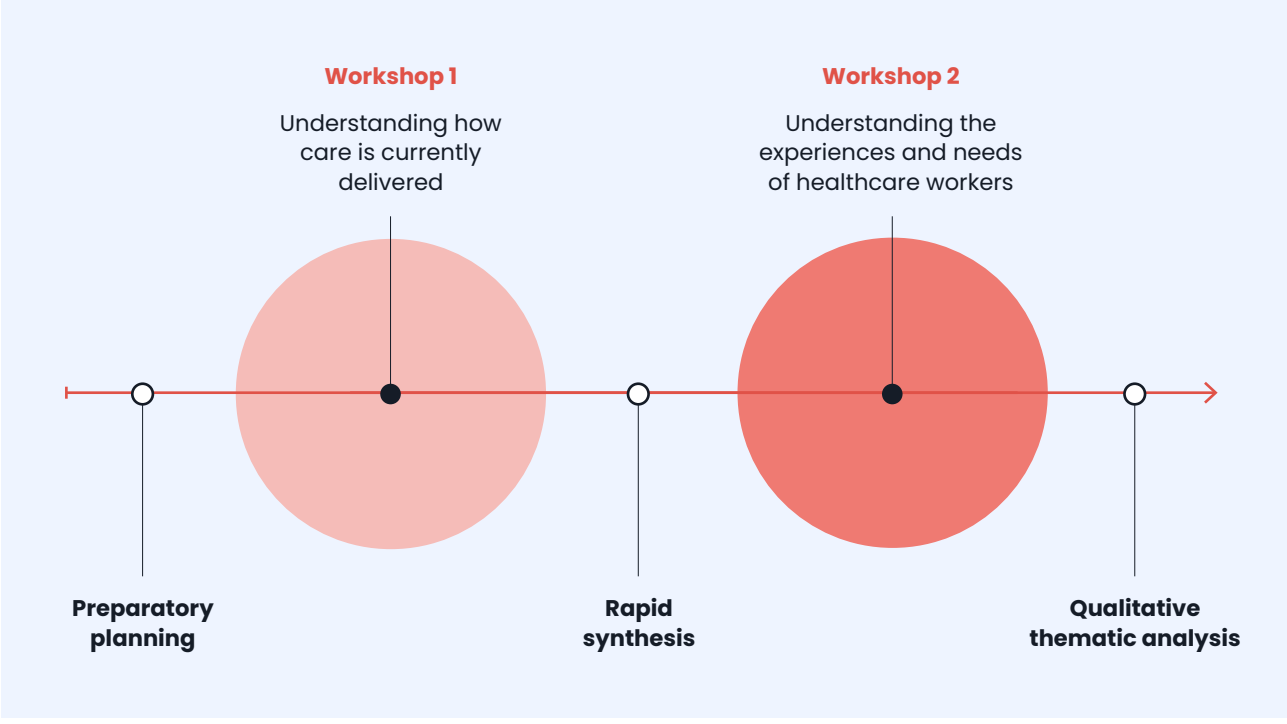


Figure 1 The co-design process

Key findings

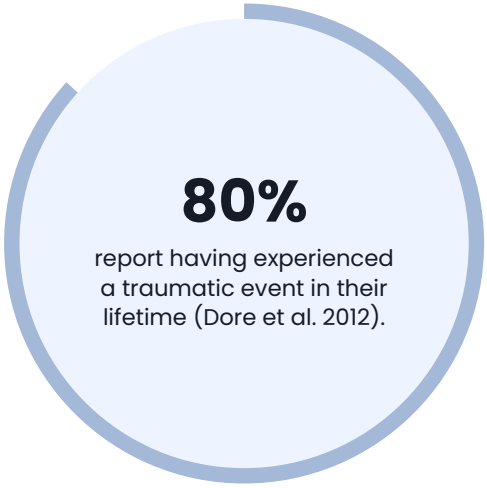
Participants in this research described a *breadth* of clinical and practical supports in use including treatments such as Cognitive Behavioural Therapy and Acceptance and Commitment Therapy, as well as psychoeducation, medication, housing/financial/legal, family/peer/cultural supports. They also highlighted fragmentation, variable delivery, time/resource constraints, and poor fit of Emergency Department (ED)/Inpatient Unit (IPU) environments for addressing the co-occurring needs of SUD, trauma and PTSD. We discuss these findings in relation to the emergent themes of Consumer experience and impacts in the current system; Workforce culture and supports; Service and team environment; Service model and pathways; and Governance and leadership. These findings are detailed in section 3 of this report. We translate these themes into seven Pathway Principles — No-Wrong-Door & Single-Story Choice; Care Delivery in Parallel; Right-Time Navigation; Trusted Transitions; Role Clarity & Shared Accountability; Cultural Safety by Design; and a Supported Workforce — developed to guide care models and service delivery for integrated, trauma-informed care and trauma-focussed treatment. While trauma-informed care aims for all services to consider and account for the pervasiveness and impacts of trauma in their design, trauma-focussed treatments directly target traumatic stress symptoms. These Pathway Principles are detailed in section 3 of this report, along with Prototyped Touchpoints: actionable approaches to service delivery aligned with the principles, generated based on workshop findings.

Participants share their group's discussion about their persona's experience in the current system. Photography by Adam R. Thomas.

1 Introduction

In 2025, the Hamilton Centre and Monash University Art, Design and Architecture (MADA) embarked on a partnership with Spectrum (Victoria's Specialist Centre for Personality Disorder and Complex Trauma) and Phoenix Australia (Australia's National Centre of Excellence in Post-traumatic Mental Health) to investigate the competencies and supports needed for co-occurring trauma/PTSD and SUD, across the Mental Health and Wellbeing (MH), Alcohol and Other Drug (AOD), and community health sectors. The MH and AOD workforce represents a highly diverse, passionate and dedicated community at the frontlines of supporting people with complex health and social needs. The strengths, efforts, resilience and capabilities of this workforce provide a powerful enabling resource, without which Victoria's MH and AOD sector could not function. The longer-term goals of this work are to operationalise practical guidance to support the workforce in health settings where people with co-occurring trauma/PTSD and SUD may present (for example, hospitals, acute and community care, AOD, community health and Victorian emergency departments(EDs)).

Trauma commonly co-occurs with mental health, AOD and Substance Use Disorder (SUD) presentations. Studies report up to two-thirds of people in Australian AOD treatment report symptoms of PTSD (Kingston et al. 2017), and 80% report having experienced a traumatic event in their lifetime (Dore et al. 2012). There are high rates of co-occurring trauma/PTSD and SUD, with complex interrelationships between the conditions, and significant implications for treatment. Trauma can be both a causative and perpetuating factor for other co-occurring conditions, and so sequential service responses that ask people to "address X before Y" are misaligned with trauma-informed principles and can inadvertently entrench harm. Research indicates that an integrated approach to treatment of SUD and trauma is preferable to a sequential or an unintegrated, parallel approach (Roberts et al. 2022, Najavits et al. 2020).

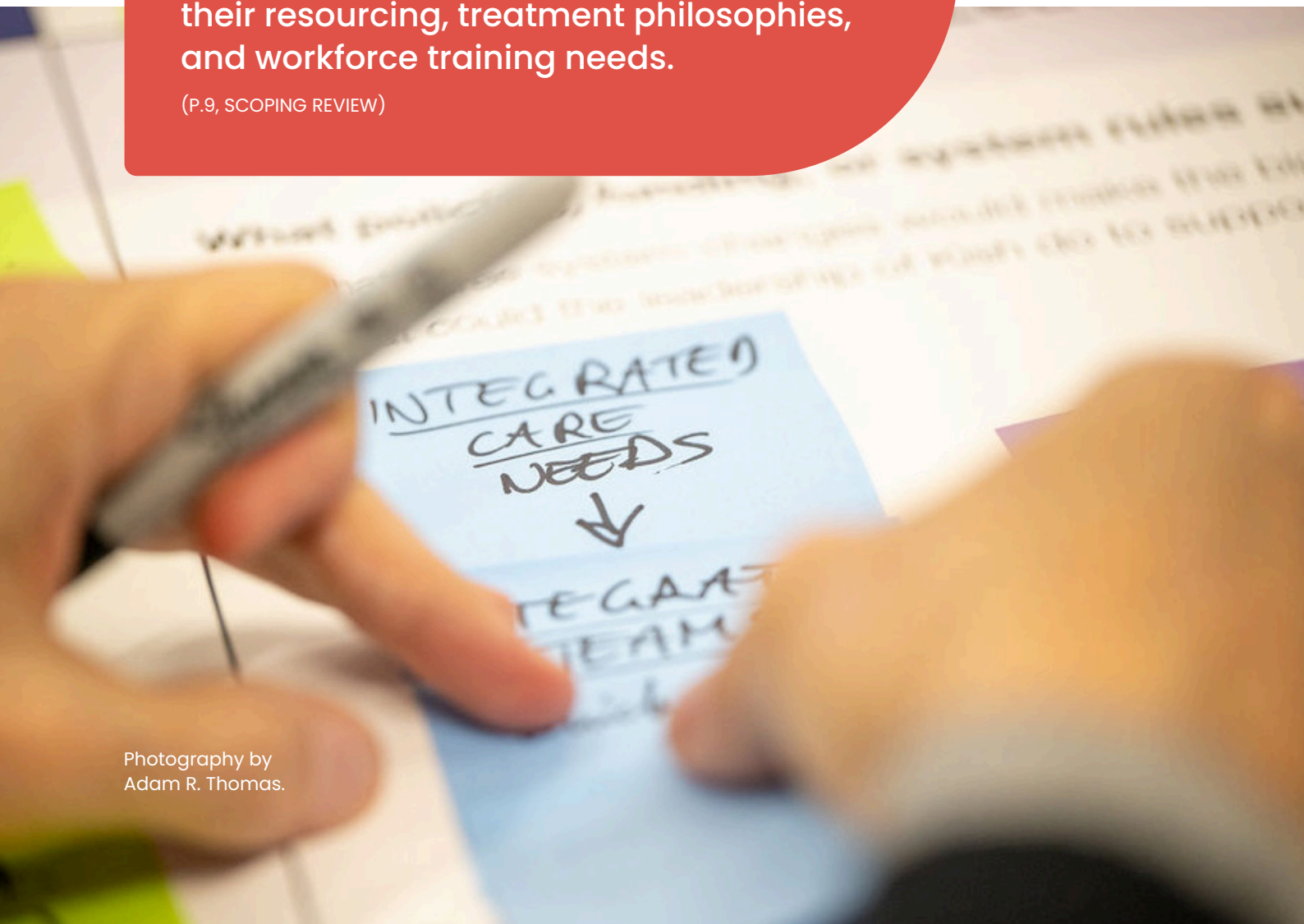


Evidence also shows that supporting the needs of people with co-occurring trauma and SUD requires both a trauma-informed approach to service delivery as well as the provision of integrated, trauma-focussed treatments (Substance Abuse and Mental Health Services Administration 2014). Trauma-informed care principles emphasise understanding the pervasiveness and impact of trauma, prioritising safety, trust, choice, collaboration and empowerment in all interactions, in contrast to trauma-focussed treatments that directly target traumatic stress symptoms. Co-occurring needs should therefore be addressed concurrently, with attention to choice, safety and person-centredness — key features of trauma-informed care (Elliott et al. 2025). Further, effective integration of care for co-occurring trauma/PTSD and SUD requires clarity around key terms (trauma-informed vs trauma-focussed), a shared understanding of "co-occurring needs," and pathway designs that reflect the real interrelationships between trauma and other disorders (Fazio et al. 2018; Edvardsson & Innes 2010).

Participants presenting their design canvas from workshop two. Photography by Adam R. Thomas.

This research follows from the findings of a scoping review conducted by the Hamilton Centre, which found there are numerous factors that facilitate or impede integrated care delivery. The review highlighted that there is a lack of research into effective approaches to operationalising integrated care in practice, particularly in the Australian context. This is particularly crucial, given that the historic separation of the MH and SUD treatment sectors means integration is required across a variety of service settings that differ significantly in their resourcing, treatment philosophies, and workforce training needs.

> **Integration is required across a variety of service settings that differ significantly in their resourcing, treatment philosophies, and workforce training needs.**
>
> (P.9, SCOPING REVIEW)



Photography by
Adam R. Thomas.

2

Project Methods

Image from co-design workshop 1. Photography by Adam R. Thomas.

2
co-design workshops

28
Stakeholders

Two sequenced, in-person co-design workshops were conducted, bringing together 28 stakeholders from across Victoria to explore the competencies needed to deliver integrated care to individuals with co-occurring trauma/PTSD and SUD. Participants included MH, AOD and community health practitioners, clinical leaders and service managers, peer support workers (PSWs) and lived experience advocates. A breakdown of participants, their expertise and organisation type is available in Table 3.

Both workshops used an applied, practice-based sequenced co-design approach (Heiss et al. 2025) that sought to bring together interdisciplinary teams to address complex healthcare and service challenges. This approach has previously been used to co-design new models and systems of care (Heiss & Kokshagina 2021; McGee et al. 2022) and is grounded in participatory, co-design and human-centred design epistemologies. Consistent with Sanders and Stappers (2008), this approach positions people as experts in their own lived and living experience, and foregrounds their needs and goals in the design process.

The workshop activities were conducted over three hours and provided structure to enable small groups of participants to collaboratively explore what is needed to enable effective integrated care delivery. This included the use of consumer and workforce personas (Fig. 3 and Appendix C), and design canvasses (Fig. 4 and Appendix B) featuring prompts to support focussed discussion.

Small group of participants using the personas and design canvases. Photography by Adam R. Thomas.

Drawing on multi-level quality frameworks in health services and lessons from large-system transformation (Ferlie & Shortell 2001) the prompts were developed to support participants to explore the layered, systemic factors that may influence care delivery in a setting (Fig. 2). This included considerations of the micro (clinician–consumer interactions), meso (team/service coordination and handovers), macro (MoC's, care pathways, cross-organisation governance) and meta (policies, funding, government priorities) levels.

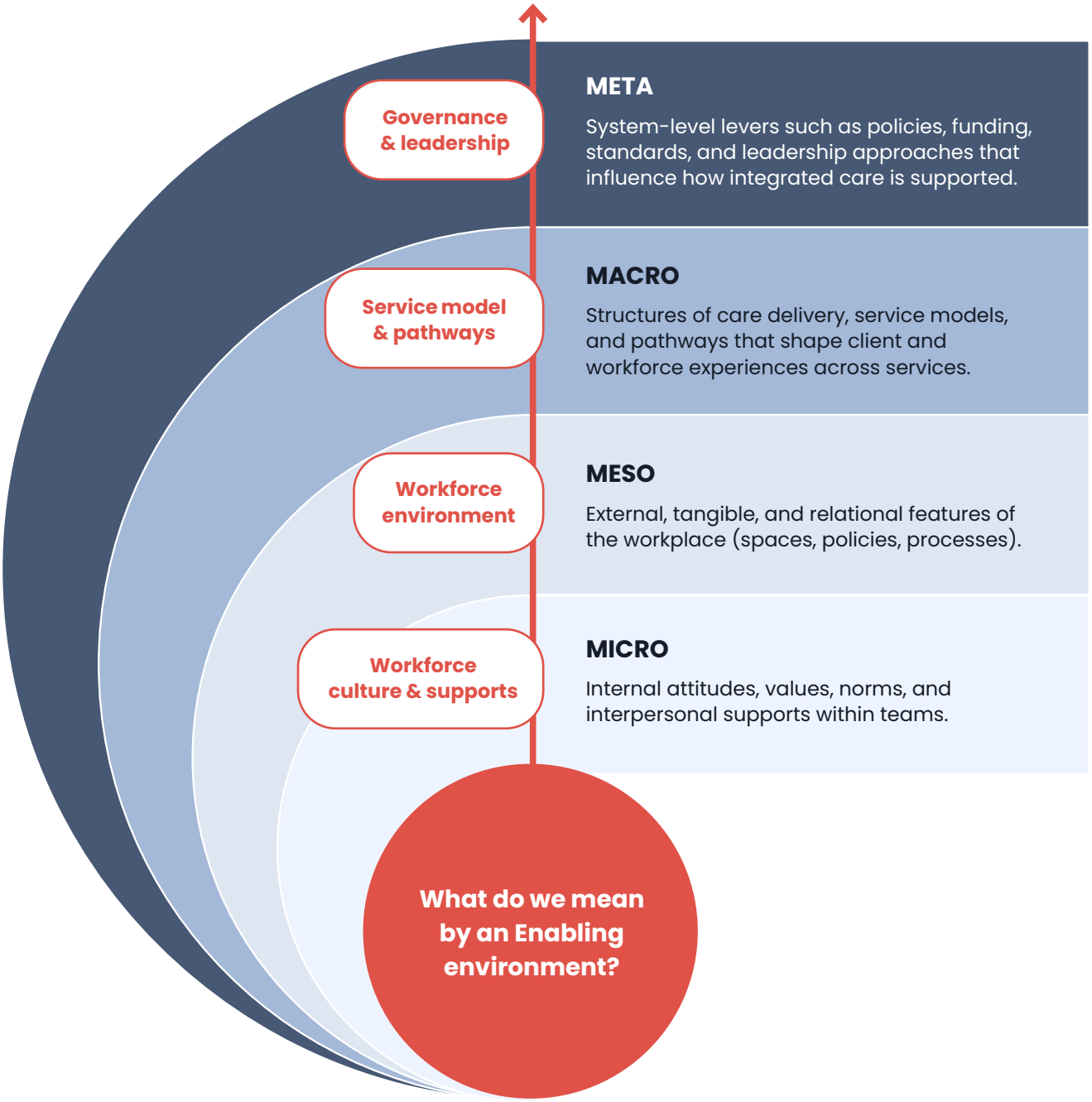


Figure 2 Understanding the enablers of Integrated care as operating at different levels of the system on micro-meta layers. This framework was used to structure workshop activities and inform analysis.

Data was collected through audio recordings of the workshop discussions, professional photographs as well as documentation of notes made by participants and facilitators.

Table 1 Outline of co-design workshop activities and prompts

	Workshop 1	Workshop 2
Workshop aim (Why)	To map how people with co-occurring trauma/PTSD and SUD needs currently move through and experience care across hospital, community, primary and emergency settings, and to surface what helps or hinders integrated, trauma-informed responses.	To understand what healthcare workers (AOD, MH, acute, peer/lived experience) need in order to provide safe, integrated, trauma-informed care to people with co-occurring needs, and to identify the conditions that create an enabling environment[1].
Participant (Who)	Mixed tables including AOD and MH clinicians, peer/lived experience practitioners and hospital-based staff, asked to speak to current service realities.	Similar mixed tables, but with stronger emphasis on staff/workforce perspectives and organisational/ service leads.
Persona / scenario used	Consumer persona (e.g. April, Fig. 3 and 4) representing co-occurring trauma/ PTSD and SUD, used to walk through current pathways.	Workforce persona (e.g. Leila, Fig. 5) and consumer persona, together used to explore what workers require to deliver care to people with co-occurring trauma/PTSD and SUD
Workshop prompts (What)	*Focussing on a consumer persona's experience of two different care settings, participants discussed:* Who are the healthcare workers the persona encounters? What interventions or approaches are the healthcare workers using? What are the healthcare workers' fears and concerns about using these interventions or approaches with the persona? What supports healthcare workers?	*Focussing on the experience of two different workforce personas providing care to a consumer persona, participants discussed:* What supports the workforce persona and their ability to do their job? What parts of the workplace (spaces, policies, relationships) help deliver safe, integrated care? Where does the current service model or pathway work well for (consumer persona) and their trauma/PTSD and SUD needs? What policies, funding or system rules support integrated care?
Workshop outputs (So what)	Consolidated view of current-state pathways and pressure points in the system.	Specification of workforce and service conditions required to sustain trauma-informed, integrated care.

[1] In this context, enabling environment refers to various factors at different levels that support or hinder delivery of care in a setting, including workforce culture, supports, environment, service model and pathways, and governance and leadership

A total of seven personas were used across the two workshops to anchor focussed discussions in the needs of people with co-occurring trauma/PTSD and SUD, and the healthcare workers that they encounter. Four existing, evidence-informed consumer personas developed for the co-design of the Hamilton Centre's service model were leveraged and adapted for this work (McGee et al. 2022).

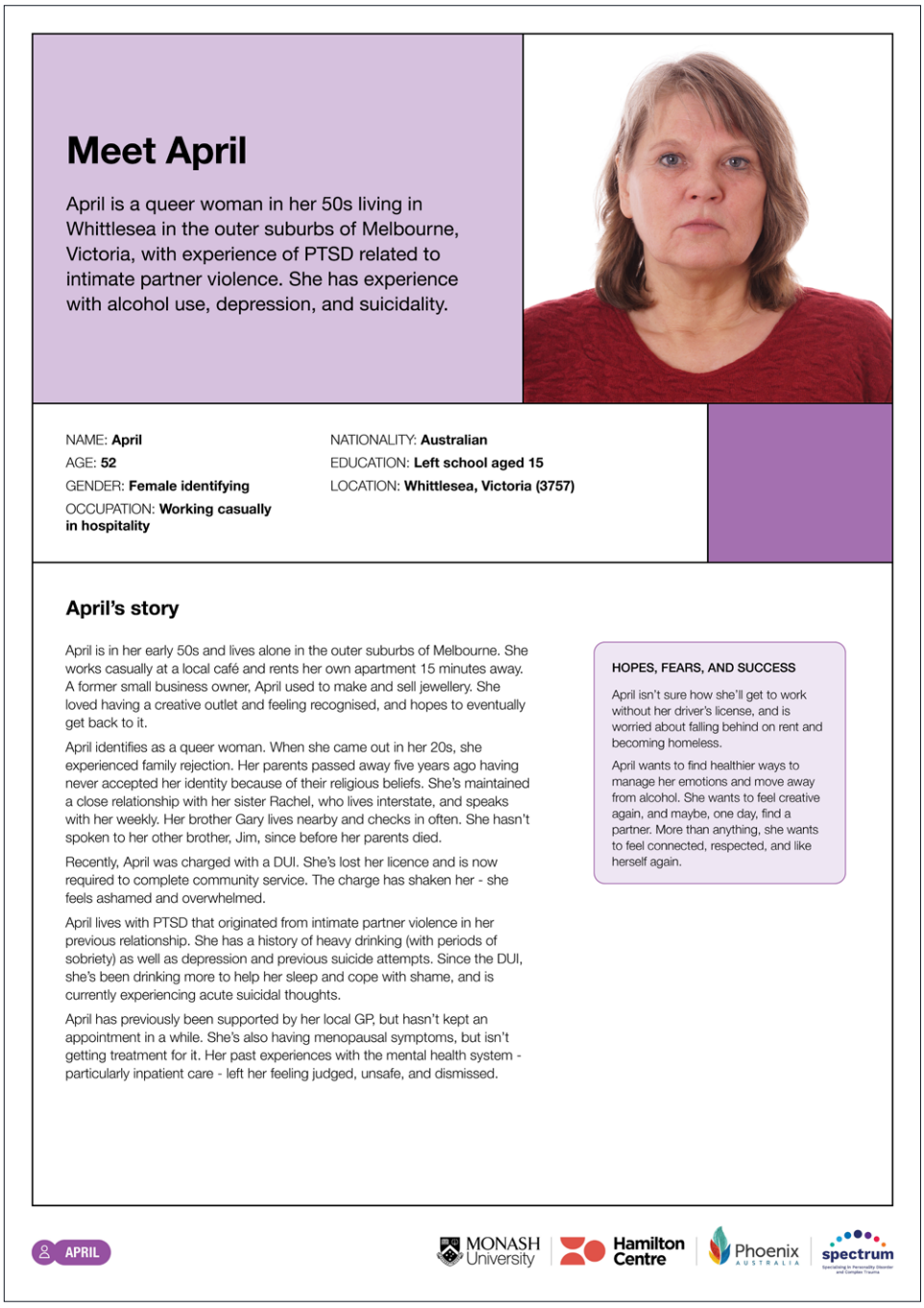


Figure 3 The four consumer personas used across both workshops

The consumer personas used across the two workshops were:

Mary: Mary is a woman in her early 20s who arrived in Australia as a child. She has experience of PTSD related to her refugee experience and multiple sexual assaults. She also has experience of GHB[2], alcohol use, and occasional methamphetamine use.

Johan: Johan is a man in his early 40s living in outer regional Victoria, with experience of PTSD related to childhood trauma and a car crash in his 20s. He has experience with opioid use, anxiety, and suicidality.

April: April is a queer woman in her 50s living in Whittlesea in the outer suburbs of Melbourne, Victoria, with experience of PTSD related to intimate partner violence. She has experience with alcohol use, depression, and suicidality.

Jarrah: Jarrah is a First Nations man in his mid-to-late 20s, with experience of PTSD related to the criminal justice system and intergenerational trauma. He has experience with cannabis use and anxiety.

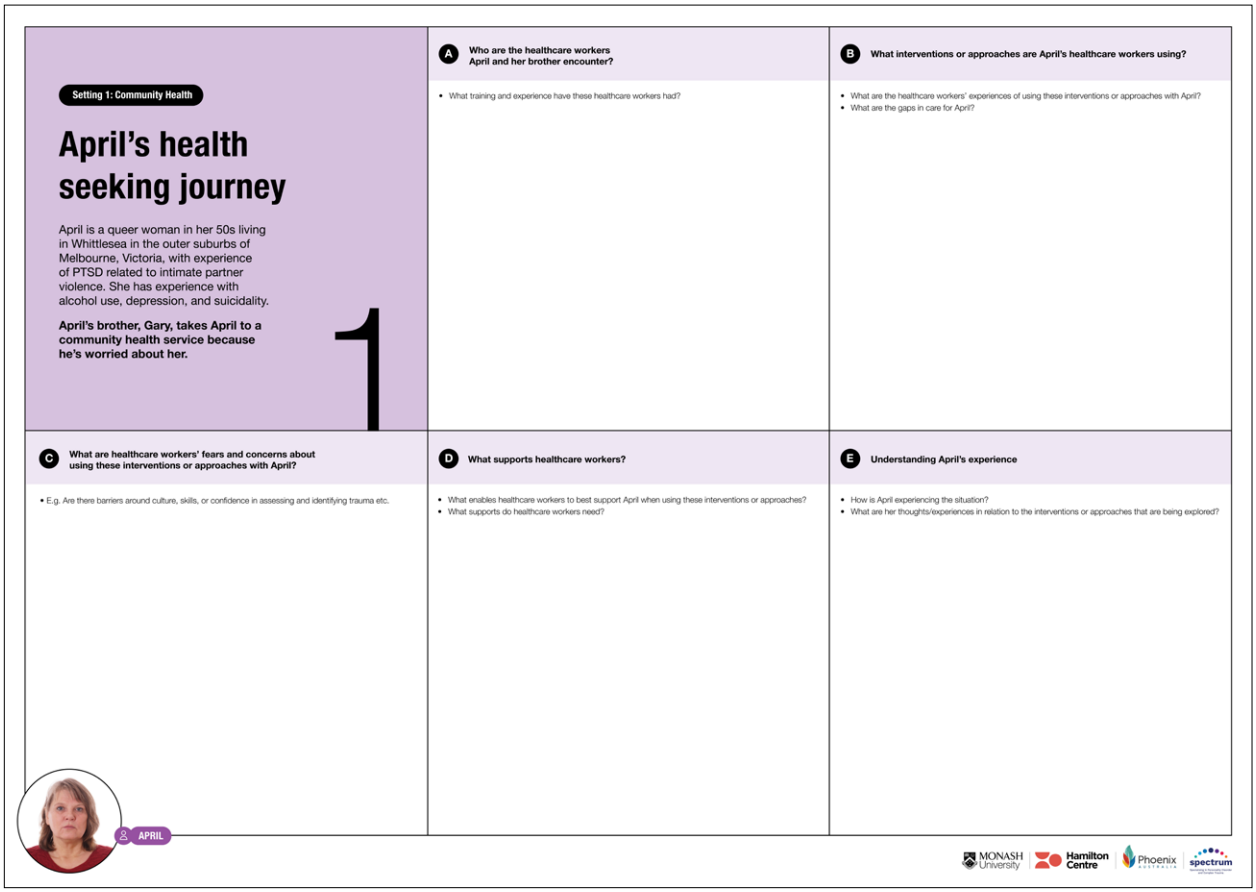


Figure 4 Example of a canvas from workshop 1 for the April persona

[2] GHB is short for gamma-hydroxybutyrate, an illegal drug increasingly used recreationally in Australia (Chrzanowska et al. 2024)

Based on findings from the first workshop and expertise of the Hamilton Centre, Spectrum and Phoenix project team members, workforce personas were developed to support deeper inquiry in the second workshop. These personas were:

Ben: A dedicated AOD counsellor who is passionate about harm reduction, but feels his expertise is undervalued in mainstream health settings.

Kish: A passionate but overstretched mental health clinician balancing risk management pressures with a desire to provide trauma-informed, person-centred care

Leila: A peer support worker with lived experience of MH recovery, who bridges trust between consumers and clinicians, but feels her role is undervalued and poorly understood.

Figure 5 The three healthcare worker personas used in workshop 2

3

Findings

Our analysis yielded cross-cutting themes that describe what must change at consumer experience pathway level to provide trauma-informed treatment for co-occurring trauma/PTSD and SUD. The five findings discussed in this section include Consumer experience and impacts on the current system; Worker confidence and supports; Service and team environment; Service model and pathways; and Governance and leadership. From these findings, we translated seven pathway principles, discussed in section 4: No Wrong Door & Single-Story Choice; Care Delivery in Parallel; Right-Time Navigation; Continuity Scaffolds — Transitions You Can Trust; Role Clarity & Shared Accountability; Cultural Safety by Design; and Supported Workforce & Learning System. Together, the principles offer a framework for operationalising an integrated, trauma-informed service within the existing constraints and policy settings of the current mental health service system.

3.1 Consumer experience and impacts in the current system

> *I think this goes back to that point we made …about the fragmented system because someone's going to make a decision on what your priority of care need is, and "I think you need to treat your PTSD", "I think you need to treat your AOD" or "You need to get your menopause sorted" or whatever. But that would actually be the pathway she goes on, which is not really an integrated or a holistic approach.*
>
> - April's table, Workshop 1

The current system presents significant challenges for meeting the needs of people with co-occurring trauma/PTSD and SUD through trauma-informed care and trauma-focussed treatment. Trauma-focussed treatments are interventions that seek to address the symptoms of trauma or PTSD. In contrast, trauma-informed care relates to delivering services in a way that prioritises consumer safety and empowerment, facilitates participation, acknowledges trauma prevalence and interrelationships with SUD, and avoids re-traumatisation (Substance Abuse and Mental Health Services Administration, 2014).

In the experience of participants, trauma-focussed treatments are not often used in the current service landscape. Through the workshops, it emerged there is a practical tension between the need to start trauma-focussed treatment, and provision of trauma-informed approaches that prioritise consumer safety, empowerment, and readiness.

An example of this played out in an interaction between two participants at the Johan table, described below;

> **AOD Residential Service Leader**
> *If we had resources, let's say that there was 3 sessions, when you know someone's gonna need 10, do you not do it? Do you save it up and just give one person a full 10?*
>
> **AOD Team Leader**
> *Our code is not to cause anymore harm, you know if we start something....*
>
> **AOD Residential Service Leader**
> *...And you can't follow through?*
>
> **AOD Team Leader**
> *Then it's causing harm.*
>
> **AOD Residential Service Leader**
> *Unless you're giving someone a taste of something that's really good, and it gives them a positive experience and you're upfront at the start...You shouldn't pretend or start something and let someone go really deep then say "Sorry, that's it, we're done". That's really harmful. But there might be a way you can do it with transparency and honesty. Even a single session...We're not building expectations. What's something we can achieve today that's going to give you a reasonable experience?*
>
> - Johan's table, Workshop 2

This exchange highlights that workers trained in 'do no harm' trauma-informed care paradigms may find it difficult to reconcile the need to treat trauma with the perceived risks. This may be contributing to the limited use of trauma-focussed treatment options in the Victorian context.

In addition to challenges for trauma-focussed treatment, there exist barriers to the delivery of trauma-informed care. Participants consistently described how service delivery approaches across Victorian AOD and MH care environments are not trauma-informed in practice. Rather than being conducive to recovery, current services do not acknowledge trauma prevalence and complex interplays with substance use, or support safety, empowerment and consumer participation. As a result, the way in which services are delivered may be contributing negatively to consumer wellbeing.

Participants described key challenges for consumers including the following;

a

Process vs. person-centred systems

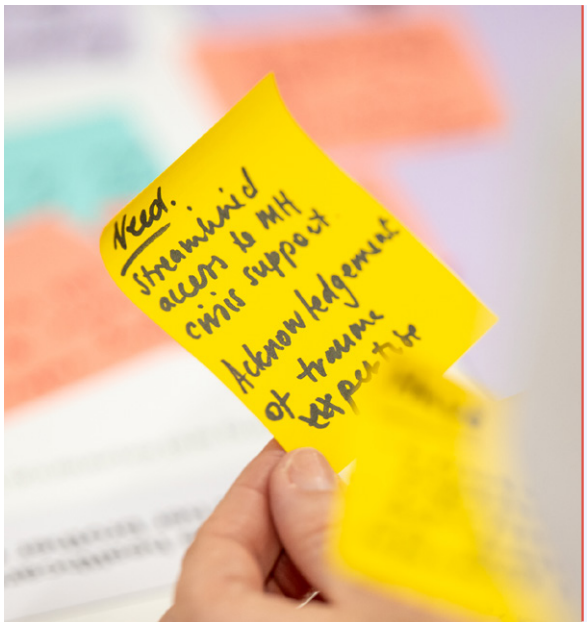
For consumers with co-occurring SUD and trauma/PTSD, services can impose rigid, alienating processes and procedures that do not support their wellbeing or recognise them as whole people. Risk-averse, treatment-specific approaches without multidisciplinary input miss client complexity, do not respond effectively to consumer circumstances, readiness, and goals, and fail to support long-term engagement needed for recovery.

> *It's about meeting her where she's at, isn't it? Finding that 'in' whatever that might be for her and then building the rest of the treatment continuing into that. Engagement is the critical first step.*
>
> - Mental Health Clinician, April's table, Workshop 1

b

Access and navigation barriers

Where services are available, the experience of accessing and navigating them often makes it harder for consumers with co-occurring needs to engage, resulting in burdensome and inefficient processes for staff, and reduced service impact. Between different settings, fragmented referrals, duplicated processes, separate systems, stalling waitlists, and rigid eligibility and access times mean that consumers can not benefit from available services in the critical, finite periods they are seeking them.



> *She's referred back to community health - what's her choice in that? … so you may have some resistance, and it brings up the key coordination aspect… In an ideal world, she would have someone she can contact that reaches out to her post discharge, that's able to then reengage her and walk through the journey with her so that she can work with that ambivalence and that fear rather than having to go back through the process.*
>
> - Mental Health Clinician, April's table, Workshop 1

Image from co-design workshop 1. Photography by Adam R. Thomas.

c

Time and resource pressures

When accessing services, limited time and resources create challenges for engaging consumers and for enabling workers to provide necessary care. Instead of being able to focus on the therapeutic relationship building and long-term healing work needed, overstretched staff default to 'risk reduction' and stabilising measures in the short-term that have limited benefit beyond rapid discharges. It also contributes to deprioritisation of critical staff supervision and reflective practices that support embedding learning, worker wellbeing, and fostering strong teams.

As a healthcare worker, if you have an idea of the scope of Johan's issues, you're going to be concerned that will your organisation allow you and the team enough time and continuity of care. Can we look after him for as long as he needs us? Will I have time to meet with my colleagues or will I have seven half interventions a day?

- AOD residential rehabilitation worker, Johan's table, Workshop 1

Image from co-design workshop 2. Photography by Adam R. Thomas.

d

Care delivery that doesn't match needs

Variability in expertise, disciplinary perspectives on care, and availability currently contribute to inconsistent experiences and interventions received by people with co-occurring trauma/PTSD and SUD. Interventions are applied superficially or without integration. Workers less familiar with AOD and/or trauma-informed care approaches can unintentionally stigmatise consumers and their own AOD and peer worker colleagues, impacting consumer engagement and team collaboration.

One of the issues about integrated care is that we very quickly go to all the disciplines and all the interventions and he'd be better off with two of them well integrated than a scatter gun.

- Community Health Leader, Johan's table, Workshop 1

e **Difficult environments for SUD/trauma integrated care**

Some settings and environments have particularly limited capacity to provide the long-term, holistic approaches required to support co-occurring trauma/PTSD and SUD needs. In Emergency Departments (EDs) and Inpatient Units (IPUs), trauma/PTSD and SUD can receive less attention due to the important role these settings play in providing urgent medical care for acute illness, injury, and crisis. Limited tools supporting trauma assessment and treatment, significant discharge pressures, and mostly junior, inexperienced staff with lower levels of confidence reduce opportunities for trauma-informed care. Other factors such as busy, overwhelming, overstimulating environments, lack of private areas for discussing sensitive topics, intimidating, institutional spaces with armed security guards, and involuntary admission/inability to leave can reduce safety and agency.

> *Often the IPU's that I've visited, those security [guards] have very general training. Sometimes they are outsourced security so they actually don't have healthcare specific training, which can be particularly problematic… really reinforcing trauma.*
>
> - Nursing Industrial Relations Organiser, April's table, Workshop 1

3.2 Worker confidence and supports

Participants described how worker confidence in the face of the perceived risks is a key factor in whether appropriate trauma-informed care or trauma-focussed treatments are provided.

Limited experience, training and understanding of trauma/PTSD makes it difficult for workers to deliver trauma-informed care. Awareness of critical factors for supporting people with co-occurring trauma/PTSD and SUD to access services is limited - such as the ability to recognise trauma, the prioritisation of safety and trust, and the valuable role of peer workers - contribute to missed engagement opportunities.

Workers often know enough about trauma to fear that acknowledging it without treating it "correctly" could make things worse. In the context of co-occurring trauma/PTSD and SUD, these fears can include consumer safety concerns such as the risk of disengagement or overdose, as well as potential legal consequences for misguided actions. This anxiety can be amplified where workers hold stigmatising views of people with SUD or lack confidence in providing trauma-informed AOD care.

> *I guess thinking about if somebody's come in with an acute mental health challenge, there can be a sense that it may destabilise them more to discuss trauma-related things. And so in my training, I was taught to sort of not go there in one inpatient setting because people perceive that it can make things worse.*
>
> - Mary's table, Workshop 1

The combination of high stakes and uncertainty drives defensive, risk-averse practice, with workers avoiding "opening up the box" altogether, as a participant on Mary's table in workshop 1 said. This can mean "shutting down" trauma discussions or seeing trauma as something specialists do where role clarity is lacking. In environments with a stronger focus on risk-reduction, such as EDs or IPUs, these tendencies are especially pronounced.

Conversely, workers may know how to provide trauma-informed care or interventions, but feel that they lack the resources and support to do so effectively. Participants described how working in a setting that cannot provide appropriate conditions for healing, such as longer-term service access or timely referrals, can contribute to workers feeling it is not worth starting an intervention. Workers may also be afraid for their own safety and the possibility of suffering vicarious trauma, especially where there is limited capacity to access support themselves. Providing time and resources needed for intervening, and supporting staff wellbeing encourages delivery of services, and prevents burnout and "empty cup" care, as described by a participant on Mary's table in workshop 1:

> *I think when you are on the wards and as a staff member, the horrific things that I have seen... just everything that you see, like self-care is so important. I hated the world at one point because I've seen things that they haven't. Why should I have to see that? It took a lot to get past that and now it's all good. It's a real thing, like taking on those things blow after blow after blow, it hits you eventually.*
>
> - Mary's table, Workshop 1

Image from co-design workshop 2. Photography by Adam R. Thomas.

Workshop participants highlighted that in combination with feeling fearful and unsupported to deliver interventions, many workers in AOD and MH spaces do not have access to secure, appropriately-paid employment, or professional development and career progression opportunities. This contributes to staff turnover as workers tend to leave for more rewarding, higher-paid roles elsewhere. On Johan's table, an AOD residential service leader described how several staff had each left after receiving EMDR training and moved into more lucrative roles in the MH sector. A participant on April's table in workshop 1 commented that often community health services have junior workforces "because the more experienced workforce goes to the areas of better paying conditions and often that's embedded within a mental health service". This creates challenges for services retaining and building an experienced workforce with the networks and knowledge required to support people with co-occurring SUD and trauma/PTSD.

Participants emphasised that confidence grows not just from individual capability but from organisational support. Strengths-based workplaces that recognise and enable staff to work to their strengths were described as more effective in supporting confidence. This support is reinforced through team cohesion and alignment on roles and responsibilities, as well as access to training and embedding learning into practice, as are described in the following section.

3.3 Service and team environment

Team roles, responsibilities, cohesion

Delivering integrated care for co-occurring trauma/PTSD and SUD requires effective collaboration between a diverse team of workers, including mental health clinicians, AOD workers, and PSWs. Participant accounts of how staff from different disciplines and backgrounds work together revealed in-practice complexities and challenges.

For example, MH clinicians and PSWs can have contrasting pre-existing assumptions about team hierarchy which can inadvertently undermine collaboration in the treatment space with direct impact on consumer outcomes.

> *A friend of mine is a psychiatrist at a major hospital…He has been in meetings at the hospital where the peers, the peer team has walked in and some of the senior psychiatrists have left the room.*
>
> - April's table, Workshop 2

Historically, the MH and AOD treatment sectors have been separate. In the context of integrated care, territorial behaviours can emerge related to power differences where some clinicians are accustomed to having authority, and lack understanding, appreciation, and trust in colleague capabilities. This was seen as poorly impacting care-coordination.

> *It's probably also the culture of [the MH clinician's] fellow workers too. If they see themselves as "We're mental health" and their attitude is "This is what we do, it's not our job" [it's challenging]... their interest, desire, willingness to make themselves uncomfortable and learn those integrated approaches.*
>
> - Johan's table, Workshop 2

These dynamics also lead to contraction of what certain workers are allowed to do, and scope creep for others as responsibilities shift, adding to already overwhelming clinical workloads. On Jarrah's table, participants discussed a situation where peer workers had previously been trained and permitted to conduct safety narrative interventions, but they were no longer allowed to do so.

> **Speaker 1**
> *What peer workers are allowed to do gets less and less and less and less and less, while clinicians have to do more and more and more and more and more.*
>
> **Speaker 2**
> *Which is disempowering our peer work force.*
>
> - Jarrah's table, Workshop 1

Limits around the familiarity clinicians have for the skills of colleagues (in other but adjacent sectors) also limits the potential for those skills to be used. For example, AOD and peer worker ability to build rapport and engagement with consumers is an essential skill, but can go undervalued. Bringing these skills of AOD workers and PSWs to the fore is an opportunity for both developing connections between clinician and consumer, and exposure to affirming practices that counter the more common stigma associated with AOD. AOD staff and PSWs being unable to contribute to aspects of consumers' care such as through formulations and effective case-conferencing undermines effective integrated care delivery.

Participants suggested approaches to better shared understanding and cohesion. These included providing data reports to demonstrate the impact of peer workers in supporting consumer outcomes, cross-disciplinary learning to recognise complementary, differing skillsets offered by different colleagues, and approaches to collaborative work that promote inclusion and mitigate power-differences, such as promoting active listening practices in multi-disciplinary teams, and well-facilitated case meetings.

Training and embedding learning into practice

> *A friend once said to me, training has the shelf life of yoghurt. If you're not doing anything to keep it fresh and alive it just rots.*
>
> - April's table, Workshop 1

Access to appropriate tools and training, embedded within a supportive environment that has the capacity to nurture skills through practice, mentoring and reflection, is seen as critical to supporting integrated care delivery. In particular, participants felt that healthcare worker access and awareness of trauma-informed tools and resources is not currently consistent or adequate.

In particular, the need for trauma-informed/AOD tools and training that is tailored to a worker's discipline and therefore more relevant and coherent for them was highlighted. As an example resources such as AOD-specific guidelines, clarity on the right AOD-relevant questions to ask consumers - in the right way, and knowing which dedicated AOD phonelines or organisations they can reach out to are valuable supports for MH workers. This was seen by participants as important for bridging siloes of expertise and enabling individuals to develop capacity across the overlapping fields of trauma/PTSD and SUD.

Supportive processes and time for embedding training and tools into practice are essential, and a factor that is currently lacking in many environments.

> *Trauma informed training [is needed], but how that looks in practice rather than the theory of it? Because we all know the theories, but how does that look in that nuanced situation, with someone from that background?*
>
> - Mary's table, Workshop 1

Various approaches to embedding training and resources into practice were suggested. These mostly focussed on mechanisms that enable individuals and teams to systematically reflect productively and process new learnings and unfamiliar experiences. Suggestions included mentoring, supervision, reflective practice, and debriefs in various compositions; with peers and supervisors, in 1-on-1s and groups, and internally and externally. Allowing time to enable these practices is seen as key.

> *To be developing new skills to work with PTSD and unpacking the trauma and giving strategies - if that's new to you, and you're in a workplace that's just all about throughput and you're overstretched, then you're not going to have the capacity. So a supportive culture is one that has sufficient resources, a team culture that gives you time to learn, reflect, discuss, talk to mentors, talk to your colleagues, peers in order to grow and develop and learn. And you can't do that if you've got no time and you're overstretched.*
>
> - Johan's table, Workshop 2

It was noted that beyond embedding learnings into practice, team-oriented approaches such as these offer substantial benefits for team building and mutual understanding that supports quality integrated care, as well as building confidence in skills and having the support of colleagues.

Image from co-design workshop 1. Photography by Adam R. Thomas.

3.4 Service model and pathways

> *To be honest, at this stage people feel overwhelmed. Lost in the hoops and processes. If we could present it in plain English, 'Here's where you are now, and here's what we need to do to get you there', it would help.*
>
> - Jarrah's table, Workshop 1

Care model approaches that work for co-occurring trauma/PTSD and SUD

Consumers with co-occurring trauma/PTSD and SUD are often stigmatised and experience shame which subsequently can create barriers for healing. Integrated care models should take this into consideration, and support consumers to feel connected and engaged through strength-based approaches. Strengths-based engagement in this context can be defined broadly as an approach that focuses on positive attributes including consumer resilience, capabilities, and goals. The support and knowledge of peer workers is critical in destigmatising AOD and empowering individuals to address trauma/PTSD and SUD concurrently. This is achieved through recognising individuals as active agents in their recovery, emphasising their existing resources and potential, and supporting them to define and pursue their own wellbeing objectives.

> *There's often quite a bit of stigma. And so the peer workers sometimes have to spread their time between direct peer work and education of supportive staff to kind of gently challenge some of those ideologies.*
>
> - Johan's table, Workshop 1

Several challenges exist for workers in recognising important contextual information to assist better integrated trauma/PTSD and SUD treatment. These include, but are not limited to: recognising cultural context, siloed information systems, and inconsistent screening for contributing factors such as gender identity and family violence. Participants felt services that are not able to support workers to recognise, understand, and respond to an individual's past experiences and current circumstances struggle to deliver care that is suitable to the whole person.

AOD and MH services data is kept on siloed information systems that aren't easily accessible to workers in different settings, limiting their capacity to provide care that is more informed and relevant based on a person's history.

> *It's a very fragmented system and that's a huge barrier. Even clients that may present to [an AOD] clinic may then have an acute episode, present to hospital, and there's no way of looking up case management notes …to have that knowledge of what's the case management plan, what's the client's plan, what's the history and what does the case manager want in this situation when they present in an acute setting?… So it's too fragmented, but it's even fragmented within the health service like the one that I work for. The mental health case management system doesn't talk to the acute case management system. So there's no way of actually knowing what has occurred in the past. And then you're trying in that situation to get a history from someone who's acutely unwell at that point in time. And often you don't get the whole picture. You get what their crisis is in that moment, but you might miss the housing situation or the financial situation. And so you just sit there giving them diazepam, which isn't probably going to fix anything in the long run.*
>
> - April's table, Workshop 1

Failure to recognise the importance of cultural context in a consumer's experience of care also contributes to poorer outcomes. Delivering care that responds to an individual's context and culture is a critical aspect of successful integrated care models. This includes ensuring consumer identity is respected, regardless of ethnicity, culture, gender, spirituality and more, and ensuring care practices are inclusive, welcoming, and affirming. Approaches include providing workers with appropriate training, supporting clinicians with diverse backgrounds, and access to diverse community groups and peer workers. Responding to context can also relate to providing flexible care models that correspond to what will work for the person, in contrast to the rigid policies, restrictive service hours and funding conditions that currently undermine engagement.

> *And then it depends what day of the week she's admitted to whether she gets [family violence services]. If it's a Friday to a Monday, she's not getting any of these wrap-around services because they're most likely Monday to Friday in-hours roles and not on the weekends and not after hours.* - April's table, Workshop 1

Gender identity and family violence are inconsistently screened and poorly supported, yet have profound consequences for individual engagement and outcomes. For example, participants on April's table described screening for gender identity in practice as a "vexed question" because the experience of being screened can be alienating rather than affirming.

> *You can ask somebody about their gender identity as part of an intake and assessment. Does that make the way that that question is asked and the response following it … it can be hopeful and helpful or it can be totally inappropriate, and irrelevant.*
>
> - April's table, Workshop 1

In the current system, participants reported that across the sector, current experiences of accessing integrated care for co-occurring trauma/PTSD and SUD does not support the trust and rapport-building seen as foundational for trauma-informed care.

> *The wards, they're horrible, they're confronting, they're noisy, they're intimidating, they're very 'us-against-them' mentality … we're supposed to be the safe place. We're supposed to be the person that people can come to. We want to be able to build that rapport…I want people to feel safe with me and I want people to be able to open up because without that information, I can't then provide the best care to them… You come in as a voluntary patient and then you're being told you can't leave, so there's no transparency. It's just all wrong.*
>
> - Mary's table, Workshop 1

Building a strengths-based approach to address these challenges included focussing on building trust, bringing families on the care journey, and relational approaches that support connection.

Suggestions for practical care model approaches to supporting trust included outreach that allows workers to meet clients in safe, non-triggering environments; flexible referral timeframes that prioritise consumer readiness over pressuring against rigid deadlines; and service hours at quieter times of day to support engagement.

Families were recognised as an important resource in a care model, where meaningful and appropriate involvement could occur through contact, support, and participation in processes such as case conferencing. This can strengthen integrated care delivery and provide consumers with additional continuity, emotional support, and advocacy throughout their care journey.

Relational approaches, allowing time (described in detail as an enabler below), and connecting clients with relatable workers were recommended as ways to help individuals feel safe, understood, and supported for the ongoing engagement needed in meaningful trauma/PTSD and SUD work.

Care model enablers

The success of care models designed to support people with co-occurring trauma/PTSD and SUD is significantly affected by how and in what context the care is delivered. Workshop participants described how the design and atmosphere of the environment in which services are accessed can influence healing. Institutional, overstimulating, busy public spaces that afford no privacy for sensitive conversations can feel unsafe and risk retraumatising consumers. In comparison, calm, welcoming, flexible spaces are more appropriate for fostering connection, compassion, dignity, and healing. Access to outdoor spaces or adaptable areas such as for private conversations supports choices and relational care.

> *It's hard to feel like you're gonna heal in a place that's surrounded with concrete.*
>
> - Mary's table, Workshop 2

Time is an important enabling element for supporting integrated care, both for workers and consumers. For consumers with histories that make it difficult to build trusting relationships, feeling rushed can undermine treatment. For workers, lack of time due either to understaffing or overwhelming workloads constrains capacity work that is foundational for consistent, quality care, such as training, self-care, team building, cultivating networks, and coordination.

> *Trauma informed care, like trying to manage or address PTSD and CPTSD [complex PTSD], takes an extensive amount of time. You can't do that in four to six sessions, which is probably what Jarrah will be referred for. And if he hasn't built rapport in those four to six sessions, which I don't think he probably will, is he really going to continue to engage? And then it's just confirmation bias, you know, it's like "All these systems weren't built for us. They can't help me," and then he feels more hopeless and more isolated and less connected because perhaps there aren't as many other options for him.*
>
> - Jarrah's table, Workshop 2

Appropriate service referrals and access are key to supporting individuals with co-occurring trauma/PTSD and SUD. Supporting workers to know what suitable services are available and how best to connect consumers with them was seen as a key enabler. In addition to resourcing needed services, participants reported that this required enabling workers to do research, make personal inter-service contacts, and build relationships. This also assists with smooth transitions and continuity of care, which participants

emphasised as essential. Approaches to this include warm handovers to assist workers with smoothly transferring responsibility for consumer care, navigator roles to help consumers access services, transport resources to ensure consumers are able to attend locations where they receive services, and follow-through after referrals to avoid gaps or breakdowns in care coordination. This is particularly important during high-risk transition periods, such as exiting a rehabilitation service.

> *From my own experience working with clients in this space, there is no case manager. So things do fall through the gaps. And even if someone does pick up the responsibility for that, coordinating with all the other services is impossible because everyone's time-pressured and under-resourced.*
>
> - April's table, Workshop 1

Communication and information sharing are key for a successful integrated care model. Factors that contribute positively to this include tools and technology such as worker phones, accessible case management software, possible integrations of AI, but also processes and ways of working that support workers from different disciplines to collaborate effectively. Suggestions included establishing expectations for equitable and inclusive multi-disciplinary team meetings.This may involve skilled facilitation to mitigate power differences (see above: *Team roles, responsibilities, and cohesion*), providing appropriate time to discuss client needs, meeting in person, and enabling peer workers to contribute their perspective in collaborative case formulation.

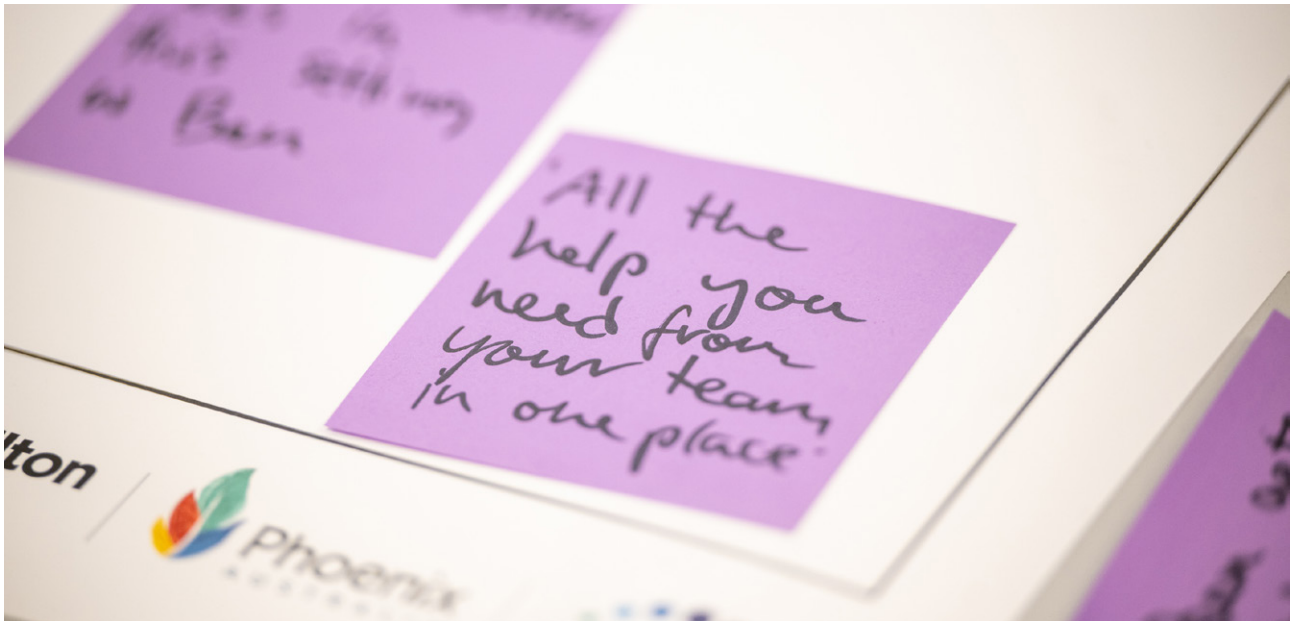


Image from co-design workshop 1. Photography by Adam R. Thomas.

3.5 Governance and leadership

> *The first [barrier] I suppose is the funding. Clinical mental health services get significantly more funding than AOD services. Yet there's a common understanding amongst AOD services that trauma is the expectation, not the exception [AOD services are nearly always treating co-occurring needs, which requires more financial support.]*
>
> - April's table, Workshop 2

The workshops sought to identify practical opportunities for improving integrated care at the micro, meso, and macro levels across different MH and AOD settings. Across both workshops, participants emphasised that the success of integrated care implementation would rely on appropriate structural support at the governance, funding, and leadership levels.

> *Whatever your best practice model is, how do you drive that through a funding formula? So it comes back to the KPIs and things. If you've got a KPI that says you do something around integrated care, well then it's more likely to get done.*
>
> - April's table, Workshop 1

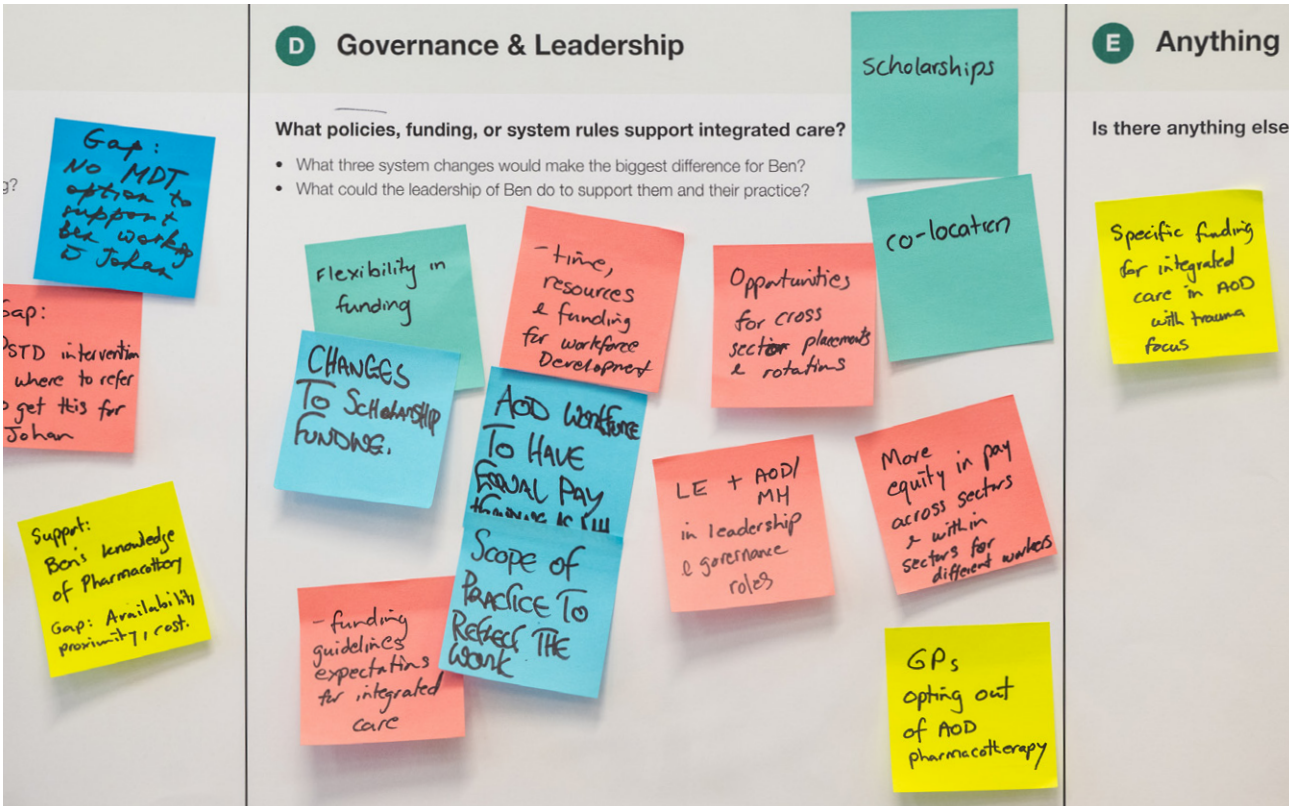


Image from co-design workshop 2. Photography by Adam R. Thomas.

Aligning policy mechanisms with integrated care goals presents the opportunity to reinforce what works, such as through data reporting that effectively captures and demonstrates the value of peer workers to other disciplines.

Participants highlighted that limited understanding and stigma affecting consumers as well as workers also shapes decision-making about governance and funding. For the impact of integrated care to be realised, participants believe a deeper awareness of the complex relationships between SUD and trauma/PTSD, and of trauma-informed, strength-based approaches is needed at senior and leadership levels. Meaningful inclusion of lived experience in senior contexts and more substantial cross-sector collaboration were recommended so that policies would reflect the conditions needed for success.

> *What I see in the locals I have been working with around trauma informed practice is, for example, leadership understanding that avoidance and ups and downs of being at risk and being suicidal is part of PTSD presentation. And how you support staff to deal with those without punishing the client, without immediately going on the phone and sending them to hospital. Having an understanding of what PTSD looks like, especially in what they see as difficult presentations, but they're not. They're just normal presentations of PTSD.*
>
> - Jarrah's table, Workshop 2

While funding and training were emphasised as critical additions to an improved model of care for treating co-occurring trauma/PTSD and SUD, it was also noted that the sector is feeling fatigued as a result of numerous, rapid rollouts of new initiatives. Participants recommended that future change be implemented with care and consideration for context, avoiding unnecessary duplication or rapid turnover of processes.

4

Pathway Principles

Integrated, trauma-informed care requires small, well-placed changes that shift system behaviour — what Wright & Meadows (2009) call "leverage points," where modest interventions can generate disproportionate effects. In complex adaptive systems like healthcare, we highlight that improvement emerges from iterative, context-sensitive adjustments rather than linear rollout (Weick 1984).

In light of this and to translate the workshop findings into practice, we specify seven Pathway Principles - inspired by Lou Downe's (2020) general principles of good service design - for making integrated, trauma-informed care tangible given the complex realities of the current system. The principles support translating "what" we learned into "how" an integrated service for treatment of co-occurring SUDs and trauma/PTSD might operate. Each principle is written in plain language, paired with: (a) why it matters (the problem it solves), (b) what it looks like in practice (behaviours and rules), and (c) examples of service prototypes (non-exhaustive potential approaches to implementing the principles into service delivery, requiring testing and iteration at a local service level). This supports context-specific implementation that connects micro practice to macro or meta intent — consistent with contemporary complexity-informed improvement and implementation science (Braithwaite et al. 2018; Greenhalgh & Papoutsi 2018). Implementing these principles in ways that are responsive to the needs of consumers and healthcare workers, and that embed trauma-informed care approaches, offers an opportunity to maximise their impact in enabling integrated care for co-occurring trauma/PTSD and SUD across the sector.

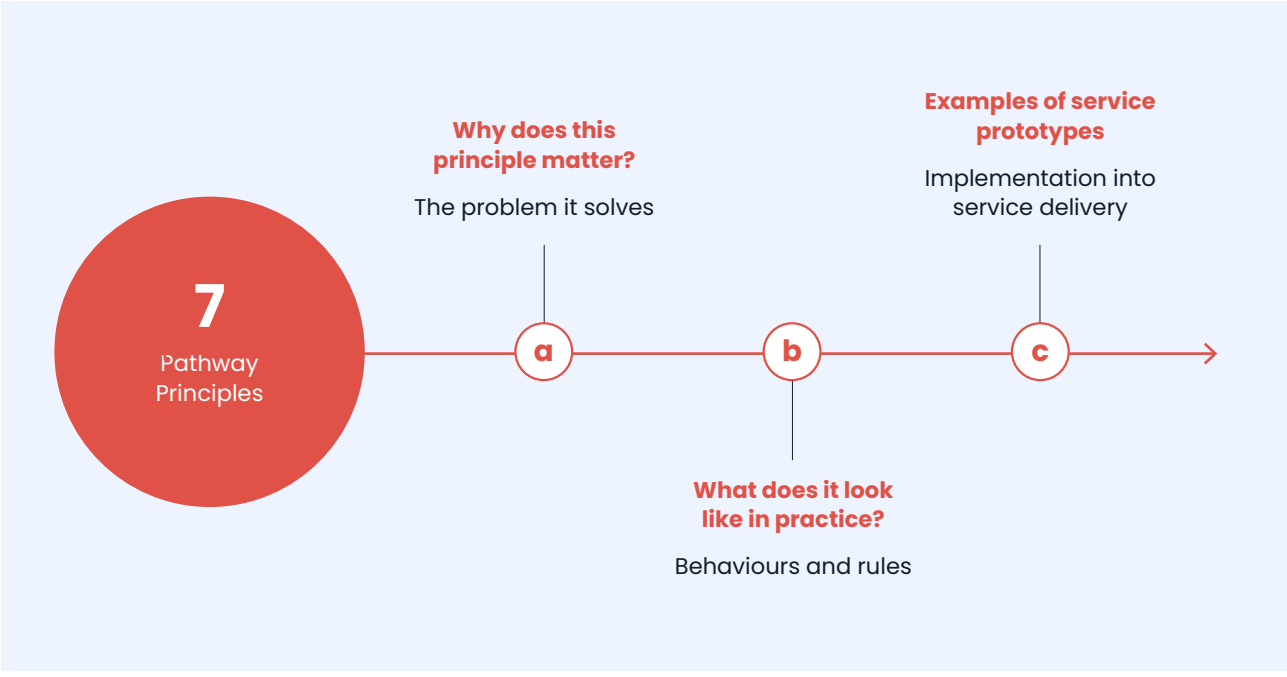


Figure 6 Structure of each Pathway Principle

We also recognise the limitations of these specific Pathway Principles. They are both time- and context-bound, reflecting Victorian service models and systems of care following the first five years of mental health and AOD sector reform following the Royal Commission into Victoria's Mental Health System (State of Victoria 2021). They assume a system with a formal mandate for change that is simultaneously in flux and under strain. As such, the principles may not be directly transferable to other jurisdictions or service contexts without further consideration for the context of that jurisdiction.

The pathway principles are summarised in table 2, and discussed in further detail in this section, alongside example service prototypes that illustrate how the principles may be operationalised in practice.

Table 2 Pathway Principles summary view

#	Pathway Principle	Why does this principle matter?
1	**No Wrong Door & Single-Story Choice**	People bounce between entry points and must re-tell traumatic histories; this delays care and erodes trust.
2	**Care Delivery In Parallel**	Sequential "finish X before Y" models of care leave co-occurring needs unaddressed and untreated.
3	**Right Care, Right Time Navigation**	People need timely access and guided progression through a complex system.
4	**Continuity Scaffolds — Transitions You Can Trust**	Most drop-offs happen at service handovers; fragmented notes and "cold" transfers break continuity of care and overall patient experience.
5	**Role Clarity & Shared Accountability**	Scope confusion, territorial behaviour, and unclear escalation slow care and increase risk.
6	**Cultural Safety By Design**	Engagement, trust, and outcomes depend on culturally safe, identity-affirming care.
7	**Supported Workforce & Learning Systems**	Worker confidence and consistency rise when supports and feedback loops are built in.

4.1 No Wrong Door & Single-Story Choice

People bounce between entry points and must re-tell traumatic histories; this delays care and erodes trust.

What does this principle look like in practice?

Any service can start the pathway. At the first safe point, a consent-aware "single-story" summary is created and travels with the person; choices about pace/topics/peer or cultural options are offered upfront.

Example Service Prototypes

- Single-Story Consumer Summary (presenting issues, safety flags, strengths, supports, consent/sharing rules, preferred language/culture), tech-enabled to travel with the person through intuitive interfaces and integrations with existing Electronic Medical Record systems.
- Trauma-informed intake script (ask–explain–ask) with light-touch, relational assessment tools for consumer context built in.
- Support settings to have spaces available that are welcoming for people with co-occurring needs to encourage engagement; private, quiet, calming. Include visible inclusive welcoming signs for consumer groups, e.g LGBTQIA+ rainbow flags, First-nations flags.
- All staff are trained in 'Welcoming'; raising awareness of the impact of early interactions on engagement, and providing practical interpersonal approaches for helping people feel safe and appreciated.

4.2 Care Delivery in Parallel

Sequential "address X before Y" models of care leave co-occurring needs unaddressed and untreated, ultimately failing the people the service aims to support.

What does this principle look like in practice?

Trauma-informed treatment of concurrent trauma and SUD needs for consumers, that does not require one need to be 'finished' before another need can be addressed. Services should seek to identify step-up/step-down options available as required (e.g., acute withdrawal, referral to IPU, etc.).

Example Service Prototypes

- Support resourcing to reduce waitlists, accommodate demand.
- Develop materials that address worker hesitancy about trauma and trauma-focussed treatment, highlighting the need for acting when opportunities arise rather than when stability is achieved. As with discipline-specific training, ensure these resonate across contexts.
- Where feasible, recruit PSW's into senior and leadership roles to strengthen trauma-informed culture.
- Integrated care case-conference protocol: template with a fixed agenda and rotating chair to ensure common approaches across services.

4.3 Right Care, Right Time Navigation

People need timely access and guided progression to relevant, appropriate services through a complex system.

What does this principle look like in practice?

People 'fall between' services at points of handover, and can struggle to find the right service if they drop out. A Pathway Navigator (peer/practitioner) helps to coordinate bookings, reminders, transport, and warm handovers at the start of the care period as required.

Example Service Prototypes

- Dedicated time and resource to support and incentivise workers to establish and maintain professional networks for streamlined, needed referrals.
- Support model flexibility to better respond to consumer needs and readiness, such as expanding time frames within which someone can access referrals.
- Provide scripts for engaging consumers on safe family involvement, and scripts for engaging family so they can support engagement and navigation. Establish protocols for including family in conferencing appropriately.
- Provide staff with clear referral pathways to needed services and co-locate services where possible. Provide transport options including cars, travel vouchers, phones, and user-friendly case management technology to support effective case coordination.

4.4 Continuity Scaffolds — Transitions You Can Trust

Most drop-offs happen at service handovers. Fragmented notes and "cold" transfers break continuity of care and negatively impact overall consumer and staff experience.

What does this principle look like in practice?

Live contact-to-contact handovers between services. Systems and mechanisms to share notes between services to avoid repeating stories and associated retraumatisation. Next appointment booked before transfer/discharge; 48–72h follow-up after every transition.

Example Service Prototypes

- Warm handover protocol: A mandatory, brief warm handover procedure (in person or by phone/secure message) supported by a standard handover template, follow-up protocols, and checklist to help workers coordinate confidently without unnecessary burden.
- Enable case systems to link and share data appropriately for streamlined co-ordination and continuity of care between services.
- Consistent 48–72h follow-up protocol for providers to use with consumers.
- Protected time for case preparation and administrative work, and referral network maintenance.

4.5 Role Clarity & Shared Accountability

Scope confusion, territorial behaviour, and unclear escalation slow care and increase risk.

What does this principle look like in practice?

Named roles at each touchpoint (Clinical Lead, AOD Lead, Trauma-Informed Lead, Navigator, Peer Partner) with a simple escalation ladder; regular, structured case-conference meeting cadence.

Example Service Prototypes

- Integrated care case-conference protocol: template with a fixed agenda and rotating chair to ensure common approaches across services.
- Co-create a one-page role profiles matrix (who does what, when, handover triggers, overlaps) for all disciplines.
- Warm handover protocol: A mandatory, brief warm handover procedure (in person or by phone/secure message) supported by a standard handover template, follow-up protocols, and checklist to help workers coordinate confidently without unnecessary burden.
- Cross-discipline upskilling protocol: shadowing and reflective practice to build integrated care skills and knowledge, trust, mutual understanding, and confidence.
- Manager playbook and mediation pathway to address territorial behaviours and power imbalances.

4.6 Cultural Safety by Design

Engagement, trust, and outcomes for consumers depend on culturally safe, identity- affirming care.

What does this principle look like in practice?

Early, non-mandatory offer of culturally specific supports (e.g., First Nations–led options, CALD services, interpreters). Co-authored goals for treatment that include identity, family, community and what this means for each unique consumer. Services respect and honour the choice of the consumer at each step in their recovery.

Example Service Prototypes

- Cultural options provided to consumers at intake.
- Cultural-safety review checklist for providers, revisited at a regular cadence and informed by shared staff input.
- Consent conversation guides to support providers on how they engage family.
- Specific options for First Nations people to have First Nations involvement.
- Services to have established referral MOUs in place with community services.

4.7 Supported Workforce & Learning Systems

Worker confidence and consistency rise when they are supported by appropriate trauma-informed training, advice on appropriate supports, and feedback loops to support iterative professional development that is built into the service.

What does this principle look like in practice?

Trauma-informed training and learning is embedded into practice, and available across settings, with discipline-specific and context-relevant approaches and tools that make sense and integrate with workers' knowledge. Scheduled team micro-huddles, cross-discipline mentoring/debriefs in addition to discipline-specific supervision support workers to build confidence and their own professional development.

Example Service Prototypes

- Shared trauma-informed competency framework outlining core skills per role, with clear career and remuneration pathways.
- Structured learning such as discipline-specific peer support, supervision, shadowing and reflective practice to build skills, process challenges, embed learnings, build confidence, and promote self-care.
- Practical decision aids and conversation guides for safe, confident trauma-informed interactions.
- Simple feedback loops (e.g. dashboards, debrief postcards) to inform shared learning and service and workforce improvement.
- Ongoing co-design with lived experience and cultural advisory groups to shape practical tools, training, and recruitment.
- Regular rituals that celebrate collaboration and learning, such as team spotlights or gratitude boards.

5

Conclusion

The system through which integrated care for co-occurring trauma/PTSD and SUD is delivered is highly complex, requiring close collaboration from workers with diverse experiences, training, and treatment philosophies in a previously siloed environment with finite funding. The strength, hope, dedication and expertise of workers and consumers in this space is foundational for achieving future improvements, and this project aims to provide practical guidance and support to assist this work. The two workshops convened 28 participants that represent deep expertise and experience delivering care in various Victorian settings in which people with co-occurring needs present. Their contributions provide insights into the barriers and enablers encountered by consumers and workers day-to-day, and highlight many opportunities for achieving better outcomes.

Image from co-design workshop 1. Photography by Adam R. Thomas.

The findings of this project reveal that achieving truly integrated, trauma-informed care for people with co-occurring trauma/PTSD and SUD requires more than hiring peer roles or providing isolated training; it requires structural alignment to foster collaboration, sustained workforce support, and strong leadership. Across mental health, AOD, and community health settings, participants described a workforce that is deeply committed yet constrained by fragmentation, fear of doing harm, and inconsistent resourcing. Without enabling conditions; trauma-informed care models, access to trauma-focussed treatment, clear guidance, cohesive teams, healing environments and protected time, the system will continue to reinforce procedural over person-centred care and risk retraumatising the people it seeks to help.

This work highlights a clear path forward. By resourcing services to deliver safe, relational, and context-responsive care, and by strengthening the environments and policies that enable these safe environments, integrated care for co-occurring trauma/PTSD and SUD is an achievable, sustainable reality.

MADA and the Hamilton Centre would like to thank all those who participated in the workshop and contributed to this research.

Image from co-design workshop 2. Photography by Adam R. Thomas.

References

Braithwaite, J., Churruca, K., Long, J. C., Ellis, L. A., & Herkes, J. (2018). When complexity meets implementation science: a theoretical and empirical analysis of systems change. BMC medicine, 16(1), 63.

Chrzanowska, A., Man, N., Darke, S., Tierney, L., Sutherland, R., Grigg, J., Dietze, P., Brown, J., Ezard, N., Siefried, K., Bruno, R., Salom, C., and Peacock, A. (2024). Unravelling the impact: analysis of trends in GHB use and related harms in Australia. Annual NDARC Research Symposium, Sydney, NSW Australia, 20 September 2024. Sydney, NSW Australia: UNSW Sydney.

Dore, G., Mills, K., Murray, R., Teesson, M., & Farrugia, P. (2012). Post-traumatic stress disorder, depression and suicidality in inpatients with substance use disorders. Drug and Alcohol Review, 31(3), 294-302.

Downe, L. (2020). 15 Principles of Good Service Design. NASWA Workforce Technology.

Edvardsson, D., & Innes, A. (2010). Measuring person-centred care: a critical comparative review of published tools. The Gerontologist, 50(6), 834–846.

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. Journal of Community Psychology, 33(4), 461–477. https://doi.org/10.1002/jcop.20063

Fazio, S., Pace, D., Flinner, J., & Kallmyer, B. (2018). The fundamentals of person-centered care for individuals with dementia. The Gerontologist, 58(suppl_1), S10–S19

Ferlie, E. B., & Shortell, S. M. (2001). Improving the Quality of Health Care in the United Kingdom and the United States: A Framework for Change. The Milbank Quarterly, 79(2), 281–315. https://doi.org/10.1111/1468-0009.00206

Greenhalgh, T., & Papoutsi, C. (2018). Studying complexity in health services research: desperately seeking an overdue paradigm shift. BMC medicine, 16(1), 95.

Heiss, L., Hamilton, O., Coombs, G., McGee, T., & O'Kane, C. (2025). Sequenced co-design with stakeholder communities to support the development of spaces for mental health recovery and healing. *The Design Journal*, *28*(2), 279–299. https://doi.org/10.1080/14606925.2024.2420156

Heiss, L., & Kokshagina, O. (2021). Tactile co-design tools for complex interdisciplinary problem exploration in healthcare settings. Design Studies, 75, 101030.

Kingston, R. E., Marel, C., & Mills, K. L. (2017). A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. Drug and Alcohol Review, 36(4), 527-539.

McGee, T. Killen, A. Heiss, L. Coombes, G., Thiessen, M. (2022). Statewide Centre for Addiction and Mental Health Consultation: Synthesis and Insights report. (Melbourne: Monash University, Design Health Collab).

Najavits, L.M., et al. (2020) PTSD/substance use disorder comorbidity: Treatment options and public health needs. Current Treatment Options in Psychiatry, 7: p. 544-558.

Roberts, N.P., A. Lotzin, and I. Schäfer (2022). A systematic review and meta-analysis of psychological interventions for comorbid post-traumatic stress disorder and substance use disorder. European Journal of Psychotraumatology, 13(1): p. 2041831.

Sanders, E. B. N., & Stappers, P. J. (2008). Co-creation and the new landscapes of design. CoDesign, 4(1), 5–18. https://doi.org/10.1080/15710880701875068

State of Victoria (2021) Royal Commission into Victoria's Mental Health System, Final Report, Parl Paper No. 202, Session 2018–21

Substance Abuse and Mental Health Services Administration (2014) S., SAMHSA's concept of trauma and guidance for a trauma-informed approach. US Department of Health and Human Services.

Weick, Karl E. "Small wins: Redefining the scale of social problems." American psychologist 39, no. 1 (1984): 40.

Wright, D., & Meadows, D. H. (2009). Leverage Points—Places to Intervene in a System. In Thinking in Systems (pp. 152–172). Routledge. https://doi.org/10.4324/9781849773386-15

7

Appendices

A Appendix A: Participant expertise area (facilitators & participants)

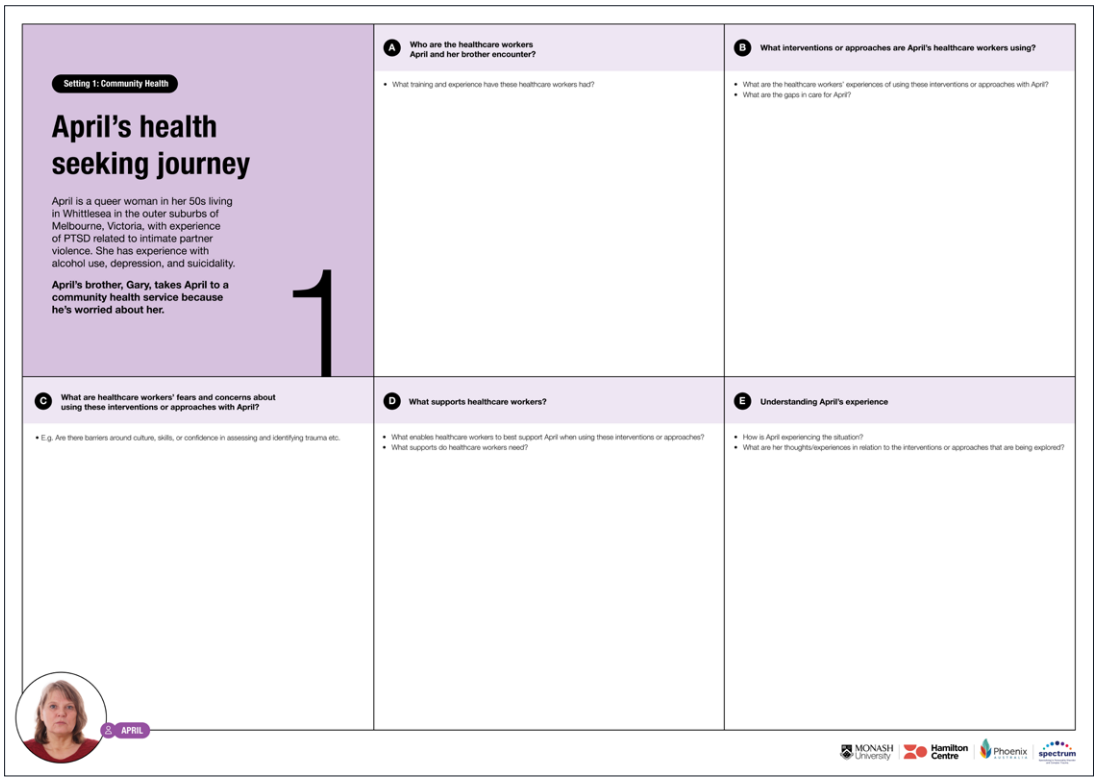
Table 3 Workshop attendees and their expertise backgrounds. The same stakeholder groups and individuals attended both workshop 1 and 2.

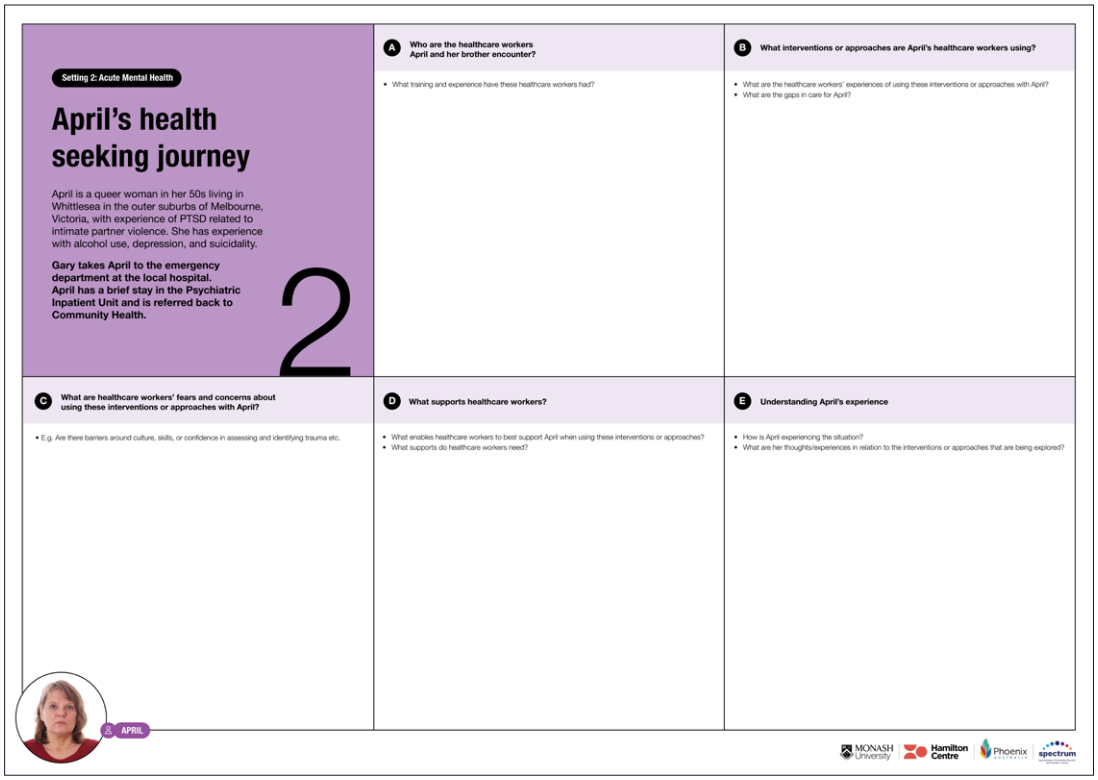
Expertise area	Number of participants	Organisations, roles and professions represented*
Alcohol and Other Drug (AOD) Practitioners	9	Addiction Nurses Addiction Medicine Physician Addiction NGO staff AOD Addiction Service Leader
Mental Health Practitioners	5	Mental Health Nurse Psychologist Psychiatrist Psychiatric Nurse Mental Health NGO Staff Clinical Directors
Lived Experience & Peer Workers	8	Peer Workers Consumers with lived experience of both LGBTQIA+ and Indigenous perspectives
Researchers	10	Mental Health and AOD Researchers Design Researchers/ Facilitators
Total	**32**	

* Many individual participants brought multiple perspectives through their current and past positions and experiences.

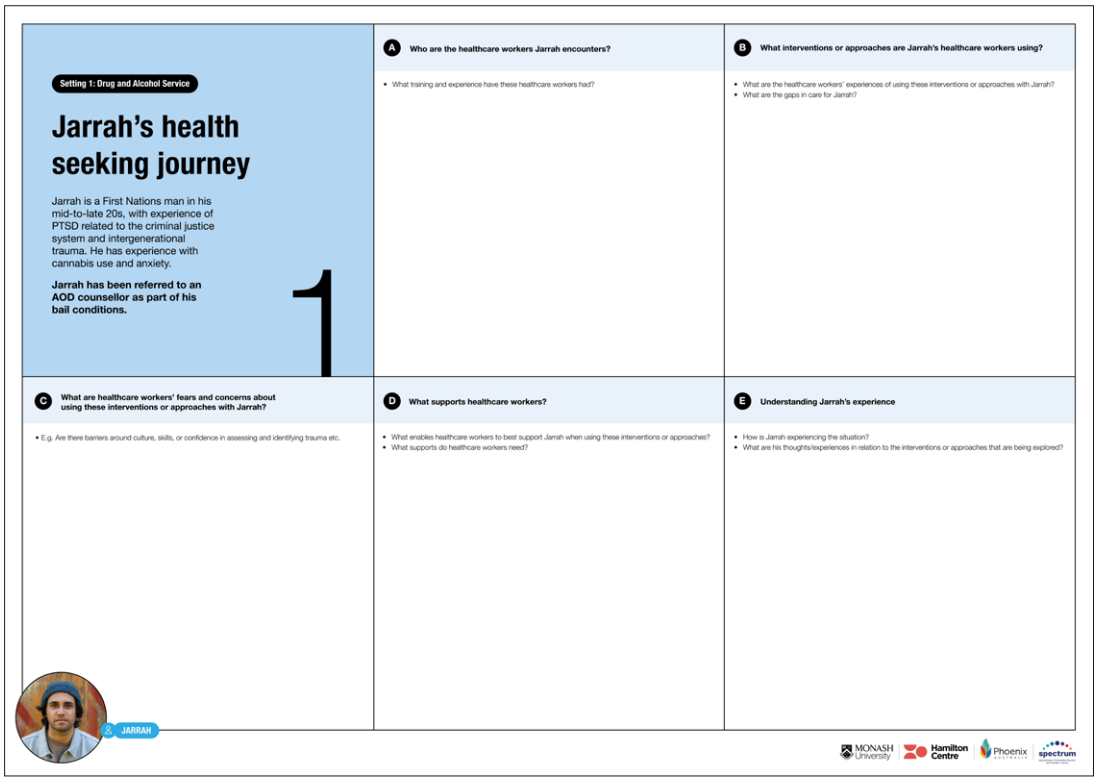
B Appendix B: Blank Workshop Canvases

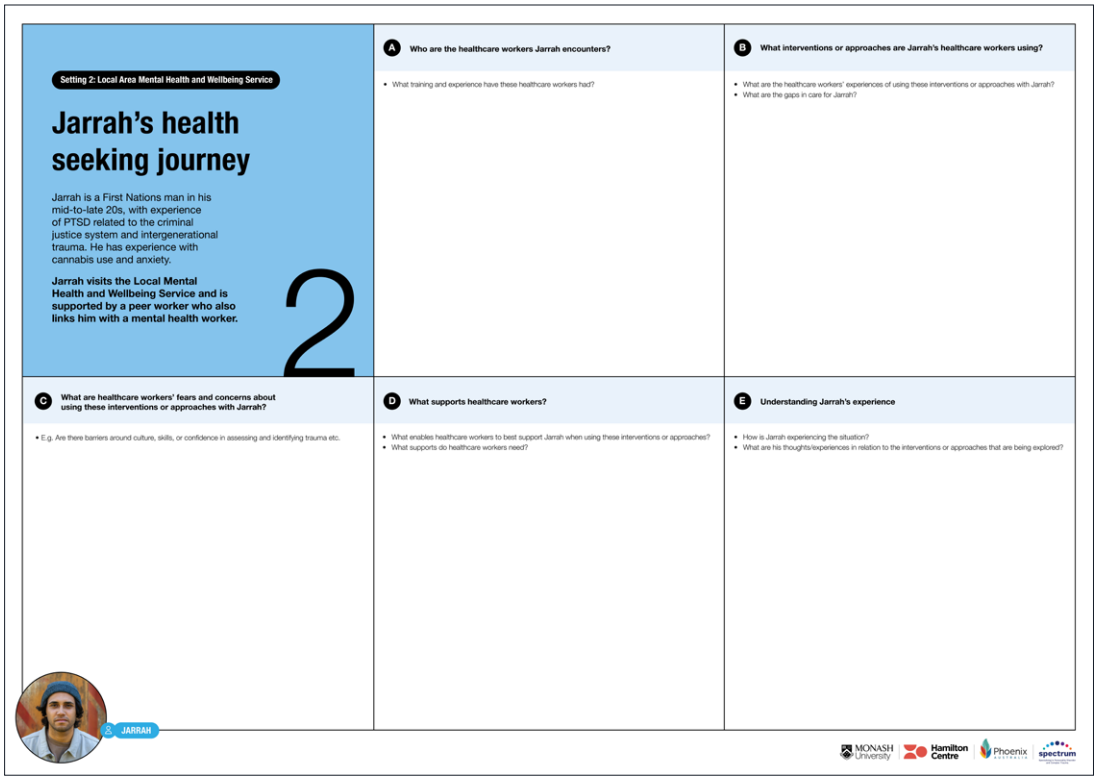
B1 Workshop #1



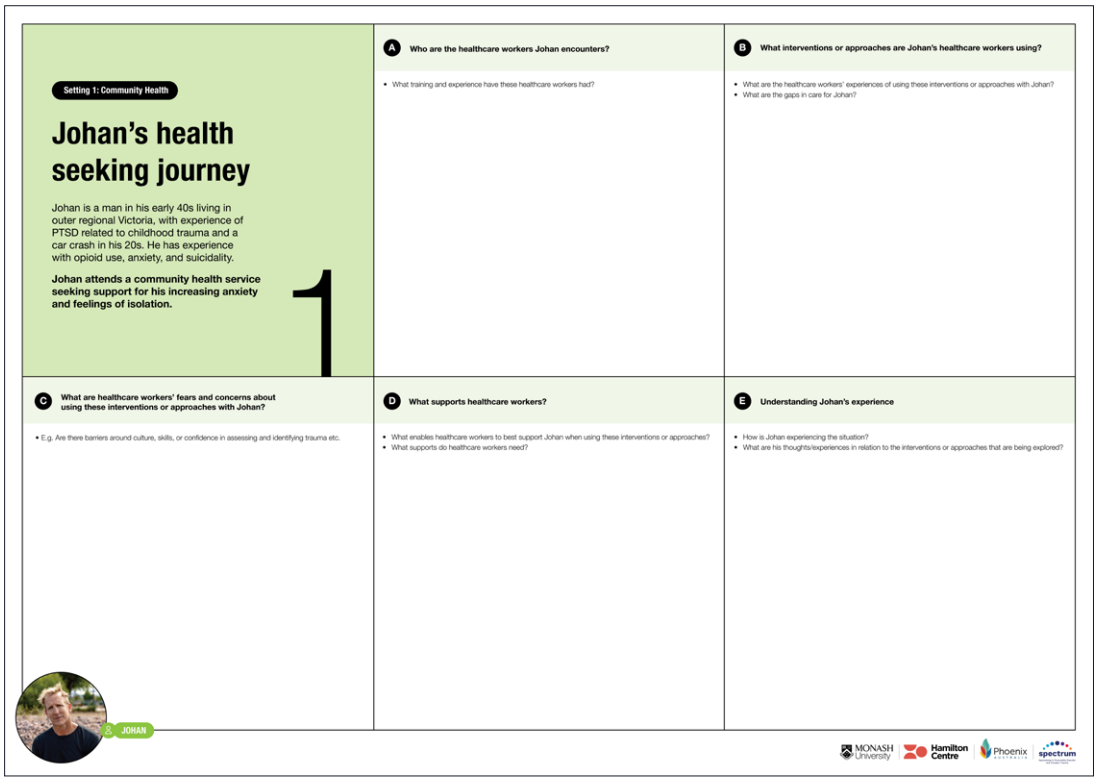


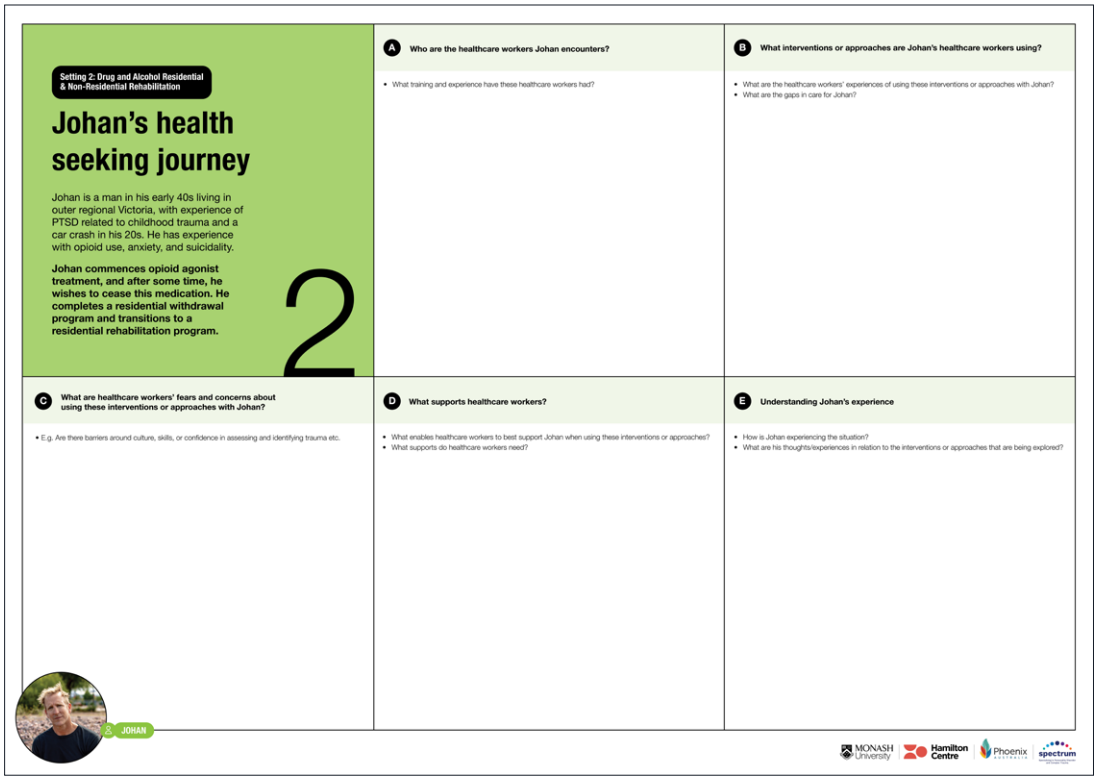
Canvases from workshop 1 for the April persona



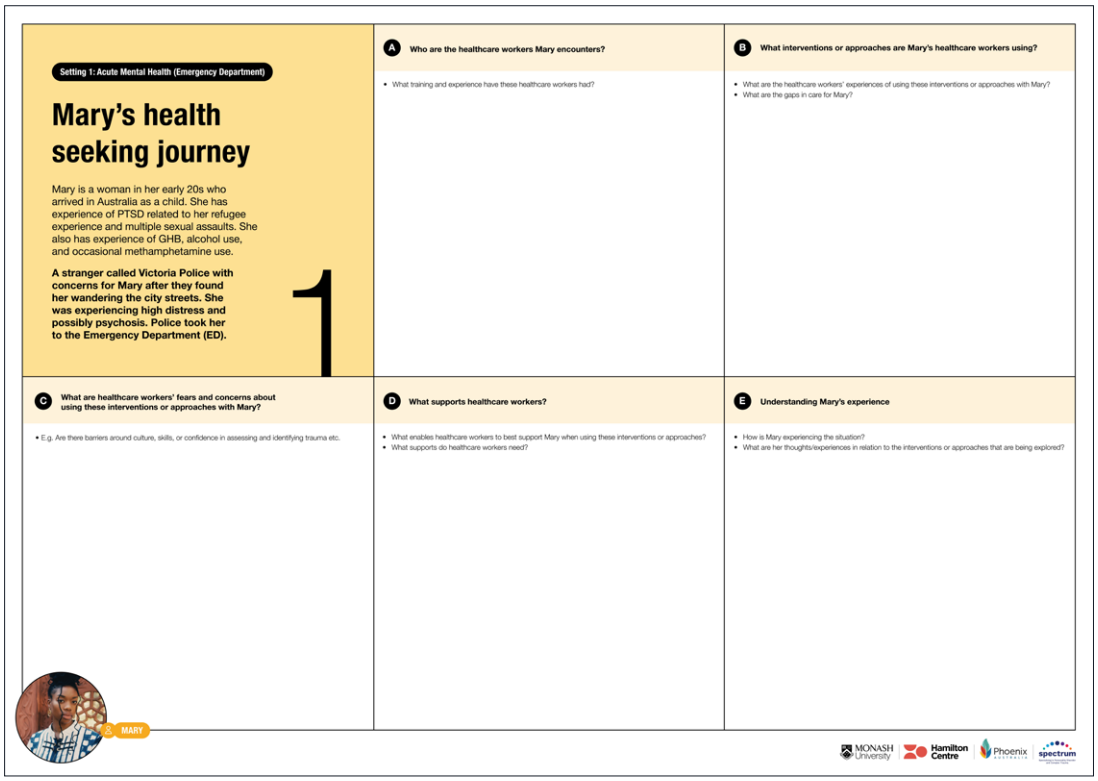


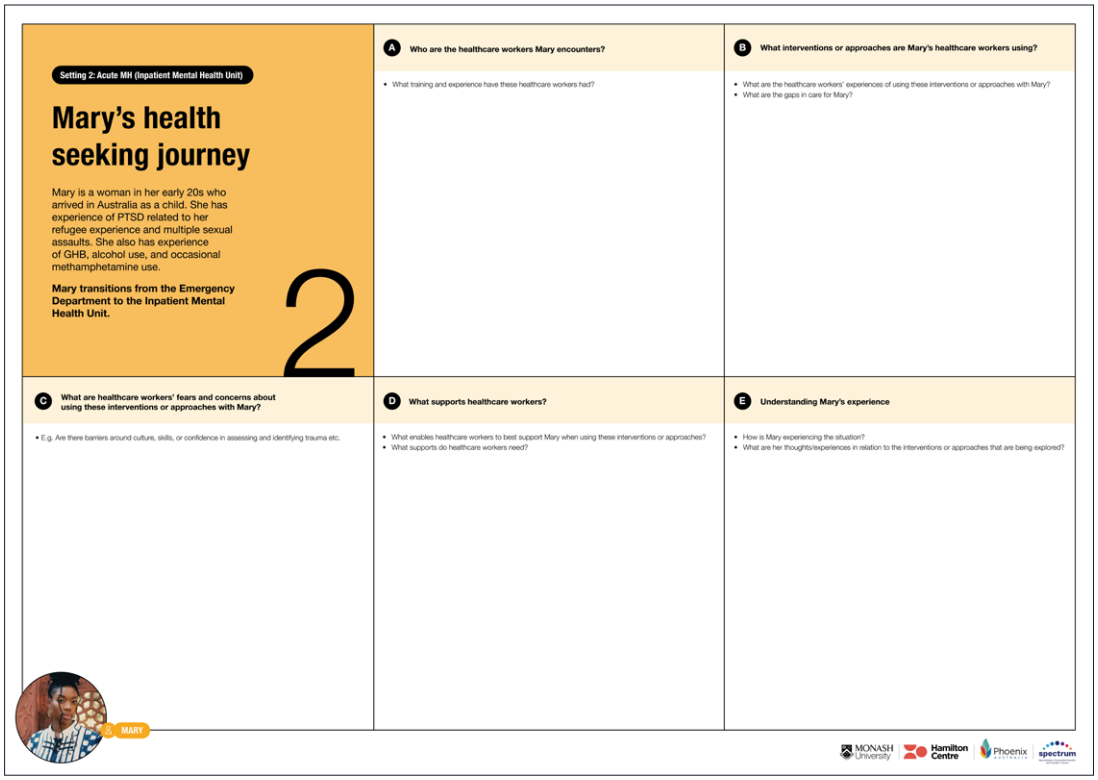
Canvases from workshop 1 for the Jarrah persona





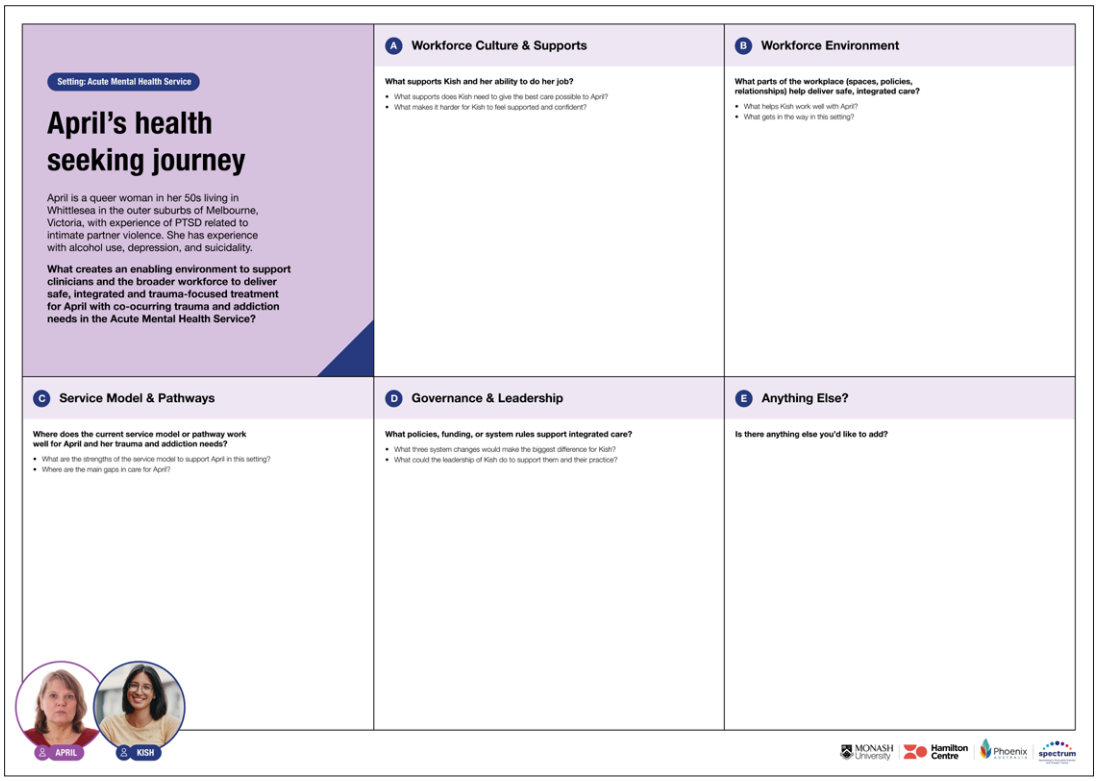
Canvases from workshop 1 for the Johan persona

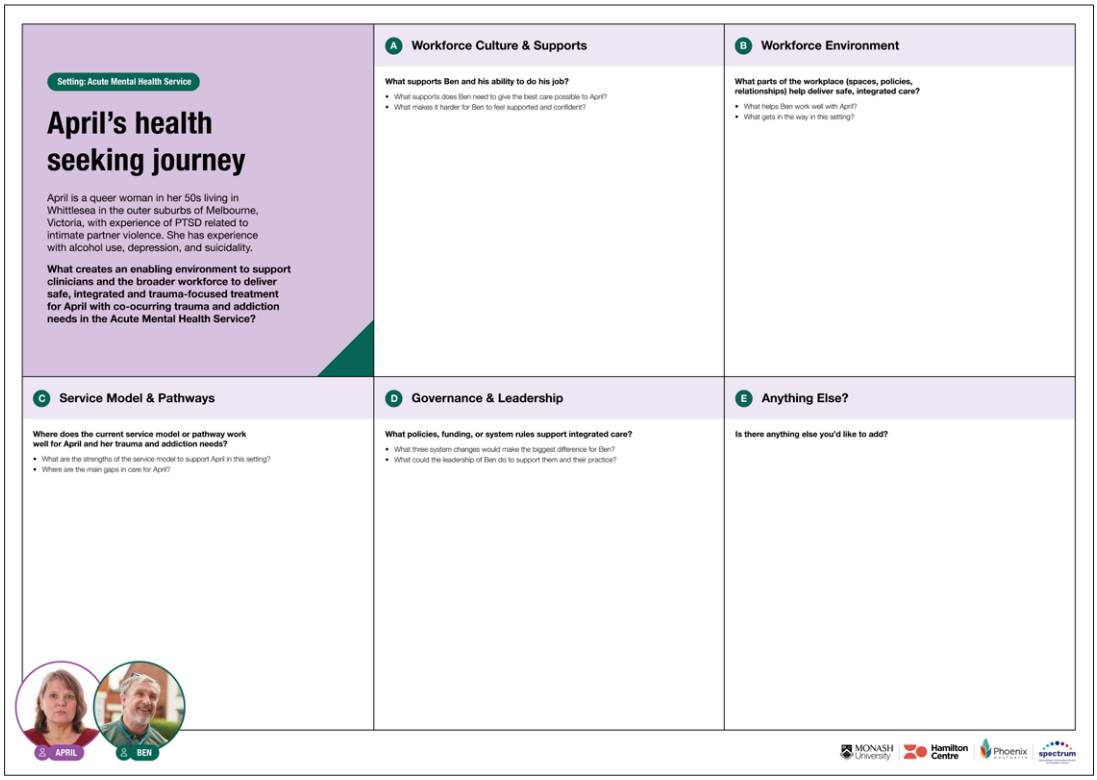




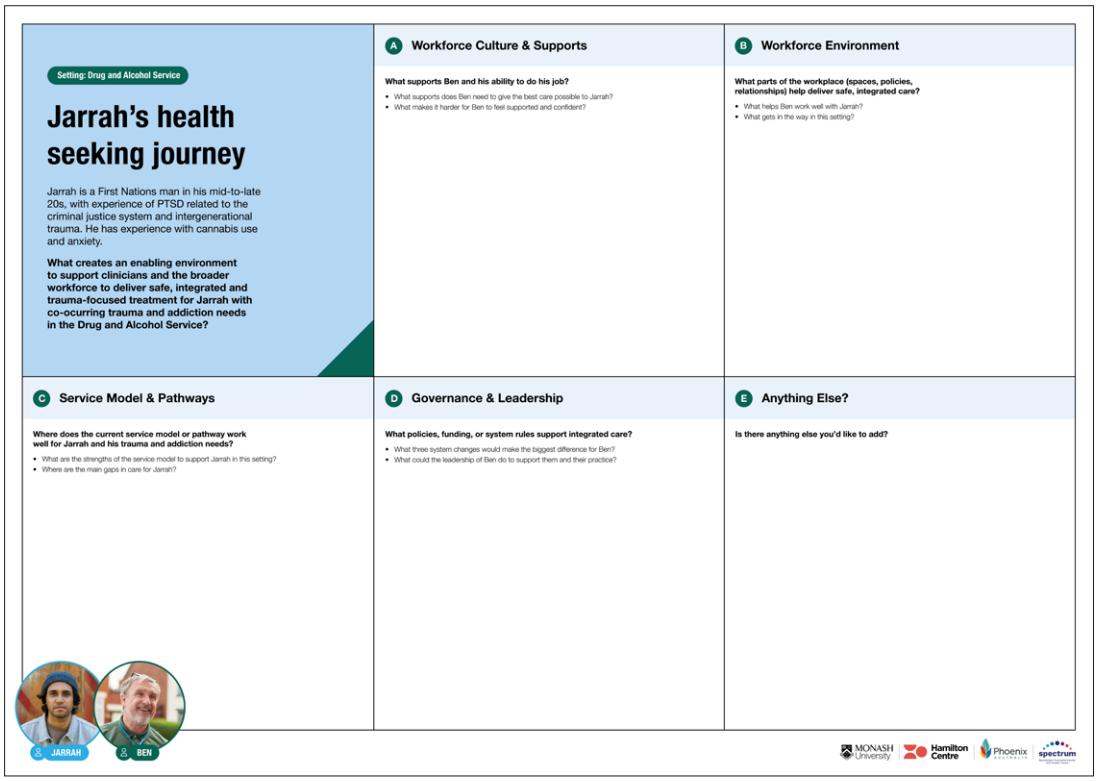
Canvases from workshop 1 for the Mary persona

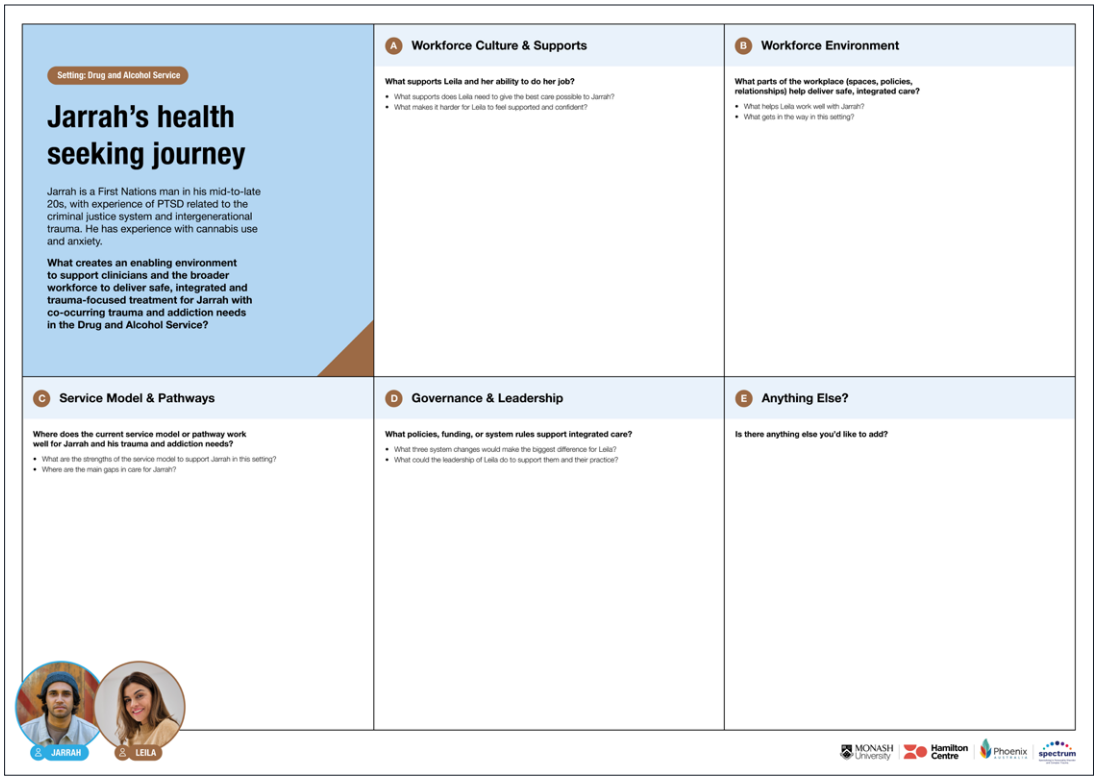
B2 Workshop #2



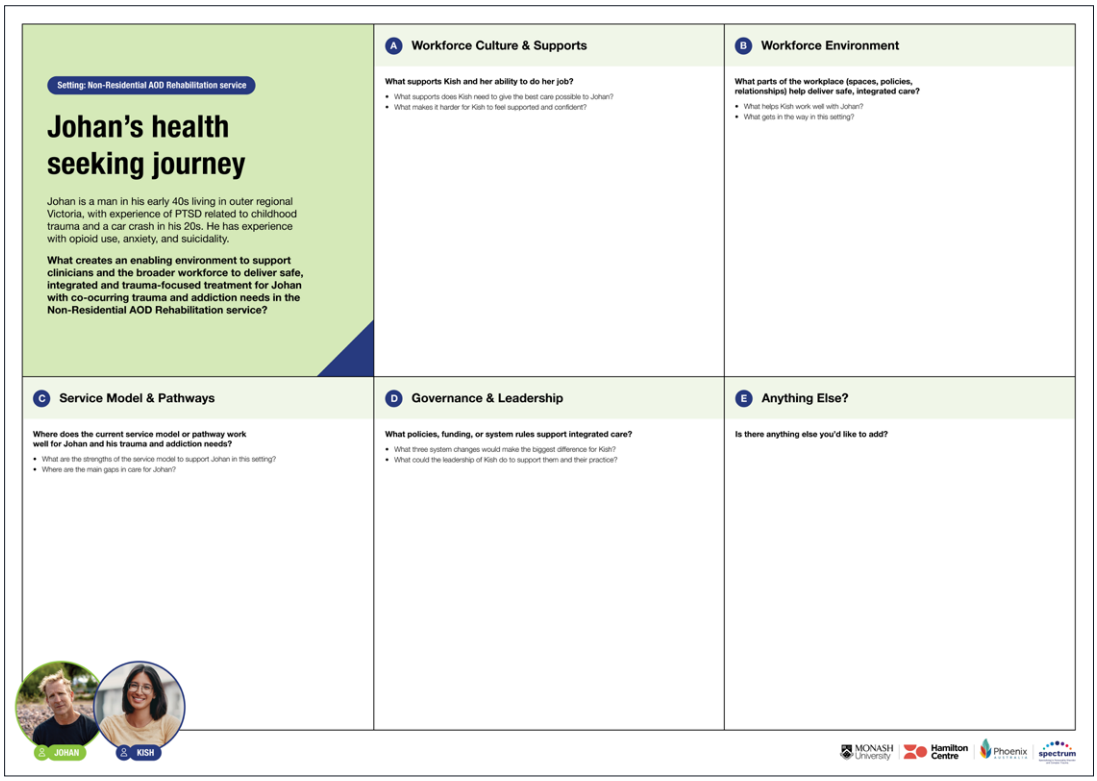


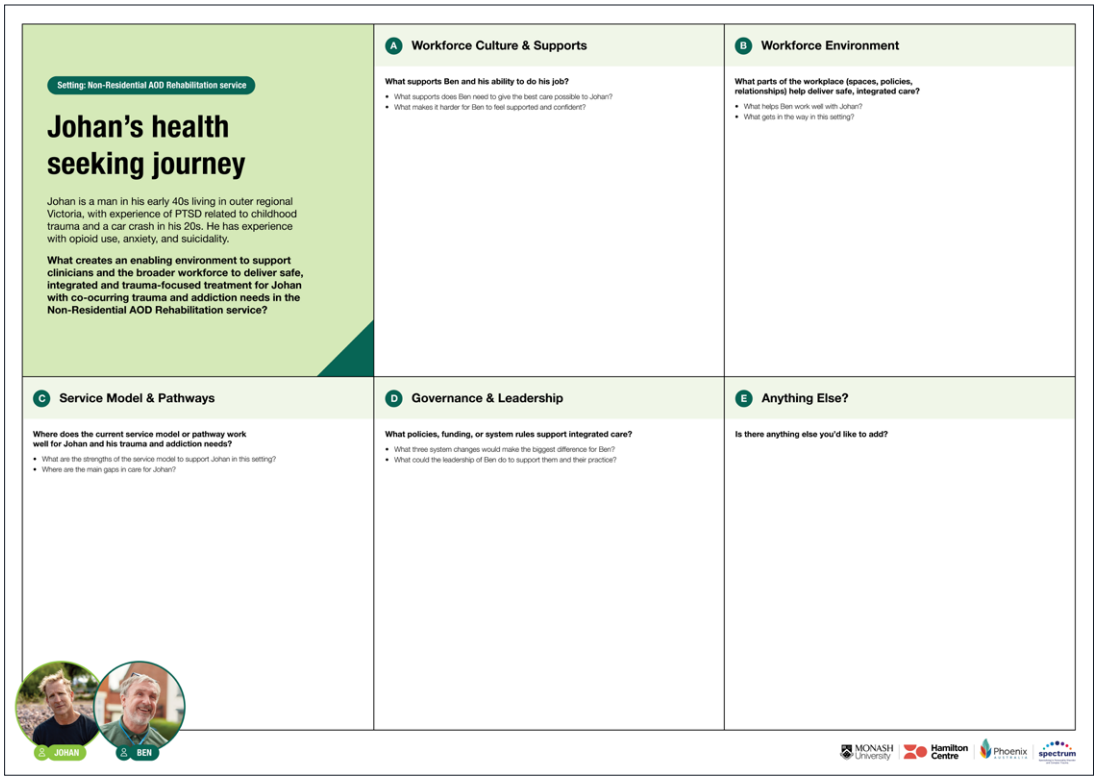
Canvases from workshop 2 for the April persona



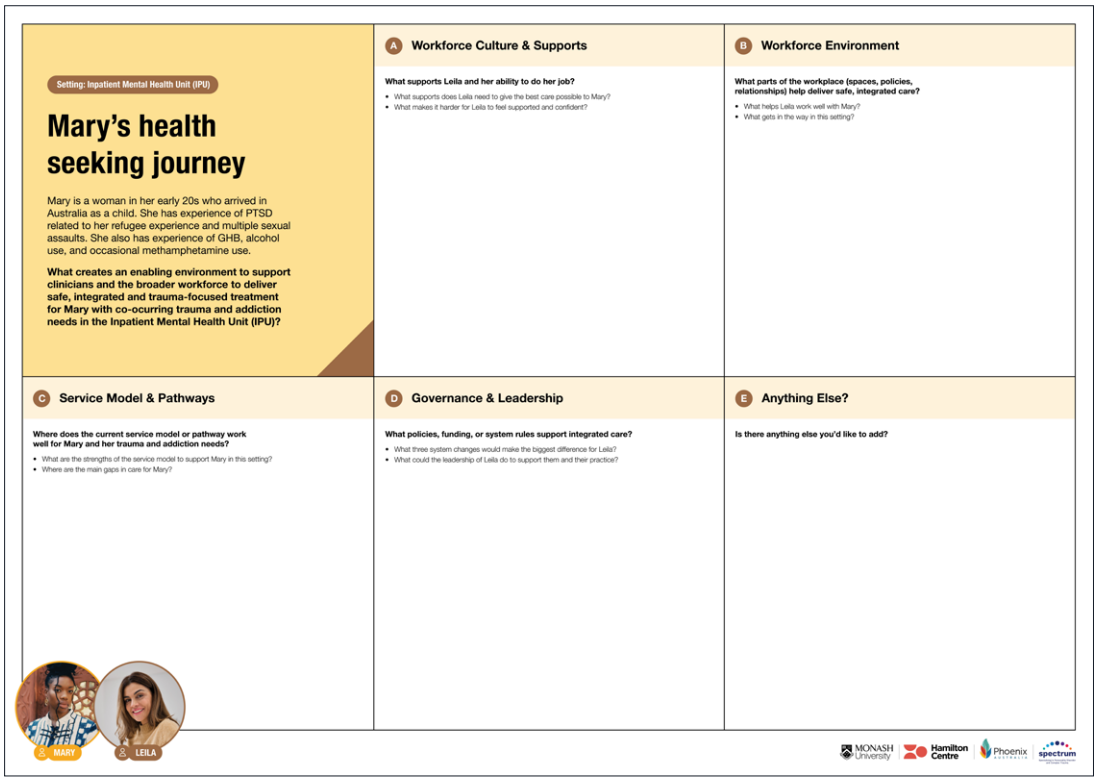


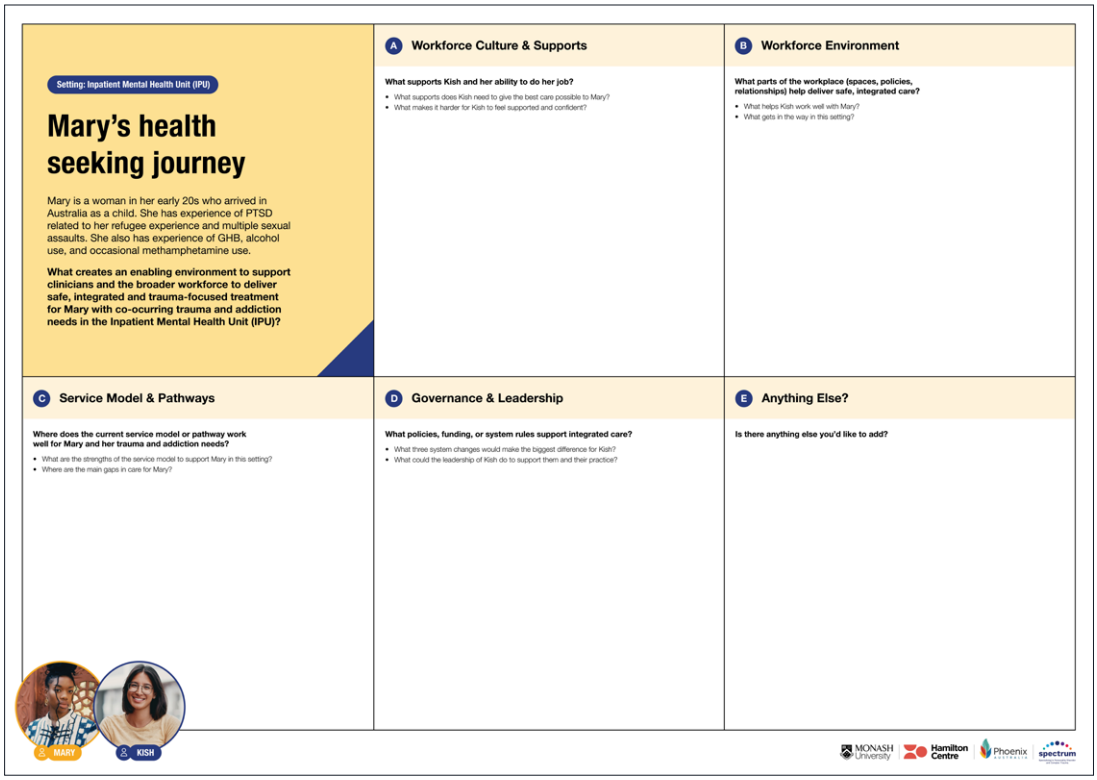
Canvases from workshop 2 for the Jarrah persona





Canvases from workshop 2 for the Johan persona





Canvases from workshop 2 for the Mary persona

C Appendix C: A2 Persona Posters that were provided to participants

Meet April

April is a queer woman in her 50s living in Whittlesea in the outer suburbs of Melbourne, Victoria, with experience of PTSD related to intimate partner violence. She has experience with alcohol use, depression, and suicidality.

NAME: **April**
AGE: **52**
GENDER: **Female identifying**
OCCUPATION: **Working casually in hospitality**

NATIONALITY: **Australian**
EDUCATION: **Left school aged 15**
LOCATION: **Whittlesea, Victoria (3757)**

April's story

April is in her early 50s and lives alone in the outer suburbs of Melbourne. She works casually at a local café and rents her own apartment 15 minutes away. A former small business owner, April used to make and sell jewellery. She loved having a creative outlet and feeling recognised, and hopes to eventually get back to it.

April identifies as a queer woman. When she came out in her 20s, she experienced family rejection. Her parents passed away five years ago having never accepted her identity because of their religious beliefs. She's maintained a close relationship with her sister Rachel, who lives interstate, and speaks with her weekly. Her brother Gary lives nearby and checks in often. She hasn't spoken to her other brother, Jim, since before her parents died.

Recently, April was charged with a DUI. She's lost her licence and is now required to complete community service. The charge has shaken her - she feels ashamed and overwhelmed.

April lives with PTSD that originated from intimate partner violence in her previous relationship. She has a history of heavy drinking (with periods of sobriety) as well as depression and previous suicide attempts. Since the DUI, she's been drinking more to help her sleep and cope with shame, and is currently experiencing acute suicidal thoughts.

April has previously been supported by her local GP, but hasn't kept an appointment in a while. She's also having menopausal symptoms, but isn't getting treatment for it. Her past experiences with the mental health system - particularly inpatient care - left her feeling judged, unsafe, and dismissed.

HOPES, FEARS, AND SUCCESS

April isn't sure how she'll get to work without her driver's license, and is worried about falling behind on rent and becoming homeless.

April wants to find healthier ways to manage her emotions and move away from alcohol. She wants to feel creative again, and maybe, one day, find a partner. More than anything, she wants to feel connected, respected, and like herself again.

APRIL

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The April persona

Meet Jarrah

Jarrah is a First Nations man in his mid-to-late 20s, with experience of PTSD related to the criminal justice system and intergenerational trauma. He has experience with cannabis use and anxiety.

NAME: **Jarrah**
AGE: **27**
GENDER: **Male identifying**
OCCUPATION: **Unemployed**

NATIONALITY: **Aboriginal and Torres Strait Islander**
EDUCATION: **Left school in year 10**
LOCATION: **Morwell, Victoria (3840)**

Jarrah's story

Jarrah is 27 and lives with his mum, Keira, in Morwell on the traditional lands of the Brayakaulung people of the Gunaikurnai Nation in South Eastern Victoria. They have a strong relationship and have been through a lot together. Jarrah left school in Year 10 to help support his family and has worked mostly as a labourer since, though he's currently unemployed.

Jarrah lives with PTSD and intergenerational trauma, shaped not just by his own encounters but also by those of his family. Jarrah's father struggled with his mental health and alcohol use much of his life and didn't get the support he needed. He died in police custody when Jarrah was ten. The trauma of that loss has shaped much of Jarrah's life.

Jarrah doesn't have a criminal record but has been arrested in the past for public order offences and is currently facing a cannabis possession charge. He started using cannabis socially in high school and now relies on it to manage anxiety. While cannabis use is common in his social circle, he's the only one who has been charged. He used to love going to music festivals but with his experiences of being singled out and racially profiled, particularly by police and security, it feels too stressful.

Jarrah has recently started withdrawing from the people and activities that once made him feel good. The upcoming charges and not having a job have made him severely anxious. He's been increasingly isolated, and has been experiencing poor sleep and intrusive thoughts, including thoughts of self-harm.

Keira is worried and finds it hard. She is feeling like she's the only one looking out for him. Friends have suggested she encourage him to get help, but both Jarrah and Keira have little trust in mainstream services because of his father's experiences. In their view, 'white person' systems are unlikely to understand where they're coming from or be able to help, and they might even make things worse.

HOPES, FEARS, AND SUCCESS

Jarrah is anxious about the upcoming court case. He's worried it might mean he goes to prison and make it harder for him to find work. He's also scared about being in the same system where his dad died and where First Nations people aren't supported.

Jarrah wants to be able to manage his anxiety without needing cannabis, and to be able to live without fear. He'd like to find a long-term job, feel more independent, and one day go back to playing music, maybe in a band again.

JARRAH

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The Jarrah persona

Meet Johan

Johan is a man in his early 40s living in outer regional Victoria, with experience of PTSD related to childhood trauma and a car crash in his 20s. He has experience with opioid use, anxiety, and suicidality.

NAME: **Johan**
AGE: **42**
GENDER: **Male identifying**
NATIONALITY: **White Australian**

OCCUPATION: **Unemployed, receiving Centrelink support**
EDUCATION: **Left school aged 15**
LOCATION: **No fixed address. Presents at Pakenham, Victoria (3810)**

Johan's story

Johan is in his early 40s and currently experiencing homelessness. He grew up on the Mornington Peninsula and had a difficult childhood; his father drank heavily and was violent, contributing to Johan's PTSD. His parents divorced when Johan was five. He lived with his mother, but left home at 13 and never returned. He hasn't spoken to her in over a decade.

Johan left school at 15 and began working in a butcher shop, then later as a labourer. In his late teens and early twenties, he spent time in crisis accommodation before moving into a share house with some mates from work. Johan liked hanging out with them socially. In his spare time he would go to the local library to use the computers and eventually taught himself some computer programming.

Being involved in a major car crash in his late 20s left Johan with chronic back pain, further contributing to his experience of PTSD. He's since found it hard to do things he likes. He was prescribed oxycodone for pain, and over time became dependent. In his 30s, he began using heroin and has since been in and out of treatment a few times trying to get help for it. He doesn't have a regular GP and hasn't received consistent health care in over ten years.

Johan has recently found it difficult to get consistent work and eventually wasn't able to pay rent, which is when he became homeless. He is using heroin multiple times a day to manage both physical pain and his PTSD, but it's expensive, hard to get, and risky, so he's considering trying opioid pharmacotherapy again. He's experienced multiple accidental overdoses and recently has felt overwhelmed by thoughts of hopelessness and self-harm.

HOPES, FEARS, AND SUCCESS

At the moment Johan can't see how things will get better. He's afraid he'll always be alone, in pain, and a failure.

He wants to find healthier ways to feel better and be able to manage chronic back pain, anxiety and isolation without heroin.

He'd like to find stable housing and a secure job that suits his needs, including his back pain. He wonders if he could find work in an office, but he doesn't know how he'd go about it.

He'd eventually like to feel more connected. He wonders if he could find a way to contact his mother and have a good relationship with her, and he'd like to make friends with people who he can be himself with.

JOHAN

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The Johan persona

Meet Mary

Mary is a woman in her early 20s who arrived in Australia as a child. She has experience of PTSD related to her refugee experience and multiple sexual assaults. She also has experience of GHB, alcohol use, and occasional methamphetamine use.

NAME: **Mary**
AGE: **22**
GENDER: **Female identifying**
NATIONALITY: **South Sudanese**

EDUCATION: **Left school in Year 10 (in Australia)**
OCCUPATION: **Part-time Student**
LOCATION: **Public Housing. Flemington, Victoria (3031)**

Mary's story

Mary is 22 years old and lives in an inner city suburb of Melbourne with her mother and brother. She was born in what is now South Sudan, which they left when she was six. Mary attended school in Australia but left high school early after struggling with bullying and difficulty focusing in class. While she speaks English fluently, she finds reading and writing more difficult. Her favourite subjects were always art and music - spaces where she could express herself more freely. Mary has been studying hospitality at TAFE and working casual shifts at a local café.

Mary lives with PTSD originating from her refugee experience and also more recent sexual assaults. Her family left South Sudan seeking safety after witnessing intense violence including the death of her father during a street riot. Before arriving in Australia at nine, Mary spent several years in refugee camps across different parts of Africa. Her family rarely talks about what they experienced, and much of that pain remains unspoken.

Mary has also experienced multiple sexual assaults over the last few years - most recently by someone she trusted. She often has vivid nightmares in which she relives her past trauma, and sleep is a major struggle. She has started using alcohol and other substances, including GHB, to manage distress and help her sleep.

Mary carries deep shame related to both the assaults and her substance use, which has led to further isolation. She worries that talking about her mental health or trauma will bring shame to her family. She used to be close to her mother, but their relationship has become strained since she's been using substances. She's not currently connected to mental health or alcohol and drug services and isn't sure where to turn.

HOPES, FEARS, AND SUCCESS

Mary is afraid of letting herself and her family down. She's scared that she'll be unable to sleep, grow further apart from the people she cares about, and have to keep relying on substances to cope.

She wants to sleep peacefully through the night, and be able to manage her emotions in healthy ways. She hopes to finish her studies, find regular work, and eventually move out of home. Most of all, she wants to feel safe, rebuild trust with her mother, reconnect with her community, and feel in control over her future.

MARY

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The Mary persona

Meet Kish

A passionate but overstretched mental health clinician balancing risk management pressures with a desire to provide trauma-informed, person-centred care.

NAME: **Kish**

AGE: **Mid 30's**

NATIONALITY: **Indian-Australian**

LOCATION: **Metro Hospital**

ROLE: **Senior Mental Health Clinician (Psych nurse with additional responsibilities in ED triage)**

EDUCATION & TRAINING

Bachelor of Nursing, Postgraduate Diploma in Mental Health Nursing. Ongoing mandatory training in risk assessment, culturally safe care, and code grey and code black management.

Some exposure to trauma-informed care frameworks, but feels training is often rushed and not embedded into practice. Has done an introductory online module on alcohol and other drug care, but has not received any other formal training or exposure to AOD.

BACKGROUND & EXPERIENCE

Kish has worked across acute inpatient units and community teams for over a decade. She's skilled in risk assessment, crisis management, and coordinating care, but feels she spends more time on paperwork and short-term discharge planning than engaging with consumers. She has supervised junior staff but rarely receives mentoring herself.

HOPES

To build deeper therapeutic relationships with consumers; to feel confident and capable working with trauma and AOD, and less like the combination of these issues make providing care too difficult for her to help without additional resources or support; to see more holistic, integrated pathways.

FEARS

Missing critical risks, retraumatising consumers, or feeling powerless within a service setting that is reluctant or unable to adopt the organisational changes needed to provide trauma-informed treatment.

Touchpoints with Consumers

Kish first meets April in the emergency department while assessing her for a possible IPU admission. The process is dominated by mandated screenings (risk, trauma, AOD), and time pressure means Kish has little space for meaningful engagement.

She knows that how April is received in this first encounter — tone of voice, whether April feels safe, whether her queer identity is acknowledged — will strongly influence her willingness to continue with care. Kish feels the tension between being process-centred (completing forms, meeting KPIs) and person-centred (building trust and validating April's experiences).

Kish meets Mary again in the IPU setting, where risk management dominates the culture — containment, discharge planning, and system throughput. Kish worries that trauma responses may be misunderstood as behavioural or personality issues, reinforcing stigma.

Still, she knows establishing trust and signalling that Mary is safe and feels heard will be key. She also reflects that continuity of care across the admission and into discharge planning is critical, but difficult to achieve under current pressures.

Kish meets Johan in a community mental health service, in the last few weeks of his stay at a residential rehab. Kish is focused on building trust and rapport with Johan, recognising that he wants to 'work on his trauma'. She worries that their service may not be set up to offer the longer term care, support and trauma treatment that Johan is seeking. She also wonders about where she might be able to refer him to meet these needs.

KISH WORKFORCE

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The healthcare worker persona, Kish

Meet Ben

A dedicated AOD counsellor who is passionate about harm reduction, but feels his expertise is undervalued in mainstream health settings.

NAME: **Ben**

AGE: **Early 40's**

GENDER: **Male**

NATIONALITY: **Anglo-Australian**

LOCATION: **AOD service with outreach into the justice system**

ROLE: **AOD Clinician (counsellor and case manager)**

EDUCATION & TRAINING

Diploma in Alcohol and Other Drugs, Certificate IV in Mental Health.

Limited formal trauma training, mostly short continuing professional development (CPD) workshops when funding and time allows.

BACKGROUND & EXPERIENCE

Ben started his career in harm reduction services (needle and syringe program, overdose prevention) and now works as a counsellor and case manager. He is confident with motivational interviewing and relapse prevention but struggles to know what's best to do when consumers disclose significant trauma histories or present with PTSD, severe mental illness or psychosis. Ben has strong relationships with local housing and justice agencies in Victoria.

HOPES

To see substance use disorders recognised as equal to other mental health disorders in care pathways; to have better access to trauma-informed training; to help consumers stabilise and build safer lives.

FEARS

Being sidelined in multidisciplinary settings; losing consumers to relapse or overdose due to gaps in the system, long wait times or barriers to accessing treatment; the negative impacts of high staff turnover on client care, feeling powerless when referrals are blocked or delayed.

Touchpoints with Consumers

Ben first encounters Jarrah through a justice referral, where attendance at AOD counselling is mandated. Jarrah is wary and mistrustful, seeing the intervention as punitive rather than supportive. Ben tries to focus on harm reduction and practical support (housing referrals, transport, family connections), while gently building rapport. He's aware that culturally safe care is essential but often unavailable in his regional service. Conscious that trust at this stage is fragile, Ben sees rapport-building as critical — not only to keep Jarrah engaged now, but also to lay the foundation for him to take the next step in his support and recovery journey. Ben knows even small demonstrations of flexibility — a chat over a coffee, meeting outside the clinic — can make a difference.

Ben connects with Johan during outreach at a community AOD service and later in a residential rehab setting. Johan arrives with complex trauma, unstable housing, and recurring overdoses. Ben begins with stabilisation — providing harm reduction supports, group counselling, and linking him to housing and social services — before moving towards skills-building (emotional regulation, vocational support). He knows that unless Johan's basic needs (food, housing, safety) are met, therapeutic interventions won't "stick."

Johan has expressed that he wants his "trauma treated," but Ben is uncertain where to refer him, who should coordinate his MH care, and how to avoid Johan having to retell his story again and again. Resource constraints and unclear role boundaries across services make coordination difficult, and Ben worries about burnout from the constant "stop–start" cycle when consumers disengage. Even so, he finds hope in the role of peer workers and the power of trust-building, believing that with time and consistent care coordination Johan can move toward greater stability.

Ben meets April after she is referred back to her community AOD service following her inpatient mental health admission, for AOD counselling. Ben is focused on understanding April's experience of her mental health admission, and what her expectations and goals are in relation to her alcohol use. April has expressed that she has been "drinking to cope", and that trauma and sleep problems are a big part of why she has found it hard to stop and stay stopped.

Ben worries about whether April will get the mental health care and support she needs to treat the underlying problem that is fuelling her drinking. He isn't sure where is best to link her into, and whether there is a service that would be able to offer her care in their regional town.

BEN WORKFORCE

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The healthcare worker persona, Ben

Meet Leila

A Peer Support Worker with lived experience of MH recovery, who bridges trust between consumers and clinicians, but feels her role is undervalued and poorly understood.

NAME: **Leila**

AGE: **Late 30's**

GENDER: **Female**

NATIONALITY: **Sri Lankan-Australian**

LOCATION: **Mental Health service and local area wellbeing hub**

ROLE: **Peer Support Worker (lived experience of PTSD recovery)**

EDUCATION & TRAINING

Certificate IV in Mental Health, Intentional Peer Support training, Culturally Safe training in First Nations care and support, and ongoing workshops in trauma-informed care.

Informal mentoring from other peer workers, and receives discipline specific peer led lived experience supervision.

BACKGROUND & EXPERIENCE

Leila completed treatment of PTSD five years ago, and now works across MH and AOD settings. As a consumer peer support worker, Leila uses intentional disclosure of her own recovery story. She is highly skilled in building rapport and breaking down stigma, but often finds her role misunderstood or minimised by clinical colleagues.

She is passionate about cultural safety and community connections, especially for young people, CALD and First Nations consumers.

HOPES

To show consumers they're not alone; to normalise peer work as a vital part of integrated care; to reduce stigma and strengthen cultural safety in services.

FEARS

Peer drift — being asked to do "clinical" tasks outside her scope; burnout from holding too many client stories; being excluded from care planning despite being closest to the consumer.

Touchpoints with Consumers

Leila first meets Jarrah after a justice referral to community MH and AOD services. Jarrah is cautious, expecting stigma and judgement, and feels forced into the system by bail conditions. As a consumer Peer Support Worker, Leila uses intentional disclosure of her own recovery story to create safety and trust. She chats with Jarrah over coffee, focusing on the relationship before the process. She recognises his First Nations identity and advocates for culturally safe pathways, but often finds appropriate supports scarce in her service.

Leila feels frustrated when her role is undervalued by clinicians or when she's excluded from formal care planning, despite being the one Jarrah opens up to. She knows continuity and flexibility — meeting him where he's at, celebrating small wins, linking him to housing and community mentors — are key to keeping him engaged.

Leila encounters Mary during a crisis admission to ED, where Mary is frightened, overstimulated, and overwhelmed by police and security involvement. Clinical staff focus on risk and containment, but Leila sees her role as reducing fear, stigma, and isolation.

She sits with Mary, listens without judgement, and reassures her that her reactions are normal given her trauma history. Drawing on trauma-informed peer practice, Leila helps Mary feel seen and safe in an environment that often retraumatises consumers. She also tries to bridge communication between Mary and the clinical team, advocating for her preferences and her need to be heard. While Leila sometimes feels stretched thin and excluded from discharge planning, she knows her presence in these early moments of trust-building can shape whether Mary engages with care or retreats from it altogether.

LEILA WORKFORCE

MONASH University | Hamilton Centre | Phoenix AUSTRALIA | spectrum

The healthcare worker persona, Leila

Understanding competencies:
Integrated Care for Co-occurring
Trauma/PTSD and Substance Use

Hamilton Centre
https://www.hamiltoncentre.org.au/